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:	St Rita's Residential Service
Name of provider:	Western Care Association
Address of centre:	Mayo
Type of inspection:	Unannounced
Date of inspection:	16 June 2025
Centre ID:	OSV-0003915
Fieldwork ID:	MON-0046604

About the designated centre

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

St Rita's Residential Service can support four male and female adults, with intellectual disability and or autism as well as additional physical and or sensory disability. Residents supported at the service range in age from 18 years upwards. The centre comprises of a purpose built house in a rural town. Residents are supported by a staff team that includes the person in charge, social care workers and social care assistants. Staff are based in the centre when residents are present, including at night.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	4

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 June 2025	10:38hrs to 15:22hrs	Alanna Ní Mhíocháin	Lead
Monday 16 June 2025	10:38hrs to 15:22hrs	Stevan Orme	Support

What residents told us and what inspectors observed

This inspection was a follow-up of the last inspection of this centre that happened on 6 February 2025. At that time, seven regulations were found to be not complaint and the provider was issued with a warning letter outlining that they were required to come into compliance. In response, the provider submitted a compliance plan that outlined the actions that they would take to improve the quality of the service. The purpose of this inspection was to review the effectiveness of these actions and their impact on the quality of the service in the centre.

Inspectors found that the provider had implemented new systems of oversight, had ensured that residents' communication needs were assessed by a speech and language therapist, and had commenced a review of the restrictive practices in the centre. However, further improvement was required to ensure that all areas for service improvement were identified, that all actions and recommendations from the multidisciplinary team were implemented, and that all restrictive practices were identified, assessed and reviewed appropriately.

As this was a focussed inspection, the entire premises were not inspected on the day. However, inspectors noted that the centre was clean and tidy. It was in a good state of repair. As noted on the previous inspection of this centre, refurbishments had been made to the centre to provide a resident with a new kitchenette, larger bedroom and larger en-suite bathroom. Inspectors noted that two cupboards in the kitchenette were locked and that the key was kept by staff. One cupboard contained cleaning materials and a waste bin. The other cupboard contained breakfast cereal, chocolate bars, a kettle, and the resident's dishes, cups and plates. The impact of the locked cupboards on the rights of the resident and the assessment of this practice will be discussed later in the report.

The inspection was facilitated by the assistant manager of the centre and a member of senior management. The person in charge was not available as they were on leave at the time of the inspection. The inspectors also met with two other members of staff. These staff members were very familiar with the residents and had worked with the residents for a number of years. They were knowledgeable on the needs of residents and knew what supports they required in relation to their daily needs. They were familiar with the residents' preferences. Staff were aware of the recent changes that had been made to the restrictive practices in the centre. They knew the supports that were needed by residents inside the centre and the supports needed if the residents went on an outing.

Inspectors met with three of the four residents who lived in this house. Residents spent time relaxing in the centre and also left the centre later in the day. Inspectors greeted the residents and introduced themselves. One resident engaged with inspectors and brought them through the centre by the hand. The number of staff on duty on the day of inspection was reduced due to a staff absence that had not been filled. This meant that one resident could not attend their day services. Staff

and management reported that this had happened on occasion and that the assistant manager had filled shifts when required. Three new members of staff had recently been recruited in the centre and would be available to provide relief cover when they had completed their induction.

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

Inspectors noted that new systems of oversight and governance had been introduced in the centre. These included new governance meetings and a new staff training recording system. These arrangements created opportunities for the progress service improvement targets to be monitored. However, the systems were not always effective at identifying all areas of service improvement. In addition, not all actions identified through the provider audits were implemented.

Inspectors noted that, though the training needs of staff had been identified, the records available in relation to staff training required review. Inspectors found that the requirements for staff to complete mandatory training was not clearly recorded by the provider. Therefore, it was unclear if all staff had completed the required training modules that were necessary to support staff in this centre.

The provider had completed a review of incidents in the centre to ensure that all incidents that should be notified to the Chief Inspector of Social Services had been completed as required under the regulations. In addition, the new oversight system included a discussion of incidents in the centre to ensure that all notifications were submitted going forward.

Regulation 16: Training and staff development

Staff had received training in modules that the provider had identified as relevant to the care and support of the residents in this centre. There was a system in place for staff to enrol in refresher training, as required. However, improvement was required in relation to the documentation and recording of staff training to ensure consistency and clarity.

The minutes of the governance meeting between the person in charge and their line manager in April 2025 that were reviewed by inspectors showed that staff training was discussed at this meeting. An analysis of the new training and refresher training required by staff was completed at the meeting. However, the most recent training records available in the centre did not show up-to-date information or adequately

identify the mandatory training for all staff.

Judgment: Substantially compliant

Regulation 23: Governance and management

The provider had introduced new systems in the centre to strengthen the governance and oversight of the service since the last inspection. This had resulted in improved systems to progress service improvement issues. However, further improvement was required in relation to the auditing procedures in the centre to ensure that all service improvement issues were identified and addressed.

Since the last inspection, the provider had introduced a new schedule of meetings between the person in charge and their line manager. The first of these meetings had occurred on 18 February 2025 and the subsequent meeting on 25 April 2025. Inspectors reviewed the minutes of the most recent meeting. This showed that service improvement issues identified through inspections of the centre and provider-led unannounced audits were discussed and actions updated. The meeting also included discussion and actions relating to risk management, incidents reviews, restrictive practice review, resource planning and safeguarding. This meant that service improvement actions were regularly reviewed and that progress towards service improvement goals were monitored.

Inspectors also reviewed the routine audits that had been completed in the centre since the last inspection. These showed that there had been improvement in this area with audits completed in line with the provider's schedule. However, the audits had not identified all areas of service improvement as noted by inspectors. For example, the audits had not identified that the residents' restrictive practice guidance documents had not been updated to reflect a number of restrictive practices that had been discontinued in the centre in March 2025. This will be discussed further under regulation 7: positive behavioural support. In addition, where actions had been identified on audit, these had not always been addressed. For example, two of the residents' audits of their personal plans completed in May 2025 identified that the residents required an updated assessment of their health, social and personal needs as they had not been updated in the previous 12 months. One resident's assessment of need had not been updated since April 2024 and another had not been updated since January 2023.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

The inspector reviewed the records of incident reviews that had taken place in the

centre since the last inspection of the service and found that the provider submitted notifications to the Chief Inspector in line with the regulations.

Inspectors reviewed a report from the provider's quality department that had been completed since the last inspection of this centre. This report reviewed all recorded incidents in the centre from March 2024 to March 2025. This identified incidents in the centre that should have been submitted to the Chief Inspector. These notifications were retrospectively submitted in May 2025.

Inspectors also viewed the minutes of the most recent governance meeting that had taken place between the person in charge and their line manager on 25 April 2025. This included a review of the incidents that had taken place in the centre and compared the incidents from the last three months of 2024 and the first three months of 2025. This meant that the provider had introduced a new system of oversight in the service to ensure that incidents were reported appropriately.

Judgment: Compliant

Quality and safety

Inspectors noted that the provider had completed actions to address the issues found on the last inspection in relation to the quality of the service delivered to residents in this centre. However, further improvement was needed in this area in relation to restrictive practices, the promotion of the rights of residents, risk assessment and implementing the recommendations of the multidisciplinary team.

The provider had ensured that all residents in this centre had an assessment of their communication needs by a speech and language therapist. This had resulted in a number of recommendations in relation to each residents' individual communication needs. However, on the day of inspection, these recommendations had not been implemented and there was no plan in place to indicate when these recommendations would be trialled. In addition, since the development of these communication reports, these recommendations had not been implemented when supporting the residents to make choices in relation to their daily lives and the setting of their personal goals.

The oversight and review of restrictive practices in the centre required further improvement. Though some restrictive practices had been discontinued, the full review of restrictive practices by the rights review committee had not yet occurred on the day of inspection. In addition, inspectors found that improvement was needed in relation to the documentation of restrictive practices in rationale documents and risk assessments.

Regulation 10: Communication

The provider had employed the services of a speech and language therapist to provide guidance and recommendations to staff in relation to the supports required by the residents regarding their communication. However, on the day of inspection, there was no definite plan to implement these guidelines.

The inspectors reviewed the speech and language therapy reports that had been developed for two residents. These reports had been developed in April 2024 and gave recommendations about documents that should be developed to guide staff on how to support residents with their communication. The reports also outlined specific communication strategies that should be tried with residents to see if additional supports could be put in place to meet their communication needs. On the day of inspection, the guidance documents had not yet been developed. In addition, the assistant manager and senior manager reported that there was no plan in place to commence the trial of other communication strategies with the residents. This meant that the service improvement initiative relating to the residents' communication supports did not have a timeline for completion and the resources needed to implement these recommendations had not been identified. This meant that progress towards these goals could not be measured and the provider could not give assurances that these recommendations would be implemented in a timely fashion.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

The provider had a system in place to manage risk. Improvement in relation to the oversight of risk management since the last inspection was noted by inspectors. However, further improvement was required in order to ensure that all risk assessments were up-to-date, reflective of the most recent recommendations made by members of the multidisciplinary team and gave accurate information to guide staff practice.

Inspectors noted that risk management was now included as a standing agenda item in the governance meetings held between the person in charge and their line manager. This was evident in the meeting minutes of April 2025 reviewed by inspectors. This gave improved oversight of the risk assessments and risk management procedures in the centre. However, the new oversight arrangements had not detected all issues relating to risk management as noted by inspectors. The inspectors reviewed the risk assessments that had been developed for all four residents in the centre. These had been updated recently. However, inspectors noted that the risk assessments contained out of date information. For example, one resident's risk assessment was reviewed in April 2024. This risk assessment made reference to a 2016 report relating to the resident's feeding, eating, drinking and

swallowing (FEDS) recommendations. However, a more up-to-date report relating to the resident's FEDS recommendations had been completed in 2024. In addition, residents' risk assessments relating to staffing did not always provide clear guidance in relation to the level of support and supervision needed by residents.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

Improvement was required in relation to the provider's arrangements to support residents to manage their behaviour. Specifically, improvement was required to ensure that all restrictive practices in the centre were accurately assessed, documented with a clear rationale, and implemented accordingly. Inspectors were not assured that all restrictive practices had been fully assessed to ensure that they were required and that they were the least restrictive option for residents.

Inspectors reviewed the restrictive practice guidance documentation for two residents and noted that the documents were not up to date. The assistant manager and senior manager reported that certain restrictive practices had been discontinued in the centre in March 2025. This was also reported by staff to inspectors. However, this change was not outlined in the residents' restrictive practice guidance documents. For example, bedroom doors were no longer locked for 30 minutes following meals as decided at a multidisciplinary team meeting. Minutes of this meeting were viewed by inspectors. However, the residents' restrictive practice guidance documents still referred to this practice. In addition, this practice was also documented as a control measure for one resident in their risk assessments. This risk assessment had been updated in April 2024, following the agreed discontinuation of this practice. This meant that written guidance to staff in relation to this practice was inaccurate.

Inspectors also observed that restrictive practices were in place that were not in keeping with the rationale and guidance documents. Inspectors noted that one resident's restrictive practice advised that a cupboard containing the waste bin be kept locked for the resident's safety. However, on the day of inspection, inspectors found that cupboards in the resident's kitchenette that contained the resident's crockery, food and a kettle were locked. This practice had not been assessed to determine if it was necessary and that it was the least restrictive option. This was also found on the previous inspection of this centre.

In response to the previous inspection of this centre, the provider had committed through its compliance plan that the provider's rights review committee would visit the service to review all rights checklists. Though an update of the rights checklists had been completed by the person in charge, the visit by the rights review committee had not taken place by the day of the current inspection. The senior manager reported that this was due to take place on 18 June 2025.

Judgment: Not compliant

Regulation 9: Residents' rights

Improvement was required in order to ensure that the rights of residents were promoted in this centre.

Inspectors reviewed a document that had been developed for one resident entitled 'What's important to me?' This document outlined the residents' views and opinions on issues that were important to their day-to-day living including their opinions on their access to recreation, their living arrangements and the respect of their rights. This document had been completed by a member of staff on 11 May 2025. Inspectors noted that it was not clear that the resident had been supported or consulted in the development of this document. Communication supports and strategies for this resident had been outlined in a speech and language therapy report dated April 2025. However, there was no evidence that these strategies had been used in consulting the resident about this document.

Inspectors also reviewed the personal goals that had been developed for two residents. It was unclear how residents had been consulted in the development of these personal goals. Again, one resident's personal goals had been devised since the completion of their speech and language therapy report but the strategies outlined in the report to support the resident to make choices had not been implemented.

Inspectors reviewed the activity records that had been maintained for two residents from 1 June 2025 to the day of inspection. Though these records showed that residents engaged in activities in the community, it was unclear how the residents had been offered choices in relation to these activities. Inspectors noted that systems to offer choices to residents and to record those choices had not been established or formalised in the centre. This included systems to offer choices in relation to everyday issues, for example, meals and activities, and larger, long term issues, for example, personal goals for the year ahead. Therefore, it was unclear how residents were supported to exercise choice or control over their daily lives.

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 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 10: Communication	Substantially compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for St Rita's Residential Service OSV-0003915

Inspection ID: MON-0046604

Date of inspection: 16/06/2025

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: The Person in Charge has completed a Training Needs Analysis reflecting an up-to-date record of staff training and mandatory training specific to the service. This will be available in the Centre for review. The person in charge will continue to complete site specific Training Needs Analysis quarterly. The person in charge will continue to enroll staff in training as required. The provider will review the training information system to ensure it provides accurate information to the person in charge.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: Training for internal auditors to conduct provider unannounced visits took place on 22/05/2025, ensuring comprehenisve oversight of the auditing process. A review of the process of provider unannounced visits took place on 01/07/2025 where feedback from the auditors and from recent HIQA inspection has been incorporated into the guidance template that is used by the auditors. Review of audit actions will be a standing agenda item on schedule of business meetings between the Social Care Leader (SCL) and person in charge. The finance audit has been reviewed and amended by the organisation's pilot group and	

has been uploaded onto an online system. The Finance Department has provided feedback which has enhanced this audit, and the pilot group will test the audit for accuracy and effectiveness, and this will be rolled out to the wider organisation by 31st July 2025.

Additional supports have been put in place to support staff and management with completion of audit actions and personal plans. Outstanding actions on personal plans and Assessments of need will be completed by the person in charge.

Restrictive practice guidance documents for each resident will be updated by person in charge to reflect current restricitive practices in the service.

Behaviour Support will review all restrictive practices in the centre. 09/09/2025

The Registered Provider will establish a Compliance Oversight Group, to meet quarterly, to monitor progress of all actions towards compliance set out in the Compliance Tracker and to address/problem solve issues identified. (18/08/2025)

Regulation 10: Communication	Substantially Compliant

Outline how you are going to come into compliance with Regulation 10: Communication:

The person in charge will liaise with the staff team to ensure that guidance documents are developed to guide all staff on Communication plans.

The person in charge/Team Lead will facilitate a team meeting on 23/07/2025 to discuss further implementation of recommendations from Speech and Language Therapist for each resident.
Progress of communication recommendations will be an ongoing agenda in Service Governance and staff meetings.
Daily log templates will be reviewed and updated to ensure that choices offered and made are accurately captured throughout each day. 25/07/2025
Implementation of objects of reference for each person will be in each person's Individual Plan (IP) and will be recorded daily in their daily logs.
Staff will attend Lámh training on 1/8/25 facilitated by SLT.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:

The person in charge/Team Lead will review Personal risk management plans for each resident , reflecting current risks, up-to-date information and practices around risks in the service and specific guidance in relation to staffing and supervision of residents will be clearly outlined.

The SCL will attend training for the new risk management system on 29/07/2025.

The Registered Provider has reviewed and updated the Risk Management Policy to include guidance on, and signposting for, all of the specific risks identified in Regulation 26, to include control measures and mitigating actions in place, including the following risks:
• Unexpected absence of any resident
• Accidental injury to residents, visitors or staff,
• Behaviours of concern (to include aggression and violence)
• Self-harm.
The Registered Provider has provided training in the understanding of Risk Management to 7 Areas. In addition, all of those Areas have live risk registers. Further engagement and support to understand the concept and system of Risk Management will be delivered to Area Teams over the coming months. The next phase includes community supports and Senior Management / Department Heads to develop Risk Registers for each department and the Corporate Risk Register. 19/08/25.

The revised Risk Management Policy will be issued 01/09/2025.

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:

All restrictive practice guidance documents will be updated for all residents by person in charge/Team Lead. All restrictive practice documents will be reviewed by the person in charge and MDT to ensure that restrictions in place are appropriate to the risk.
All Personal Risk Management Plans will be updated by person in charge/Team Lead to reflect current risks and restrictive practices in the services and shared with staff team.
The Rights Review Committee undertook a visit to the service on 18th June 2025
The person in charge/Team Lead will follow the recommendations set out by the Rights Review Committee and provide an update on the current status and rationale of all restrictions in the service in 3 months or before, if any changes occur.
Rights restrictions are a continuous item on the agenda in Service Governance meetings and will be discussed at team meetings.

Regulation 9: Residents' rights	Not Compliant

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

The person in charge/Team Lead will review "What's important to me" documents with residents and named/link staff to ensure the residents are consulted and supported to complete the document using communication supports and strategies outlined in Speech and Language reports.

The person in charge will ensure that residents House meetings are facilitated by staff team to discuss choices of activties for the week, meals for the week, news updates and ad hoc items.The staff team will consult with the residents using the communication supports and strategies outlined in the Speech and Language reports to determine will

and preference of residents.

Staff will attend Lámh training on 1/8/25 facilitated by SLT.

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 10(1)	The registered provider shall ensure that each resident is assisted and supported at all times to communicate in accordance with the residents' needs and wishes.	Substantially Compliant	Yellow	19/09/2025
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	15/07/2025
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	01/08/2025

	to residents' needs, consistent and effectively monitored.			
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Substantially Compliant	Yellow	25/07/2025
Regulation 07(5)(b)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation all alternative measures are considered before a restrictive procedure is used.	Not Compliant	Orange	22/07/2025
Regulation 07(5)(c)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation the least restrictive procedure, for the shortest duration necessary, is used.	Not Compliant	Orange	09/08/2025
Regulation 09(2)(a)	The registered provider shall ensure that each resident, in accordance with his or her wishes,	Not Compliant	Orange	11/08/2025

	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.			
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	11/08/2025
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	11/08/2025