Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Disabilities (Adults)

Name of designated centre:	Barr-an-Chnoc Residential Service
Name of provider:	Western Care Association
Address of centre:	Mayo
Type of inspection:	Short Notice Announced
Date of inspection:	08 February 2018
Centre ID:	OSV-0001780
Fieldwork ID:	MON-0021009

About the designated centre

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

Barr-an-Chnoc services provide full-time residential support to adults with an intellectual disability and or autism, who present with associated complex needs such as visual impairment, epilepsy and mental health difficulties. The service is located in a rural setting in County Mayo. A vehicle is provided due to the rural location of the centre, which enables residents to access local amenities such as shops, cafes, and leisure facilities in the surrounding area. Barr-an-Chnoc services comprises of a two storey dwelling. One resident lives in their own self-contained apartment adjoining the main house. All residents are over 18 years of age. Residents are supported by a staff team in this house who work on a roster basis. This roster is developed on a two or three weekly basis and staff numbers are based on the support needs of individuals. There are staff contracted to the centre to provide leave cover for regular staff. Currently there is a waking night staff at night time and a sleep in staff, for support. Staff attend a range of basic skills training courses with a three year refresher training cycle. Training is provided in the areas of protection and welfare, fire, first aid, and minimal handling.

The following information outlines some additional data on this centre.

Current registration end date:	22/09/2018
Number of residents on the date of inspection:	6

How we inspect

To prepare for this inspection the inspector or 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
08 February 2018	09:15hrs to 19:00hrs	Catherine Glynn	Lead

Views of people who use the service

At the time of inspection, the centre was at full occupancy. Residents, although introduced to the inspector, did not wish to speak about the support and care they received. Furthermore, some residents were non-verbal.

The inspector observed that residents were comfortable with the support staff provided during the inspection. Staff had supported the residents to complete questionnaires on the service they received, in which they stated that they were happy and satisfied.

Capacity and capability

Governance and management arrangements were not ensuring that all aspects of a quality and safe service were being provided for residents living at the centre.

The provider had not ensured a system was in place for the oversight, monitoring and escalation of incidents in the centre. The inspector found that the provider's procedures had not been followed and that investigations of incidents were not being completed in a timely and responsive manner with minimal impact to residents. In addition, the provider had failed to coordinate a multidisciplinary review in response to the number of incidents occurring in the centre and had not ensured that all residents were supported and safeguarded in line with organisational policy.

The provider had implemented and sustained ongoing monitoring, review and development of the service provided to residents living in the centre. Six-monthly audits of the centre’s practices were carried out by the management team and regular audits were carried out by the management team on the services and supports in place, in the centre. This included; medication management, health and safety, residents’ finances and personal plans. Results of these audits were maintained and records showed that staff had an awareness and understanding of results and actions required.

The person in charge was full-time in the centre and had worked in the service for a number of years. She had a familiarity and knowledge of the up-to-date care and support needs of all residents. There was a suitable cover arrangement in place to ensure that staff were supported and guided in their practice with residents in the absence of the person in charge.

The provider had produced a statement of purpose which detailed the service

provided and additional services that could be offered to meet all residents' needs. It also included the care provided and the management structure of the centre. However, the inspector found that further improvement was required to ensure that all information contained in the statement of purpose was up to date.

Sufficient staffing and appropriate skill mix had been allocated by the provider. Furthermore, the provider had allocated additional staff to offer residents choice with social outings. This included individual events and also group activities as identified from house meetings. As a result, residents engaged consistently with their local community in activities such as; meals in cafes, attending day services, music and sporting events.

Regulation 15: Staffing

The provider had ensured that an appropriate number of qualified and skilled staff were employed to meet the assessed needs of residents. In addition, following a review of residents' needs in 2016, additional staffing hours had been allocated to provide residents with opportunities for one to one and also ensure adequate staffing levels were available, in line with behaviour support plans. Another service review had been conducted in 2017, to guide management on the needs of residents and explore choices around services provided.

In addition, the provider's recruitment process ensured that all staff documentation required under schedule 2 of the regulations was obtained.

Judgment: Compliant

Regulation 16: Training and staff development

The person in charge had not ensured that staff were up-to-date in their training, in line with the organisational policies. For example, staff had not completed medication training within the three year cycle, as required by the organisation.

Staff also had access to copies of the Health Act (2007), regulations and national standards at the centre for their information.

Supervision was provided to all staff in the centre as scheduled; however, staff knowledge had not been kept up-to-date and did not ensure that residents were

supported in line with best practice.

Judgment: Substantially compliant

Regulation 19: Directory of residents

The person in charge had maintained a directory of all residents in the centre and this contained the information required by the regulations. It also reflected any nights when residents did not reside in the centre.

Judgment: Compliant

Regulation 21: Records

The provider had not ensured that all records were kept up-to-date. For example, incidents had not been appropriately escalated where required; therefore, investigations had not been commenced or completed in-line with local policy.

The provider had failed to identify and respond to incidents in line with requirements of safeguarding policies and best practice.

Judgment: Not compliant

Regulation 22: Insurance

The provider had maintained up-to-date insurance for the centre as required by the regulations.

Judgment: Compliant

Regulation 23: Governance and management

The governance systems did not ensure that service delivery was safe and effective through the ongoing monitoring and audit of its performance; which did not result in a thorough and effective quality assurance system in place in the centre. For example, the annual review of the quality and safety of care and the six month unannounced audits, failed to identify these gaps with incident reporting and did not address unexplained bruising, in-line with the local policy.

Judgment: Not compliant

Regulation 3: Statement of purpose

The statement of purpose reflected both the services and facilities provided at the centre; however, it did not contain all of the information as required by schedule 1 of the regulations. This included changes to management structure and the correct name of the centre. The statement of purpose was regularly reviewed and available to residents and their representatives.

Judgment: Substantially compliant

Quality and safety

The provider had failed to ensure that residents were protected and kept safe from harm, in-line with local policy. The management team had not taken effective measures to safeguard residents from being harmed or from abuse. While there was a policy and procedure in place, the inspector found that some incidents of unexplained bruising had not been responded to effectively. In addition, the incidents had not been adequately recorded and had not been escalated to senior management or the designated officer, as required by policy. An urgent action was issued to the management team during the inspection which required a comprehensive review of all incidents within a specified time period and to submit all retrospective notifications where identified. The provider was required to submit the report with all findings from the investigation and clearly identify areas of improvement.

Risk management processes were in place in the centre and guided by local policies and procedures. However, improvement was required, as the provider had failed to identify the risk associated with the number of incidents that had occurred over a period of time in the centre. The systems in place had failed to escalate these risks and therefore appropriate actions had not been completed. For example, where unexplained bruising was recorded, environmental assessments, falls risk

assessments or review by an occupational therapist had not been completed to mitigate risks identified.

Overall, the centre was suitably decorated, furnished and laid out to meet the needs of all residents in the centre. The person in charge had ensured that there was adequate communal space for relaxation or to meet with visitors.

Personal planning was in place for all residents in the centre. This was reviewed on an annual basis or sooner where required. Records of annual reviews showed that residents' family members participated in the review meeting. Goals identified offered choice and reflected resident's wishes. The names of the staff members who were responsible for assisting residents to achieve these goals were clearly recorded. Details of short, medium and long-term goals were clearly documented. Residents were supported to maintain contact with family and records were maintained of any trips and visits completed made to their family.

The provider had effective measures in place to protect residents and staff from the risk of fire. These included up-to-date servicing of fire fighting equipment, heating and the fire alarm system. Staff had maintained a record of checks completed to monitor the fire safety systems throughout the centre. Evacuation procedures were displayed throughout the centre. Staff had received training and engaged with fire drills as scheduled by the person in charge.

Overall, the inspector found that residents received person centred care and were provided choice in daily activities. Residents engaged with the inspector throughout the inspection and were observed to be treated with respect. The inspector found that staff were familiar with the residents' support needs and preferences. Residents were provided with individual bedrooms which had appropriate storage, furniture and photographs displayed. Each room reflected residents' personal choices.

Regulation 13: General welfare and development

Residents were supported to participate in activities and social events in line with their personal choices and interests. Residents had been involved in developing their personal plans and were being actively supported by staff to achieve their personal

goals. The person in charge and staff were responsive to the needs of residents and were ensuring that their personal plans were being regularly updated with new activities and any progress the residents had made towards achieving their goals.

Judgment: Compliant

Regulation 17: Premises

The provider had ensured that the premises met the requirements of Schedule 6. The centre reflected residents' needs, was well-maintained and provided a safe and homely environment.

Judgment: Compliant

Regulation 26: Risk management procedures

Risk management arrangements had not ensured that risks were identified, monitored and regularly reviewed in line with local policy. Incidents recorded as unexplained bruising had not been escalated and investigated to ensure that residents were protected and supported in line with policy.

Judgment: Not compliant

Regulation 28: Fire precautions

There were suitable fire safety arrangements in place in the centre. Staff and residents were involved in regular simulated fire drills. Regular fire safety check were being completed by staff on a daily, weekly or monthly basis in line with the provider's policy. These checks included all fire doors, emergency lighting and equipment in place at the centre.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

Residents' medication was securely stored at the centre, in-line with local policy. Medications were administered by trained staff, in accordance with the organisational policy. Arrangements were in place for the segregation and disposal of out-of-date or discontinued medication. Regular audits into medication practices were being completed by the person in charge.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

Residents were supported to identify and achieve a range of interesting activities. These activities covered a range of different interests and included areas to support them with developing their independence, money management and community engagement. Personal plans had been developed in an accessible format which clearly described these activities and how staff would support the resident to achieve them.

Staff responsible for supporting residents were clearly identified. Personal plans were being reviewed on an annual basis or sooner if required.

Judgment: Compliant

Regulation 7: Positive behavioural support

The person in charge had ensured that appropriate arrangements were in place to support residents who presented with behaviour that challenges. Those residents had an individual behaviour support plan, which guided staff on the proactive and reactive strategies that could be used to support residents.

The rights and dignity of residents was maintained as a result of these plans being in place. All plans were reviewed as scheduled. All staff had completed training in relation to behaviour that challenges.

Judgment: Compliant

Regulation 8: Protection

The provider had ensured that all staff were trained and were aware of the local policies regarding safeguarding. All staff were up-to-date with their training on safeguarding and were found to complete incident forms where unexplained bruising was identified.

Staff had acted in accordance with local policy and completed incident forms; however, management in the centre had failed to recognise or escalate the incidents to the designated officer as required. Furthermore, where incidents were escalated to the designated officer, no preliminary investigation had occurred which would have resulted in positive outcomes for the residents.

As a result an immediate action was issued to the management to address these areas of concern and to complete a robust review of all incidents that had occurred in the centre, within a specific time frame. In addition, the provider was required to provide assurance to HIQA of the actions they would take to ensure such gaps did not occur in future.

Judgment: Not compliant

Regulation 6: Health care

The health care needs of residents were assessed and they had good access to a range of allied health professionals and consultants. Plans were in place for health care supports based on residents' assessed needs. However, improvement was required to ensure that where incidents occurred, that these were linked to a comprehensive review of all health needs.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 19: Directory of residents	Compliant
Regulation 21: Records	Not compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Substantially compliant
Quality and safety	
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 28: Fire precautions	Compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Not compliant
Regulation 6: Health care	Not compliant

Compliance Plan for Barr-an-Chnoc Residential Service OSV-0001780

Inspection ID: MON-0021009

Date of inspection: 08/02/2018

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:

Staff member 0056 has successfully completed their medication refresher training on 12/03/18.

The staff team at Barr an Chnoc have completed training on incident injury and safeguarding in line with organisation policy. This was completed on 06/03/18. This training was delivered by the Designated Officer and the Research & Systems Officer from the Training & Evaluation Department. This training covered staff understanding with regard to the rating of incidents in the areas of severity and manageability to ensure that the ratings indicated acknowledges the concerns associated with the event. It also covered education and learning with the staff to embed a better understanding of the definitions of concern and how they apply to the incident injury recording and to national safeguarding. Finally it gave guidance on the text written in the forms by the staff to develop a better outline of the event and the identified hazards or issues.

Regulation 21: Records	Not Compliant

Outline how you are going to come into compliance with Regulation 21: Records:

Training for all staff in the service was completed on 06/03/18. This covered incident injury reporting and safeguarding. The practice of reporting peer to peer, and unknown origin incidents has changed so that all incidents regardless of scoring will be reported to the Designated Officer and Regional Service Manager.

The Designated Officer will do a quarterly analysis of the incidents in Barr an Chnoc for the year 2018 to identify trends and to isolate out any particular approaches required. The Designated Officer will meet with the Regional Services Manager every quarter to ensure findings and

learnings get addressed. These meetings have been timetabled for the year.

The Regional Services Manager has supported the PIC to take a more reflective approach to the quarterly incident review process to ensure incident trends and patterns are followed up more proactively. This review has taken place for the first quarter of the year with the Regional Services Manager mentoring the PIC to do so. The analysis of quarter one was completed on 13/04/18.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:

Following on from the organisation Leadership Team meeting on 20/2/18, all incidents of peer to peer, and incidents of unknown origin, whatever the severity or manageability rating, must be forwarded to the Regional Services Manager and the Designated Officer. This was communicated organizationally to all services and departments.

The Regional Services Manager will support the PIC to review all incidents within Barr an Chnoc on a quarterly basis as per organisation policy. The data will be reviewed to establish if there are incident trends and patterns and a proactive action plan to be put in place to address same.

The Evaluation and Training Department have amended the internal template for unannounced inspections to direct reviewers to examine incident reporting practices during visits.

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 in line with the regulations and HIQA guidance and updated accordingly.

Regulation 26: Risk management procedures	Not Compliant

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

The local risk register for Barr an Chnoc, together with the personal risk management plan for residents and staff risk register were updated on 20th February 2018 following review by the PIC and Regional Services Manager.

Staff in Barr an Chnoc has received additional training on safeguarding and incident/injury reporting on 06/03/18. This ensures all staff have a good working knowledge of the policy, with the emphasis of unknown origin and peer to peer incidents regardless of severity, to be reported to Regional Services Manager and Designated Officer who can ensure that they receive timely and necessary follow up. The Designated Officer will review all reports for the service on a quarterly

basis with the Regional Services Manager. In addition to this the Designated Officer will carry out unannounced visits throughout 2018.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:

The PIC will take a more reflective approach in analysing their quarterly incident report to ensure trends and patterns are followed up more pro-actively. The analysis for quarter one of 2018 was completed on 13/4/18.

Staff in Barr an Chnoc have received additional training on safeguarding and incident/injury reporting on 06/03/18. This ensures all staff have a good working knowledge of the policy, with a particular emphasis on incidents of unknown origin and peer to peer.

The agency has instituted a practice of forwarding all incidents of unknown origin and peer to peer incidents, regardless of severity to the Regional Services Manager, who can then follow up to ensure that the reporting requirement to the Designated Person is completed as required. This will allow the Regional Services Manager in particular to check the scoring of all peer to peer incidents to ensure that these receive the necessary follow up.

The Designated Officer will do a quarterly analysis of the incidents in Barr an Chnoc for the year 2018 to identify trends and to isolate out any particular approaches required. The Designated Officer will meet with the Regional Services Manager every quarter to ensure findings and learnings get addressed. These meetings have been timetabled for the year.

The Regional Services Manager has supported the PIC to take a more reflective approach to the quarterly incident review process to ensure incident trends and patterns are followed up more proactively. This review has taken place for the first quarter of the year with the Regional Services Manager mentoring the PIC to do so. The analysis of quarter one was completed on 13/04/18.

Following the review of all incidents in Barr an Chnoc additional staffing hours are in place for two residents as a support until a review of the service is completed.

There is a service review taking place in Barr an Chnoc which is actively being progressed in this case so that alternative living options are developed for people. The Regional Services Manager will oversee the completion of a compatibility assessment with input from the Behaviour Support Specialist which will be finalised by 31/05/18. Following on from this formal planning meetings will be convened for each individual with their family to discuss and plan for the future.

Regulation 6: Health care	Not Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:

The service continues to maintain a strong focus on health care needs for all residents. For one

individual a report was compiled reviewing all relevant information looking at all aspects of their life in all environments. As part of this review a multidisciplinary approach is in place to address areas of concern identified. This includes a wide range of allied professionals including neurology, GP, OT, BSS, but to name a few. Going forward a health advocacy group will meet on a monthly basis for this individual to ensure there is a coordinated approach to their healthcare needs. This will comprise of PIC from service, together with named and link staff along with the necessary MDT personnel, the Regional Services Manager and family, where feasible. This will ensure areas of concern are dealt with in a timely manner going forward.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	13/02/2018
Regulation 21(1)(b)	The registered provider shall ensure that records in relation to each resident as specified in Schedule 3 are maintained and are available for inspection by the chief inspector.	Not Compliant	Orange	06/03/2018
Regulation 21(1)(c)	The registered provider shall ensure that the additional records specified in Schedule 4 are maintained and are available for inspection by the chief inspector.	Not Compliant	Orange	06/03/2018
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place	Not Compliant	Orange	06/03/2018

	in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.			
Regulation 23(1)(d)	The registered provider shall ensure that there is an annual review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards.	Not Compliant	Orange	13/04/2018
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.	Not Compliant	Orange	20/02/2018
Regulation 26(1)(a)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: hazard identification and assessment of risks throughout the designated centre.	Not Compliant	Orange	20/02/2018

Regulation 26(1)(b)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: the measures and actions in place to control the risks identified.	Not Compliant	Orange	20/02/2018
Regulation 26(1)(c)(ii)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: the measures and actions in place to control the following specified risks: accidental injury to residents, visitors or staff.	Not Compliant	Orange	20/02/2018
Regulation 26(1)(d)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: arrangements for the identification, recording and investigation of, and learning from, serious incidents or adverse events involving residents.	Not Compliant	Orange	06/03/2018
Regulation 26(1)(e)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: arrangements to ensure that risk control measures are	Not Compliant	Orange	20/02/2018

	proportional to the risk identified, and that any adverse impact such measures might have on the resident's quality of life have been considered.			
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.	Not Compliant	Orange	13/04/2018
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose containing the information set out in Schedule 1.	Substantially Compliant	Yellow	06/03/2018
Regulation 06(2)(a)	The person in charge shall ensure that a medical practitioner of the resident's choice or acceptable to the resident is made available to the resident.	Not Compliant	Orange	06/03/2018
Regulation 06(2)(c)	The person in charge shall ensure that the resident's right to refuse medical treatment shall be respected. Such refusal shall be documented and the matter brought to the attention of the resident's medical practitioner.	Not Compliant	Orange	06/03/2018
Regulation 08(2)	The registered provider shall protect residents from all forms of	Not Compliant	Orange	06/03/2018

	abuse.			
Regulation 08(3)	The person in charge shall initiate and put in place an Investigation in relation to any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.	Not Compliant	Orange	06/03/2018