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:	Cherry Orchard Hospital
Name of provider:	Health Service Executive
Address of centre:	Dublin 10
Type of inspection:	Unannounced
Date of inspection:	30 January 2019
Centre ID:	OSV-0003730
Fieldwork ID:	MON-0025381

About the designated centre

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

The centre is based in Dublin and operated by the Health Service Executive. It consists of two buildings in close proximity to each other, within a hospital campus. Care and support is provided for up to 25 residents over the age of 18, both male and female with a disability. There are 19 long term residents and six respite beds. One building consists of two single bedrooms, six shared bedrooms, two bathrooms and two shower rooms, a dining room, day room, physiotherapy gym, multisensory room and an adjacent family room. The other building consists of three single bedrooms and four shared bedrooms. All bedrooms in this building are ensuite. In addition, there is a dining room, day room and family room. Support is provided for residents over a 24 hour period by registered nurses, healthcare assistants and social care workers. The last inspection in this centre was completed on 04 December 2018. The purpose of this inspection was to monitor the providers regulatory compliance and progress in achieving actions detailed in a transition plan submitted to the Office of the Chief Inspector in September 2018.

The following information outlines some additional data on this centre.

Current registration end date:	21/10/2021
Number of residents on the date of inspection:	20

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
30 January 2019	09:15hrs to 16:45hrs	Maureen Burns Rees	Lead
30 January 2019	09:15hrs to 16:45hrs	Marie Byrne	Support

Views of people who use the service

As part of the inspection, the inspectors met with a significant number of the residents living in the centre and observed elements of their daily lives at different times over the course of the inspection. Three of the residents showed one of the inspectors their bedrooms which had been personalised to their own taste. A number of residents were unable to tell the inspectors their views of the service but the inspectors observed warm interactions between the residents and the staff caring for them. Residents spoken with, told the inspectors that they enjoyed living in the centre and of the activities they enjoyed engaging in. Overall, residents were supported to choose goals that were meaningful to them.

There was evidence that residents and their family representatives were consulted with, and communicated with, about decisions regarding their care and the running of the centre. Residents were actively supported and encouraged to maintain connections with their families through a variety of communication resources and facilitation of visits. The inspectors did not have an opportunity to meet with the relatives of any of the residents on this inspection but staff reported that they were happy with the care their loved ones were receiving.

Capacity and capability

Management systems in place to promote the service provided to be safe, consistent and appropriate to the residents' needs had improved since the last inspection. However, there remained areas for improvements so as to ensure that the service provided was safe and appropriate to meet each of the resident's needs.

The centre was managed by a suitably qualified, skilled and experienced person who had a good knowledge of the needs of each of the residents. The person in charge was in a full time position and was not responsible for any other centre. She was a registered general nurse and registered midwife. In addition, she had completed a degree in nursing studies and held a certificate in management. At the time of this inspection, she was in the process of completing a masters in ageing health and well being in intellectual disabilities. She had been working with the provider for 17 years and in total had more than 13 years management experience. Staff members spoken with told the inspector that she supported them in their role.

There was a clearly defined management structure in place that identified lines of accountability and responsibility which ensured staff were aware of their responsibilities and who they were accountable to. The person in charge reported to the assistant director of nursing who reported to the director of nursing who in turn

reported to the general manager. There was evidence of regular formal and informal contact between the person in charge and the management team. The person in charge was supported by a clinical nurse manager and a vacancy for a second clinical nurse manager was in the final stages of recruitment.

An annual review of the quality and safety of care and six monthly unannounced visits to assess the quality and safety of the service had been completed. There was evidence that actions were taken to address issues identified on these visits. The person in charge and or the clinical nurse manager compiled a quality care matrix on a monthly basis which included a review of medication management practices, nursing care plans and personal plans. There was evidence that a safety walk around was completed on a monthly basis by the general manager and or risk manager. At the time of the last inspection it was found that the frequency by which audits were to occur were unclear. Since that inspection an audit schedule had been put in place. Audits recently completed included audits of finances, complaints and health and safety. However, the inspectors found that some reviews and audits undertaken were not fully effective and had failed to identify issues detected by the inspectors on this inspection in relation to residents' finances, medication practices and care plans.

At the time of the last inspection it was identified that there had been a decrease in the number of meetings between the person in charge and her manager and between the management team. On this inspection, it was found that the person in charge and assistant director of nursing met at regular intervals to review all incidents, audit finding and progress in implementing the transition plan submitted by the provider to the Office of the Chief Inspector. A schedule of management meetings had been put in place which included an oversight meeting on a two weekly basis which was attended by the senior management team, a provider and person in charge meeting on a monthly basis and a project group meeting on a monthly basis which involved members of the senior management team, the multidisciplinary team and three residents from the centre. Staff meetings were occurring on a monthly basis and there was evidence that learnings attained from review of incidents were shared at these meetings.

The staff team were found to have the right skills, qualifications and experience to meet the assessed needs of the residents. This was a nurse led service with nursing staff on duty 24/7 to meet the residents' care needs. A medical officer was also available. The full complement of staff was in place, with the exception of a clinical nurse manager. Recruitment was reportedly underway for this position. A small number of relief staff were used to cover leave which meant that there was consistency of care for the residents.

Training had been provided to staff to support them in their role and to improve outcomes for residents. There was a staff training and development policy. A training programme was in place which was coordinated by the provider's education coordinator. Training records available on the day of inspection indicated that a small number of staff were overdue to attend some mandatory training. Specific training to meet residents' assessed needs had been provided for staff. There were

no volunteers working in the centre at the time of inspection.

Staff supervision arrangements were being rolled out for all staff at the time of this inspection. However, a staff supervision policy had not yet been approved. The inspectors reviewed a sample of staff supervision files and found that they were of a good quality and would support staff to perform their duties to the best of their abilities.

Following on from the last inspection residents' satisfaction with complaints was clearer as to was the outcomes of the complaint. This was due to a revision of the complaints log which now included a section for the complainant to sign that complaints were dealt with to their satisfaction. There was also a section for further follow up and steps taken in an attempt to resolve complaints. There was information on display in the centre in relation to how to access advocacy services should they require their support.

Regulation 15: Staffing

The staff team in place were considered to have the required skills and competencies to meet the needs of the residents living in the centre. At the time of this inspection there was one vacancy for a clinical nurse manager and recruitment was underway for this position.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Training had been provided for staff to improve outcomes for residents. However, records available on the day of inspection indicated that a small number of staff were overdue to attend some mandatory training. Formal staff supervision was being rolled out for all staff. However, a staff supervision policy had not yet been approved.

Judgment: Substantially compliant

Regulation 23: Governance and management

The governance and management systems in place promoted the delivery of a quality and safe service. However, the inspectors found that some reviews and audits undertaken had failed to identify issues detected by the inspectors in relation

to residents' finances, medication practices and care plans.

Judgment: Not compliant

Regulation 34: Complaints procedure

There were policies and procedures in relation to complaints which were available and on display for residents. There was a local complaints officer. There was evidence that complaints were recorded and investigated and that complaints audits were being completed regularly. Recent changes had been made to the complaints log to ensure that the satisfaction levels of complainants were recorded. There was also a section on the complaints log to show any actions and follow up to attempt to resolve complaints.

Judgment: Compliant

Regulation 14: Persons in charge

The person in charge was found to be competent, with appropriate qualifications and management experience to manage the centre.

Judgment: Compliant

Quality and safety

Overall, the residents living in the centre received care and support which was of a good quality and person centred. However, as identified on previous inspections, the overall setting was not designed and laid out to meet the aims and objectives of the service, and the number and needs of the residents.

The centre comprised of two units. One unit consisted of three single and four shared rooms whilst the other unit had two single and six shared rooms. Improvements had been made since previous inspections with the introduction of partial room dividers in a number of shared bedrooms and the inclusion of additional soft furnishings. A number of bedrooms had been personalised to residents taste. However, the centre had an institutional feel and concerns remained regarding the suitability and fitness for purpose of the building.

The residents' well-being and welfare was maintained by a good standard of evidence-based care and support. Residents had access to a medical professional

and allied health professionals in line with their assessed needs. Overall, care plans and personal support plans reflected the assessed needs of the individual residents and outlined the support required to maximise their personal development in accordance with their individual health, personal, communication and social needs and choices. However, it was noted that goals set for some residents were not specific or measurable and in others, monitoring of progress made in achieving goals was not always monitored. Deficits were also identified in relation to plans to meet residents' assessed heathcare needs. Personal plans in place were reviewed at regular intervals with the involvement of the resident's multidisciplinary team, the resident and family representatives where appropriate.

Since the last inspection, improvements had been made in relation to meeting residents' social care needs with increased access for some residents to activities in the community. A number of residents had recently been supported to develop goals to join local community groups and they were in the process of exploring these opportunities. Other residents were continuing to regularly attend day services, computer classes and other local community groups. However, there remained a number of residents who had limited access to meaningful activities.

The inspectors found that each resident was not being supported at all times to communicate in accordance with their needs and wishes. This had also been identified at the time of the last inspection. Improvements had been made to a number of residents' communication plans. Some plans required review as they did not outline what interventions were required to support them to communicate.

There was evidence that residents were offered a variety of meals, drinks and snacks. Meal planners were in place and residents were offered a choice for mealtimes in advance. However, if they changed their mind on the day they were offered alternatives. The inspectors observed residents being supported during mealtimes in line with their assessed needs and preferences in an appropriate manner. Snacks and drinks were available for residents outside of mealtimes. Due to the design of the premises residents were not being supported to buy, prepare and cook their own meals.

There were appropriate policies, procedures and practices in relation to ordering and receipt of medicines. Overall, there were suitable practices in relation to the storage of medicines. However, there was not separate storage area for out of date medicines or those for return to the pharmacy which was segregated from other medicinal products. There was a central pharmacy on the campus and the pharmacist regularly reviewed stock levels and staff ordered any additional medicines as required. At the time of the inspection no resident had indicated that they they wished to self-administer their medicines. This was documented in their personal plan. Medication errors, suspected adverse reaction and incidents were recorded and audited. The inspectors reviewed a number of residents' prescriptions and medication administration records and found that clear guidelines were not in place in relation to the circumstances when to administer some as required medicines.

There were measures in place to keep residents safe and to protect them from

harm. However, on the day of inspection, the inspectors identified discrepancies in the financial records held for a sample of residents which could not be accounted for. For example, records from the providers finance department did not correlate with records in the centre indicating that some individual residents' monies might not be accounted for.

Regulation 10: Communication

The inspectors found that the necessary supports were not in place for all residents to communicate in line with their needs. The required communication supports were not in place for all residents.

Judgment: Not compliant

Regulation 13: General welfare and development

Improvements were noted in the level and variety of activities for some residents. However, this was not consistently found for all residents and a number of residents' activity records showed limited access to meaningful activities in line with those identified as their preferred activities in their personal plan. A number of residents had limited access to education, training or employment, or their local community.

Judgment: Substantially compliant

Regulation 17: Premises

The centre had an institutional feel and concerns remained regarding the suitability and fitness for purpose of the building. The centre was not designed and laid out to meet the aims and objectives of the service, and the number and needs of the residents.

Judgment: Not compliant

Regulation 18: Food and nutrition

Residents food and nutritional needs were appropriately assessed. Residents were encouraged to eat a varied diet and they were communicated with about their meals and food preferences. The design of the premises impacted on residents' ability

to prepare and cook their own meals

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

There were policies and procedures in place in relation to medication management. Improvements were required in relation to the storage of out of date or medicines for return to the pharmacy and guidance for staff in relation to the administration of some as required medicines.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Overall, care plans and personal support plans reflected the assessed needs of the individual residents and outlined the support required to maximise their personal development in accordance with their individual health, personal, and social needs and choices. However, it was noted that goals set for some residents were not specific or measurable and in others, monitoring of progress made in achieving goals was not always monitored.

Judgment: Substantially compliant

Regulation 6: Health care

The inspectors found that residents were being supported to enjoy best possible health. However, healthcare plans and were not in place for some residents' assessed needs.

Judgment: Substantially compliant

Regulation 8: Protection

There were measures in place to keep residents safe and to protect them from harm. However, on the day of inspection, the inspectors identified discrepancies in the financial records held for a sample of residents which could not be accounted

for.
Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 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	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 34: Complaints procedure	Compliant
Regulation 14: Persons in charge	Compliant
Quality and safety	
Regulation 10: Communication	Not compliant
Regulation 13: General welfare and development	Substantially compliant
Regulation 17: Premises	Not compliant
Regulation 18: Food and nutrition	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Substantially compliant
Regulation 8: Protection	Not compliant

Compliance Plan for Cherry Orchard Hospital OSV-0003730

Inspection ID: MON-0025381

Date of inspection: 30/01/2019

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	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: The process for recruiting a new CNM1 has commenced and is now with Human Resources. It is hoped to have this person in place by 31/05/19	
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 mandatory training is being monitored by the Education Officer and it is highlighted to PIC when staff are reaching their renewal dates. It is now also being addressed in Supervision documentation and meetings to further improve compliance. The Supervision Policy is completed and signed off. It will be available on units from 31/3/2019 and training on Supervision and the policy has been provided by the Education Officer.	

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The care plans are in place for each care needs. The nursing care plans are written and are in place for any deficit occurring as result of health problems.

An Audit has been completed on Person Centred Plans. An action plan is presently being developed and will be completed by 15/03/2019. The audit outcomes and proposed actions will be communicated to the PIC and discussed and disseminated at the oversight and quality and safety scheduled meetings.

A review of the process for the management of resident's finances has commenced. The discrepancies identified have been corrected and missing receipts have been accounted for. The Standard Operating Procedure on the management of resident's money will be amended to reflect changes made following the review process.

The monthly monitoring visit will incorporate reviews of finances held at ward level. A regular audit will also be carried out by the PPIM.

Regulation 10: Communication	Not Compliant

Outline how you are going to come into compliance with Regulation 10: Communication:
Residents still have access to Speech and Language Therapists onsite. Recruitment is underway for a Senior SLT to support the current resource.

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 increased access to revised activities continues to be reviewed by the M.D Team. For example:
One resident has been given a slot in the National learning network to attend a baking class every week. This commenced on the 18/02/2019. A second resident is exploring occupational therapy and has indicated interest in attending the men shed which will commence in due course.

Access to community is improving all the time and will be reviewed in line with individual resident's needs on an ongoing basis.

Regulation 17: Premises	Not Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: It is intended to close Lisbri as per condition of registration by 31/10/2021. In the meantime the HSE will continue to explore available options to create additional single rooms and continuing to make the centre more homely for residents	

Regulation 18: Food and nutrition	Substantially Compliant
Outline how you are going to come into compliance with Regulation 18: Food and nutrition: A breakfast table has been placed in Lisbri dining area where residents have access to tea, coffees, snacks regularly depending on their ability to make use of it. A functional kitchen for baking has been provided depending on the residents functional limitations. Lisbri/Elm residents actively participate in baking as a group in Silver Birch one day a week.	

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant
Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services: The unused medicines will be put in the house pharmacy box and returned to the pharmacy. Senior Medical Officer will review all medication Prescription Kardexes and ensure that all are in the newly introduced format and will liaise with nursing staff to ensure that guidance in relation to administration of as required medicines is listed clearly and	

unambiguously. This will be completed before end of March 2019.

Regulation 5: Individual assessment and personal plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
Individual assessment and personal plan: The individual assessment and personal plan have all been reviewed and are in accordance to the resident's needs.

An Audit has been completed on Person Centred Plans. An action plan is presently being developed and will be completed by 15/03/2019. The audit outcomes and proposed actions will be communicated to the PIC and discussed and disseminated at the oversight and quality and safety scheduled meetings.

Funding has been sought from the NMPDU for training in a one-day course on Healthcare Records on Trial which will address key areas such as Accountability ,Negligence and Deficiencies and Guidelines for Record Keeping to address present difficulties with care planning and documentation

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
The care plans are in place for each care needs. The nursing care plans are written and are in place for any deficit occurring as result of health problems.

Funding has been sought from the NMPDU for training in a one-day course on Healthcare Records on Trial which will address key areas such as Accountability, Negligence and Deficiencies and Guidelines for Record Keeping to address present difficulties with care planning and documentation.

Regulation 8: Protection	Not Compliant

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

A review of the process for the management of resident's finances has commenced. The discrepancies identified have been corrected and missing receipts have been accounted for. Individual ledger book has been ordered for accurate recording of the residents' finances.
The Standard Operating Procedure on the management of resident's money will be amended to reflect changes made following the review process.

Protection Audit; monthly monitoring visit will incorporate reviews of finances held at ward level. A regular audit will also be carried out by the PPIM.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 10(1)	The registered provider shall ensure that each resident is assisted and supported at all times to communicate in accordance with the residents' needs and wishes.	Not Compliant	Orange	30/06/2019
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	31/03/2019
Regulation 13(2)(c)	The registered provider shall provide the following for residents; supports to develop and maintain personal relationships and	Substantially Compliant	Yellow	31/03/2019

	links with the wider community in accordance with their wishes.			
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.	Substantially Compliant	Yellow	31/05/2019
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	31/03/2019
Regulation 17(1)(a)	The registered provider shall ensure the premises of the designated centre are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.	Not Compliant	Orange	31/10/2019
Regulation 18(1)(a)	The person in charge shall, so far as reasonable and practicable, ensure that residents are supported to buy, prepare and cook their own meals if they so wish.	Substantially Compliant	Yellow	31/03/2019
Regulation 23(1)(c)	The registered provider shall ensure that management	Not Compliant	Orange	30/04/2019

	systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.			
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.	Substantially Compliant	Yellow	31/03/2019
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	Substantially Compliant	Yellow	31/03/2019

	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.			
Regulation 05(2)	The registered provider shall ensure, insofar as is reasonably practicable, that arrangements are in place to meet the needs of each resident, as assessed in accordance with paragraph (1).	Substantially Compliant	Yellow	31/03/2019
Regulation 06(1)	The registered provider shall provide appropriate health care for each resident, having regard to that resident's personal plan.	Substantially Compliant	Yellow	31/03/2019
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	31/03/2019