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:	Bród
Name of provider:	Saint Patrick's Centre (Kilkenny)
Address of centre:	Kilkenny
Type of inspection:	Unannounced
Date of inspection:	04 February 2020
Centre ID:	OSV-0005809
Fieldwork ID:	MON-0025834

About the designated centre

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

Bród designated centre provides community based living arrangements for up to four adult residents. Bród is a detached one storey, modern and spacious property that provides residents with a high standard living environment which meets their assessed mobility and social care needs. Each resident has their own large bedroom. This service provides supports for residents with severe to profound intellectual disabilities and complex needs. The provider identifies that residents living in this centre require high levels of support and has staffing arrangements in place to ensure residents needs are met. There is a person in charge assigned to the centre who also has responsibility for another designated centre a short distance away. Three staff work during the day to support residents in having a full and active life and two waking night staff are also in place. The centre is resourced with one transport vehicle to support residents' community based activities.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	4

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 - 2015 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
Tuesday 4 February 2020	09:00hrs to 16:30hrs	Laura O'Sullivan	Lead
Tuesday 4 February 2020	09:00hrs to 16:30hrs	Deirdre Duggan	Support

What residents told us and what inspectors observed

The inspectors had the opportunity to meet and spend time with residents at intervals through the day. On arrival the inspectors were introduced to each resident individually by the person in charge and the purpose of the visit explained. One resident was relaxing in bed where he enjoyed having a lie in the morning. One resident was watching his favorite show in his bedroom. This resident, as did the others, had a large amount of family photos in his room. Each resident had a private Netflix account to watch their favorite shows, one gentleman was watching his favorite movie on his personal bedroom TV.

Two residents headed out in the morning for their haircut and a treat in the local coffee shop. One resident was very happy with their new look and enjoyed looking in the mirror on his return. Following a social outing another resident returned smiling and laughing and engaging with staff through smiles and vocalisations.

When staff were affording supports to residents they did so in a jovial and respectful manner. When approached by staff, residents smiled. Resident's eyes followed staff around the room. Staff possessed a clear understanding to the needs of the residents. When one staff become upset staff supported him to his room to have a break from his chair and to listen to his music. This made the resident happy and relaxed. All interactions observed were positive in nature.

Capacity and capability

This was an unannounced inspection to Bród. Overall, the centre presented as a service where the registered provider was required to review the roles and responsibility of the governance structure and monitoring systems to ensure the centre was operated in a safe and effective manner to drive service improvement and to achieve regulatory compliance.

The registered provider had ensured the appointment of a suitably qualified and experienced person in charge to the centre. This person had also been appointed to the person in charge role to another designated centre in close proximity. On the day of inspection the person in charge was allocated to provide direct support to residents. Upon review of the previous week's roster, it was confirmed that a large amount of the person in charges' time was allocated to direct support of residents. This did not afford the person in charge sufficient time to complete governance duties within both centres, including, following through with actions or concerns. For example, staff reported an issue relating to evacuation procedures in July 2019, this concern remained outstanding. A person participating in management had been appointed to the centre, however there was little evidence of their participation in

the centre. The person participating in management had visited the centre once since their appointment at the beginning of December 2019.

The registered provider has allocated an appropriate staffing level to the centre to meet the assessed needs of the residents. The whole time equivalent of staffing levels was to be allocated in the coming days post the inspection. The registered provider informed the inspector post inspection that this appointment would reduce the direct support duties of the person in charge.

Whilst a clear governance structure was in place, the roles and responsibilities of each individual had not been identified including lines of accountability. Whilst an annual review of service provision had been completed in January 2019, no date was planned for the completion of a 2020 review. This was also the case for the six monthly unannounced visit to the centre which was last completed August 2019. Whilst areas for service improvement had been identified within both monitoring systems, a plethora of actions were identified as being "ongoing" with no time frames allocated. The person in charge had completed regular reviews to attempt adherence to actions being completed. At centre level monitoring systems were not consistently completed to ensure effective oversight was in place. Organisationally an audit schedule had been developed to guide staff and management to which audit tool was to be developed and whom was responsible. A number of these audits had not been completed in accordance to the schedule including the restrictive practice audit and hygiene audit.

Following the notification of an incident, assurances had been received of actions to be completed at governance level to ensure practices were safe within the centre. This included governance meetings and action learning analysis. Whilst actions had been completed to address the original concern by the person in charge and staff team to ensure the safety of residents, minutes of the meetings to be held were not available for review and the action learning analysis had yet to be completed. A verbal description from the person in charge of the meetings did not correlate with the assurances received.

The registered provider had ensured the development of an effective complaints procedure. Through an organisational policy, staff and residents were provided with guidance on procedures to adhere to should a complaint arise. Two versions of the complaints policy were available on site on the day of inspection. The complaints poster was visible throughout the centre, however this had not been reviewed to reflect the change to the appointed personnel within the organisation. Whilst a complaints log was available to review, information relating to the complaint including the outcome and satisfaction of the complainant was not clear.

Regulation 14: Persons in charge

The person in charge appointed to the centre was suitably qualified and experienced. However due to their current workload within this centre there was not clear evidence that they could ensure effective governance systems in both

residential centres under their governance.

Judgment: Substantially compliant

Regulation 15: Staffing

The registered provider has allocated an appropriate staffing level to the centre to meet the assessed needs of the residents. The whole time equivalent of staffing levels was to be allocated in the coming days post the inspection.

Judgment: Compliant

Regulation 23: Governance and management

Whilst a clear governance structure was in place the roles and responsibilities of each individual had not been identified including specific roles and lines of accountability.

Management systems in place were not effective to ensure the service provided was safe, appropriate to the resident's needs , consistent and effectively monitored.

Judgment: Not compliant

Regulation 3: Statement of purpose

The registered provider had prepared in writing a statement of purpose containing information set out in schedule 1.

Judgment: Compliant

Regulation 34: Complaints procedure

The registered provider had not ensured the development of an effective complaints procedure. Two versions of the complaints policy were available on site on the day of inspection. The complaints poster was visible throughout had not been reviewed to reflect the change to appointed personnel within the organisation. Whilst a complaints log was available to review, information relating to the

complaint including the outcome and satisfaction of the complainant was not clear.

Judgment: Not compliant

Quality and safety

The inspectors reviewed the quality and safety of Bród and found residents were afforded a good quality of life. Social activities were encouraged, choice of in house activities were made available including sound therapy for one individual. Participation in meaningful individualised activities was supported and facilitated by staff members. Through comprehensive individualised personal plans residents were supported to implement all multidisciplinary recommendations to achieve a high quality of life. Improvements were required to ensure the service provided was consistently safe and monitored.

The person in charge had ensured the development of a comprehensive individual personal plan for each resident. These plans incorporated multidisciplinary recommendations and guidance. A number of support needs were addressed and reviewed on a monthly basis by the staff team. Residents were supported to engage in wide range of activities such as trips to the local hairdresser, social outings to the cinema, sound therapy and sensory session. Whilst staff members had developed some personal plans for the residents; visioning meetings had not occurred since 2018. Evidence of consultation with residents or rationale for goals was not evident.

The area of risk management was reviewed on this inspection and overall residents were found to be well protected with systems and practices in place. A risk register was used by the provider which outlined the predominant risks in the centre such as falls, behavioural risks and environmental risk. Improvements were required to ensure the ongoing review of risk. A number of risk assessments had not been reviewed within the allocated time frame to ensure control measures were effective, this also included the need for review of standard operating procedures.

Safeguarding policies and practices were clearly understood by staff and there was evidence in place of follow up and appropriate investigation where allegations were made. Safeguarding plans were in place as required and were regularly reviewed. A spot check of finances evidenced that residents were supported by staff to manage their finances in a safe manner. The personal and intimate care needs of all residents was laid out in their personal plan in a dignified and respectful manner.

The registered provider had ensured effective measures were in place for the detection and containment of fire. Through ongoing monitoring by the staff team, through daily and weekly checks, any issues were identified and addressed in a timely manner. Improvements were required to ensure that all staff and residents were aware of safe evacuation procedures. A standard operating procedure was in place for evacuation of residents at night with assistance from neighbours. However,

this had not been trialled to ensure its effectiveness. Also, a concern relating to evacuation via two doors when residents were in comfort chairs had first been reported to the person in charge in July 2019 and remained outstanding.

The person in charge had ensured that all staff had been provided with up to date guidance to respond to behaviour that is challenging. Through regular review guidance for staff was reflective to the current needs of the residents. Any incident was recorded in detail to ensure this review was comprehensive and incorporated all identified triggers and reactive strategies. However, not all staff had been supported to receive training in the management of behaviour that is challenging. The registered provider had ensured following a review that where restrictive practices were utilised in the least restrictive manner for the shortest duration required.

Regulation 13: General welfare and development

The registered provider had ensured that residents were facilitated and supported to participate in a range of meaningful activities. They were supported to develop and maintain personal relationships and links in the wider community .

Judgment: Compliant

Regulation 17: Premises

The registered provider had ensured the premises of the designated centre was designed and laid out ot meet the aims and objectives of the service. The centre was clean, warm and tastefully decorated.

However, some aspects of the interior of the premises required attention.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

The registered provider had ensured the risk management policy included the regulatory required information.

Whilst a risk register had been developed including corresponding standard operating procedures, review dates had not been reviewed to ensure control

measures were effective.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The registered provider had ensured effective fire safety systems were in place for the detection and containment of fire. However, improvements were required to ensure that all residents could be evacuated from the centre in a safe manner.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

The person in charge had ensured that each individual had a comprehensive personal plan in place. This provided staff with clear guidance on support needs of residents and incorporated monthly review. Whilst an annual multidisciplinary review was completed an annual visioning meeting had not occurred to ensure personal goals reflected the aspirations of individual.

Judgment: Not compliant

Regulation 6: Health care

The registered provider had ensured that each resident was supported to achieve and maintain the best possible physical and mental health.

Judgment: Compliant

Regulation 7: Positive behavioural support

The person in charge had ensured that all staff had been provided with up to date guidance to respond to behaviour that is challenging. However, not all staff had been supported to receive training in the management of behaviour that is challenging.

The registered provider had ensured following a review that where restrictive practices were utilised in the least restrictive manner for the shortest duration

required.

Judgment: Substantially compliant

Regulation 8: Protection

The registered provider had ensured that each resident was assisted to protect themselves from abuse. Where a safeguarding concern was identified, measures were implemented to protect the individual from all forms of abuse.

The personal and intimate care needs of all residents was laid out in personal plan in a dignified and respectful manner.

Judgment: Compliant

Regulation 9: Residents' rights

The centre operated in a manner which respected the privacy and dignity of residents. Where possible residents were consulted and supported to consent to decisions about their care and supports.

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 - 2015 as amended and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Substantially compliant
Regulation 15: Staffing	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Compliant
Regulation 34: Complaints procedure	Not compliant
Quality and safety	
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Bród OSV-0005809

Inspection ID: MON-0025834

Date of inspection: 04/02/2020

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 14: Persons in charge	Substantially Compliant
Outline how you are going to come into compliance with Regulation 14: Persons in charge: The PIC assigned to Brod is responsible for a second designated centre as PIC where she is supported by a Team Leader. Since the 09/02/2020 a full staff team is now assigned to Brod, which ensures that the PIC has sufficient protected time for her PIC duties. The PIC is now providing 10 hours per week direct support in each of her designated centres and has therefore 19 hours of protected time for PIC duties, supported by a Team Leader.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: A new PPIM is assigned to Brod, supporting the PIC and staff team. Monthly Quality Conversations are scheduled between the PIC and PPIM and have commenced on the 19/02/2020. As part of the Quality Conversations the PPIM and PIC develop action plans, which are followed through at each QC. Cluster meetings are held monthly to support the PIC within her cluster team. As part of the development of the compliance plan after the inspection in Brod, the role of the PPIM and PIC was discussed to highlight each person's responsibility and also ensure support documents, such as action plan templates are being used to facilitate support and development. Also the importance of action plans as preparation for Quality Conversations was	

discussed and the development of SMART goals to ensure accountability.

Quality Conversations:
The PIC has scheduled Quality Conversations with all staff members in Brod and will use the action plan templates to create SMART goals with each staff member focusing on delegated duties, keyworker duties, actions arising of those and training needs for the staff member.

The CSM and PIC have monthly to 6 weekly Quality Conversations and also attend the Team Leader and Cluster meetings.

Provider audits:
Annual and 6 monthly provider audits were completed as per schedule in 2019. The next annual provider audit is currently in process of completion. Identified actions from the audits are part of the PIC's action plans for completion.

Regulation 34: Complaints procedure	Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
Quality Department has now ensured that only the most current Complaints policy is available for staff in Brod. The old document was removed from the Q drive, where staff have access to read policies within the service.
The complaints poster in Brod was updated and is now reflecting the most current management structure in Brod and SPC.

The PIC is currently in the process of updating the complaints log for Brod to reflect complaints, communication around the status of ongoing complaints and documentation relation to the process of complaints.
The review and updating of the complaints log will be finalised by the 06/03/2020.

The documentation of complaints and administration of the complaints log were also discussed with all PIC's, Team Leaders and the complaints officer at the Quality Assurance meeting on the 19/02/2020.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:

The outstanding repair works regarding holes in the wall area beside a sliding door were completed by the 20/02/2020.

Since the inspection took place the staff team got quotes for replacing a broken wardrobe for one person supported in Brod. The quotes are currently with the finance department and purchase of a new wardrobe will be completed latest by 30/03/2020.

The chest of drawers for another person supported was repaired immediately. The person supported chooses to mobilise independent and take out items of his chest of drawers in his bedroom. By doing so the person sometimes removes the front of the drawers. The PIC and staff team will ensure the chest of drawers will be kept in appropriate condition and parts replaced or repaired as needed. Additional the PIC and staff team are currently discussing if there is a different, more suitable piece of furniture to suit the needs of the person supported, which could be purchased.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
The PIC has met with a staff member (Social Care Worker) for Quality Conversation on the 13/02/2020 to discuss the review of risk assessments as a delegated duty. The PIC is supporting the staff member in reviewing all risk assessments in line with SPC policy and will ensure all risk assessments are updated by the 30/03/2020.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
A night time fire drill was completed on the 05/02/2020 to include the assistance from a neighboring house. The scenario and learning from the drill was documented. Also the use of leisure chairs and the currently installed ramps for Brod were trialed and successful.

All PEEP's and CEEP were reviewed and updated to reflect any changes for evacuation of people supported in Brod.

The PIC discussed the outcome of the HIQA inspection regarding fire precautions, experiences and learning from the completed fire drill and fire evacuation procedures with the staff team at Brod team meeting on the 18/02/2020.

Regulation 5: Individual assessment and personal plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
The PIC and staff team completed review of visioning for three people supported since the inspection took place. Review for another person living in Brod is scheduled for the 15/03/2020.

The roles based planning documentation is introduced as part of the review of visioning for each person supported. Roles and goals are documented within the planning toolkit and progress sheets will now be completed when supporting the people living in Brod.

As part of the scheduled Quality Conversations the PIC will discuss the action plans with each keyworker and follow up with SMART goals to ensure the people are supported in working towards achieving their goals.

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
The PPIM and PIC have discussed the training requirement for Brod regarding Studio 3 training. It was identified, that low arousal training would be more suitable for the staff team to support the people living in Brod.
The PIC sent an email on 22/02/2020 to the behaviour support specialist to request low arousal training for the staff team in Brod. The behaviour support specialist will provide a support session at the next staff meeting March about low arousal approach.

In the meantime another staff member is booked to complete Studio 3 training on the 19th March 2020.

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 14(4)	A person may be appointed as person in charge of more than one designated centre if the chief inspector is satisfied that he or she can ensure the effective governance, operational management and administration of the designated centres concerned.	Substantially Compliant	Yellow	09/02/2020
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Substantially Compliant	Yellow	30/03/2020
Regulation 23(1)(b)	The registered provider shall ensure that there is a clearly defined management	Not Compliant	Orange	19/02/2020

	structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.			
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.	Not Compliant	Orange	19/02/2020
Regulation 23(1)(d)	The registered provider shall ensure that there is an annual review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards.	Substantially Compliant	Yellow	30/03/2020
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the	Substantially Compliant	Yellow	30/04/2020

	chief inspector and shall prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.			
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Substantially Compliant	Yellow	30/03/2020
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.	Not Compliant	Orange	18/02/2020
Regulation 28(4)(b)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, in so far as is reasonably practicable, residents, are	Not Compliant	Orange	28/02/2020

	aware of the procedure to be followed in the case of fire.			
Regulation 34(1)(a)	The registered provider shall provide an effective complaints procedure for residents which is in an accessible and age-appropriate format and includes an appeals procedure, and shall ensure that the procedure is appropriate to the needs of residents in line with each resident's age and the nature of his or her disability.	Not Compliant	Orange	06/03/2020
Regulation 34(1)(d)	The registered provider shall provide an effective complaints procedure for residents which is in an accessible and age-appropriate format and includes an appeals procedure, and shall display a copy of the complaints procedure in a prominent position in the designated centre.	Not Compliant	Orange	19/02/2020
Regulation 34(2)(f)	The registered provider shall ensure that the nominated person maintains a record	Not Compliant	Orange	06/03/2020

	of all complaints including details of any investigation into a complaint, outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.			
Regulation 05(4)(a)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which reflects the resident's needs, as assessed in accordance with paragraph (1).	Not Compliant	Orange	15/03/2020
Regulation 05(4)(c)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which is developed through a person centred approach with the maximum participation of each resident, and where appropriate his or her representative, in accordance with the resident's wishes, age and the nature of his or her disability.	Not Compliant	Orange	15/03/2020
Regulation 07(2)	The person in	Substantially	Yellow	19/03/2020

	charge shall ensure that staff receive training in the management of behaviour that is challenging including de-escalation and intervention techniques.	Compliant		