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:	Mountain View
Name of provider:	Resilience Healthcare Limited
Address of centre:	Kerry
Type of inspection:	Announced
Date of inspection:	15 September 2021
Centre ID:	OSV-0007982
Fieldwork ID:	MON-0032571

About the designated centre

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

Mountain View a full-time residential service is provided to a maximum of four residents with Intellectual disability, and/or Autistic Spectrum Disorder and/or Challenging Behaviour and/or Physical / Sensory Disability, over 18 years of age and under 65 years of age. The service will operate 365 days a year. The provider aims to work with residents and as appropriate their families so as to provide residents with a safe home, with person-centred care and support linked to the local community in which the centre is located. The staff ratio in Mountain View is at an appropriate levels to meet the needs of every individual and this takes into account staffing on nights/evenings/weekends etc. The staffing ratio will particularly reflect the mix of adults in the service to ensure appropriate safeguarding.
The premises are a dormer type house located in a rural setting. Each resident is provided with their own bedroom and share communal, dining and sanitary facilities. The design, layout and available space were suited to the intended purpose and the individual and collective needs of the residents.

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 - 2015 as amended. To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 15 September 2021	09:00hrs to 16:45hrs	Laura O'Sullivan	Lead

What residents told us and what inspectors observed

This was an announced inspection completed to monitor compliance with the regulations. The centre had registered in April 2021 and became operational following this. The centre currently provided supports to three individuals with one vacancy. This was the first inspection of the centre.

On arrival the inspector was greeted by the person in charge and appointed team leader. Residents were being supported by staff to start their day routine. Following a brief introduction to the centre the inspector completed a walk around with the person in charge. Overall, the centre presented as a warm clean centre. Some areas identified at this walk around which required review included the privacy arrangements to the front of the property, containment measures in the centre and the closing of the external gate. This will be discussed further it the report.

The inspector met and said hello to the resident's whilst they were getting ready for their day in the main dining room in the centre. Residents chose not to interact with the inspector and this was respected. Interaction between staff and residents were observed to be positive in nature. Staff spoke of the residents schedule for the day which included a trip to the cinema as the weather was poor on the day of inspection. The music channel was playing on the TV and the environment was chatty and interactive.

From discussion with staff and review of documentation it was evident that the service provided to residents was paternalistic in nature. It was not evidenced that residents were consulted in the operations of the centre, consent for interventions was sought from family in such areas as medication and restrictive practices. Efforts were not evident to communicate information to residents in these areas in a manner which they could understand. Access to advocates had not been reviewed since the admission of residents to the centre.

Whilst efforts had been made to ensure that all residents were safe in the centre some improvements were required to ensure measures in place were consistently reviewed and implemented. For example, on the inspectors' arrival to the centre the main gate was open. Upon discussion with staff and review of such documents as risk assessments to be reported that this gate was to be closed at all. The opening of the gate had also been reported from a concerned person.

Following a significant incident actions to be completed had not been completed. For example, following an incident it was recommended for a fence to be installed to the exterior of the property. Despite re occurrence of similar incidents this action had yet to be completed. Where an incident had a potential impact there was no evidence that this had been reviewed. For example, should a resident remain awake at night or should property damage occur during an incident.

The registered provider had ensured the appointment of a clear governance

structure to the centre. The inspector met and spoke with the person in charge and team leader during the day of the inspection. However, the registered provider had not ensured that monitoring systems in place were effective to identity and address areas of non-compliance and drive service improvements. For example, whilst a medication audit had been completed this did not identity areas requiring improvement such as PRN (as required) protocols and inappropriate storage of medications.

The regulations reviewed as part of the inspection will be discussed in more detail throughout the remainder of the report.

Capacity and capability

The inspector reviewed the capacity and capability of the service provided to the resident within Mountain View. This was the first inspection of the centre since becoming operational in April 2021. It was not evident that there were management systems in place to ensure that there was effective oversight of the designated centre, and that it provided a safe service to residents in line with their assessed needs. Effective governance arrangements were not in place to ensure the service continued to provide a good quality service to residents.

A clear governance and management structure was in place, which outlined the lines of authority and accountability in the centre. This included the person in charge, who held the necessary skills and qualifications to fulfil the role. The person in charge was supported in the day to day operations of the centre by an appointed team leader. The person in charge at the time of inspection had governance responsibility in two designated centers. As the governance team were not present on the staff roster, staff informed the inspector that they were only aware if a member of the governance team were on duty if they were present in the centre.

The inspector was presented with an annual review of service provision for the centre. It was not clear from this report when this was completed and by whom. This report did identify a number of areas which required review including the requirement for external fencing and medication management system reviews. These actions remained outstanding with no clear plan to address these in presented. Where monitoring systems were in place these were not utilised to drive service improvements or identify areas of concern. For example, whilst a medication audit had been completed this did not identity areas requiring improvement such as PRN (as required) protocols and inappropriate storage of medications.

Some monitoring systems reviewed demonstrated lack of consultation with residents. For example, a review of individualised plans was completed. However, actions identified by the provider required consent and consultation with family members rather than joint consultation with the resident and their circle of support. Within this audit all areas were ticked as being reviewed and complete however, this

did not correlate with the information present within the service manager audit.

The registered provider had ensured the allocation of an appropriate skill mix of staff. Staff spoken with were very aware of the resident's needs. however, the staff roster reviewed did not consistently reflect that this allocation was present in the centre. Within the roster should a shift required to be filled this was not clearly reflected. This at times resulted in reduced staff members present, especially for community activities.

Regulation 14: Persons in charge

The person in charge appointed had the necessary experience and qualifications to perform the role. At the time of this inspection the person in charge was responsible for a total of two designated centres.

Judgment: Compliant

Regulation 15: Staffing

Appropriate staffing levels were allocated to the designated centre to support the assessed needs of the residents living in this designated centre. However, the planned and actual staff rosters in place did not reflect this these levels were consistently in place.

Judgment: Substantially compliant

Regulation 19: Directory of residents

The registered provider had ensured the establishment of the directory of residents.

Judgment: Compliant

Regulation 23: Governance and management

A clear governance and management structure was in place, which outlined the lines of authority and accountability in the centre.

The registered provider had not ensured that monitoring systems in place were

effective to identity and address areas of non-compliance and drive service improvements.

Judgment: Not compliant

Regulation 3: Statement of purpose

The provider had prepared in writing a statement of purpose containing the information as set out in schedule 1 of the regulations. However, this had not been reviewed as required such as conditions of registration and the governance structure in place.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

The person in charge had given in writing to the chief inspector details of any adverse incidents in the designated centre, within the allocated time frame.

Judgment: Compliant

Regulation 34: Complaints procedure

The registered provider had an effective complaints procedure in place that was appropriate for residents.

Judgment: Compliant

Quality and safety

Through a review of documentation and observations on the day of the inspection in was evident that the designated centre was not operated in a manner that was respectful of all residents valuing their individualism and was paternalistic in nature. Residents were not consulted in the day to day operations of the centre and consulted on all aspects of their support needs including personal plans the use of restrictive practices. Consent was sought from family members with no evidence of consultation with residents or access to advocacy services. Information was

presented to residents in an accessible format to promote understanding and participation. This will be discussed further within the report.

The person in charge had ensured that each resident had a comprehensive personal plan in place. These plans incorporated a holistic approach to support needs and incorporated guidance from relevant members of the multi-disciplinary team. However, improved consultation with residents was required to ensure the personal plan reflected the individual and unique interested of the residents. Residents were supported to be active in their community. They participated in a day activity programme which incorporated the use of a "hub" in the nearby town three days a week. As part of their day to day routine some residents were supported to help out with house hold chores such as emptying the bins and the weekly shop.

The person in charge had not ensured that appropriate guidance was in place to support and respond to behaviour that is challenging. One resident had not been supported for a full review of their behaviour support plan following transition to the centre to reflect the change in their environment and house mates. Information present in all behaviour support plans was not present and did not reflect the current needs of each individual. Where a restrictive practice was in use this was done so in the least restrictive manner for the shortest duration required. However, consultation with residents in the use of restrictive practices was not evident. Whilst one restrictive practice was introduced to ensure the safety and well-being of a resident following a significant incident the rationale for this had not been communicated to the resident in a manner which they would comprehend.

The registered provider had not ensured that effective fire safety management systems are in place, this incorporated staff training, fire fighting equipment. A number of main exit door had the main lock changed to key lock with no emergency key in place, a number of fire doors were damaged. The mechanism ion the door had been broken on a number of occasions with no review completed to determine an alternative mechanism to ensure the safety of residents. The safe evacuation of residents required review to ensure all staff and residents were aware of the correct procedures to adhere in the event of an emergency this included a variety of scenarios such as full capacity of resident with minimum staff. This would facilitate the review of personal evacuation plans in place.

The registered provider had not ensured that each resident was assisted and supported to develop knowledge and self-awareness required for keeping safe. Where actions had been identified in a safeguarding plan following a significant incident, these were not consistently adhered to or implemented to ensure the safety of resident. For example, one plan stated the main gate was to be closed at all times. This was open on the arrival of the inspector. Also, this plan stated a fence was to be erected to the exterior of the building in May 2021. Despite re occurrence of similar incident this fence was yet to be erected at the time of inspection. Also, it was not evident that the impact of incidents on all residents had been assessed. For example should; a resident observe negative interactions or property damage within the communal areas it was not clear if this was discussed.

Regulation 13: General welfare and development

The registered provider had ensured the provision of the following for residents:

(a) access to facilities for education and recreation;

(b) opportunities to participate in activities in accordance with their interests, capacities and developmental needs; and

(c) supports to develop and maintain personal relationships and links with the wider community in accordance with their wishes.

Judgment: Compliant

Regulation 17: Premises

The centre presented as a large detached house in a rural setting. Each resident was supported to have their own private room which staff had supported residents to decorate. A number of bedrooms were located to the front of the house with large windows. These bedroom were close to the main road and did not afford privacy for these residents was supported at all times. This requires review.

Judgment: Substantially compliant

Regulation 27: Protection against infection

Overall, the registered provider ensured that residents who may be at risk from a health care associated infection were protected and that precautions and systems were in place in relation to the COVID-19 pandemic.

Judgment: Compliant

Regulation 28: Fire precautions

The registered provider had not ensured that effective fire safety management systems are in place, this incorporated staff training, fire fighting equipment. A

number of main exit door had the main lock changed to key lock with no emergency key in place, a number of fire doors were damaged.

The safe evacuation of residents required review to ensure all staff and residents were aware of the correct procedures to adhere in the event of an emergency.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

The registered provider had not ensured effective systems were in place for the receipt, storage and administration of medicinal products.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Each resident had a comprehensive personal plan in place. These plans incorporated a holistic approach to support needs and incorporated guidance from relevant members of the multi-disciplinary team. However, improved consultation with residents was required.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

The person in charge had not ensured that appropriate guidance was in place to support and respond to behaviour that is challenging.

Where a restrictive practice was in use this was done so in the least restrictive manner for the shortest duration required. However, consultation with residents in the use of restrictive practices was not evident. This required review

Judgment: Not compliant

Regulation 8: Protection

The registered provider had not ensured that each resident was assisted and

supported to develop knowledge and self awareness required for keeping safe. Where actions had been identified in a safeguarding plan these were not consistently adhered to or implemented to ensure the safety of resident. For example, one plan stated the main gate was to be closed at all times. This was open on the arrival of the inspector.

It was not evident that the impact of incidents on all residents had been assessed.

The intimate care supports needs of each resident was documented within each personal plan in a respectful and dignified manner.

Judgment: Not compliant

Regulation 9: Residents' rights

Through a review of documentation and observations on the day of the inspection in was evident that the designated centre was not operated in a manner that was respectful of all residents valuing their individualism and was paternalistic in nature. Residents were not consulted in the day to day operations of the centre and consulted on all aspects of their support needs including personal plans the use of restrictive practices.

Consent was sought from family members with no evidence of consultation with residents or access to independent advocacy services. Information was presented to residents in an accessible format to promote understanding and participation.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 as amended and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 19: Directory of residents	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Mountain View OSV-0007982

Inspection ID: MON-0032571

Date of inspection: 15/09/2021

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: The roster template for the service has been reviewed and revised to include; staff titles, Team Leaders office and floor hours and the dates that the PIC will be in the centre. Risk assessment has been completed regarding the requirement for sleepover shift patterns to replace live nights in response to Covid-19 staffing difficulties. The real and actual rosters will be kept in a clear and organized fashion and kept up to date.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: New weekly medication audit put in place, which audits, storage of medication, MARS,completes an assessment of medication administration with a staff member, spot checks medication counts and reviews any medication errors to ensure clear actions in place such as re-assessment. New monthly medication audit put in place, audits the storage of medication, MARS, reviews PRN protocols, completes a spot check on counts and ensures that any actions from medication errors have been completed. New monthly Support File audit has been put in place. Reviews the contents of the	

individual support plans, risk registers, restrictive practices, health action plans and behaviour support plans. These reviews will generate clear action plans that are to be completed within the month.

A bi-annual human rights audit has also been put in place my the PIC to review restrictive practices, risk assessments, service user meetings, independent living skills development, available advocacy and access the personal finances. The service is the process of working through the actions of this first audit.

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
The statement of purpose has been reviewed and updated to include the team leader in the management structure diagram and include the conditions of registration.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
The bedrooms at the front of the property will have the windows partially frosted to increase privacy of the residents. This will be done in conjunction with the blinds currently in place.

The external fencing required for the service is in process and the PIC is awaiting for a date for the work to commence.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Break glass boxes with keys will be added to all external doors in the service.

Fire doors were broken at time of inspection following an incident the day before. These have been fixed and are in working order.

There were 2 outstanding new starters who required fire training at time of inspection. The have both completed fire training since the inspection.

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
New weekly and monthly medication audits have been put in place which include, staff observations of medication administration, review of MARS, spot checks on medication counts, review of PRN protocols and physically checking medication storage and labelling.

PRN protocol doses have been amended to match the Kardex.

Regulation 5: Individual assessment and personal plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
Social stories have been put in place around personal plans for each resident.

KW meetings take place monthly and now include the review of the social story for each residents personal plan.

Social stories are now in place around MDT appointments.

All service users have PCP's scheduled for January 2022.

Social stories are now in place for each residents restrictive practices.

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
Social stories are in place for all restrictive practices for each resident.

The service user whose Behaviour Support Plan required review at time of inspection has been reviewed and updated by the behaviour support specialist.

MDT to review how residents' consent and residents input is recorded in all MDT reports.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
Restrictive practice in relation to the external gate has been reviewed and updated.

Impact risk assessments regarding displays of challenging behaviour to be completed for all residents.

The external fencing required in the service is in process, the PIC is awaiting a date for the project to break ground.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
Contact is to be made with the Cork and Kerry Advocacy service. Social stories are now available to all residents in relation to their support plans, restrictive practices and MDT report. Service users are providing consent via this medium. Weekly service users meetings are now in place in the service. A bi-annual human rights audit is also now in place in the centre.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(4)	The person in charge shall ensure that there is a planned and actual staff rota, showing staff on duty during the day and night and that it is properly maintained.	Substantially Compliant	Yellow	19/11/2021
Regulation 17(6)	The registered provider shall ensure that the designated centre adheres to best practice in achieving and promoting accessibility. He. she, regularly reviews its accessibility with reference to the statement of purpose and carries out any required alterations to the premises of the designated centre to ensure it is accessible to all.	Substantially Compliant	Yellow	30/04/2022

Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	19/11/2021
Regulation 28(2)(b)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Orange	31/12/2021
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	19/11/2021
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.	Not Compliant	Orange	19/11/2021
Regulation 29(4)(a)	The person in charge shall ensure that the designated centre has appropriate and suitable	Substantially Compliant	Yellow	19/11/2021

	practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that any medicine that is kept in the designated centre is stored securely.			
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	19/11/2021
Regulation 03(2)	The registered provider shall review and, where necessary, revise the statement of purpose at intervals of not less than one year.	Substantially Compliant	Yellow	19/11/2021
Regulation 05(4)(c)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal	Not Compliant	Orange	19/11/2021

	plan for the resident which is developed through a person centred approach with the maximum participation of each resident, and where appropriate his or her representative, in accordance with the resident's wishes, age and the nature of his or her disability.			
Regulation 07(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.	Not Compliant	Orange	19/11/2021
Regulation 07(4)	The registered 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.	Substantially Compliant	Yellow	19/11/2021
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	19/11/2021

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.	Not Compliant	Orange	19/11/2021
Regulation 09(2)(d)	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 access to advocacy services and information about his or her rights.	Not Compliant	Orange	31/01/2022
Regulation 09(2)(e)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability is consulted and participates in the organisation of the designated centre.	Not Compliant	Orange	19/11/2021