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:	Teach Cairdeas
Name of provider:	St Hilda's Services Limited
Address of centre:	Westmeath
Type of inspection:	Unannounced
Date of inspection:	10 September 2018
Centre ID:	OSV-0001831
Fieldwork ID:	MON-0024873

About the designated centre

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

Teach Cairdeas designated centre run by St. Hilda's provides services to five adults of a mixed gender whose primary diagnosis is an intellectual disability who have a level of independence such waking night cover is not required. Teach Cairdeas is a 5 day service opened from Monday to Friday, on weekends residents return home to their families. The service can accommodate those with a range of medical and physical issues. Residents should be able to attend day services during the day and in cases of short term illness arrangements are made for residents to return home. The service has fixed closures in line with the operations of the day service. Teach Cairdeas consists of five double bedrooms and one single bedroom with a combined kitchen and dining area with a separate sitting room. Residents avail of organised transport for day services and local bus services and taxis outside of these times.

The following information outlines some additional data on this centre.

Current registration end date:	17/04/2020
Number of residents on the date of inspection:	5

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
10 September 2018	09:00hrs to 17:00hrs	Erin Clarke	Lead

Views of people who use the service

The inspector spent time with four residents living in the centre when they returned from day service and work, two of whom were happy to speak in more detail about their experiences of living there and to show the inspector their room. residents were observed using their own keys to enter their bedrooms. Residents pointed out various areas of interest to the inspector such as goals they were working on, photographs of activities they had taken part in and personal possessions.

Residents informed the inspector that they were happy with their home and that all staff were very good to them. All of the residents appeared at ease and familiar with when in the company of staff and management. Staff interactions with residents were observed to be respectful and friendly at all times. Inspectors observed residents being supported to take part in activities and the preparation of dinner.

Residents advised the inspector that they knew who to go to should they have a concern. One complaint by a resident had occurred since the previous inspection and this recorded, actioned and followed up by the person in charge, the resident said that they were satisfied with how their complaint was handled. Residents advised the inspector that they enjoyed each others company and that they all helped each other out with the household tasks. The inspector was shown the timetable for the week and how these was agreed upon in weekly resident meetings.

Residents were supported to engage in meaningful roles. One of the residents advised the inspector about a job that had were involved in and her enjoyment of it. Another resident spoke of their excitement in attending a local football match that week.

Capacity and capability

The inspector found that the capacity and capability of the provider to deliver a safe quality service was adversely affected by the current operational management systems in this centre and required significant improvement. The current person in charge, also the residential services manager for five designated centres, was acting in the absence of two persons in charge for a prolonged absence for three centres since May 2018. The office of the Chief Inspector had written to the provider to seek their assurances that these arrangements were effective. It was not notified to the Chief Inspector that a change of person in charge had occurred for this centre.

Upon inspection the inspector found that the management arrangements in place and the person in the role of person in charge were not appropriate as it created a conflict of roles and presented a capacity issue in carrying out their responsibilities. The person in charge, although possessed extensive experience and the relevant qualifications, their duel role of residential services manager and person in charge

did not allow them to have the capacity to fulfill their legal requirements and responsibilities of the person in charge which had an adverse affect on the day to day operation of the centre. The role of the residential services manager included line managing the persons in charge and monitoring of the centre through audits resulting in non compatible roles. This was communicated to the provider during the inspection and at the feedback session.

The centre had a publicly available statement of purpose but the service being delivered to the residents was not observed to be in keeping with the current statement of purpose. The centre closed for several weeks throughout the year which was not reflected in this document or the residents contract of care. The person in charge full time equivalent was not accurate as it did not reflect the time required for the duel role of residential service manager. From discussion with the person in charge it was apparent that they were not based in the centre or were involved in the day to day operations of the centre.

The inspector found that there was enough staff with the right skills and experience to meet the assessed needs of the residents. Furthermore the providers recruitment process ensured that all staff documentation required under schedule two of the regulations was obtained. Staff demonstrated knowledge in safeguarding, safe administration of medication and fire safety. The inspector observed positive interactions between staff and residents. Improvements were required however, as there was no planned or actual staff roster in the centre. Relief staff that covered training days were not identified and the inspector was informed by staff that the roster was devised by another centre and when it was sent to them, staff amended the roster for changes.

A schedule of audits was available for the centre but improvement was needed in their effectiveness and also these were not carried out in line with the organisations policy. Personal Care Plan audits had not taken place for 2018 and previous audits had not identified that annual assessment of need had not taken place.The last announced six month visit by the provider was not available in the centre to review, this was later retrieved from the main office. Improvement was required within the annual review as it was too generic and not specific to the centre, it had included narrative on the process of notifable events and incident reporting but omitted information on whether any of these had occurred in the centre. It was also not clear who had completed the annual review.

From a review of the training matrix it was evident that staff received training relevant to their roles and attended refresher training as required. Staff minutes of meetings were reviewed and these discussed agenda items relating to the service user and designated centre. Improvements were identified in the use of the staff meetings for the only form of staff supervision, this was not in line with best practice. Staff meetings occurred with another designated centre and discussions involving supervision were discussed in a group setting.

Registration Regulation 7: Changes to information supplied for registration purposes

Changes to the person in charge was not notified as per regulation.

Judgment: Not compliant

Regulation 14: Persons in charge

The person in charge was not full time in their role or had the capacity to be involved in the day to day operation of the designated centre.

Judgment: Not compliant

Regulation 15: Staffing

There was no planned or actual roster in the designated centre.

Judgment: Not compliant

Regulation 16: Training and staff development

Staff have received relevant training relevant to their roles but were not in receipt of appropriate supervision.

Judgment: Substantially compliant

Regulation 19: Directory of residents

A directory of residents is up to date with all the required information.

Judgment: Compliant

Regulation 21: Records

Records in relation to each resident as specified in Schedule 3 were not maintained.

Judgment: Not compliant

Regulation 23: Governance and management

The person in charge was absent from the centre and suitable arrangements were not made for their absence. The management systems in place to ensure that the service provided is safe, appropriate to residents' needs, consistent and monitored are not effective.

Judgment: Not compliant

Regulation 24: Admissions and contract for the provision of services

The contract of care in place did not list the closures that occur in the centre and provided inaccurate information for transport options.

Judgment: Not compliant

Regulation 3: Statement of purpose

The statement of purpose did not accurately reflect the services provided for the resident nor was it updated for the change in person in charge and management structure.

Judgment: Not compliant

Regulation 34: Complaints procedure

Complaints are well managed and bring about changes when required.

Judgment: Compliant

Regulation 4: Written policies and procedures

All schedule 5 policies were present and reviewed within the relevant time lines.

Judgment: Compliant

Quality and safety

There was evidence that residents received a person centred service and experienced a good quality of life in the centre. However significant improvement was required in the individual health, personal and social assessment of need that details the supports required by the residents and the risk management processes in place, to ensure that the service has the ability, facilities and resources to support people to maintain or improve their health and well being. From an analysis of a sample of residents' health, personal and social plans it was found that an annual review of the assessed needs had not occurred to inform an associated plan of care. The inspector therefore, could not be assured that all residents' needs were being met or the appropriate support plans were in place to provide staff with the appropriate knowledge to support residents' assessed need. This had been identified in two previous inspections of the centre and agreed action plans had not succeeded in addressing these concerns. It was unclear from discussions with staff, management and review of documentation when the last GP, dentist, allied health professions and blood test had last occurred or was next due, results of same and details for follow up. The care needs that had been identified such as intimate care, communication and eating drinking and swallowed did not provide sufficient information to guide staff in the delivery of care.

The provider had in place a risk management policy but it was found to be missing critical information regarding the identification, recording and investigation of incidents or adverse risks involving residents. From conversations with staff they were unsure of the procedures in place to record and report incidents, there was confusion as to whether this involved a paper based or online approach. Neither staff or the person in charge could gain access to the online reporting system and the inspector could not review incidents that had occurred as part of the inspection. The last annual health and safety audit completed by the coordinator of services, as referred to in the risk policy, were not available on site, but was subsequently sent to the inspector post inspection, however it was completed by the person in charge. The audit dated February 2018 reported that the bath was classified as a hazard and was to be replaced by a shower, this had not been entered into the action plan with the person responsible for carrying out the action. On inspection this was not relayed to the inspector when asked was the use of a bath deemed a risk to any resident as no risk assessments had been completed for this activity. It was noted on inspection that it was unknown whether the annual audit on infection control carried out by a nurse had occurred since 2016. A copy received by the inspector after the inspection did not identify the person completing the audit, or compile an action plan to address actions identified. A risk assessment identified carbon monoxide as a high risk and the measure in place was the use of a carbon monoxide alarm in the kitchen area, this was observed to have

been taken down and batteries removed. This was brought to the attention of the person in charge.

The fire safety management systems and frequency of fire drills had improved since the previous inspection. The fire alarm and emergency lighting had been serviced on a quarterly basis and fire fighting equipment serviced on an annual basis. Regular fire drills had taken place with a stimulated night time drill. Monthly fire safety inspection checklists had been completed by staff that involved checks of the fire measures in place. There was an accessible version of the procedure in the event of a fire located in prominent areas.

The centre had in place a medication policy which detailed the procedures in place for the ordering, receipt, storage, administration and disposal of medication. The inspector met with a member of staff that was very knowledge of the various processes involved and the medication administered on a daily basis. Staff carried out weekly stock checks of the medication and all staff were found to have the relevant safe administration of medication training. Improvements in the auditing of the medication were however identified as the last quarterly audit completed by the person in charge was December 2017 and the last audit carried out by the nurse was December 2015. Errors had been identified by the inspector in relation to the storage of medication and information written for the dosage and frequency of medication.

All residents attended a day service and the inspector found that there were effective lines of communication between staff in the designated centre and day service. This was facilitated through the residents personal plan which traveled with them which contained details of the personal goals each resident was working towards so there was continuity of progress and. The goals were reviewed regularly and no less frequently than on a six month basis which was consistent with the centres' policy. Personal planning meetings were held with the resident and their families every 6 months and reviewed the plan to date. Whilst the majority of activities and goals were taking place during day service provision it was recognised that residents liked to watch their programmes in the evening time and relax with their peers. The inspector observed residents being involved in the planning of dinner but they were not able to participate in shopping for groceries with staff as there was no vehicle available for the house and staff were not indemnified to take residents in their own vehicles. This contradicted what was stated in the contract of care and limited the opportunities for residents in the evening time.

On inspection of the centre no restrictive practices were in use and it was reported to the inspector that there was no behaviours of concern and that no behavioural support plan were required or in use. Whilst there was mention of an incident of inappropriate behaviour in the annual review report, details or knowledge of this incident was unknown in the centre. by staff or the person in charge. A review of the positive behavioural support policy found that it required revision to ensure that it reflected best practice. A reference within the policy on the possible use of suspension was deemed to impinge on the rights of the resident and was found

not to be in line with the admission policy and contract of care.

New systems had been implemented to ensure the safeguarding of residents monies, staff were aware of the progresses in place to record expenditure, income and recording of receipts. Oversight and auditing were required from a management level to ensure that discrepancies and inconsistencies were investigated and rectified.

Regulation 26: Risk management procedures

The risk management system in place does not identify all risks in the centre.

Judgment: Not compliant

Regulation 28: Fire precautions

Suitable fire prevention and fire fighting equipment were in place and serviced as required. A carbon monoixde alarm was not replaced when faulty.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

Out of date medication are not appropriately managed in line with policy.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

A comprehensive assessment of the health, personal and social care needs of each resident which reflects the assessed needs and outlines the supports required had not been carried out.

Judgment: Not compliant

Regulation 7: Positive behavioural support

Improvements were required for the use of restrictive practices as detailed in the positive behavioural support policy.

Judgment: Substantially compliant

Regulation 8: Protection

The person in charge has ensured that all staff have received appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse.

Judgment: Compliant

Regulation 13: General welfare and development

Residents have opportunities to particulate in activities but not as often as they would like.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 7: Changes to information supplied for registration purposes	Not compliant
Regulation 14: Persons in charge	Not compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 19: Directory of residents	Compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Admissions and contract for the provision of services	Not compliant
Regulation 3: Statement of purpose	Not compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 26: Risk management procedures	Not compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 13: General welfare and development	Substantially compliant

Compliance Plan for Teach Cairdeas OSV-0001831

Inspection ID: MON-0024873

Date of inspection: 10/09/2018

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**
Registration Regulation 7: Changes to information supplied for registration purposes	Not Compliant
Outline how you are going to come into compliance with Registration Regulation 7: Changes to information supplied for registration purposes: Person In Charge has been appointed on 20th September 2018. All documentation has been reviewed with RST and Provider errors / omissions in relation to notification corrected. The Statement of Purpose and Function has been amended and had been sent to RST on 19th October 2018 and will be further amended on receipt of updated Certificate of Registration.	
Regulation 14: Persons in charge	Not Compliant
Outline how you are going to come into compliance with Regulation 14: Persons in charge: A new Person In Charge has been appointed to this centre 20/9/2018 This PIC will be in charge of 2 Designated Centres. Due regard has been given by provider to the size of centre and needs of residents. Arrangements for governance Administration and operational management in terms of time off roster are in place. The Provider has met with the PIC at the centre to review operational procedures with PIC and review provider requirements. A further meeting is planned for 7th November 2018.	
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing:	

Planned and Actual Rotas have been implemented on 1st October 2018. A 5 Day roster is in place. This is a fixed roster for 4 nights for 2 staff - 2 S/over plus 2 evening Mon/Wed and Tues/Thur/Fri alternating weekly.
The actual roster will how show any change, (example cover for sick leave).

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 Supervision one to one has been implemented in this centre commencing 6/10/2018 and will be twice annually. There is one staff member outstanding who carries put relief work. Her supervision meeting will be completed by 26th October 2018. This will be carried out by the Person In Charge.

Regulation 21: Records	Not Compliant

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

The Provider has reviewed the system of records, the quality of records and in particular the arrangements in place for how they are organised. The provider will implement a Single Folder of documentation consistent with Schedule 3 for each resident. This has been agreed with PIC and has commenced. Completion Date for same is 26/10/18
On completion the system will be rolled out to all centres.

Regulation 23: Governance and management	Not Compliant

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

The management structure of the centre has been revised to reflect the reporting system. The provider has commissioned an external organisation to conduct 6 monthly audits (5th - 27th) November to ensure quality and safety of care and to give effect at greater capacity within management system. The Provider will revise the approach to internal Audit in terms of effectiveness and detail be provision of mentor to Residential manager.

Regulation 24: Admissions and contract for the provision of services	Not Compliant

Outline how you are going to come into compliance with Regulation 24: Admissions and

contract for the provision of services:

The contract of care is being revised to outline when residents pay for their own taxi and when provider pays. These will issue for signature by 19/10/18

Regulation 3: Statement of purpose	Not Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:

The Statement of Purpose and Function has been revised and sent to RST on 19/10/18

Regulation 26: Risk management procedures	Not Compliant

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

The Procedures for operation of on line system for Incident Reporting have been circulated and training provided to all staff - 18/10/18. These procedures will be inserted to the policy as essential steps by 26/10/18. The amended policy will be put to the Board at November meeting- 13th November 2018.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:

The Person In Charge has reviewed the fire precautions in the centre including the PEEP for each individual resident, 4/10/18 this has been updated for each resident on 4/10/18

Regulation 29: Medicines and pharmaceutical services	Not Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:

Returns Medication will be kept in locked box separately 19/10/18.

Regulation 5: Individual assessment and personal plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:

All families have received a letter outlining the requirements for Annual Health Assessment, see attached. All Annual Health Personal care Plans have been reviewed and updated. All PCP review meetings with families and individuals have been held to assess social, personal supports and set goals 18/10/18. Where additional needs or observations have been identified i.e. eating or swallow referrals for assessment and future care planning are now being requested and followed up. Expected completion subject to appointments 8/11/2018.

Regulation 7: Positive behavioural support	Substantially Compliant

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

An amended policy removing Suspension will be presented to the Board on 13/11/18

Regulation 13: General welfare and development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 13: General welfare and development:

Residents planning and Participation in shopping is facilitated through residents meetings. The PIC ensures the resources are allocated for taxi use as necessary 1/10/18

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
Registration Regulation 7(1)(a)	The registered provider shall as soon as practicable give notice in writing to the chief inspector of any intended change in the identity of the person in charge of a designated centre.	Not Compliant	Orange	19 October 2018
Regulation 13(2)(b)	The registered provider shall provide the following for residents; opportunities to participate in activities in accordance with their interests, capacities and developmental needs.	Substantially Compliant	Yellow	01 October 2018
Regulation 14(2)	The post of person in charge shall be full-time and shall require the qualifications, skills and experience necessary to	Not Compliant	Orange	20 September 2018

	manage the designated centre, having regard to the size of the designated centre, the statement of purpose, and the number and needs of the residents.			
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.	Not Compliant	Orange	30 September 2018
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	26 October 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	26 October 2018
Regulation 23(1)(b)	The registered provider shall ensure that there is a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service	Not Compliant	Orange	30 November 2018

	provision.			
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	30 November 2018
Regulation 24(4)(a)	The agreement referred to in paragraph (3) shall include the support, care and welfare of the resident in the designated centre and details of the services to be provided for that resident and, where appropriate, the fees to be charged.	Not Compliant	Orange	26 October 2018
Regulation 24(4)(b)	The agreement referred to in paragraph (3) shall provide for, and be consistent with, the resident's needs as assessed in accordance with Regulation 5(1) and the statement of purpose.	Not Compliant	Orange	19 October 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	Not Compliant	Orange	13 November 2018

	following: hazard identification and assessment of risks throughout the designated centre.			
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 November 2018
Regulation 28(1)	The registered provider shall ensure that effective fire safety management systems are in place.	Substantially Compliant	Yellow	04 October 2018
Regulation 28(2)(b)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Substantially Compliant	Yellow	04 October 2018
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	Not Compliant	Orange	19 October 2018

	administered as prescribed to the resident for whom it is prescribed and to no other resident.			
Regulation 29(4)(c)	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 out of date or returned medicines are stored in a secure manner that is segregated from other medicinal products, and are disposed of and not further used as medicinal products in accordance with any relevant national legislation or guidance.	Not Compliant	Orange	19 October 2018
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose containing the information set out in Schedule 1.	Not Compliant	Orange	19 October 2018
Regulation 05(1)(b)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health,	Not Compliant	Orange	08 November 2018

	personal and social care needs of each resident is carried out subsequently as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.			
Regulation 05(4)(a)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which reflects the resident's needs, as assessed in accordance with paragraph (1).	Not Compliant	Orange	08 November 2018
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.	Not Compliant	Orange	13 November 2018