Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Office of the Chief Inspector

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

Name of designated centre:	Glencorry
Name of provider:	St Michael's House
Address of centre:	Dublin 9
Type of inspection:	Announced
Date of inspection:	26 March 2019
Centre ID:	OSV-0002383
Fieldwork ID:	MON-0022462

About the designated centre

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

The designated centre forms part of a campus based service for persons with intellectual disabilities and is located in North Dublin. The centre is comprised of one large building and provides full time residential services to six persons. The building consists of six resident bedrooms, a large living room, a large dining room, a kitchen and separate pantry space, a staff office, a staff room, a bathroom, a separate shower room, a utility room, and a large entrance hallway. There is an outdoor patio space to the front of the centre with an area for outdoor dining, a seating area, raised planting beds and a water feature. Residents are supported by a person in charge, a clinical nurse manager, staff nurses, social care workers, care workers, a cook, and a household worker.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	6

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 as amended. To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
26 March 2019	09:20hrs to 18:30hrs	Thomas Hogan	Lead

Views of people who use the service

The inspector met with a number of residents who were availing of the services of the designated centre and observed care and support being delivered. In addition, six questionnaires which were completed by residents, and persons on behalf of residents, were reviewed by the inspector. Overall, the inspector found that residents experienced a good quality of life and were very happy with the services and supports they were in receipt of.

Capacity and capability

Overall, the inspector found that this was a good centre and residents were supported and cared for in an appropriate manner. There were; however, mixed findings across the regulations inspected against and a number of areas were identified which required improvement and development in order to ensure regulatory compliance. Some strong areas identified by the inspector included the person-centred culture which had been established and promoted in the centre. Residents were supported and cared for in a timely fashion and staff members were observed to be very knowledgeable of residents' individual needs. Areas of non-compliance identified by the inspector included: deficits in staff training, unsatisfactory arrangements for the supervision of staff members, and a requirement for further strengthening of the management systems in use.

A review of staffing arrangements was completed by the inspector and it was found that there was an appropriate number of staff deployed in the centre and there was an appropriate skill mix amongst the staff team. There were planned and actual rosters maintained in the centre and a review of a sample of four staff files found that all required information was present. There were two recent vacancies in the centre and the person in charge and service manager outlined plans for recruitment which were underway at the time of inspection. The inspector found that staff treated residents with kindness and respect in all interactions observed at the time of inspection.

The inspector reviewed staff training records and found that there were deficits in all nine mandatory training programmes. Oversight of staff training required improvement to ensure that requirements of organisational policy were met. The person in charged outlined an informal training plan to address the identified deficits. Arrangements in place in the centre for the formal supervision of staff members was found not to be satisfactory. A sample of three staff supervision records were reviewed and it was noted that in all three cases there were 17 month gaps between supervision meetings. The frequency of supervision meetings was not

in line with requirements outlined by the organisation policy. Informal staff supervision arrangements were found to be satisfactory and included both the person in charge and clinical nurse manager working front line and ensuring that in their absence a shift leader was appointed.

The person in charge, a service manager and a clinical nurse manager were met during the course of the inspection. The inspector found that the management team were very knowledgeable and committed to the on-going development and improvement of the services provided by the centre. Both the person in charge and clinical nurse manager were based in the centre and worked on a full-time basis. While the governance structures were clearly defined, some management systems required improvement and enhancement to ensure that the services provided were safe, appropriate to the needs of residents, and effectively monitored. Annual reviews and six-monthly unannounced visit reports were reviewed by the inspector and it was found that the registered provider or management team had failed to self-identify some areas of non-compliance and concern. These areas included staff training, medication management and fire safety. The inspector found that arrangements for the performance management of staff members were not in place in the centre.

The inspector reviewed admissions to the centre which had occurred since the time of the last inspection. There were clear records maintained and transition plans developed to support residents during this time. The inspector found that the admissions to the centre were well managed and complied with organisational policy on this matter. Written contracts for the provision of services were reviewed by the inspector and it was found that four of the six residents did not have signed contracts on file. In addition, the inspector found that the contracts did not clearly outline details of the services which were to be provided to residents.

A statement of purpose in place in the centre (dated 04 March 2019) was reviewed by the inspector and found not to contain a number of areas outlined as required in the regulations. An opportunity was provided to the person in charge and service manager to revise and update the statement of purpose and submit same to the inspector following the inspection. This revised version of the statement of purpose was found to contain all required information.

Regulation 15: Staffing

The inspector found that the number, qualifications and skill mix of the staff team was appropriate to the number and assessed needs of residents availing of the services of the centre.

Judgment: Compliant

Regulation 16: Training and staff development

The inspector reviewed staff training records and found that a number of staff members had not completed training or refresher training in all nine mandatory areas as outlined as required by the person in charge. These were as follows:

- three staff members had not completed training or refresher training in manual handling
- eight staff members had not completed training or refresher training in environmental first aid
- two staff members had not completed training or refresher training in fire safety
- five staff members had not completed training or refresher training in evacuation aid training
- four staff members had not completed training or refresher training in safeguarding vulnerable persons
- five staff members had not completed training or refresher training in children first
- four staff members had not completed training or refresher training in positive behaviour supports
- six staff members had not completed training or refresher training in food safety and
- one staff member had not completed training or refresher training in hand hygiene.

Arrangements in place for the formal supervision of staff members was not satisfactory. Supervision records demonstrated a considerable time gap in the periods between one-to-one supervision meetings with staff members and was not in line with organisational policy which required such meetings to take place on four occasions annually.

Judgment: Not compliant

Regulation 22: Insurance

There was a contract of insurance in place in the centre which insured against injury to residents.

Judgment: Compliant

Regulation 24: Admissions and contract for the provision of services

Four of the six residents availing of the services of the centre were found not to have signed contracts for the provision of services in place. A review of the contracts found that the services which were to be provided were not clearly outlined in the document.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

A revised statement of purpose submitted to the inspector following the inspection was found to contain all required information as outlined in schedule 1 of the regulations.

Judgment: Compliant

Regulation 23: Governance and management

Management systems in use in the centre required improvement and development. Annual reviews and six-monthly unannounced visits failed to self-identify a number of non-compliances such as staff training, medication management and fire safety. Arrangements were not in place for the performance management of staff members.

Judgment: Not compliant

Quality and safety

The inspector found clear examples which demonstrated residents were supported to live active and meaningful lives and were in receipt of person-centred care through services provided in the centre. Residents were supported to develop and maintain relationships and links with their local communities and resided in a comfortable and homely environment. However, there were a number of areas of non-compliances identified though the inspection process. Ares of non-compliance related to risk management, fire safety, and medication management. The inspector found that improvement were required in these areas to ensure that the care and support being delivered to residents was consistently safe and of a good standard.

A review of communication supports in place found that appropriate arrangements were in place for the assessment of needs and required supports to be made available for residents. A number of residents had inputs from allied health

professionals to support their communication needs and all residents had a support plan in place to address communication support needs. There were a variety of assistive technologies in use to aid residents with communication which included electronic tablets, communication tools, objects of reference, communication switches and push buttons, and easy read timetables. Residents had access to a telephone with loudspeaker functionality and the centre had televisions, radios, hi-fi stereos, electronic tablets, and wi-fi.

The inspector completed a full walk through of the centre in the company of the person in charge and service manager. The premises were recently renovated internally and were found to be very clean, suitable decorated and maintained to a high standard throughout. All residents had individual bedrooms which were decorated and furnished in line with personal tastes. There was sufficient storage facilities and an adequate number of toilets and shower facilities. There were appropriate aids in place to support and promote the full capabilities and independence of residents. The centre was found to be fully accessible for residents and persons with reduced mobility.

A review of a risk management policy (dated April 2016) in place in the centre found that it did not contain all required information as set out in the regulations. A risk register maintained in the centre was reviewed by the inspector. All risks outlined on the registered were categorised as 'low' despite some evidence identified at the time of inspection indicating that there were greater risks in the centre in areas such as fire safety for example. In some instances, risk control measures listed on risk assessments were found not to be in place. One example involved a risk assessment which was completed for the 'storage of medication and medication management' in which one control measure is listed as staff being up to date on with the drug error policy and reporting system. The inspector found that this was not in place and a considerable number of drug errors occurred in the centre which were not identified or reported. The inspector completed a review of incident, accident and near miss records for 2019 to date. Appropriate follow up actions were found to have taken place in the cases of all records reviewed.

The inspector reviewed fire safety measures in place in the centre and found that there were a number of concerns in this area. While there appeared to be fire doors fitted throughout the premises, there was no certification available to confirm this. The inspector observed 15 fire doors to be either wedged open or held open through the use of a latch in the centre which compromised the effectiveness of these fire containment measures. While there were self-closing mechanisms fitted to some doors, the inspector noted that all doors which required these devices did not have them installed. Personal emergency evacuation plans (PEEPs) were reviewed and found to provide clear and unambiguous direction on how to support resident in the event of a fire or similar emergency. Staff members and managers spoken with all stated that they were assured that residents could be safety evacuated from the building in the event of a fire; however, a review of three fire drills records which were made available to the inspector demonstrated that on two of the three occasions it took a prolonged time to evacuate residents during the completion of fire drills.

A review of medication management was completed by the inspector. Medication was found to be securely stored in the centre and all medication was clearly labelled and within the stated expiry dates. Staff members spoken with were knowledgeable of the actions to take in the event of a medication error. A review of resident files found that no capacity or risk assessments had been completed relating to the self-administration of medication by residents. A review of medication prescriptions and administration records found a considerable number of occasions where medications had not been signed as having been administered to two residents. The inspector also identified that a resident was recorded as having been incorrectly administered a medication on two occasion in one day when they were only prescribed to take ti once daily. A review of accident, near miss and incident records found that these medication errors had not previously been identified or reported in the centre. PRN medication (medication administered as the need arises) guidelines were not signed by a prescribing clinician.

The inspector reviewed accident, near miss and incident records maintained in the centre and found that there were no recorded incidents of a safeguarding or protection nature. Staff members and the person in charge demonstrated appropriate awareness of the different types of abuse and the appropriate actions to take if abuse was ever witnessed, alleged or suspected.

Regulation 10: Communication

The inspector found that residents were supported to communicate in accordance with their needs and wishes.

Judgment: Compliant

Regulation 17: Premises

The premises of the centre were found to be designed and laid out to meet the aims and objectives of the service and the number and needs of residents.

Judgment: Compliant

Regulation 26: Risk management procedures

A risk management policy (dated April 2016) in place in the centre did not contain all required information as set out in the Regulations. The policy did not outline:

- the arrangements for the identification, recording and investigation of, and

learning from, serious incidents or adverse events involving residents or
- the arrangements to ensure that risk control measures are proportional to the risk identified, and that any adverse impact such measured might have on the residents' quality of life have been considered.

Some risks in the centre had not been appropriately risk rated and some control measures listed were not found not to be in place.

Judgment: Not compliant

Regulation 28: Fire precautions

There was an absence of certification to confirm that doors fitted in the centre were fire rated. A large number of fire doors were observed to be wedged or latched open. A number of doors did not have self-closing mechanisms fitted. There was an absence of evidence to demonstrate that residents could be safely evacuated from the centre in a reasonable time in the event of a fire or similar emergency.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

The inspector found that medication had not been recorded as having been administered on 10 occasions to two residents in a sample of administration records reviewed. One resident was also recorded as having been administered a medication on two occasions in one day when only prescribed to take it once daily. PRN guidelines were not signed by a prescribing clinician. Capacity or risk assessments had not been completed for the self-administration of medication by residents.

Judgment: Not compliant

Regulation 8: Protection

The inspectors found that residents were protected from experiencing abuse while availing of the services of the centre.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Views of people who use the service	
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Not compliant
Regulation 22: Insurance	Compliant
Regulation 24: Admissions and contract for the provision of services	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 8: Protection	Compliant

Compliance Plan for Glencorry OSV-0002383

Inspection ID: MON-0022462

Date of inspection: 26/03/2019

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	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: In response to the area of non-compliance found under Regulation16(1)(a): • The Person in Charge will ensure that staff have access to appropriate training, including refresher training, as part of continuous professional development programme. • The Person in Charge will develop a quarter check systems as part of the Monthly Data Report to monitor completion and track refresher needs of mandatory training. In response to the area of non-compliance found under Regulation16(1)(b): • The CMN2 and CNM1 have developed a schedule of supervision meetings for all staff in the centre in line the SMH supervision policy.	
Regulation 24: Admissions and contract for the provision of services	Substantially Compliant
Outline how you are going to come into compliance with Regulation 24: Admissions and contract for the provision of services: In response to the area of non-compliance found under Regulation 24(3): • The Registered Provider will amend the contract of care to clearly state the terms and	

entitlements of each resident that resides in the centre and the services available to them.

In response to the area of non-compliance found under Regulation 24(4)(a):

• The Registered Provider will ensure that the Contract of care will be updated to include the provision of health care supports provided to each individual resident by the Centre.

• Contract of care once updated will be sent to all residents family members for signing.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
In response to the area of non-compliance found under 23(1)(c):

• Monthly data reports will be introduced in the centre and will include information and analysis of accidents /incidents/ behaviours that challenge/ peer to peer interactions/ complaints. These will be discussed and necessary actions agreed by the PIC and Service Manager at their monthly meetings.

In response to the area of non-compliance found under 23(3)(a):

• The Registered Provider will ensure that Supervision and Support meetings will take place 4 time per year for each staff member in the centre. The structures in place within this policy allow for all PICs to provide support and to identify development opportunities for all of their team specifically in relation to their roles and the services they provide. The policy also is designed to identify performance related concerns that will be addressed.

• Pending the agreement and implementation of a national Performance Achievement Scheme, the St. Michael's House Supervision and Support policy provides a robust framework to ensure the organisation is compliant in this regard

Regulation 26: Risk management procedures	Not Compliant

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

management procedures:
In response to the area of non-compliance found under 26(1)(d):

• The Provider will update the Risk Management policy to address the arrangements for the identification, recording, investigation of and learning from serious incidents or adverse events involving residents.

In response to the area of non-compliance found under Regulation 26(1)(e):

• Since the inspection the Person in Charge completed a full review of all designated centre risks and proportionate risk allocation with the Health and Safety Manager

• The Person in Charge will ensure that the impact of identified risks is correctly rated within the centre.

In response to the area of non-compliance found under Regulation 26(2):

• A full review of all designated centre risks and proportionate risk allocation has been completed since the inspection with the PIC and the Health and Safety Manger.

• The PIC is trained in the management of risk and in consultation with the health and safety Manager they will develop systems in the centre for the assessment, managements and ongoing review of risk, which include a system for responding to emergencies.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
In response to the area of non-compliance found under Regulation 28 (3)(a):

• For the doors in the centre all existing bedrooms doors do not have certification. The new bedroom corridor door sub compartmenting the means of escape has the necessary documentation and is a Falcata 30 min fire door blank. The registered provider is awaiting the tender process to be completed and once contractor has been appointed work will be completed in order to bring the doors up to specification of FD30S. This should be completed by end of July 2019 as we are awaiting completion of the tender process.

• The registered provider has a plan for a phased process of installing free swing closers. Kitchens were identified as being the highest risk and were completed first. In Glencorry there are closers linked to the fire alarm system on the corridor doors, dining room door. The utility room has a closer in place and this is another high risk area. The registered provider is satisfied that the key areas of risk in the unit have been covered by self

closing devices.
• The eye and hooks will be removed from the doors. This should be completed by 31st May.
• Hook and eyes removed from all doors within the centre.

In response to the area of non-compliance found under Regulation 28 (3)(d)
• A run through of the fire plan was carried out with the fire officer, PIC and Service Manager the 28th of March 2019. The use of evacuation aids for individuals in the event of an actual fire will reduce evacuation time as hoist will not be used for individuals.

Regulation 29: Medicines and pharmaceutical services	Not Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
In response to the area of non-compliance found under Regulation 29(4)(b):

• The Person in Charge has completed an audit for the last 12weks in order to identify for each resident possible drug errors in order to reduce potential reoccurrence and to ensure appropriate reporting structure.

• This audit will be completed fortnightly and will be included in the Monthly Data Report for the Centre each quarter.

• The PIC has arranged for the Medical trainer to attend staff meeting 30/04/19 to complete refresher training on medication management and recording sheets.

In response to the area of non-compliance found under Regulation 29(5):

• The Person in Charge has completed a capacity and risk assessment for each resident within the Centre.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 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.	Not Compliant	Orange	16/05/2019
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	28/06/2019
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	28/06/2019

Regulation 23(3)(a)	The registered provider shall ensure that effective arrangements are in place to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.	Not Compliant	Orange	31/12/2019
Regulation 24(3)	The registered provider shall, on admission, agree in writing with each resident, their representative where the resident is not capable of giving consent, the terms on which that resident shall reside in the designated centre.	Substantially Compliant	Yellow	10/05/2019
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.	Substantially Compliant	Yellow	10/05/2019
Regulation 26(1)(d)	The registered provider shall	Not Compliant	Orange	31/05/2019

	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.			
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 proportional to the risk identified, and that any adverse impact such measures might have on the resident's quality of life have been considered.	Not Compliant	Orange	30/04/2019
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	Not Compliant	Orange	30/04/2019

	emergencies.			
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	31/07/2019
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.	Not Compliant	Red	05/05/2019
Regulation 29(4)(b)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine which is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.	Not Compliant	Red	05/05/2019
Regulation 29(5)	The person in charge shall ensure that following a risk assessment and assessment of capacity, each resident is	Not Compliant	Orange	30/04/2019

	encouraged to take responsibility for his or her own medication, in accordance with his or her wishes and preferences and in line with his or her age and the nature of his or her disability.			