Cara Cheshire Home, OSV-0003441, 16 October 2019

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:	Cara Cheshire Home
Name of provider:	The Cheshire Foundation in Ireland
Address of centre:	Dublin 20
Type of inspection:	Unannounced
Date of inspection:	16 October 2019
Centre ID:	OSV-0003441
Fieldwork ID:	MON-0027967

About the designated centre

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

The Cara Cheshire Home provides support to adults with primarily physical disabilities and or neurological impairments 24 hours per day seven days per week. Staff support people with a variety of disabilities including the following: cerebral palsy, multiple sclerosis, hydrocephalus and acquired brain injuries. Some residents have secondary disabilities which could include an intellectual disability, mental health difficulties or medical complications such as diabetes.The centre is set on extensive grounds set in park lands, which is located near Dublin city centre and other amenities. Currently there are 13 people living in Cara Cheshire House, each with their own individual bedroom. The accommodation at Cara Cheshire House is suitable for a maximum of 14 residents. The service has a large dining room, a laundry, kitchen, an activities room, office spaces, a large sitting room, a sun room, landscaped grounds, a patio area, a quiet room and a family room. The service has a range of staff supporting the individuals living here which include a service manager, nursing staff, service coordinator, activities coordinator, senior care staff, care support workers, domestic and kitchen staff, administrators, a maintenance/driver person, a community employment supervisor, and a team of community employment staff who assist in maintenance, driving and activities. There is also an health executive (HSE) multi-disciplinary team based in the service on a part-time basis who support the individuals and the staff team to assist them.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	13

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
16 October 2019	09:30hrs to 18:30hrs	Erin Clarke	Lead

What residents told us and what inspectors observed

The inspector of social services had the opportunity to meet with a number of residents and observe residents take part in planned activities in the centre.

Residents were observed engaged in decorating the centre for Halloween, making cards for family members, gardening and going out for coffee. All residents appeared comfortable with staff members present and were observed engaging with them in a positive manner throughout the inspection.

The inspector observed lunch time in the dining area during this inspection. Appropriate numbers of staff were available to assist residents and residents were supported to eat and drink in a sensitive and appropriate way. Residents were offered choice around meal times and what they wanted to eat and some residents spoken with stated they enjoyed the food. The mealtime was not rushed and was in line with residents assessed needs.

Residents spoken with said they were happy with the support of staff and being supported to access activities in the community. There were a few areas that they had negative feedback about, in relation to some aspects of the service which required improvement. The inspector was made aware that residents had made a number of complaints in relation to behaviours from other residents. The inspector also viewed other complaints made in relation to the quality of food when the chef was not available.

Capacity and capability

This unannounced inspection was carried out to monitor compliance with the regulations and to follow up on actions issued on the previous inspection. Due to the noncompliance identified during the inspection this inspection was changed from a monitoring inspection to a risk-based inspection. The inspector found the capacity and capability of the provider to deliver a safe quality service was impacted by the current operational systems in this centre and required improvement. The provider's oversight of key areas and procedures were not in line with policy, and as a result, the quality of life which residents experienced was negatively impacted upon.

The provider had notified the Chief Inspector of Social Services in July 2019 that the person in charge had resigned and recruitment was underway to appoint a replacement. At the time of the inspection, the person in charge had not commenced post. The inspector was informed that this delay was due to the first round of interviews being unsuccessful. A second round of recruitment had identified a successful candidate and this person would commence on 1 November

2019.

The inspector reviewed the complaints log and a large number of complaints had been raised in relation to the impact of challenging behaviour on other residents. A detailed discussion took place with the management team in relation to the management of these complaints. A business case proposal had been developed for the centre due to 52 incidents over a three month period. It was noted on the report that these incidents resulted in 51 complaints from residents. The impact of the behaviours were reported as distressing and frightening for other residents. The inspector was therefore not satisfied that these incidents were managed appropriately under the national safeguarding policy as discussed under quality and safety.

The inspector requested to review the complaints policy and found that it did not afford adequate guidance to follow in the event of a complaint. For example, it did not state how the complaints could be escalated if they could not be solved at a local level. This did not provide assurance that complaints were being well managed and brought about sustained, positive change in accordance with residents' rights and wishes. While residents were aware of the complaints process and were supported to make complaints, it was evident that these complaints were not resolved to the satisfaction of complainants despite being recorded otherwise. The provider's annual review of the quality and safety of the service in 2018 reported that all 32 complaints made in that year were resolved. An unannounced audit in December in the same year stated that residents' rights were being compromised by the behaviours of others and it was clear that these complaints had not been resolved as they were ongoing at the time of the inspection.

The provider had prepared a statement of purpose that was reviewed at regular intervals. The statement of purpose is a key governance document which sets out how the centre is to run and what residents and staff can expect to see in the service. It sets out the aims, objectives and ethos of the designated centre. Some of the requirements for this document were missing; for example, the criteria for admission to the centre. The inspector received unclear information during the inspection, as to whether the centre was open to receiving new admissions.

Regulation 23: Governance and management

Management systems within the centre were not effective in ensuring the service provided is safe, appropriate to the residents needs, consistent and effectively monitored.

Judgment: Not compliant

Regulation 3: Statement of purpose

There was statement of purpose in place which was regularly reviewed and accessible to residents and staff. However, the inspector observed the statement of purpose required further review to ensure it accurately described the services delivered in relation to:

- the information set out in the certificate of registration

- any separate facilities for day care

- criteria used for admission to the designated centre, including the designated centre's policy and procedures (if any) for emergency admissions

- the arrangements for residents to access education, training and employment

Judgment: Not compliant

Regulation 31: Notification of incidents

A record of all incidents occurring was maintained in the designated centre; however, not all of these incidents were reported to the Chief Inspector as required by the regulations.These related to a large number of peer to peer safeguarding concerns.

Judgment: Not compliant

Regulation 34: Complaints procedure

Improvement was required with regard to the recording of the outcome of the complaint, actions taken, follow up, the complainant's level of satisfaction and recording of whether the complain was resolved or unresolved. The complaints policy also required review to ensure that it included an appeals procedure and steps to be taken if the complaint could not be resolved at a local level.

Judgment: Not compliant

Quality and safety

Overall the inspector found significant improvements were required to ensure residents were fully supported and in receipt of a safe and quality driven service which promoted their rights.

The centre commenced operating in 1974, as a purpose-built home. The centre was originally designed to accommodate a larger number of residents, 13 residents were present on the day of the inspection with one vacancy. Inspectors were informed at previous inspections that the process of de-congregation had begun; however, this had not commenced at the time of this inspection.

The design and layout of the centre was found to be suitable to meet the current profile of residents' individual and collective needs, although some improvements were necessary. The inspector carried out a walk-through of the centre with a member of the management team. Rooms were laid out in a male corridor and female corridor, and this accommodation was separate to the living, dining and office spaces. All residents had their own bedroom and contained hand washing facilities, bed and adequate storage for all residents. The living room was large in size and provided a television, several seating areas and separate space for communal computer use for residents. The living room was notably colder than the rest of the building, and the inspector did not observe any residents using this room for the duration of the inspection. This was discussed with the centres' supervisor, and they were aware of this issue, although there were no plans to address this issue. In addition, a residents' relaxation room was used as a storage room for wheelchairs.

There was a large dining room area where the inspector observed a mealtime experience. Residents were afforded food choices from a menu daily. Residents did not have access to the kitchen, but the inspector could see that a selection of food items were laid out for residents. There was further improvement required in this area, as when the inspector asked where residents could heat food when the kitchen was closed, they were informed that some residents had a microwave in their bedroom. Appropriate and hygienic food preparation space had not been made available to residents; this was in contrast to the availability of a staff canteen that contained these facilities.

The inspector observed several boxes of rubber gloves on wall mounted shelves outside residents' bedrooms and incontinence pads on clear display in two bathrooms as opposed to stored away privately and in line with best practice. Such measures in place were observed to be designed for staff convenience as opposed to resident's right to privacy and dignity. Also, care planning information was stored in an office that was not found to be locked. This was despite the presence of nine managerial and administration offices. These issues were not found to be promoting resident's privacy needs in terms of their care and support and personal information and were all previously actioned on a previous inspection. The inspector was informed that the safe storage of residents' personal files would be completed by the end of the inspection.

A newly landscaped garden area was shown to the inspector. A gardening area was in use where one resident was observed working with a member of staff. The

inspector noted that improvements had taken place with regard to the external spaces and gardens to make them accessible to all residents.

In relation to safeguarding and protecting residents from potential harm, the provider was aware of many ongoing issues such as the incompatibility of residents. The inspector found that the provider did not sufficiently act upon these concerns. The impact of this inaction resulted in residents being exposed to potential harm as detailed in incident forms and complaint forms. Safeguarding procedures were not aligned with national policy, and the inspector found that the majority of all incidents of a safeguarding nature were not appropriately screened and notified to the national HSE safeguarding team. While there was evidence that the HSE safeguarding team had been contacted in August 2019 for advice, the communication from the safeguarding team indicated that the continued and repeated peer to peer incidents could be viewed as institutional abuse if plans to reduce these were not implemented. While the provider was aware that these repeated incidents were causing harm to other residents and stated that the centre was at a 'critical level' in its funding business case, the inspector viewed safeguarding emails that showed there was disagreement with the national safeguarding teams rationale for institutional abuse. The reasoning for the uncertainly of whether peer to peer and institutional abuse had occurred was due to the understanding of the safeguarding policy. The inspector requested a copy of the provider's safeguarding policy along with the HSE national policy and highlighted were the policy clearly stated that the incidents occurring constituted abuse.

The inspector found that the centre did not meet all the needs of the residents residing there. For example, a psychologist report stated that behaviours would not improve while the environment remained a congregated setting. Residents that had expressed a desire to move out of the centre were dependant on further funding to do so.

Regulation 17: Premises

Premises matters needing to be addressed included the provision of adequate cooking facilities for residents, ensuring that there was suitable and usable social and recreation space and the facilitation of adequate heating in all areas of the premises.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

The inspector found that while there was ongoing compatibility issues, residents had

not had a compatibility assessment to ensure that residents receiving a service together would be safe and that they would receive appropriate care and support.

The centre was not meeting the needs of all residents and the service acknowledged that one resident's needs in particular were not being met.

Judgment: Not compliant

Regulation 8: Protection

Measures to protect residents being harmed or suffering abuse were not effective and appropriate action was not taken in response to allegations, disclosures or suspected abuse.

Judgment: Not compliant

Regulation 9: Residents' rights

The registered provider had not ensured that each resident, in accordance with their wishes, participated in decisions about their care and support. Not all residents had the freedom to exercise choice and control in their daily lives. There was also repeated breach in the dignity and privacy of residents in relation to the storage of their personal information and personal care items.

Judgment: Not 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 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Not compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Not compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Cara Cheshire Home OSV-0003441

Inspection ID: MON-0027967

Date of inspection: 16/10/2019

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 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • The Provider will submit an Assurance Report to HIQA by 31/12/19 outlining the status of situation with the person at the centre of the noted 52 incidents over a three month period, the measures engaged in to resolve these matters, and how the service has and will mitigate, manage, monitor, and review any associated risks associated with this person's support needs. • AERs and complaints are now continuously reviewed by the Person In Charge with consideration given to safeguarding. AERs and complaints will be further reviewed to monitor actions and possible trends during the fortnightly local management team meeting and during the monthly Clinical and Quality Partner site visits. • Local audit P.I.C systems are currently being reviewed by the Provider and new templates for such audits are being developed for use in the service. Once finalized these will be introduced by 31/01/2020. • The Cheshire Ireland Safeguarding Lead conducted an audit on 12/11/19. A Regional Support Services Meeting will take place by 6/12/19 to discuss results of this audit and ensure that actions to be progressed are identified with persons responsible and timelines noted.	
Regulation 3: Statement of purpose	Not Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
An updated Statement of Purpose was submitted to HIQA on 1/11/19.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
• AERs and complaints are now continuously reviewed by the Person In Charge with consideration given to safeguarding. AERs and complaints will be further reviewed to monitor actions and possible trends during the fortnightly local management team meeting and during the monthly Clinical and Quality Partner site visits.

• Commencing immediately the Person In Charge will report all safeguarding concerns as required by Regulations and according to HSE and Cheshire Ireland Safeguarding of Vulnerable Persons at Risk of Abuse policy and procedures.

Regulation 34: Complaints procedure	Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
• The Person In Charge will ensure oversight, follow up, and review of complaints is completed thoroughly on a consistent basis and that recording of satisfaction and outcome are documented appropriately, particularly in the case of complaints that are of a recurring nature and/or where the complainant reports satisfaction with the immediate handling or explanation of the matter but the issue reoccurs.

• All complaints will be reviewed and monitored at the fortnightly local management meetings and monthly partner visits. The regular review and monitoring of complaints and service-user feedback will seek to identify possible trends and patterns that require to be appropriately addressed.

• The Cheshire Ireland Complaints Policy will be reviewed and updated by 31/1/20 with clear guidance on the appeals process. All complaints will be review by PIC and Quality Partner and will become part of the Quality Improvement strategy of the service.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• The Activities Coordinator is consulting with residents and updating with each the "Person Centred Approaches /Service users Choice and Involvement in Cooking Assessment" that were conducted in 2017 as per previous HIQA compliance plan.
• A plumber attended the service on 20/11/19 and adjusted radiators in the living room which has increased the heat output. Quotes will be attained by 31/11/19 in relation to possible insulation of the 3 large windows and 1 patio door in this room.
• Wheelchairs observed by inspector in the residents' relaxation room have been removed.
• The Person In Charge is consulting with residents to enquire if they wish the microwave, toaster, and fridge that is available in the dining room to be moved to a different location in the room. No person has a microwave in their rooms and two individuals who have small fridges in the living area of their rooms will be consulted with to ensure this is still as per their wishes.
• A separate identified food preparation area will be created in the main dining area to facilitate residents to prepare or heat food.

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:
• A Regional Support Services Meeting will take place by 6/12/19 and will review the work conducted by the behavioural psychologist and the behavior support plan for the individual at the centre of the 52 incidents. The support plan will be updated to reflect the services' learnings and guidance for staff in relation to mitigating and managing the triggers for this individual.

• As the last new admission to the Cara was approximately 17 years ago planning for how who we can best support individuals who reside alongside others will take place in care and future planning exploring their goals, wishes, will, and preference, and in risk assessments to manage issues related to congregated living.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
• AERs and complaints are now continuously reviewed by the Person In Charge with consideration given to safeguarding.

• AERs and complaints will be further reviewed to monitor actions and possible trends during the fortnightly local management team meeting and during the monthly Clinical and Quality Partner site visits.

• Safeguarding will be discussed at each fortnightly management team meeting. This will include reviewing and monitoring active safeguarding concerns, plans and measures.

• The DO/PIC will ensure that any concerns of abuse, including concerns of peer abuse, are notified and responded to appropriately, according to policy and regulation and that measures are in-place to support all persons involved. All peer incidents will be discussed during the above noted meetings to monitor and review any identified measures and to identify possible trends/patterns that require further action.

• The Provider will provide instruction to staff on how to complete AERs and complaints and in particular how to ask questions of residents in order to gain a full understanding of the circumstances of the event.
• Safeguarding has become a standing agenda item on all meetings within the service and will be included in other aspects of the service including staff handovers and in staff 1:1 discussions. The importance of recognising and responding to peer to peer incidents will be emphasised to all staff members.

• The importance of safeguarding, recognizing abuse, and protecting their rights will be discussed with residents at their ongoing 1:1's and at a resident meeting by 31/12/19.

• The Person in Charge will liaise with the Safeguarding Team about doing a visit to the service for an information session with the residents.

• A Regional Support Services Meeting will take place by 6/12/19 and will review the outcome of the work completed by the behavioural psychologist and the behavior support plan for the individual at the centre of the 52 incidents. The support plan will be updated to reflect the services' learnings and guidance for staff in relation to mitigating and managing the triggers for this individual.

• The service will ensure that all peer incidents are responded to appropriately, according to policy and in a person-centred manner. Important in this is that all Personal Approach Plans, Risk Assessment, Safeguarding measures etc. that relate to possible peer incidents and/or the impact of individual service-users on others will be reviewed regularly by the PIC and during local management meetings and Quality/Clinical site visits to ensure that all persons enjoy a safe, quality life in the Cara.

• All peer incidents will include consideration of safeguarding for everyone involved, including those who may have been present or witnessed an incident.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• The staff hub that contains care planning information is now locked with a code for access. All personal care items are now stored appropriately with Senior Care Workers responsible for continuous oversight.

• The Provider has a person-centered approach to care planning. A national Rights Review Committee is being established and will commence in the first quarter of 2020.

• The Person In Charge is consulting with residents to enquire if they wish the microwave, toaster, and fridge that is available in the dining room to be moved to a different location in the room. No person has a microwave in their rooms and two individuals who have small fridges in the living area of their rooms will be consulted with to ensure this is still as per their wishes.
• A separate identified food preparation area will be created in the main dining area to facilitate residents to prepare or heat food.

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 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Not Compliant	Orange	31/12/2019
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	Red	31/01/2020
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose containing the information set out in Schedule 1.	Not Compliant	Orange	01/11/2019
Regulation 31(1)(f)	The person in charge shall give the chief inspector notice in writing within 3 working days of the	Not Compliant	Orange	31/12/2019

	following adverse incidents occurring in the designated centre: any allegation, suspected or confirmed, of abuse of any resident.			
Regulation 34(1)(c)	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 the resident has access to advocacy services for the purposes of making a complaint.	Not Compliant	Orange	31/01/2020
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	31/01/2020
Regulation 34(2)(d)	The registered provider shall	Not Compliant	Orange	30/11/2019

	ensure that the complainant is informed promptly of the outcome of his or her complaint and details of the appeals process.			
Regulation 34(2)(e)	The registered provider shall ensure that any measures required for improvement in response to a complaint are put in place.	Not Compliant	Orange	30/11/2019
Regulation 34(3)(a)	The registered provider shall nominate a person, other than the person nominated in paragraph 2(a), to be available to residents to ensure that: all complaints are appropriately responded to.	Not Compliant	Orange	30/11/2019
Regulation 05(2)	The registered provider shall ensure, insofar as is reasonably practicable, that arrangements are in place to meet the needs of each resident, as assessed in accordance with paragraph (1).	Not Compliant	Orange	31/01/2020
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	31/01/2020
Regulation 08(3)	The person in charge shall initiate and put in place an	Not Compliant	Orange	31/01/2020

	Investigation in relation to any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.			
Regulation 09(2)(b)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability has the freedom to exercise choice and control in his or her daily life.	Not Compliant	Orange	31/03/2020
Regulation 09(3)	The registered provider shall ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.	Not Compliant	Orange	31/12/2019