Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Office of the Chief Inspector

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

Name of designated centre:	Logan House
Name of provider:	RehabCare
Address of centre:	Galway
Type of inspection:	Unannounced
Date of inspection:	24 July 2019
Centre ID:	OSV-0003468
Fieldwork ID:	MON-0026609

About the designated centre

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

Logan House provides supported accommodation to people with an acquired brain injury and is based in a large city in the west of Ireland. The centre comprises of a two storey house and one external apartment to the rear of the premise. The centre operates as five units, where up to seven people reside. The centre caters for residents with high, medium and low support needs. Each resident had a private bedroom (some en-suite) with shared communal facilities, and there are two apartments with kitchen/dining/sitting room, bathroom and bedroom. Some residents access day service, where other residents like to choose their individual daily activities. The centre is located in close proximity to a range of shops and local amenities. Transport is provided so that residents can avail of community-based facilities and access amenities such as libraries, parks, hotels, cafes, hairdressers, beauticians, shopping centres and cinema. Access to allied healthcare professionals is available to the residents as required and includes; G. P. services, psychology and psychiatry services. The centre is managed by a person in charge, two team leaders, and team of social care professionals and assistant support workers. Residents are supported by staff during the day in response to their assessed needs and a waking night staff, and a sleep over staff is rostered for nights to ensure all residents support needs are met as required.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	7

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
24 July 2019	10:30hrs to 18:30hrs	Thelma O'Neill	Lead

Views of people who use the service

The inspector met with six residents during the inspection. Residents told the inspector that their quality of life had improved since the last inspection. Residents told the inspector that they were supported to attend more meaningful activities in the community.

Residents told the inspector that they were looking forward to moving accommodation within the service, which would allow them more privacy and space to mobilise within the house, but were frustrated that this had not yet occurred.

Capacity and capability

This inspection was completed as a follow-up to two previous inspections carried out in January 2019 and December 2018, where significant risks were identified in the centre. As a result, of those inspections, a warning letter was issued to the provider and a regulatory plan put in place requiring them to address all regulatory non-compliance at the centre.

The Health Information and Quality Authority renewed the registration of this centre in May 2019, but due to the continued risks in the centre, a restrictive condition was placed on the registration. This restrictive condition requires the provider to adhere to their compliance plan response by the 30 September 2019. However, on this inspection, the inspector found that the provider had not achieved the actions they had set within their agreed time frames. Furthermore, the inspector found that the provider had not adhered to the registered bed capacity for the centre, despite the provider requesting that it be reduced to seven following the recent renewal of registration of the centre. This has resulted in a serious breach of its conditions of registration, and as a result, the provider was issued a further warning letter following this inspection.

In relation to the previous non compliance's identified on inspection, the inspector found that the provider had made improvements at the centre and addressed many of the previous non-compliance, leading to positive impacts for the residents. However, some actions were not completed within the agreed timelines. These included issues such as staffing, protection, fire safety, medication management, complaints, and governance and management.

Residents told the inspector that since the last inspection, there were more structured activities planned during the week and staff were available to support them to participate in the community or their chosen activities in the centre.

The provider had not been successful in implementing its reconfiguration of staffing as planned. The provider had held recruitment drives to employ a specific skill mix of staff, but the inspector was told that it had been unsuccessful, and three staff vacancies still existed at the centre. The provider continued to use agency staff to cover the staffing vacancies in the centre. However, the inspector noted that a resident had made several complaints to management about the continued use of agency staff working in the centre, stating that they were not supporting them in lines with their wishes. For example, with their personal care, and the fact that agency staff were not able to drive the residents to their activities in the centre's transport.

Since the last inspection, the provider had completed a staffing needs assessment to determine the number of hours of staff support and skills each resident required to meet their specific care and support needs. However, the team leader and person in charge were not clear as to how many hours each specific resident was entitled to, and had not amended the staff roster to reflect any recommendation made in the recent staffing needs assessment.

There was a revised management team in place in this centre. There was a new regional operations officer, a new team leader and in June, a new person in charge was appointed. The provider was monitoring the centre on a monthly basis with regular audits and unannounced inspections taking place. Throughout the inspection, the person in charge was found to be suitably experienced, knowledgeable and qualified to undertake their role at the centre and in line with the regulations. At the time of the inspection, the person in charge told the inspector she was in the process of progressing actions identified in the compliance plan, however, work remained in the areas of; staffing, fire safety, medication management, complaints, safeguarding, and governance and management.

The management of complaints had improved in the centre since the last inspection. While there were a number of complaints recorded in the centre, staff had addressed most of the complaints in the centre. However, further action was required to ensure full compliance with the regulations as records did not document complainants' satisfaction with the outcome of their complaint.

Regulation 14: Persons in charge

The person in charge was newly appointed to the post in June 2019 and was responsible for the management of two designated centres. The inspector found her to be suitable skilled, experienced and qualified to manage the centre.

Judgment: Compliant

Regulation 15: Staffing

The provider had commenced a process of recruiting new staff to work in the centre, however, this was not yet completed. As a result, the provider had continued to use a staffing agency to fill vacancies in the centre. However, the skill- mix and experience of the relief staff was not meeting all of the residents care and support needs, and this was reinforced by concerns raised by residents'. about the staff supporting them. Furthermore, there was no evidence that
the support hours identified through a recently completed staffing needs assessments were being provided to residents as required.

Judgment: Not compliant

Regulation 16: Training and staff development

A programme of planned training was in place for full-time staff at the centre, with staff either having completed said training or scheduled to undertake it following the inspection.

Judgment: Compliant

Regulation 23: Governance and management

The provider had breached their conditions of registration by admitting an additional resident, on set days, over a two month period to the centre. Furthermore, the provider's own internal audits had failed to identify this breach prior to the inspection. In addition, the provider had not fully implemented agreed actions within their own timelines, as described in their previous inspection's compliance plan response. For example, staffing, fire safety, complaints, medication management, safeguarding and premises.

Judgment: Not compliant

Regulation 34: Complaints procedure

Although improvements had been made to the management of complaints at the centre, records did not document the complainants' satisfaction with the actions taken in response.

Judgment: Substantially compliant

Quality and safety

The quality and safety of care in this centre had significantly improved over the past two inspections in January 2019 and December 2018. On this inspection, the inspector found that improvements had occurred in areas such as residents' assessments, general welfare and development, positive behaviour support and healthcare. However, further actions identified in previous inspections were not yet complete.

The centre's risk management practices were robust in nature and in line with the provider's organisational policies and staff were knowledgeable on risk management practices and the procedures in place to safeguard residents from harm. However, one resident continued to smoke in their apartment despite being advised of potential fire risks and previous incidents of setting off the fire alarm. On review of recent incidents, the inspector was told that there was no risk management protocol in place to guide staff on how to manage this risk when it occurred in the centre.

The centre's management team had improved measures to safeguard residents from experiencing possible abuse at the centre. A detailed safeguarding policy was in place, and the provider had ensured that all staff had received specific safeguarding of vulnerable adults training.The inspector was told by residents that they felt safer at the centre and introduced one-to-one staffing supports since the last inspection had prevented any new safeguarding issues arising. However, two residents had experienced financial abuse (outside of the centre) over the past year.The inspector found that they did not have financial safeguarding plans in place and the financial checks advised in the residents' support plans were not adhered to in practice.

The provider had completed compatibility assessments on all residents living at the centre and had proposed plans to reconfigure the centre to more effectively meet residents' long-term care and support needs. However, the planned reconfiguration had not occurred by the day of inspection, which lead to one resident expressing their frustration with the delay, and that the centre's design and layout was not meeting their assessed needs.

Residents told the inspector that they were more actively involved in their local community since the last inspection at the centre and were supported to participate in a range of structured and varied activities. However, residents told the inspector that they had complained about the frequent use of agency staff at the centre, with some relief staff not being able to drive the centre's vehicle. This had impacted on their social activities on occasions.

A number of structural fire works had taken place in the centre to improve the

centre's fire safety; however, a review of the fire evacuation procedures in the centre found that the provider had not completed fire drill with minimum staffing levels in place, this was required to ensure that all residents could be safely and effectively evacuated in the event of an emergency. In addition, two residents' emergency evacuation plans (PEEPS) did not state that they required staff support to evacuate from the centre, due to their mobility issues.

Residents had access to medical services which ensured they received a good level of health care. All residents had access to allied health professionals in line with their assessed needs; however, some residents were on waiting lists for access to allied health treatment. In some cases, residents chose to pay privately to attend private health appointments.

Medication management arrangements were in place at the centre, although these were not effective in nature. The person in charge had completed a medication audit in June 2019 which had identified that 28 medication errors had occurred since the last inspection in January 2019. Although, a review of medication administration practices had been completed and additional control measures introduced, records showed that a further four medication errors had occurred subsequently.

The inspector reviewed the progress the provider had made to complete agreed building works to ensure the centre's design and layout met residents' assessed needs. The provider had completed a large proportion of the recommended works since the last inspection; however, the installation of an additional upstairs bathroom and planned renovations to the centre's attached apartment had not been completed within the agreed time frames. This had prevented a resident from moving into their new apartment.

Regulation 13: General welfare and development

Residents told the inspector of improvements in their daily activities and increased access to the local community.

Judgment: Compliant

Regulation 17: Premises

A series of renovation works had been completed to upgrade fire safety arrangements at the centre following the last inspection. However, further planned works such as the installation of an additional upstairs bathroom and renovations to the centre's attached apartment had not been completed, impacting on the design and layout the centre to meet residents' assessed needs.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

In general, risks identified in the centre were effectively risk assessed and managed. However, the inspector found that the no smoking policy in the centre was not been adhered to, as there were seven incidents since April where a resident was found smoking in their apartment. This was a concern, as this activity was an identified fire hazard, and there were previous incidents, which had resulted in the centre's fire alarm being activated. On review there was no written guidance for staff on how to mange this risk when it occurred, or how to ensure this risk was appropriately managed.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The provider had not ensured that there were suitable evacuation arrangements in place for all residents. For example, fire evacuation drills had not been completed under minimum staffing conditions, and two residents' personal evacuation plans did not identify the specific supports they required to evacuate due to their mobility needs.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

The provider's medication management arrangements had not ensured residents received their medication as prescribed. Furthermore, no protocol was in place to guide staff on how and when to administer one resident's PRN medication.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

All residents had annual health assessments and person-centred plans completed. All residents' plans were kept under review.

Judgment: Compliant

Regulation 6: Health care

All residents had access to a general practitioner; however, three residents were on a waiting list to access allied health professional services. When it was deemed urgent, the residents could access private treatment.

Judgment: Compliant

Regulation 7: Positive behavioural support

The management of behaviours that challenge had improved since the last inspection. There had been a reduction in incidents and residents told the inspector that they were happy living in the centre. However, as part of a behaviour management plan, four restrictions were in place for a resident, but no record was available on how these restrictions should be managed and recorded in the resident's notes.

Judgment: Substantially compliant

Regulation 8: Protection

Safeguarding plans had not been developed and personal plans updated to include agreed supports to assist residents who could be subject to financial abuse when accessing the local community.

Judgment: Substantially 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
Views of people who use the service	
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 34: Complaints procedure	Substantially 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 29: Medicines and pharmaceutical services	Not compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Substantially compliant

Compliance Plan for Logan House OSV-0003468

Inspection ID: MON-0026609

Date of inspection: 24/07/2019

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 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • Current vacancies are being filled by regular relief and agency staff who are familiar to the residents. • One vacancy has been filled from a recent recruitment drive however it was necessary to re-advertise due to the calibre of applicants applying. Further interviews will be held on the 20th September to fill the outstanding vacancies. A full complement of staffing appropriate to the assessed needs of residents will be in service by the 29th of November 2019. • A new staffing structure has been identified to include an additional Team Leader. This staffing structure will be in place in service by the 29th of November • Through this recruitment process the provider will ensure the skill mix of staff will meet the identified needs of residents. • A full review of support hours will be revisited by the PPIM and PIC on the 1st of October 2019 and will be reflected on the rota and the residents' weekly planners	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • The arrangement in place to transition the resident out of service was completed on the 31st of July.	

• Outstanding actions from previous compliance plan identified are ongoing and the provider is applying to vary the condition of registration to ensure all actions are completed in line with timelines set out to the 31st of January 2020.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
• A new daily notes template has been introduced in the service on the 27th June 2019 which records complaints. All staff will record on the daily notes template in the event of a complaint being made. The staff member will subsequently complete the complaints template to escalate the complaint to the Team Leader.

• The PIC conducted an audit of complaints on 09/07/2019 and subsequent to this audit, prepared a complaints template that included the complainants' responses & satisfaction with the actions taken in respect of their complaints. This has been introduced in the service as part of the standard complaints documentation.

• The Team Leader will conduct an audit of Complaints on a monthly basis to ensure all complaints are being appropriately responded to and records of all complaints are maintained appropriately in the service and management in line with Rehab Group Complaints Procedures. The PIC will overview this audit on a monthly basis.

• Complaints Management will continue to form part of the agenda at all monthly team meetings.

• A refresher session on the management of Compliments and Complaints will be facilitated at the next team meeting on the 24th September by the PIC/Team Leader

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• A series of renovation works has been completed however some works were delayed due to the impact of building works on the residents. Works are planned for completion by December 2019 however, owing to availability of builders, the provider is applying to vary in this regard to the 31st January 2020.

• The upstairs bathroom renovation was postponed as one resident was significantly

impacted by the works being carried out. This renovation will be completed by 6th December 2019.

• Works to the attached apartment will be completed and the resident will be transitioning in to the apartment by 31st January 2020.

• Additional works identified by Health and Safety Team have identified the need to repair paving works to the rear of the building. This will be complete by the 25th of October.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
• The PIC will consult with the MDT and Health and Safety Team regarding written guidance for staff on how to manage the risk of smoking in the service by 27th of September.

• The BT will review the Restrictive Practice in place in service and provide guidance to staff by the 27th September.

• The Team Leader will conduct an audit of Risk Management on a monthly basis to ensure all risks are being appropriately managed. The PIC will overview this audit on a monthly basis.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• A fire drill was completed with minimum staffing on the 11th of September. All residents evacuated safely.

• The PEEPS and Evacuation Procedure for all residents are currently being reviewed and will identify specific supports required, this will be completed by the 04/10/2019.

Regulation 29: Medicines and pharmaceutical services	Not Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:

• PRN protocols are currently under review by the PIC/Quality & Governance and GPs and will be completed by 04/10/2019. PRN protocols will be in place in the service for all residents by the 11th of October 2019.

• One resident is currently not self-administering and is engaging in an individualized medication management education programme. This resident is being supported to resume self-administration and is being reviewed weekly by Team Leader and monthly by PIC.

• The PIC will conduct a check of all incidents on a monthly basis and will share learning from outcomes of this exercise with regards to zero tolerance to medication errors and effective medication practices with the team at each team meeting. This is ongoing from July 2019.

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:

• PIC and Behavioral therapist will review all Restrictive Practices in place in the service on the 19th September 2019. As an outcome of this review a management protocol of restrictions in place will be devised with regards to the four restrictions in place for one resident. This will be advised to the team by the 27th of September.

• All Restrictive Practices within the service will be reviewed at the Restrictive Practices Committee meeting with Senior Management, BTs and Advocacy Officer on the 23rd of September.

• The BT is currently reviewing all Behaviour support plans. This will be completed by the 25th of October 2019.

• Restrictive Practices & BSP will be agenda items team meetings on a monthly basis.

• The BT and PIC will review all BSPs and Restrictive Practices on a quarterly basis.

• The BT will provide refresher training to the team on Restrictive Practices and Positive Behaviour Support on the 24th of September and 30th of October.

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
• All Safeguarding plans will be reviewed in service with DO, PPIM, PIC and Team Leaders on the 4th of October 2019.

• Two residents are engaging in a Vulnerability in the Community Programme, the aim of which is to support residents to identify and manage risk scenarios in the community. This is a six session intervention which will continue to the 31st of December 2019.

• A Money Management programme is to commence on the 1st of October and will be facilitated by Keyworkers for all residents.

• The Neuropsychologist is reviewing a residents PCP and their financial capacity assessment and will provide guidance in relation to this resident who is non-consenting to financial checks. This will be completed by 30th September.

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 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Not Compliant	Yellow	29/11/2019
Regulation 17(1)(a)	The registered provider shall ensure the premises of the designated centre are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.	Not Compliant		31/01/2020
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in	Not Compliant	Orange	31/01/2020

	place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.			
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	27/09/2019
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	04/10/2019
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 aware of the procedure to be followed in the	Not Compliant	Orange	04/10/2019

	case of fire.			
Regulation 29(4)(b)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine which is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.	Substantially Compliant	Yellow	11/10/2019
Regulation 34(2)(f)	The registered provider shall ensure that the nominated person maintains a record 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.	Substantially Compliant	Yellow	24/09/2019
Regulation 07(5)(b)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation all alternative measures are	Substantially Compliant	Yellow	30/10/2019

	considered before a restrictive procedure is used.			
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Substantially Compliant	Yellow	31/12/2019