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:	Forest View Apartments
Name of provider:	Western Care Association
Address of centre:	Mayo
Type of inspection:	Unannounced
Date of inspection:	16 September 2024
Centre ID:	OSV-0001783
Fieldwork ID:	MON-0043879

About the designated centre

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

Forest View apartments is a designated centre which has been designed to provide full-time accommodation for three residents. The service can accommodate both male and female adults who may have autism, additional complex needs and behaviours of concern. The centre consists of three individualized apartments and separate staff accommodation which is adjacent to the apartments. The centre is located in a rural setting and is within walking distance of a day centre, which some residents attend. Forest View apartments have access to their own transport to enable residents to access the community. A social care model is provided in this centre, and a combination of social care workers and social care assistants support residents with their daily needs. Residents are supported by up to three staff during daytime hours and two staff provide sleepover cover each night.

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 16 September 2024	13:30hrs to 17:40hrs	Alanna Ní Mhíocháin	Lead

What residents told us and what inspectors observed

This was an unannounced inspection of this centre. This inspection was a follow-up inspection to one that had taken place on 1 May 2024 and 16 May 2024. At that time, seven regulations were found to be not compliant. As a result, the provider was issued with a warning letter by the Chief Inspector of Social Services. In response to the warning letter, the provider submitted a plan to outline how they would come into compliance with the regulations. On this inspection, it was found that the actions, as outlined by the provider, had been implemented. These actions had resulted in better communication with staff and improved oversight of the service. The centre was also more accessible to residents. However, improvement was still required in order to ensure that residents had opportunities to access activities that were in line with their interests.

The centre consisted of three separate apartments in a rural location. Each resident had their own apartment. Each apartment had a bedroom, bathroom and kitchen-living room. Residents also had their own outdoor areas with garden furniture and potted plants. There was a central location between the three apartments that was used by staff. The apartments could be accessed through their own individual front door or through the central staff area. The central area had a staff office, two staff sleepover bedrooms and the laundry facilities for the three apartments.

The inspector had the opportunity to inspect all three apartments. Issues relating to the premises, which had been identified on the previous inspection, were addressed by the provider. This included the replacement of damaged items of furniture. A new couch had been purchased for one resident to replace a damaged one. The resident had added their own cushions to the couch to personalise it. Staff reported that the resident was very happy with their new couch. A new armchair had been ordered for another resident. The inspector reviewed emails between the person in charge and an occupational therapist confirming that the chair was due to be delivered soon. Accessibility had been improved for two residents. A shelving unit had been installed in one resident's bedroom. The person in charge reported that the resident could now point to items and that staff could get them for the resident. A shower chair had been purchased for a resident to replace a plastic garden chair that had been used previously.

The inspector met with all three residents during the inspection. Residents greeted the inspector and engaged with the inspector for a few minutes. They were supported by staff to speak with the inspector. Residents spoke about what was happening in that moment. They asked the staff for help, for example, one resident asked for a cup of coffee.

Staff were observed speaking to residents in a friendly manner. Staff were heard greeting residents warmly when they returned from their day services. They understood the residents' communication style and chatted comfortably with

residents. They responded quickly when residents asked for help.

In addition to the person in charge, there were two other members of staff on duty in the afternoon. The inspector spoke to one of those staff members. This staff member spoke about the ways that residents can decline choices that have been offered to them. They were knowledgeable on the residents' preferences. The staff member knew the strategies that should be used to support residents with their behaviour and gave an example of a recent incident where these strategies were used. This example was in line with the guidance that was in the resident's behaviour support plan.

The next two sections of this report present the inspection findings in relation to the governance and management in the centre, and describes about how governance and management affect the quality and safety of the service provided.

Capacity and capability

Overall, the inspector found improved arrangements for the management and oversight of the service. Staff training had been completed in mandatory modules and areas specific to the needs of residents. However, improvement was required in relation to the system for contacting management outside of regular hours and the information obtained through audit.

The provider maintained oversight of the service through the use of audit and incident reviews. Audits were completed in line with the provider's schedule. Where issues had been identified on audit, these were recorded on an action tracker document. However, the quality of information recorded on audit did not always drive service improvement. Incidents were reviewed regularly to identify any trends and to implement actions needed to reduce the reoccurrence.

Communication with staff had improved through regular team meetings, staff supervision and improved documentation in relation to the care and support of residents. Staff knew who to contact should any issues arise. However, the system to contact a member of management outside of regular business hours required improvement.

The staffing arrangements in the centre were in line with the residents' assessed needs. The number and skill-mix of staff on duty was appropriate. Staff had received training in modules that the provider had identified as mandatory. They had also completed training in areas that were identified as high-risk to residents.

Regulation 15: Staffing

The staffing arrangements in the centre were resourced to meet the assessed needs of residents.

The inspector reviewed the rosters from August 2024 and found that there were two members of staff on duty at all times. In addition, a third member of staff was on duty two evenings per week and for a number of hours over the weekend. The person in charge reported that this arrangement was flexible and that a third staff member could be rostered on different days or at different times, as required by the residents.

Judgment: Compliant

Regulation 16: Training and staff development

The provider had ensured that staff received appropriate training to meet the needs of residents.

The training records for staff were reviewed by the inspector. It was noted that most staff had up-to-date training in areas that the provider had identified as mandatory.

Since the last inspection, staff had completed training in areas that had been identified as high-risk in the centre. Staff had received training in supporting residents with feeding, eating, drinking and swallowing. They had also received training in manual handling. Where staff required refresher training, this had been identified by the person in charge and staff were enrolled for refresher training courses.

Judgment: Compliant

Regulation 23: Governance and management

The governance and management arrangements had improved since the previous inspection of the centre. However, further improvement was required in relation to the quality of information obtained through audit, the on-call arrangements for staff to contact senior management, and the centre's annual report.

The provider maintained oversight of the quality of service delivered to residents through the review of incidents and the use of a series of audits.

Incidents that occurred in the centre were reviewed on a three-monthly basis. The most recent review was completed in July 2024 and was viewed by the inspector. This quarterly review identified if there were any trends in incidents and if any

actions should be taken to avoid the reoccurrence of incidents.

The inspector reviewed the audits that had been completed in the centre since June 2024. It was noted that there had been an improvement in the completion of audits since the last inspection and all audits had been completed in line with the provider's schedule. Further, the person in charge had devised a document that recorded the actions that needed to be taken to address issues identified on audit. This document recorded the actions needed to address issues, the person responsible, and the target timeline for completion.

However, as had been noted in the previous inspection, the quality of information recorded on audit did not always identify areas for service improvement. For example, some audit questions were subjective and asked the opinion of the auditor, rather than the recording of fact. While the provider had plans to address these shortcomings, these had yet to be implemented on the day of inspection.

Communication with staff had improved since the previous inspection. Supervision sessions with staff had been scheduled and some had been completed. Team meetings occurred monthly in the centre. The inspector reviewed the minutes from the most recent staff meeting on 31 July 2024. This meeting covered issues relating to the care and support of residents, for example, a speech and language therapist attended the meeting to provide guidance to staff on how to support residents to communicate. The meeting also included operational issues relating to the centre, for example, updates on budget and staffing.

Staff knew who to contact should any issues arise. A system was in place to contact a member of management outside of regular office hours. This involved staff contacting the person in charge via telephone. If the person in charge was unavailable, staff were instructed to continue to the next most senior member of staff until they received a response. This system was not adequately robust to ensure that staff could always receive a timely response. The provider had plans to improve this system in the coming months. However, at the time of inspection, this had not yet commenced.

The provider had completed an annual report into the quality and safety of care and support in the centre. The most recent report was completed on 11 July 2024. While this report gave an overview of the service and identified six actions for improvement, it was not reflective of the issues that had been identified in the previous inspection of the centre or the quality improvement initiatives that were planned to address these issues.

Judgment: Substantially compliant

Quality and safety

Overall, the inspector noted that the provider had taken measures to improve the

quality of the service in the centre and to promote the safety of residents. This included a review of the residents' assessments of need, risk assessments and behaviour support plans. However, further improvement was required in relation to the supports given to residents to express their choices in relation to their social activities and personal goals.

The provider had made improvements to systems in the service that ensured the safety of residents. This was mainly achieved by ensuring that staff had the information that was necessary to support residents appropriately. Residents' risk assessments had been updated. They were comprehensive and gave guidance to staff on how to reduce risks to residents. The risk assessments were available for staff to read. This was also the case in relation to the residents' positive behaviour support plans. These had recently been devised by a suitably qualified professional, gave clear information to staff and were available for staff to read. Staff had received training in safeguarding and were knowledgeable of the steps that should be taken to report any concerns that may arise. Issues relating to damaged furniture and accessibility in the centre had been improved since the last inspection.

The provider had taken measures to ensure that residents received a person-centred service. The provider had reviewed residents' communication profiles and a speech and language therapist had provided information to staff at a team meeting. This meant that staff had up-to-date information on how to support residents to communicate their needs and wishes. Residents' assessments of need had been recently reviewed. This identified the residents' health and personal needs. However, improvement was required in relation to the assessment of the residents' social needs and the supports they required to meet those needs. This will be addressed under regulation 13: general welfare and development. While the provider had taken some actions to ensure that residents were supported to engage in activities that they enjoyed, further improvement in this area was required. It was not clear that residents had been consulted on the activities that they enjoyed. It was not clear if residents had been included in devising some of their personal goals. In addition, the provider did not have a concrete plan as to how they would support residents to express their choices in relation to their preferred activities and how these would be supported by staff.

Regulation 10: Communication

The provider had made arrangements to support residents to communicate their needs and wishes.

The inspector noted that residents' communication profiles had been updated since the previous inspection to reflect their current communication needs and supports. A speech and language therapist had attended the most recent staff meeting to provide information to staff on how to support residents with their communication. This meant that staff had the required information to support residents to communicate. Staff were observed interacting with residents and communicating

through verbal and non-verbal means.

Judgment: Compliant

Regulation 13: General welfare and development

Improvement was required in order to ensure that residents were supported to engage in activities that were in line with their interests.

For one resident, a goal had been set to support them to increase their routine social outings. This was identified in their annual review, personal plan, and through documents that identified what was important to the resident. A target of August 2024 had been set for this goal. However, at the time of inspection, this had not been addressed by the provider. The inspector reviewed the summary of the resident's daily activities for July and August 2024. This record indicated that the resident had limited opportunities to meaningful activities. The residents activities mainly consisted of going for walks in the vicinity of the centre and engaging in household chores. The resident had been supported to go on one outing to a local pub over the course of the two months. The person in charge reported that the resident had enjoyed this very much. However, there were no definite plans to repeat this trip or to include it as part of the resident's regular routine. It was unclear what supports would be required by the resident to access the local community and this had not been fully assessed by the provider.

The person in charge reported that the provider's wellbeing and enhancement practitioner was due to visit the centre the following week to assess the residents' interests. The inspector saw emails confirming this planned activity. However, at the time of inspection, the provider did not have a clear or concrete plan on how to support residents to engage in activities that were in line with their interests.

Judgment: Not compliant

Regulation 17: Premises

The design and lay-out of the centre were suited to the needs of the residents. The centre was clean and tidy. Residents' apartments had the required equipment to support residents with their activities of daily living. The centre was in a good state of repair.

As outlined in the first section of the report, the provider had addressed the issues that had been identified on the previous inspection of this centre. New furniture had been ordered and obtained for residents. This made the premises more comfortable and more accessible for residents.

Judgment: Compliant

Regulation 26: Risk management procedures

The provider had made arrangements to adequately assess, manage and review risks to the residents. There was a significant improvement in the individual risk assessments that had been devised for residents.

The inspector reviewed the risk assessments that had been developed for two of the three residents in the centre. These assessments had been devised within the previous month. The risk assessments had been signed by staff to indicate that they had read them and were familiar with their content.

The risk assessments were comprehensive and reflective of the risks to the residents. Adequate control measures to reduce the risks to residents had been identified and clearly outlined. This meant that staff had been given the necessary information to ensure that residents were kept safe.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The inspector noted improvement in the assessment of the needs of residents and the development of a personal plan.

The provider had completed an assessment of the health, social and personal needs of residents. The inspector reviewed the assessment completed with one resident. This had been completed in September 2024.

A personal plan had been developed for residents. In reviewing one resident's personal plan, the inspector noted that the plan had been completed within the previous 12 months. The plan included input from the resident's family and a review of the previous year's plan. Personal goals for the resident had been set.

Resident's notes contained risk assessments and care plans to guide staff on how to support residents with their health and personal needs.

Judgment: Compliant

Regulation 7: Positive behavioural support

The provider had ensured that staff had the required information to support residents to manage their behaviour.

The inspector reviewed two behaviour support plans. This plans had been developed by an appropriately trained individual and gave clear guidance to staff on how to support residents with their behaviour. Staff were knowledgeable on the contents of the plans and could give an example of how the strategies were used to support the residents. Most staff had up-to-date training in supporting residents manage their behaviour. Where refresher training was required, staff were enrolled to complete this training. Behaviour support was discussed at the most recent team meeting.

Where restrictive practices were required, these had been recorded in a log and referred to a restrictive rights committee. The inspector noted that the log had been reviewed on 3 September 2024.

The inspector reviewed the two most recent incidents that had been recorded in relation to a resident and found that these had been referred to the behaviour support service.

Judgment: Compliant

Regulation 8: Protection

The provider had taken steps to protect residents from the risk of abuse.

All staff had received in-person training in relation to safeguarding. Most staff also had also completed an online module in safeguarding. Staff were knowledgeable on the steps that should be taken should a safeguarding incident occur in the centre. The contact information for designated officers was displayed within the centre.

The inspector reviewed the intimate care plans for one resident and found that it gave very clear guidance to staff on how to support the resident. This plan was reviewed in September 2024.

Judgment: Compliant

Regulation 9: Residents' rights

The inspector noted an improvement in the systems in place to promote the rights of residents. However, further improvement was required in order to ensure that residents were routinely offered choices in relation to their daily lives and activities.

Since the last inspection, weekly resident meetings had commenced in the centre. The inspector reviewed the August 2024 meeting records for two residents. These

meetings offered the residents opportunities to express some of their choices, for example, meal choices. Information was shared with residents in relation to their rights. Staff were noted offering some choices to residents on the day of inspection. Staff were aware of the residents' preferences and dislikes. They could outline how the residents could decline choices that were offered to them. For example, staff knew the specific phrases used by residents that indicated that they wanted to return to the centre when they were on the bus.

However, it was not clear that residents were routinely offered choices. For example, in reviewing the personal goals for one resident, it was recorded that a new television would be purchased for the resident. However, it was unclear how the resident had been consulted or involved in setting this goal.

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 16: Training and staff development	Compliant
Regulation 23: Governance and management	Substantially compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 13: General welfare and development	Not compliant
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Forest View Apartments OSV-0001783

Inspection ID: MON-0043879

Date of inspection: 16/09/2024

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: The provider has submitted a business case to the commissioner of services to strengthen the current on-call arrangement. An Organisational On Call Arrangement to be implemented in Q4 2024. Currently stakeholder engagement is ongoing, implementation phase will commence as soon as stakeholder engagement has been completed. The pilot project commenced on 31/07/2024 which will explore technical solutions for audit management to ensure consistency across the organisation along with a systematic scoping review. The audits were presented to the PIC forum on 16/09/2024. The medication and staff file audit will be completed on the Viclarity system for quarter 3 2024. The provider will review and revise the annual report for the centre to ensure its reflection of issues identified in previous inspection of the centre, as well as the quality improvement initiatives planned to address these issues. This will be complete by 29/11/2024	
Regulation 13: General welfare and development	Not Compliant
Outline how you are going to come into compliance with Regulation 13: General welfare and development: On the 30/09/2024 the Person in Charge and Keyworker reviewed the progress of the quarterly update, goals and monthly logs. It was identified that while one resident does engage in household chores it was established that it promotes their interpersonal skills	

and communication, independence, and it involves them in household activities. The keyworker who has a very established relationship with the resident also identified that this particular resident can also indicate their choice if not interested in participating in household chores and their wishes are always accommodated.

Speech & Language Therapy are also working on areas of communication with the residents and this particular resident is involved in this program also. It was further recognized that while they do go for walks in the vicinity, they are also afforded walks in the local park, beach or in town. Again, all participation and activities are at their own discretion and choice. The resident enjoyed an outing at the pub which will be repeated in the next two weeks and will be a regular event for them going forward. Staff members who know them well have established that they prefer a quieter time where they can enjoy the atmosphere so between lunch and evening time will be the time for this activity. 18/10/2024.

The Person in Charge has recently completed an assessment of which needs to be finalized by 11/10/2024. This also captures and identifies the support required to access community connections.

The Person in Charge and keyworker have reestablished one resident's involvement in the local tidy town's initiative. There is evidence to show that this was something meaningful to the resident in the past.

Choices are presently being offered by pictures in magazines, brochures and apps on the resident's personal tablet. One of their goals is to buy a television by 31/12/2024. A meeting took place on 06/09/2024 where the resident indicated their choice of television, and a plan has been formulated to complete this action. The keyworker is to accompany them to shops etc. to buy the television with a timeline around the black Friday week.

Presently the Person in Chage is engaging with the Behaviour Support Practitioner (BSP) who specializes in wellness and enhancement. This program commenced with a focus on how the residents spend their time, have meaningful relationships and build up community participation.

On 24/09/2024 the BSP focused on establishing how people spend their evening times. The aim is to identify if there are areas that can be enhanced and how we can do this. This will also be assessed and reviewed through feedback, observation and documentation.

The next visit for the BSP specialist is scheduled for the week beginning November 4th 2024. In the intern staff team are trialing new activities.

• The provider's wellbeing and enhancement practitioner has begun a process to assess the residents' interests and quality of life. They will carry out a period of onsite observations within the service and provide feedback and recommendations which will be complete by 06/12/2024.

• Once this period of onsite observations is complete, the Person in Charge will arrange a meeting with the team, the wellbeing and enhancement practitioner, and speech and

language to review feedback and recommendations. The focus of this meeting will be to agree appropriate systems of offering and recording residents' daily choices in line with each person's interests and communication profiles. This meeting will occur before 17/01/2025

• Once an appropriate system of offering and recording residents' daily choices in line with each person's interests and communication profiles has been agreed, the Person in charge will ensure the implementation of these systems as well as regular review through the inclusion of this on the services fixed item agenda for future meetings. The implementation of these systems and mechanism for review will be in place before 21/02/2025.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:

• The provider's wellbeing and enhancement practitioner has begun a process to assess the residents' interests and quality of life. They will carry out a period of onsite observations within the service and provide feedback and recommendations which will be complete by 06/12/2024.

• Once this period of onsite observations is complete, the Person in Charge will arrange a meeting with the team, the wellbeing and enhancement practitioner, and speech and language to review feedback and recommendations. The focus of this meeting will be to agree appropriate systems of offering and recording residents' daily choices in line with each person's interests and communication profiles. This meeting will occur before 17/01/2025

• Once an appropriate system of offering and recording residents' daily choices in line with each person's interests and communication profiles has been agreed, the Person in charge will ensure the implementation of these systems as well as regular review through the inclusion of this on the services fixed item agenda for future meetings. The implementation of these systems and mechanism for review will be in place before 21/02/2025.

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 13(2)(a)	The registered provider shall provide the following for residents; access to facilities for occupation and recreation.	Not Compliant	Orange	21/02/2025
Regulation 13(2)(b)	The registered provider shall provide the following for residents; opportunities to participate in activities in accordance with their interests, capacities and developmental needs.	Not Compliant	Orange	21/02/2025
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	Substantially Compliant	Yellow	29/11/2024

	to residents' needs, consistent and effectively monitored.			
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	21/02/2025