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:	Park View
Name of provider:	Saint Patrick's Centre (Kilkenny)/trading as Aurora-Enriching Lives, Enriching Communities
Address of centre:	Kilkenny
Type of inspection:	Unannounced
Date of inspection:	16 April 2024
Centre ID:	OSV-0005828
Fieldwork ID:	MON-0042673

About the designated centre

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

Park View is a residential service located in Kilkenny close to a range of local amenities. The service provides supports for up to four individuals with an intellectual disability, over the age of eighteen years. The service operates on a 24 hour, 7 day a week, basis ensuring residents are supported by staff members at all times, with effective governance systems in place. As set out by the provider, Park View "aims to develop services that are individualised, rights based and empowering, that are person centred, flexible and accountable". The accommodation currently consists of two apartments within a two storey house, each comprising of two bedrooms, living room, kitchen and bathroom.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	3

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Tuesday 16 April 2024	09:45hrs to 17:20hrs	Tanya Brady	Lead

What residents told us and what inspectors observed

This was an unannounced inspection, completed to review the provider's compliance with the Regulations and the quality of care and support offered to the residents living in the centre. This centre was last inspected in July 2022 and there had been a change in the local management team and in the number of residents living in the centre since that inspection.

Overall the inspector found that the provider and person in charge were working to improve consistency in their oversight and in the governance and management arrangements in the centre. The inspector found that there was an inconsistency in the implementation of some of the provider's systems and new systems were still not consistently being implemented. Improvement was in particular required in the management of resident's personal possessions, identification of restrictive practices and in medication management.

This centre is registered for a maximum of four residents and currently three individuals live here. Two live in an apartment on the first floor of the premises and one in an apartment on the ground floor. All three residents were present in the centre at varying times over the course of the inspection day and the inspector had the opportunity to meet and spend time with all three.

The inspector arrived to the door of the ground floor apartment and was greeted by the resident who lived there. They welcomed the inspector into their home and sat with the inspector and spent time engaging. They were supported by a staff member to outline activities that they enjoyed, such as going out for hot chocolate, meeting friends, going bowling and having their nails done. The resident shared that they had spent time curling their hair that morning and were pleased to show it off to the inspector. They also had an appointment on the day of inspection to have their nails done and they reported that they really liked this. They were observed to make a request of the staff member for support in preparing a drink and asking for music to be played on their electronic tablet as the morning progressed. The resident was comfortable in moving through their home and spent time sitting in the same room as the inspector or in their bedroom or kitchen both with and without staff present.

A second resident was leaving their home as the inspector arrived to attend their day service. They were observed saying goodbye to staff and bringing their belongings to the vehicle that was collecting them. On return to the centre they sat with the inspector in their kitchen and spoke of their day. They like their home and are happy there and also stated that they liked going to their day service where they meet up with friends. The resident was observed greeting their peer and the staff member on return to their home and chatting about their day.

The third resident was in their apartment on the first floor of the premises and they greeted the inspector on arrival. The resident had been recently unwell and it was

reported that they were still recovering from a stay in hospital. On the day of inspection the resident stated they were tired and they requested activities at home over the course of the day. The staff team were observed asking the resident if they would like to go for a short walk or to engage in a short drive but these requests were refused and staff respected this. Staff offered alternative activities at home. The resident was observed over the course of the day moving freely through their home, coming to the kitchen to get a drink or snack and to request preferred DVDs to watch on television.

There were staff members working in both apartments and they were observed helping the residents with activities, household tasks and personal care over the course of the day. The staff team were observed to be kind and caring and to be familiar with the residents' preferences and likes and dislikes. The staff team were focused on the individuals they worked with and they gave the inspector examples of situations where they advocated on residents' behalf such as during a recent hospital admission. They discussed skills they were learning and training they had received that supported them in carrying out their roles.

The centre is a two storey detached premises in a housing estate on the outskirts of Kilkenny city which is subdivided into two apartments, one on each floor. To the rear of the premises the garden has also been divided into two garden areas that while interconnected can be private for the residents in each apartment to access. Each apartment has resident personal bedrooms, bathrooms, kitchen-dining room, sitting room and staff areas.

The quality of care and support provided to the residents was observed to be good throughout the inspection however, the inspector as outlined above found some areas that required review and improvement in relation to the documentation and consistency of use of the systems in place. The overarching findings of this inspection will be presented in relation to the governance and management arrangements and how they impacted on the quality and safety of service being delivered.

Capacity and capability

The findings of this inspection were that residents were in receipt of a good quality of care and support however, there were areas where the provider needed to take action to ensure that the care provided was effectively monitored in order to be safe. The management structures in the centre were clearly defined and staff roles and responsibilities were clearly defined.

Some audits such as those in the management and oversight of resident personal possessions or restrictive practices for example were not being completed as per the provider processes. Where audits had been completed the actions were not tracked

or demonstrating that the required improvements had been brought about. These improvements were required by the provider and the local management team.

Regulation 15: Staffing

The provider had ensured that there were sufficient staff present to meet the assessed needs of the residents in this centre. Staffing levels and been reviewed and amended following review when a third resident had moved into the centre and following changes to a resident's health. Staffing support in the day reflected flexibility in the provision of a person centred day service in an individuals home.

There was a current and proposed roster in place that was well maintained and accurately reflected the staff on duty. The person in charge had access to the provider's relief panel if required to cover planned or unplanned leave. The inspector saw that the use of agency staff in the centre had significantly reduced and there was consistency in the centre staffing arrangements. The apartment downstairs was staffed by one staff during the day and one staff at night. The second apartment upstairs had flexibility in staffing between one and two members of staff by day that reflected residents' day service needs and a single staff member was present by night.

Judgment: Compliant

Regulation 23: Governance and management

The provider had ensured there were lines of authority and accountability in place. The person in charge was employed in a full time capacity and also had responsibility for two other centres operated by the provider. They divided their time equally between the three centres.

The provider had established oversight systems in place which included six monthly unannounced visits and an annual review. The annual review did not contain evidence of consultation with residents and their representatives as required by the Regulation. The providers' auditing systems had identified a number of actions that were required and an audit action plan was in place. The inspector found however, that there was no clear system in place to review progress towards these actions and where they had not been completed by the stated timeline evidence was not present to demonstrate these actions had been followed up. The inspector found a number of actions identified by the provider in audits completed December 2023 and again in January 2024 that remained incomplete on the day of inspection for example. While the inspector acknowledges that these monitoring systems were available and in use they needed to be consistently reviewed and the action plan mechanisms needed to be effectively implemented.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

The provider and person in charge had a system in place for the recording, management and review of incidents in the centre. The inspector reviewed the record of incidents and found that the person in charge had notified the Chief Inspector of all incidents as required by the Regulation. These notifications had been completed in the required format and within the specified timeframe.

Judgment: Compliant

Quality and safety

Overall the residents were supported and encouraged to engage in activities of their choosing and to have a good quality of life. Residents were involved in the day-to-day running of their homes and participated in discussions and decisions on what they were going to do on a daily basis.

They had access to the support of the relevant multidisciplinary team members and were supported to understand their rights and what to do if they had any worries or concerns. Some improvements were found to be required to ensure resident rights were upheld in all circumstances. They were supported to stay in contact with the important people in their life.

Regulation 12: Personal possessions

The provider had previously identified that all residents did not have consistent access to bank accounts which was as a result of the systems in place within the organisation in addition to challenges for residents in engaging with financial institutions. As part of their focused improvements in this area the provider has introduced a card system to support more regular access to their money for residents. Systems of oversight on this card run alongside systems of oversight for accounts and of cash management and other card expenditure. The inspector found that errors of oversight are occurring with staff inputting details on the wrong system sheet. While improvements have been made in this area, a clearer and more accurate standard of recording and consistent application was required regarding all aspects of residents finances

The provider had completed reviews of their financial oversight systems over the

course of this year. While the inspector acknowledges that some improvements had been made, they required further review to consistently protect residents' possessions. In this centre for example, access to resident account statements for the purposes of reconciliation of expenditure or overview of income were inconsistent. For one resident statements had not been available since March 2023 although the person in charge was endeavouring to review the balance on a regular basis. In addition, while items were recorded as having been purchased for individuals these were not reflected on residents possession lists for all individuals. The inspector found that residents possession lists were not consistently updated even following substantial expenditure for one resident home furnishings of €669.75 for example were not recorded and for another resident the purchase of an electronic item of €129.99 was not recorded.

None of the residents in this centre had completed an assessment of their capacity to manage their finances and decisions on money management plans were made in the absence of this information. One resident had been supported to have monitor their funds via an online banking system however, they had deleted this without staff support and there was limited oversight possible as an outcome.

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Judgment: Not compliant

Regulation 17: Premises

This centre was a large detached property in a residential area on the outskirts of Kilkenny city. The property had been subdivided into two self contained apartments each with its own front door and access to own garden to the rear. The premises were well maintained and where minor works were required the provider had a system in place to record prioritise these. The premises was clean, warm and comfortable and residents reported that they liked their home.

The provider and person in charge had personalised each of the apartments for the residents who lived in them and the bedrooms were painted and decorated to individual taste and preferences. Communal areas were spacious and comfortable with residents personal items available for their use.

Judgment: Compliant

Regulation 28: Fire precautions

The provider had ensured that fire safety systems were in place in the designated centre. Staff had completed fire safety related training and residents had personal

emergency evacuation plans which were reviewed and updated regularly. There was a centre evacuation procedure in place that detailed emergency procedures for staff.

Residents were supported to become aware of fire safety procedures. This was particularly important as one resident in particular was reluctant to evacuate at times. Fire drills were occurring regularly and the records of these were detailed in nature and clearly identified the supports residents required to safely evacuate. The person in charge on review of these had additional supports in place to ensure all three residents would evacuate and this had been successful during the most recent fire drill.

There were systems to ensure that fire equipment was serviced and maintained. Daily and weekly checks were occurring of fire fighting equipment, means of escape and fire containment. measures.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

The provider had policies and procedures in place for the safe management, monitoring and review of medicines.

Where medication errors and omissions had been found previously in the centre the provider had reviewed same and reviewed the controls and checks in place. There was evidence that staff were trained and supported to maintain their skills. However, the inspector found that some practices required review. Medications had been administered on the morning of the inspection and not recorded on the administration records. In addition errors in record keeping for the administration of control medicines were found with an incorrect date recorded on a number of occasions which created a potential for a mismatch in stock level recording.

One medication administration plan was found not to have been updated or reviewed within stated timelines despite this having been identified as an action by the provider in their audit four months earlier. In addition none of the three residents had completed an assessment of their skills nor consideration of their ability to possibly self-administer medication.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Each resident had an assessment of need and personal plan in place. Language in

residents' plans was person-first and positively described residents' care and support needs, and their likes, dislikes and preferences.

These plans are reviewed on a monthly basis to consider progress against residents stated goals and steps in place to meet these. These goals were varied and reflected residents' interests such as going to zumba classes or meeting friends as well as home related goals such as participating in household tasks. In all instances residents had the opportunity to guide and direct their day.

Judgment: Compliant

Regulation 6: Health care

Residents were supported to enjoy best possible health. They had their healthcare needs assessed and were supported to access health and social care professionals. An overview of medical appointments was maintained to allow for planning and scheduling of appointments and residents were supported in accessing these.

Where residents had complex health needs there were detailed plans in place that provided guidance to staff such as in the management of complex eating, drinking and swallowing difficulties or management of epilepsy. Where residents had been acutely unwell there were clearly documented reviews of plans that had been used to ensure that any changes in guidance were reflected.

Judgment: Compliant

Regulation 7: Positive behavioural support

The provider and person in charge ensured residents had support to maintain best possible mental health. There were appropriate supports in place for residents in relation to positive behaviour support. Residents had their needs assessed and behaviour support plans were in place for those who required them. These were detailed in nature and clearly guiding staff practice. Residents had access to psychiatry and psychology in addition to behaviour support specialists where required.

Improvement was required however, in the identification and monitoring of restrictive practices. There were a number of identified restrictive practices in place which were recorded on the centre register. The inspector found that the register was dated as last reviewed in September 2023 and this was also the date of the residents' restrictive practice support plans. However, other practices that were now in place and had been discussed by the providers restrictive practice review committee in January 2024 had not been added to the register nor monitored or

reviewed in the centre. These included for example, night checks for residents and a lock on their electronic tablets that prevented resident access without support.

Judgment: Substantially compliant

Regulation 8: Protection

The provider had a safeguarding policy and procedures in place to guide staff practice. Staff who spoke with the inspector were knowledgeable in relation to their roles and responsibilities.

Notwithstanding the area covered under Regulation 12, all allegations and suspicions of abuse were reported and followed up on in line with the provider's and national policy. There was evidence of the person in charge having put in place robust investigations in relation to any allegation, incident or suspicion of abuse. Safeguarding plans were developed and reviewed as required. Residents had assessments completed which guided the development of intimate and personal care plans. Areas where residents may be vulnerable had been considered and the associated risks assessed to guide the development of personal support plans.

Judgment: Compliant

Regulation 9: Residents' rights

The inspector found that for the most part the rights and diversity of residents was being respected and promoted in the centre. Residents' personal plans, keyworker meetings and their goals were reflective of their likes, dislikes, wishes and preferences. For one resident however, the inspector found documentation relating to end-of-life care that was not relevant to the resident's current presentation with no evidence that this had been discussed with the resident in an ongoing capacity.

For the most part discussions had taken place to support residents in understanding their rights and these conversations were supported with easy to read and picture supported information. Improvement was required however, in the sharing of some information with residents for example when a residents' provider held financial account was overdrawn there was no evidence that this deficit was discussed. The lack of capacity or competence assessments in areas already highlighted such as medication and finances also results in residents abilities in these areas not fully identified.

Residents were very complimentary towards how staff respected their wishes and listened to what they had to say. They talked about choices they were making every day in relation to areas such as where and how they spent their time, what they ate

and drank, and how involved they were in the day-to-day running of the centre.
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 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 12: Personal possessions	Not compliant
Regulation 17: Premises	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Park View OSV-0005828

Inspection ID: MON-0042673

Date of inspection: 16/04/2024

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	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
Actions on provider level:
1. The provider has moved to an on-line audit system (ViClarity) where a new template for the annual review has now been developed, which includes a section that identifies consultation with people supported and their representatives. This new audit will be fully implemented on ViClarity by 31.05.2024.
2. All PICs in Aurora are reporting to the DOS and ADOS in the PIC Monthly Status Report the number of Provider Audit actions Completed, Overdue and In Progress. The template has been updated and will be implemented for all May 2024 reports.
3. As part of Aurora provider audits the lead & functions auditors escalate a concern identified during an audit to DOS & relevant head of functions and can re-audit to assess progression on actions.

Actions taken on designated center level:
4. The PIC is actively working on the most recent audit action plan on the ViClarity system, address actions and update ViClarity as actions are closed out.
5. The PIC discussed audits & actions with the Parkview team in April team meeting and has now added audits as a standing topic on agenda at each team meeting, and will discuss audit actions with each team member also at Quality Conversations.
6. The PIC is delegating actions through the delegated duties system.
7. The SCW & Nurse have been identified to support on the job mentoring to the team for delegated duties and audit actions. The PIC has discussed this in quality conversation on 07.05.2024. The PIC will delegate from action plan will review on a weekly basis and update/close actions on vi-clarity.
8. The Lead auditor is attending the team meeting scheduled for 25.06.2024 to deliver overview on audits, responsibilities, actions and closure of actions to the team.

Regulation 12: Personal possessions	Not Compliant

Outline how you are going to come into compliance with Regulation 12: Personal possessions:
1. Aurora updated the policy on Person Supported Personal Property, Finance & Possessions, which was sent to each designated center on 07.03.2024.
- The PIC has added this policy to the agenda for May team meeting and has advised all team members to read prior to the meeting to discuss the systems to be adhered to.
- 4.1 on the policy outlines that the money management competency assessment form was reviewed and removed in line with ADMC legislation. Key Teams will support each person supported with their finances through skills building, Circle of Support meetings, developing spending plan and reviewing finances with person supported at monthly reviews.

2. On the job mentoring on finances, pathways & processes will be completed with all team members by 21.06.2024.
3. Circle of support meetings were held on the 14.5.2024 for two people supported to follow up on necessary improvements in relation to their finances. The PIC will support persons supported to schedule a meeting with one person bank to regain access to their account by latest 20.05.2024.
4. Easy reads on accessing statements will be completed with each person supported by latest 30.5.2024.
5. A review on the assets list is being completed by staff delegated with finance duty, this will be completed by latest 24.05.2024
6. As part of the Personal Plan framework, Finances and assets lists will be reviewed monthly by members of key team and PIC will provide oversight at this review
7. PIC has identified that all staff to receive personal plan framework training by 28.6.2024.
8. The PIC will maintain oversight through monthly finance audits in the designated Centre.

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
1. Training and reflection using the Gibbs model will to be completed with the team by the community liaison nurse by 20.06.2024. The staff nurse in Parkview will complete with any staff member that is not in attendance at the team meeting.
2. The Medication Administration Plan for a person supported was updated on the 16.04.2024 and the other two people supported medication plans were reviewed.

3. The Nurse & SCW in Parkview will finalise Medication administration assessments for three people supported by latest 13.06.2024.

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support: 1. Restrictive Practice Register was updated by the PIC to include identified restrictive practices on 09.05.2024. 2. PIC will provide training to the staff team using the HIQA PowerPoint on restrictive Practices June 2023 & Frequent asked questions by 29.06.2024.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights: 1. Staff removed documentation relating to end-of-life care removed from persons file on 16.04.2024. 2. A full file cleanse for each person supported on their personal plan folder will be completed by 29.05.2024. 3. On the 10.04.2027 team member discussed finances with the person supported, also scheduled Circle of support to review resident's finances, which was completed on the 14.05.2024 with a focus on information sharing and identifying the deficit. 4. Focus on future planning meetings are held weekly for each person supported and will include any information that is required to be shared. 5. Finances will be discussed with person supported at monthly reviews going forward, using appropriate communication tools, reviewing person's asset lists and spending in line with persons roles.

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 12(1)	The person in charge shall ensure that, as far as reasonably practicable, each resident has access to and retains control of personal property and possessions and, where necessary, support is provided to manage their financial affairs.	Not Compliant	Orange	25/05/2024
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Substantially Compliant	Yellow	29/05/2024
Regulation 23(1)(e)	The registered provider shall ensure that the	Substantially Compliant	Yellow	29/05/2024

	review referred to in subparagraph (d) shall provide for consultation with residents and their representatives.			
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	07/06/2024
Regulation 29(5)	The person in charge shall ensure that following a risk assessment and assessment of capacity, each resident is encouraged to take responsibility for his or her own medication, in accordance with his or her wishes and preferences and in line with his or her age and the nature of his or her disability.	Substantially Compliant	Yellow	13/06/2024
Regulation 07(4)	The registered	Substantially	Yellow	29/06/2024

	provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.	Compliant		
Regulation 07(5)(c)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation the least restrictive procedure, for the shortest duration necessary, is used.	Substantially Compliant	Yellow	29/05/2024
Regulation 09(2)(a)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability participates in and consents, with supports where necessary, to decisions about his or her care and support.	Substantially Compliant	Yellow	29/05/2024