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:	Bray Supported Accommodation
Name of provider:	RehabCare
Address of centre:	Wicklow
Type of inspection:	Announced
Date of inspection:	05 June 2019
Centre ID:	OSV-0002642
Fieldwork ID:	MON-0022484

About the designated centre

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

Bray Supported Accommodation is a designated centre is located in County Wicklow and is operated by RehabCare. The designated centre provides a community residential service to five adults, both male and female, with an intellectual disability. The centre provides support to residents based on the social care model and provides low support to residents to assist them to maintain and develop independence in all aspects of daily living. The designated centre is a detached house with a kitchen/dining area, office, sitting room, five individual bedrooms, a staff bedroom and a number of shared bathrooms. Staffing support were provided at key times during the day to support the residents and the centre is staffed by a person in charge, team leaders, care workers and relief care workers.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	5

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
05 June 2019	09:30hrs to 19:00hrs	Conan O'Hara	Lead

Views of people who use the service

The inspector had the opportunity to meet with the five residents living in the designated centre during the course of the inspection. The inspector also observed care practices and staff interactions with residents over the course of the inspection. In addition, feedback of the service was received through five questionnaires completed by the residents which reviewed matters such as accommodation, food and mealtime experience, visiting arrangements, residents' rights, activities, staffing and complaints.

Overall, the residents appeared happy and content in the centre and were also seen to be comfortable in the presence of both staff and management. Residents' spoken with told the inspector that they were happy living in the house. Through the residents questionnaires, residents expressed levels of satisfaction with the care and support they were in receipt of. However, a number of residents with mobility issues expressed concerns regarding the location of the centre and its accessibility to amenities such as shops and public transport. In addition, some residents raised a concern in relation to staffing arrangements, staff interactions at times and access to cooking facilities during certain hours of the day when staff members are not present.

Throughout the course of the inspection, the residents were observed by the inspector as they made preparations to engage in their daily activities such accessing the community, attending healthcare appointments and take part in activities of preference and interests.

Capacity and capability

While residents reported they were generally happy with the service provided, some issues pertaining to the staffing arrangements and the governance and management of the centre required review.

The service provided low support to residents based on the social care model in order to assist residents to maintain and develop independence in all aspects of daily living. The inspector found there was a clearly defined management structure in place which consisted of an experienced person in charge who was supported in her role by two deputy team leaders. However, the day-to-day operational management arrangements in place required improvement as to ensure effective oversight and monitoring of the centre. In addition, the provider did not demonstrate that the current staffing levels were appropriate to meet the assessed

needs of the residents.

The provider had appointed a person in charge in 2017 to manage this centre, who was found to be suitably qualified and experienced. The person in charge demonstrated a good understanding of the residents' care and support needs. There were also systems in place to monitor and evaluate the quality of care provided to residents. Quality assurance audits in place which included annual reviews and the six monthly unannounced provider visits. However, the last six monthly audit completed in May 2019 identified that local governance arrangements required improvement to effectively monitor the service and address areas which require attention in a timely manner. The person in charge was also responsible for the management of a number of other services within the organisation and could only allocate one day a week in this centre. The governance and management arrangements required review as the person in charge did not have adequate protected management time to ensure the effective delivery of care and support or to provide adequate oversight of staffing supports.

The person in charge maintained a planned and actual roster for the centre. The inspector reviewed a sample of rosters which demonstrated that staffing cover was provided at key times during the day in the morning and evening. There was also an established staff team in place which consisted of full time staff members and contracted regular relief staff. However, the staffing arrangements required review as the provider did not demonstrate that there was sufficient staffing levels at all times throughout the day to adequately meet some of the health and social care needs of the residents. For example, residents could access their home during the day when no staff were present. However, they were not permitted to utilise certain kitchen appliances to prepare certain hot meals without staff supervision. It was also observed that if a resident required support at any time when home alone, they had to contact next of kin or staff working in another service of the organisation. Additionally, some residents had expressed dissatisfaction with the current staffing arrangements in place.

There were systems in place for staff training and development. While, the inspector found that the staff team spoken to were knowledgeable of the needs of residents not all training was up-to-date. For example, some staff required refresher training in the behavioural support and manual handling.

Regulation 15: Staffing

The provider did not demonstrate that there was adequate staff support provided in this centre to meet the changing care and support needs of the residents, or the size and layout of the designated centre.

Judgment: Not compliant

Regulation 16: Training and staff development

Some staff required refresher training in the behavioural support and manual handling.

Judgment: Substantially compliant

Regulation 19: Directory of residents

The provider maintained a directory of residents in the designated centre which included all of the information as required by Regulation 19. However, some of the information was out-of-date and required updating.

Judgment: Substantially compliant

Regulation 23: Governance and management

The governance arrangements in place did not ensure that the service provided was effectively and consistently monitored or to provide adequate oversight of staffing supports

Judgment: Not compliant

Regulation 3: Statement of purpose

The Statement of Purpose dated May 2019 did not contain some of the information as required by Schedule 1 of the regulations including

- details of therapeutic techniques used in the designated centre and arrangements made for their supervision
- the total staffing complement in whole-time equivalents

Judgment: Substantially compliant

Regulation 31: Notification of incidents

All incidents or adverse events were notified to the Office of the Chief Inspector as required by Regulation 31.

Judgment: Compliant

Quality and safety

The inspector found that the quality and safety of care in this centre was person centred and aimed to promote residents' independence. In addition, residents told the inspector that generally they were happy living in the centre. However, improvements were required in the assessment of need and personal plans, risk management, fire safety and medication management.

The inspector completed a walk-through of the centre and found that the house was homely and well maintained. The centre consisted of a kitchen/dining area, sitting room, conservatory/office, five bedrooms, staff bedroom and shared bathrooms. There was well maintained gardens to the front and rear of the house. A number of residents proudly showed the inspector their rooms which were decorated in line with their individual style and preference.

The residents informed the inspector of how they like to spend their time. The residents were actively engaged in their local community through work, memberships of various clubs, volunteering and skills development. Residents also accessed a day service in line with their individual preferences and needs and were supported to develop and maintain positive personal relationships with the community and family.

The inspector reviewed a sample of residents' personal files and found that an up-to-date assessment of need had been completed for each resident. However, the assessment of need was not comprehensive as it did not identify all of the residents' health and social care needs in order to inform residents' personal support plans. This meant that the personal plan did not effectively ensure that residents' health and social care needs were being provided for in line with their individual preferences and were inadequate in guiding staff on how to meet their assessed needs. This issue was also identified by the provider in an unannounced audit dated May 2019.

Residents self-directed and managed their own health-care needs and had access to a General Practitioner and a range of allied health professionals. On the day of inspection, some residents spoke with the inspector about recent appointments with allied health professionals. However, heath-care plans were not in place for each identified health-care need to ensure that residents were supported to experience their best possible health or guide staff in providing support in this regard. This issue is referred to above under Regulation 5: Individual Assessment and Personal Plans.

There were systems in place to safeguard residents. Residents told the inspector they felt safe in their home and all staff were appropriately trained in safeguarding of vulnerable adults. Of the staff spoken with by the inspector, they demonstrated that they had the knowledge of what to do in the event of an adverse incident or allegation occurring in the centre and the appropriate reporting procedures. The inspector observed residents appearing comfortable and relaxed in the presence of staff and management and positive interactions were observed between staff and residents over the course of the inspection.

There were systems in place to manage and mitigate risk and keep residents safe in the centre. The provider had a risk management policy in place dated February 2019. The centre maintained a risk register which detailed centre risks including changing needs of residents, premises and lone working. In addition, there were individual risk assessments in place which included the mitigating factors to reduce the risks associated with mobility, falls and unexplained absence. However, it was observed that not all presenting risks in the centre had been identified and assessed by the registered provider. For example, the risks associated with residents being at home unsupervised (such as falls, residents with epilepsy or cooking unsupervised) had not been identified and did not form part of the risk register. This meant that the mitigating factors to reduce these risks had not been identified or documented in residents individual risk assessments.

There were arrangements in place for fire safety management. The centre had suitable fire safety equipment in place including emergency lighting, a fire alarm and fire extinguishers which were serviced as required. Centre records demonstrated the fire drills were carried out regularly and each resident had a Personal Emergency Evacuation Plan (PEEP) in place. These plans outlined the supports for each resident to evacuate the designated centre. However, it was observed that improvements were required in relation to fire drills. The PEEPs identified that three residents may require some physical assistance from sleepover staff at night time. From a review of the fire drill records, the inspector observed that it was over 12 months since the last night time fire drill was facilitated. This had identified by the provider in the recent six monthly audit.

Residents at the centre were assessed as being able to self administer their own medication. However, a number of issues were identified with the management of medication practices in the centre. For example, some medications were not stored securely as required by the regulations. In addition, improvements were required in the oversight systems in place to support residents to self administer short term medication. For example, one resident did not take medication as prescribed for three full days before the issue was identified as a medication error, addressed and followed up on.

For the most part residents reported that they were happy with the service provided and felt suitably safe in their home. They were living active lives and meaningfully engaged in their local community. However, the governance and management arrangements in place did not provide for the effective oversight of the service and non-compliances were found with the individual planning process and medication management practices and substantial complainces were found with fire safety and

risk management.

Regulation 13: General welfare and development

Residents were actively engaged in their local community through work, memberships of various clubs, volunteering and skills development. Residents were also supported to access day services as appropriate and had opportunities to participate in activities in accordance with their interests.

Judgment: Compliant

Regulation 17: Premises

The house was homely and well maintained.

Judgment: Compliant

Regulation 26: Risk management procedures

There were systems in place for the management of risk. However, not all presenting risks in the centre had been identified or assessed by the registered provider.

Judgment: Substantially compliant

Regulation 28: Fire precautions

There were arrangements in place for fire safety management. However, improvements were required in relation to fire drills. The PEEPs identified that three residents may require some physical assistance from sleepover staff during night time fire drills. However, from a review of the fire drill records, the inspector observed that it was over 12 months since the last night time fire drill was facilitated.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

Some medications were not to stored securely as required by the regulations.In addition, improvements were required in the oversight systems in place to support residents to self administer short term medication.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

The assessment of need was not comprehensive as it did not suitably identify all of the residents' health and social care needs in order to inform residents' personal support plans.

Judgment: Not compliant

Regulation 6: Health care

Residents self-directed their own health-care and had access to a General Practitioner and a range of allied health professionals.

Judgment: Compliant

Regulation 8: Protection

There were systems in place for the protection of residents. Residents told the inspector they felt safe in the centre. All staff were appropriately trained in safeguarding vulnerable adults and staff spoken to demonstrated knowledge of what to do in the event of an allegation or concern.

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	Not compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 19: Directory of residents	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Substantially 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 6: Health care	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Bray Supported Accommodation OSV-0002642

Inspection ID: MON-0022484

Date of inspection: 05/06/2019

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 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • Protected PIC hours- 18 hr post to be recruited immediately and be in post (given recruitment processes and notice period) at the latest by 28th October 2019. This relates to a full time post in RehabCare as per Regulation 14. • Additional TL hours- 18 hr post to be recruited immediately and be in post (given recruitment processes and notice period) at the latest by 28th October 2019. • Additional Relief Care Worker hours will be recruited immediately to cover key times as needed e.g. Saturday when staff are off site to assist with weekly shopping, and be in post (given recruitment processes and notice period) at the latest by 23rd August 2019. • Review of service including Multi-Disciplinary Team input, OT assessments, needs assessments, risk assessments, expected by 20th Sept 2019. • Ongoing Review of service will be completed every 6 months going forward by Multi-Disciplinary Team to include Manager, Team Leaders, Regional Manager and required Health Professionals. Items for review will include staffing, Residents Assessments and Support Plans to ensure service is prepared for any change in needs. 1st review and action plan to be completed March 2020. • Staff skills assessment to be reviewed once OT reports submitted. 20th Sept 2019. • Residents needs assessment review using RehabCare Needs Assessment Template (May 2015) to assist with service and staffing review to be completed 18th July 2019. • Service review with HSE regarding additional funding to be undertaken by Manager and Regional Manager by 23rd Sept 2019. • Additional support of 8 to 16 hrs weekly as required to be provided from Team Leader previously Acting RSM/ PIC in another RehabCare residential service, to be implemented week beginning 12th August 2019 until permanent PIC in post.	
Regulation 16: Training and staff development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development: • All staff will have completed mandatory training including refreshers by 30th August 2019. • Issue regarding staff number and gap on records corrected as of 12th June 2019 • Monthly Team Leader Checklist includes a review of staff training requirements, this was developed for Team Leaders use on 7th June 2019. • Team Leaders to ensure Training records maintained by Training Dept. reflect service records, reviewed every 6 weeks by 15th July 2019.	
Regulation 19: Directory of residents	Substantially Compliant
Outline how you are going to come into compliance with Regulation 19: Directory of residents: • Reviewed and amended 6th June 2019. • Staff reviewed at Team meeting 11th July. All staff to familiarise with location and content by 19th July 2019. • Team Leader to review quarterly or as changes present.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • Protected PIC hours- 18 hr post to be recruited immediately and be in post (given recruitment processes and notice period) at the latest by 28th October 2019. This relates to a full time post in RehabCare as per Regulation 14. • Additional TL hours- 18 hr post to be recruited immediately and be in post (given recruitment processes and notice period) at the latest by 28th October 2019. • Monthly comprehensive Team Leader Check tool developed for Team Leaders use May 2019 updated to reflect additional items 7th June 2019. • Additional Relief Care Worker hours will be recruited immediately to cover key times as needed e.g. Saturday when staff are off site to assist with weekly shopping, and be in post (given recruitment processes and notice period) at the latest by 23rd August 2019. • Review of service including Multi-Disciplinary Team input, OT assessments, needs assessments, risk assessments, expected by 20th Sept 2019. • Going forward once initial review is completed there will be a review of the service completed every 6 months by Multi-Disciplinary Team to include Manager, Team Leaders,	

Regional Manager and required Health Professionals. Items for review will include staffing, Residents Assessments and Support Plans to ensure service is prepared for any change in needs.
• Additional support of 8 to 16 hrs weekly as required to be provided from Team Leader previously Acting RSM/ PIC in another RehabCare residential service, to be implemented week beginning 12th August 2019 until permanent PIC in post.
• Weekly Manager and Team Leader meetings taking place to ensure appropriate oversight while compliance plan is fully implemented. Initiated 11th July 2019.
• Manager reviews Team Leader Check tool on completion. Initiated June 2019.

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
• Amended SOP with breakdown of Care Worker WTE as individual posts. Completed 1st July 2019. Copy forwarded to HIQA 17th July 2019.
• Therapeutic Techniques if requested on site are supervised by Manager/ Team Leader e.g. OT assessment. SOP references community based services accessed independently currently, to be updated after Service Review with reference to staffing structure and any additional support needs by 20th Sept 2019

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
• Risk Assessments reviewed and unsupervised access to home specified in Risk Register to be completed by 1st August 2019.
• Further Review of Residents Risk Assessments based on OT Assessment to be completed by 25th September 2019.
• Further Review of Risk register to take place after OT reports returned by 25th September 2019.
• Individual Risk assessments will be reviewed with each Resident to ensure awareness and understanding of controls, personal responsibilities and procedures by 25th August 2019.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• Night time fire drill to be completed 19th July 2019.
• Annual Schedule of Fire Drills with increased focus on night time drills was developed by 2nd July 2019.
• Review Fire safety Risk assessment with all staff team by 25th July 2019.
• Residents to complete the annual planned Fire Safety Training refresher for 2019 on site by 8th November 2019.

Regulation 29: Medicines and pharmaceutical services	Not Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
• Appropriately sized storage boxes purchased, provided to residents and residents instructed in their use Completed 10th July 2019.
• Review of Medication management policy and procedures by staff team by 25th July 2019.
• Review Medication Management policy with Residents in relation to medication storage and communication with staff 18th July 2019.
• Staff team to discuss Medication Management on an individual basis with each of the Residents to be completed by 31st July 2019.
• Weekly Prescription Medication count for all residents to take place each Sunday by staff on duty. Initiated by 14th July 2019.
• Monthly comprehensive Team Leader Check tool developed for Team Leaders use to include review of weekly staff medication counts by 31st July 2019.

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:
• Initial needs assessment review using RehabCare Needs Assessment Template (May 2015) to assist with service review to be completed 18th July 2019.
• Quality and Governance Department will issue a communication to all services relating to the process to be followed in order in ensure that annual screening is linked to the

support planning and risk assessment processes. This will be completed by July 31st 2019.
• Needs assessments to be reviewed once OT assessment has been returned 25th September 2019.
• OT assessment and reports to be completed 20th September 2019.
• Iplanit tool to be updated fully with reviewed information 3rd October 2019.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Not Compliant	Orange	28/10/2019
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	30/08/2019
Regulation 19(3)	The directory shall include the information specified in paragraph (3) of Schedule 3.	Substantially Compliant	Yellow	06/06/2019
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	25/09/2019
Regulation	The registered provider	Not	Orange	28/10/2019

23(3)(a)	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.	Compliant		
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Substantially Compliant	Yellow	25/09/2019
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	Orange	08/11/2019
Regulation 29(4)(a)	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 any medicine that is kept in the designated centre is stored securely.	Not Compliant	Orange	10/07/2019
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	Not Compliant	Orange	31/07/2019

	prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.			
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	20/09/2019
Regulation 05(1)(b)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health, 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.	Not Compliant	Orange	03/10/2019