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:	Rose Lodge
Name of provider:	Resilience Healthcare Limited
Address of centre:	Kildare
Type of inspection:	Unannounced
Date of inspection:	08 January 2024
Centre ID:	OSV-0008576
Fieldwork ID:	MON-0042268

About the designated centre

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

Rose Lodge is a designated centre which can provide full-time residential services for up to four male or female adult residents. It is situated on the outskirts of a large town in Co. Kildare. There are a number of vehicles available in the centre to support residents to visit their family and friends and to access their local community. Rose Lodge can provide a high support service for adults with Prader-Willi Syndrome who may present with complex needs. The house is sub divided into four self-contained apartments and there are a number of communal areas such as a living room, sunroom, kitchen, utility room, and office. Residents' apartments have a living room, kitchenette, bedroom and bathroom. There is a driveway at the front of the house and a garden to the back. Residents are supported 24/7 by a staff team consisting of a person in charge, service manager, and support workers.

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
Monday 8 January 2024	09:50hrs to 17:30hrs	Marie Byrne	Lead
Monday 8 January 2024	09:50hrs to 17:30hrs	Sarah Cronin	Support

What residents told us and what inspectors observed

From what residents told us and what inspectors observed, residents were engaging in activities in their community in line with their interests and were living in a pleasant environment. The findings of this unannounced risk-based inspection were that the provider had improved its levels of compliance across a number of regulations since the last inspection. However, improvements continued to be required in relation to staff training and development, governance and management, fire precautions, medicines management, and residents' rights. These will be discussed in the body of the report below.

The designated centre is a large two-storey house in the countryside outside a town in Co. Kildare. The centre opened in July 2023 and is currently home to three residents who have a diagnosis of Prader-Willi Syndrome. Residents in the centre were young adults who had all moved into the designated centre from their family homes, and were in a period of transition into residential care and living with others. The house has four self-contained apartments, each with their own sitting room, bedroom and bathroom. Two of these apartments were located on the ground floor and two on the first floor. Residents had their own keys to their apartments and these were decorated in line with residents' interests and preferences. There is a shared sitting room and dining room. The kitchen area was not accessible to residents and the door was locked at all times in line with residents' assessed needs. Since the last inspection, the office had been re-located to a building to the rear of the house. The premises was found to be warm, clean and tidy and well suited to residents' assessed needs.

Residents in the centre communicated using speech, facial expressions, body language and at times, behaviours of concern. The inspectors of social services had the opportunity to meet two of the three residents on the day of the inspection. One resident showed inspectors their apartment which was nicely decorated and personalised. The second resident was out shopping in the morning and met inspectors later in the day. Residents spoke with inspectors about where they liked to go shopping and things they enjoyed. Residents had time with their families over the Christmas break which they enjoyed. One resident spoke with inspectors about their relationship with other residents in the centre. They told inspectors that things were good in the house but that they didn't always get on with their peers. They said staff were there to support them during these times. They spoke about enjoying spending time in their apartment alone and told inspectors how they would seek staff support if they needed it.

Residents in the centre had busy schedules which included going to a local gym, going to the library, going to mass, going horse-riding and going for walks. The management team told inspectors that they were looking at accessing a day-service 'hub' in line with national policy in a town nearby. The hub had done community mapping exercises to enable the residents to explore amenities on offer. Managers spoke about their plans for residents to access the hub independently of other

residents with support from staff in the centre. Residents required clear structure in relation to their routines. There was a specific dietary plan in place for each resident and inspectors found that staff were familiar with these plans. Residents had meetings once a week and meal planning took place on an individual basis with key workers, in line with dietary recommendations. It was evident that residents were making choices in relation to their routines, within the context of their personal plans and assessed needs.

There had been some incidents which had occurred in the centre between peers since the last inspection. These incidents negatively impacted upon residents' rights in a number of ways. Residents freedom of movement was negatively impacted on due to a residents' behaviours of concern. When a resident was exhibiting behaviours of concern, this required residents being redirected from the communal area to their apartments, or some incidents had required residents to remain in an area of the centre with staff until it was deemed safe to leave that space. Residents' right to privacy was negatively impacted at times due to residents entering each others apartments and engaging in property destruction or taking one anothers possessions such as keys and phones. There had been some safeguarding incidents which had also had a negative impact on residents' quality of life in the centre. The provider was working with residents and staff to mitigate the risks of these incidents occurring in the centre.

Inspectors had the opportunity to speak with three members of staff on the day of the inspection. They reported that they had completed training on a human-rights-based approach in health and social care. While some did not have specific examples about the impact of this training, they described how it prompted them to think about how they provide support for residents. One staff member spoke about their renewed focus on residents' rights after completing the course. They spoke about the importance of residents making choices, of positive risk-taking and of discussing options and alternatives with residents on an ongoing basis. One resident told inspectors that there were a lot of different staff but that they knew most of them. The spoke about making choices daily and said "I get to use my opinion". They spoke about what they would do if they had any worries or concerns. Interactions observed between staff members and residents on the day of the inspection were found to be respectful and kind.

In summary, from what residents told us and what inspectors observed, residents were busy engaging in activities they enjoyed. However, improvements were still required in relation to staff training and development, governance and management, fire precautions, medicines management, and residents' rights. The next two sections of the report present the inspection findings in relation to the governance and management and how these arrangements affected the quality and safety of residents' care and support in the centre.

Capacity and capability

This inspection was completed to follow up on the actions outlined by the provider in the compliance plan following an inspection in the centre in October 2023 which found poor levels of compliance in a number of areas such as staffing numbers and continuity of care, staff training and supervision, the provider's oversight and monitoring of care and support for residents, risk management, fire precautions, medicines management, and safeguarding and protection. Due to the poor levels of compliance, the provider was invited by the Chief Inspector to attend a cautionary meeting. In addition, in November 2023 following the submission of a number of notifications relating to allegations of abuse and injuries for residents where medical or hospital treatment was required, a provider assurance report was issued. While outlining the responsive actions that the provider was taking to implement control measures to reduce presenting risks, a further trend of notifications was received in December 2023.

The provider had management systems in place in the centre to oversee and monitor residents' care and support. The provider's first six-monthly review had been completed and this review recognised that improvements were required in relation to residents' plans, staff training, the premises and risk management. An annual review was not yet due as the designated centre was open less than 12 months. Inspectors found that while audits were being completed, some of these were not effective in identifying areas requiring improvement, particularly in the areas of incidents and accidents, fire precautions and medicines management. Furthermore, inspectors found that where actions were required to bring about improvements, these were not completed.

The provider had successfully recruited a number of staff since the last inspection, three staff were due to start in the weeks following the inspection. In the interim, regular agency staff were completing the required shifts. In addition, the provider had recruited a person in charge who would be based in this centre full-time. They were in the process of receiving induction and handover from the current person in charge at the time of the inspection. In addition, the provider was in the process of recruiting for a full-time team leader for this centre.

Significant efforts had been made by the provider since the last inspection to ensure that staff had the required training and competencies to support residents in line with their assessed needs. This included bespoke area-specific trainings, on-the-floor mentoring and supervision, and competency assessments relating to medicines management. Despite these improvements, mandatory training sessions were outstanding in areas such as fire safety, managing behaviours of concern and positive behaviour support. Management had made arrangements for staff to do these training sessions, but they had failed to attend. These were booked in for the weeks following the inspection. Staff were in receipt of regular formal supervision and staff who spoke with inspectors said they were well supported in their role. One staff member did say that the system for accessing templates and documentation required review as at the time of the inspection this could only be accessed by the person in charge and service manager.

Regulation 15: Staffing

The provider had recruited to fill a number of staff vacancies since the last inspection. From a review of a sample of staff rosters, it was evident that efforts were being made to ensure continuity of care and support for residents through regular agency staff completing the required shifts while waiting for new staff to start working in the centre. In addition to filling the current vacancies, the provider was in the process of recruiting more staff to work in the centre prior to another resident transitioning into the centre. There were planned and actual rosters in place and these were well maintained.

Judgment: Compliant

Regulation 16: Training and staff development

Improvements had been made in staff training since the last inspection. This included provision of bespoke training relating to residents' behaviour support plans by a behaviour support specialist. However, some staff had not completed some key trainings in line with the provider's policies and residents' assessed needs. For example, a small number of staff required training in fire safety, CPR, managing behaviour of concern, and positive behaviour support. Inspectors acknowledge that some staff had been booked onto these trainings and did not attend. More training dates were being made available in the weeks after the inspection.

Staff were in receipt of regular formal supervision. Staff training, competencies and skills were discussed at these meetings. In addition, areas where staff could further develop their skills were also discussed in order to ensure that staff were carrying out their roles and responsibilities to the best of their abilities and taking responsibility for the quality and safety of care and support they were delivering.

Judgment: Substantially compliant

Regulation 23: Governance and management

Inspectors noted that there had been improvements in relation to the implementation of the provider's policies, procedures and systems since the last inspection. However, inspectors found that the systems for oversight and monitoring were not fully effective at the time of the inspection and that the provider required further time to fully implement these systems and the actions from their audits and reviews. For example, incident trending was completed by key workers and presented at staff meetings; however, there was no system in place to capture

incident trending by the local management team. The local management team had identified that staff needed to add more information and detail to incident reports. This was documented in staff supervision records and had been discussed at three staff meetings prior to the inspection. This had not brought about the required improvement based on the sample of incident reports reviewed by inspectors. Other examples of where audits were not proving fully effective were in relation to fire precautions and medicines management and these will be discussed under Regulations 28 and 29.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

The provider had not notified the Office of the Chief Inspector of three incidents which had occurred in the centre within specified time lines.

Judgment: Not compliant

Quality and safety

Residents were being supported to engage in activities they enjoyed on a regular basis and to maintain relationships with family and friends. There were two vehicles assigned to the centre to support them to access their local community. A number of actions had been taken by the provider since the last inspection which had brought about improvements in relation to their care and support, and their home. However, some further actions were required to ensure they were in receipt of a good-quality and safe service. Inspectors found that improvements had been made in relation to risk management, positive behaviour support, and safeguarding and protection. Areas identified where further improvements were required included fire precautions, medicines management and residents' rights.

Residents were protected by the policies, procedures and practices relating to risk management in the centre. There was an online system for capturing incidents, accidents and near misses. There were general and individual risk assessments in place and a number of these had been reviewed since the last inspection to ensure that the risk ratings were reflective of the the risk. Documentation relating to incidents required improvement and this is captured under Regulation 23: Governance and Management.

Since the last inspection the provider had employed the services of a fire safety expert and, as an interim measure, a hold-open device had been fitted to the door between the living room and the hallway. This was not in working order on the day

of the inspection. Fire drills were occurring regularly and residents' personal emergency evacuation plans were reviewed and regularly updated. Work was ongoing to support one resident to evacuate the centre in a timely manner in the event of an emergency.

In line with findings of the previous inspection, inspectors found that the systems to ensure the safe administration of medicines required review. Staff had received additional training, competency assessments had been completed and the frequency of completion of audits had increased since the last inspection. However, inspectors found that omissions and errors relating to the administration of medicines continued to occur and while the majority of these were picked up on audits, some were not.

Residents living in the centre had access to a behaviour specialist and had positive behaviour support plans in place which were regularly reviewed. Plans were reviewed to ensure that they were comprehensive and included all behavioural and therapeutic interventions for residents to guide staff practice. There were some restrictive practices in place. These were assessed and reviewed by a restrictive practice committee. Staff were able to describe what they would do in the event of an emergency unplanned restriction being put in place.

Residents were protected by the safeguarding policies, procedures and practices in the centre. Safeguarding plans were developed and reviewed as required. Following a recent trend of allegations of abuse, the provider had implemented a number of additional control measures and they continued to review these to ensure they were proving effective.

As outlined at the beginning of the report, residents' rights in the centre were negatively impacted upon due to behaviours of concern. Freedom of movement within the centre was impeded at times, requiring residents to vacate the communal area or to stay inside their own apartments. One incident of concern had occurred involving a resident accessing another resident's living space and engaging in property destruction, impacting upon their right to privacy and dignity in their home.

Regulation 26: Risk management procedures

The registered provider had systems in place for the assessment, management and ongoing review of risk including a system for responding to emergencies. Risk management systems had improved since the last inspection. For example, the risk register and risk assessments were now reflective of the actual risks in the centre. Incidents were documented by staff on an online system and reviewed by management. Incident forms were found to lack detail in order to ascertain what had happened prior to the incident taking place, during the incident and steps taken after the incident. This was identified by the provider and is addressed under Regulation 23: Governance and Management.

Judgment: Compliant

Regulation 28: Fire precautions

An immediate action was issued to the provider in relation to a fire door following the last inspection. This had been repaired. However, this was not functioning on the day of the inspection, meaning that fire containment in this area of the building was compromised. The door frame appeared to be moving when the door was closing and the door was observed to stuck half-open and half-closed on one occasion and had to be manually closed. The manual release button for the closing mechanism was difficult to access as it was situated very close to three shelves on the wall beside the door. The provider reported that they had ordered a replacement door which was due to be fitted once it was delivered.

Regular fire drills were occurring in the centre and residents were being supported with social stories and staff supports to evacuate in the event of an emergency. However, it remained the case that it could not be demonstrated that one resident could safely evacuate the centre in the event of an emergency. This was captured in a resident's risk assessment and personal emergency evacuation plan and the provider continued to complete drills and consider alternatives to support the resident to safely evacuate.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

Practices on the safe administration of medication continued to require improvement. Regular audits were being completed and these were picking up on the majority of errors and omissions; however, in addition to the errors and omissions picked up in these audits, inspectors reviewed a sample of residents' administration records and found a number of errors and omissions which had not been captured in one recent audit. Examples of errors and omissions included a number of occasions where prescribed medicines had not been signed as administered on residents' administration records, an occasion where a resident refused a prescribed medicine and this was not recorded in the administration records, and an occasion where one medicinal product was administered two hours later than it was prescribed.

Judgment: Not compliant

Regulation 7: Positive behavioural support

The provider had ensured that positive behaviour support plans were in place and that they gave clear guidance to staff in relation to proactive and reactive strategies to use for each resident. Bespoke training had also been provided. Restrictive practices were in place in the centre and these were reviewed by a restrictive practice committee.

Judgment: Compliant

Regulation 8: Protection

The provider had implemented actions which it committed to in the compliance plan from the previous inspection. Since the last inspection, there were a number of peer-to-peer incidents occurring in the centre. Inspectors found that these were identified, reported and investigated in line with national policy. Safeguarding plans were in place, and there was evidence of detailed safeguarding plans at centre level and for individual residents. Input from members of the multidisciplinary team had been sought in relation to these plans. Guidance in relation to residents' personal care needs was clear to guide staff practice and to ensure that residents' rights to dignity and bodily integrity were upheld. It was evident that the local management team were ensuring that residents were appropriately supervised when in communal areas.

Judgment: Compliant

Regulation 9: Residents' rights

Residents were supported to exercise choice and control in their daily lives within the context of their personal plans. However, as outlined at the beginning of the report, residents' rights were negatively impact due to behaviours of concern occurring in the house. For example, freedom of movement was impacted upon a number of times due to residents being redirected to or remaining in their own apartments when a peer was engaging in behaviours of concern. Residents' privacy was compromised by other residents entering their apartment and engaging in property destruction.

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 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 31: Notification of incidents	Not compliant
Quality and safety	
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Rose Lodge OSV-0008576

Inspection ID: MON-0042268

Date of inspection: 08/01/2024

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 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: All outstanding training identified in the training matrix will be booked for staff to attend as soon as possible. The training matrix is maintained and updated by the service manager on an ongoing basis	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: There is a new Service manager now in place. She will take over as PIC once settled in her role. We are also currently recruiting for a team lead. The service manager will continue to carry out weekly medication audits. All staff will participate in a medication administration theory refresher. Ongoing practical medication administration training will continue for staff in Rose Lodge as required. The service manager will implement a double check system on medication administration to promote best practice. All staff in Rose Lodge will be required to complete report writing training in the coming weeks. Incident reports will continue to be reviewed and discussed at the monthly team meetings or more often if required. Where necessary the Clinical services team are involved in the review of incidents to provide additional support and insight for the residents and the team.	
Regulation 31: Notification of incidents	Not Compliant
Outline how you are going to come into compliance with Regulation 31: Notification of incidents: All notifications will be sent to HIQA within the required time frames. The PIC reviews all incident reports in line with Resilience policies and procedures.	
Regulation 28: Fire precautions	Not Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: The door from the hall into the communal living area has been replaced. Resilience property coordinator will visit Roselodge on 21/03/2024 to ensure that the fire door meets the relevant fire safety regulations. The Roselodge team will continue to support residents to follow evacuation procedures during fire drills. All risk assessments and	

personal emergency evacuation plans will be reviewed and updated as required.	
Regulation 29: Medicines and pharmaceutical services	Not Compliant
Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services: There is a new Service manager now in place. She will take over as PIC once settled in her role. We are also currently recruiting for a team lead. The service manager will continue to carry out weekly medication audits. All staff will participate in a medication administration theory refresher. Ongoing practical medication administration training will continue for staff in Rose Lodge as required. The service manager will implement a double check system on medication administration to promote best practice. A staff nurse has commenced a full time role in Rose Lodge from 19/02/2024	
Regulation 9: Residents' rights	Not Compliant
Outline how you are going to come into compliance with Regulation 9: Residents' rights: Residents are protected by safeguarding, policies, procedures and practices in place. While there is currently a safeguarding plan in place residents do not have to stay in designated areas until the incident has abated. The safeguarding plan is not only designed to ensure safety but also to ensure freedom of movement to continue with planned activities for the remainder of the day. The areas that residents move to as part of the safeguarding plan ensure that there is an external door to provide safe exit from the building to proceed to their chosen activities. The safeguarding plan will be reviewed and amended in conjunction with the clinical services team as and when required. Each resident has a key to their own apartment and they are encouraged and reminded to lock their apartment doors when they are not at home. At residents meetings, the residents are reminded that it important to respect each others privacy, dignity and property. As Roselodge is a Prader Willi Specific Service it is recognised that residents may engage in property destruction when they are upset or anxious. All residents have a positive behaviour support plan in place to help them to manage this behaviour.	

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	31/03/2024
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	31/03/2024
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and	Not Compliant	Orange	28/02/2024

	extinguishing fires.			
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 case of fire.	Substantially Compliant	Yellow	28/02/2024
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.	Not Compliant	Orange	31/03/2024
Regulation 31(1)(f)	The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: any	Not Compliant	Orange	20/02/2024

	allegation, suspected or confirmed, of abuse of any resident.			
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	31/03/2024
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	31/03/2024