Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Disabilities (Adults).

Issued by the Chief Inspector

Name of designated centre:	Glade House Residential Service
Name of provider:	Western Care Association
Address of centre:	Mayo
Type of inspection:	Unannounced
Date of inspection:	14 September 2023
Centre ID:	OSV-0001752
Fieldwork ID:	MON-0040760

About the designated centre

The following information has been submitted by the registered provider and describes the service they provide.

Glade house is a residential service, which is run by Western Care Association. The centre provides accommodation and support for male and female adults with an intellectual disability. The centre comprises of one bungalow in the centre of a town in co. Mayo. The bungalow comprises of residents' bedrooms, shared bathrooms, office space, kitchen and dining area, utility and sitting rooms. Residents also have access to garden areas. Staff are on duty both day and night to support residents availing of this service. Residents have access to buses and can also walk to activities in the local town.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	2

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Thursday 14 September 2023	10:30hrs to 16:30hrs	Catherine Glynn	Lead

What residents told us and what inspectors observed

This centre is run by Western Care Association in County mayo. Due to concerns about the governance and oversight of Western care Association centres and its impact on the wellbeing and safety of residents, the chief inspector of Social Services undertook a targeted safeguarding inspection programme which took place over two weeks in march 2023 and focused on regulation 7 Positive behaviour support, regulation 8 (protection), 23 (governance and management) and regulation 26 (risk management procedures). The overview report of this review has been published on the health Information and Quality Authority (HIQA) website. In response to the findings of this review, Western care Association submitted a compliance plan describing all actions to be under taken to strengthen these arrangements and ensure sustained compliance with the regulations. Inspectors have now commenced a programme of inspections to verify whether these actions have been implemented as set out by Western Care Association, but also to assess whether the actions of Western Care Association have been effective in improving governance, oversight and safeguarding in centres for people with disabilities in county Mayo.

This inspection was an unannounced inspection and was carried out to monitor regulatory compliance in the centre. As part of this inspection, the inspector observed care and support interactions between residents and staff. The inspector met with two residents who lived in this centre, spoke with four staff on the day, and also viewed a range of documentation as part of this process.

At the time of the inspection the provider had started on all proposed actions to strengthen the organisation's governance and management, however the inspector found that while this had commenced it was still underway at the time of the inspection therefore it was not fully embedded and established into the into the provider's structures and systems.

The centre comprised of a single-storey detached bungalow, which had large gardens to the front and apace to the rear of the centre that was under development at th the time of the inspection.The centre provided full time care to both residents in line with their assessed needs. On the day of the inspection both residents remained at home due to minor illness and were supported to enjoy a restful day to recuperate. Overall, both residents were calm, relaxed and engaging with staff. Staff were observed and heard engaging with residents in a calm, respectful and pleasant manner throughout the inspection and residents were at ease at all times.

Overall, it was evident from conversations with staff and information viewed during the inspection, that residents had a good quality of life, choices in their daily lives and views, and were supported by staff to be involved in activities that they enjoyed, both in the centre, at day services and in the local community. Throughout the inspection it was clear that the management team and staff prioritised the well

being and quality of life of residents and there had been no negative impacts on this service or the residents who lived in this centre.

The inspector found that this inspection identified good practices throughout the regulations that were reviewed, there were ongoing areas for improvement which had commenced in line with the compliance plan response received, which will be discussed in the next section of this report.

The next two sections of the report outline the findings of this inspection in relation to the governance and management, and the arrangements in place in the centre and how these impacted on the quality and safety of the residents who lived in this centre.

Capacity and capability

The provider had good measures in place to ensure that this centre was well managed, and that residents' care and support was delivered to a high standard. These arrangements ensured that a good quality and safe service was provided to the residents who lived there.

The provider had submitted a compliance plan in response to the findings from some targeted inspections in March 2023. This plan outlined a number of ways in which the provider planned to strengthen the governance and oversight arrangements in this centre. These included the introduction of regular meetings in the centre and also across the service in this county. The management team spoke and discussed the enhanced arrangements as a result of the compliance plan response. They spoke about this had commenced and how this was being implemented and they showed the inspector relevant documentation to support the improved systems spoken about that were introduced as part of this compliance plan response.

The inspector found that a clear organisational structure was in place to manage this centre. Furthermore, there was a suitably qualified and experienced person in charge established in this centre. The person in charge was based in an office and worked in close proximity to this house an another centre she had responsibility for presently. The person in charge spoke about the low number of centres due to the reconfiguration of services in this area,which also minimised the number of centres person's in charge were responsible for and showed the positive steps the provider was completing to enhance oversight in this centre and across services in the region.Both residents and staff were familiar with the person in charge illustrating their presence in the centre. The inspector found that the person in charge had established effective support arrangements for the team and monitored this effectively. They also ensured that the staff team were aware of how to access support from the senior management team, when the person in charge was not available or present in this centre.

The inspector found that significant improvement to the overall organisational management process had taken place following the commencement of this regulatory process of the services since March 2023. These improvements included the introduction of a range of governance and management oversight meetings. For example, the human rights committee had been re-established, were being held quarterly to review the use of restrictive practices, as well as regular scheduled meetings with other persons in charge. This forum was used a a tool for both the sharing and receiving of information from peers and senior management. Furthermore, these meetings allowed the senior management team to provide workshops with internal and external speakers on relevant areas of information to improve practices.

The inspector noted that there were strong systems in place for reviewing and monitoring the service to ensure a high standard if safety and care was provided and maintained. Unannounced audits were being carried out on behalf of the provider. These were being carried out twice each year and identified any areas where improvement was required, with action plans to address these improvements. A detailed and comprehensive audit plan for 2023 had been developed which included a range of comprehensive audits to review the overall quality of care and safety in the centre. The person in charge and staff team were completing these audits in line with the organisation plan. These included audits of incidents, medication management, residents' finances and personal planning. The sample of audits that the inspector reviewed showed a high level of compliance and actions arising had been completed as required.

A quality improvement tool and plan had been developed by the management team which was informed by the completed audits, six-monthly provider visits and other self assessment processes as well as the planned annual review and inspections completed by HIQA for the centre.

The inspector found that this centre was suitably resourced with appropriate staffing levels and skill-mixes to meet the assessed needs of residents at all times and especially in regards to accessing leisure opportunities and to facilitate day service attendance. A planned staffing roster had been developed by the person in charge, which were updated to reflect the actual staffing arrangements as required and were accurate on the day of the inspection.

Training had been provided to staff to enable them to carry out their roles effectively. The person in charge was knowledgeable on staff training needs and was found to highlight relevant training needs to the organisation training department as required. Much of the planned training was focused on enhancing safety and welfare of residents in this centre. Staff had received mandatory training in behaviour support and safeguarding, however improvement was required to ensure that all relief staff had received fire training as required. On the day of the inspection, the inspector found that while two staff had received informal training from the local management team, they were awaiting formal fire safety training at the time of the inspection.

The centre was suitably resourced to ensure effective delivery of care and support

to residents. These resources included the provision of a safe, suitable and clean environment with adequate staffing levels to support residents with both their leisure and healthcare needs, as well as a dedicated vehicle for the centre. A range of healthcare professionals, including speech and language therapy, physiotherapy and behaviour support staff were also available to support residents where required.

On review of the schedule 5 policies, the inspector found that the provider had ensured that these were all updated and reviewed as required by the regulations at the time of the inspection, in addition the quality department monitored the review dates to ensure that all records were updated as scheduled.

Regulation 15: Staffing

The staffing numbers and skills mix were appropriate to the number and assessed needs of the residents.

Judgment: Compliant

Regulation 16: Training and staff development

The inspector found that while full-time staff were in receipt of all mandatory training and additional training specific to the needs of residents, and were appropriately supervised, two new staff had not received formal training in fire safety. The person in charge outlined that training requests were submitted and that informal training had been completed for both staff since their commencement, but no dates were provided for the formal aspects of the fire training at the time of this inspection, which included online learning and a face to face in relation to fire safety. In addition, the provider had developed a new system to ensure that all new staff would receive mandatory training through a revised induction process, however this was being developed at the time of the inspection and was yet to be implemented.

Judgment: Substantially compliant

Regulation 23: Governance and management

In response to the targeted safeguarding inspection programme, the provider had committed through its compliance plan to complete 12 actions aimed at improving governance arrangements at the centre, which would be completed by 31 January 2024. The inspector found that actions had commenced with all actions at the time of the inspection. For example, the provider had commenced reconfiguring its

organisational regions, with recruitment of additional managers to ensure effective oversight arrangements were in place. This also included a plan for more regional as well as national organisational management meetings to commence. At the time of inspection four actions had been completed with the remainder either commenced or inprogress.

The completed actions included the restructuring and appointment of new senior management positions, the re-establishment of a human rights committee which included an independent an independent chair, a quarterly incident reviews through the incident and oversight committee and also the reconfiguring of the service regions into eight regions within the county.

A review of organisational policies and procedures (which most were reviewed at the time of the inspection), the development and implementation of a staff training programme remained in progress, reviews and implementation of a range of audits in place in centres with the development of a 'governance and quality' framework. One of the aims of this was to ensure that qualitative data was gathered when completing audits.

The action that required the completion of an unannounced visit was completed in this centre at the time of the inspection in August 2023.This action agreed was to be completed between July and December 2023.

As it was still early days in the implementation of the provider's actions, the impact of these were yet to be embedded into the centre however, the management team spoke of the changes in a positive manner and were very focused on the implementation and progression of the actions identified and within the times specified. The inspector was advised by the management team that the enhancements would ensure greater oversight by the senior management team and the revised training plan when commenced should improve the waiting times for staff training.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

There was a clear complaints procedure in place. A complaints log was maintained, and complaints and complements were recorded and acted on appropriately. Residents knew how to make a complaint and who to approach for help with complaints. At the time of the inspection, there were no active complaints evident in the centre.

Judgment: Compliant

Regulation 4: Written policies and procedures

All the policies required under Schedule 5 were in place and had been reviewed within the required timeframe.

Judgment: Compliant

Quality and safety

The provider had good measures in place at the centre to ensure that the wellbeing and health of residents and keep them safe from risk and harm, evidencing that a good quality of care and support was being provided to residents.

The centre comprised of a single-storey detached dwelling on the outskirts of Ballina, and was in close proximity to other residential and day services in the area. The house was close to a variety of local amenities such as shops, cafes, restaurants and other leisure facilities in this area. The house had dedicated transport, which could be used for outings, appointments or any other activities in the area. Some of the activities that residents enjoyed included outings to local places of interest, going for tea or coffee, listening to music or radio and watching television. The residents enjoyed walks and drives in the local areas and staff ensured that these activities were relevant to each residents abilities and preference.

The inspector completed a walk around of the centre and noted that it had been further personalised following renovations completed from an inspection. The inspector found that this centre was comfortable, suitably furnished, decorated and furnished in a manner that suited the needs and preferences of the residents who live here. The inspector saw that there were family photos, artwork and various personal items displayed around the centre enhancing the homely feeling of this centre. The centre was clean and well kept but also provided both residents with ample private and communal space throughout the centre, and the provider had further plans to enhance the garden space to the benefit of both residents.

The provider had arrangements in place to safeguard the residents from any forms of harm. In response to the targeted safeguarding inspection programme, the provider had committed through its compliance plan to complete five actions aimed at improving the governance and management arrangements relating to protection at the centre. At the time of the inspection, the inspector found that all of these actions had been introduced. These related to an improved policy, development of a safeguarding oversight committee, ongoing safeguarding plan reviews, and face-to-face to staff training had commenced.

Both residents in the centre required behavioural support and had comprehensive

behaviour support plans in place to guide all staff in how to support them. In response to the targeted safeguarding inspection programme, the provider had committed to completing seven actions aimed at improving governance arrangements in relation to positive behavioural support in the centre. At the time of the inspection, the inspector found that four actions had been completed, while three were in progress and still within the proposed time frames for completion. The inspector found that clear and comprehensive behaviour support plans were in place with access to the relevant multi-disciplinary support persons where required. Furthermore, the person in charge had worked proactively to reduce restrictive practices in use at the centre through more effective staff support and communication during residents' transition to the centre.

In response to the targeted safeguarding inspection programme, the provider had committed through its compliance plan to completing three actions aimed at improving risk management arrangements at the centre. At the time of this inspection all three actions were in progress as planned, and still within the specified proposed time frames for completion. These actions related to the development of quarterly incident report reviews, development of the incident management training module, and a review of the provider's risk management policy. The inspector found that previous risks relevant to the residents were no longer apparent following the reconfiguration of the service which had resulted in individualised services begin now put in place.

The person in charge and person participating in management, were very focused on delivering a person-centred, safe and quality service for the residents, by ensuring that their general welfare, social and leisure choices, and community activities were maintained and supported at all times. Both residents could take part in a range of social and developmental activities both at the centre and at their day services, as well as within the local community. Suitable support was provided at all times for both residents to achieve this in line with their preference, choices and interests as well as their assessed needs.

Regulation 26: Risk management procedures

In response to the targeted safeguarding inspection programme, the provider had committed through its compliance plan to complete three actions aimed at improving risk management arrangements at the centre. The provider proposed that these actions would be completed by 31 October 2023. At the time of the inspection, all three actions were in progress in line with the provider's time frames for completion.

The actions related to ongoing quarterly reviews of incident monitoring and oversight committee, minutes of which were available for April and June 2023. Incident management training and a review of the risk management policy and procedure were reported to be in progress and were due for completion by the end of October 2023.

Judgment: Substantially compliant

Regulation 27: Protection against infection

Effective infection prevention and control measures were in place, in accordance with current public health guidelines. All actions from the previous infection prevention and control inspection were addressed and significant improvements had been completed to improve the residents living environment.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

The provider had appropriate structures and procedures in place to ensure the safe management of medications, this included, effective stock control, audits, training for all staff and appropriate storage as required by the regulations. In addition, residents were assessed for their ability to self administer medication as required by the regulations.

Judgment: Compliant

Regulation 7: Positive behavioural support

In response to the targeted safeguarding inspection programme, the provider had committed through its compliance plan to complete seven actions by June 2024, aimed at improving governance arrangements, as well as enhancing the therapeutic supports in relation to positive behaviour support in the organisation and the centre.

At the time of the inspection, the provider had appointed an interim head of clinical and community supports to promote effective oversight of multi-disciplinary supports required by residents and designated centres. However, although the inspector found that all of the proposed actions had commenced, they were not yet been fully established and embedded at the centre as well as organisationally.

The inspector was advised that a committee was established for reviewing all residents' behaviour support plans and there will be information-sharing sessions set up to support staff teams with the management of behaviours. In addition, the provider committed to setting up a 'neurodiversity' training programme for all staff and this was reported to be in progress. This was reported as a welcome addition to the training programmes as it would cover training on autism also.

Within this centre, it was found that where residents required supports with behaviours, that up-to-date plans were in place. There was ongoing reviews in place as required.

Judgment: Substantially compliant

Regulation 8: Protection

In response to the targeted safeguarding inspection programme, the provider had committed through its compliance plan to complete five actions aimed at improving governance arrangements in safeguarding at the centre. The proposed actions will be completed by 31 October 2023. At the time of the inspection four actions had been completed with one in progress and not due.

Actions completed included the introduction of a face-to-face safeguarding training module for staff as well as an updated and enhanced safeguarding policy. The person in charge had ensured that staff were aware of the enhanced policy and had access to the new training module. In addition, they spoke about the importance of a clear and consistent process for the reviewing of and responding to safeguarding concerns and that they were involved in the provider's working group in this area of practice.

The inspector found that presently there were no active safeguarding issues in the centre, and discussions on the improvements in safeguarding across the organisation gave further assurances to the centre's management team that any potential safeguarding concerns would be promptly addressed and suitably managed as required.

Judgment: Substantially compliant

Regulation 9: Residents' rights

The rights of residents were upheld, and the privacy and dignity of residents was respected.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Glade House Residential Service OSV-0001752

Inspection ID: MON-0040760

Date of inspection: 14/09/2023

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: Two new staff will complete the practical Fire Training as part of mandatory training 10/11/2023	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The Provider has restructured the Senior Management team has to represent Operations, Finances, Human Resources, Quality, Safety and Service Improvement, Clinical and Community Supports and Safeguarding and Protection. The Senior Operations Team has been assessed and reconfigured into defined eight service areas to ensure equitable and consistent governance, management and oversight. The HSE Service Improvement Team has established a further workstream to include Quality, Safety and Service Improvement. The Provider awaits the final quality assurance report. The Provider has revised the unannounced visit template and unannounced visits are scheduled up to 31/12/2023. The bi-annual thematic governance and quality improvement report was presented in July 2023 with next report is due in January 2024. A learning management system has been agreed for staff training and development and the provider continues to provide monthly staff regulatory events. The quarterly properties and facilities plan has been presented at senior management for oversight with regard to its monitoring and implementation. The first management learning event took place on the 21/09/2023, and staff learning events are scheduled for the 24/10/2023 and the 07/11/2023. An organisational monthly report is submitted to the provider from the senior management team through the Chief Executive Officer.	
Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures: The incident and monitoring committee continue to meet on a quarterly basis to monitor and review incident identification, recording, investigation and to ensure appropriate action shared leaning takes place through the quarterly incident data reports. Organisational policies continue to be reviewed on a regular basis and updated accordingly. The incident management policy, risk management policy and associated training modules will be completed by the 31/10/2023. A focus group is in the process of establishment to implement a systematic process for audit completion.	
Regulation 7: Positive behavioural support	Substantially Compliant
Outline how you are going to come into compliance with Regulation 7: Positive behavioural support: The Quarterly Governance and Clinical oversight has been renamed as the Critical Response Team which will meet again on the 13/12/2023. The Neurodiversity training module has been developed which will be delivered to staff up to June 2024 and refresher training every three years. The Behaviour Support Plan Governance and Oversight Committee has been established and is reviewing the Listening and Responding Policy. The rights review committee has been re-established with regular reviews and service visits taking place to ensure independent and transparent oversight.	
Regulation 8: Protection	Substantially Compliant
Outline how you are going to come into compliance with Regulation 8: Protection: The organisational safeguarding policy has been reviewed and updated in alignment to the National Safeguarding Vulnerable Person's at Risk of Abuse Policy and Procedure. A safeguarding committee has been established to ensure a robust system is in place to review safeguarding concerns. Safeguarding plans are reviewed with the HSE Adult Safeguarding and Protection Team every six weeks. A workstream has been established on safeguarding and self-guarding as part of the Service Improvement Team. The organisation will provide face to face safeguarding training to all staff by June 2024.	

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	10/11/2023
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Substantially Compliant	Yellow	31/01/2024
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre	Substantially Compliant	Yellow	31/10/2023

	for the assessment, management and ongoing review of risk, including a system for responding to emergencies.			
Regulation 07(2)	The person in charge shall ensure that staff receive training in the management of behaviour that is challenging including de-escalation and intervention techniques.	Substantially Compliant	Yellow	30/06/2024
Regulation 7(5)(a)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation every effort is made to identify and alleviate the cause of the resident's challenging behaviour.	Substantially Compliant	Yellow	30/06/2024
Regulation 08(7)	The person in charge shall ensure that all staff receive appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse.	Substantially Compliant	Yellow	31/10/2023