Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	Ballytobin Services Orchard View
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Kilkenny
Type of inspection:	Unannounced
Date of inspection:	07 March 2023
Centre ID:	OSV-0008301
Fieldwork ID:	MON-0038070

About the designated centre

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

Ballytobin Services Orchard View is a designated centre comprising of two houses, Leachre and Gabriels, located in a rural area in Co.Kilkenny. Leachare is a two storey detached house on the main grounds of the Ballytobin Service. Leachare has the capacity for four residents. Gabriel's House is a three storey detached house on the main grounds of the Ballytobin Service. Gabriel's has the capacity for four residents. The centre provides 24-hour, 7-day residential services for 52 weeks for adults. Needs of individuals within Ballytobin Services Orchard View vary. Some individuals present with high medical needs, some individuals present with Autism, behaviours which challenge and some individuals whom present with increased anxiety, all of whom have regular support and expertise of the Multidisciplinary Team. Residents attend a day service within the grounds of Ballytobin Services "The Hub", this service promotes and encourages participation within the wider community engaging in activities, such as horse riding, swimming and outdoor pursuits within their community. The centre has a full time person in charge and the staff team comprises of Social Care workers, care Assistants and staff nurses

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	7

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 (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
Tuesday 7 March 2023	10:45hrs to 17:30hrs	Miranda Tully	Lead

What residents told us and what inspectors observed

This inspection was unannounced and completed over one day. The centre was initially registered in September 2022 and is a home for seven residents.

Overall, it was found that for the most part the care and support provided was person-centred and in line with the residents' specific needs in this centre. Some improvements were required across a number of regulations to ensure quality of care could be maintained and improved on.

The centre is located in a rural setting on a large site which contains another designated centre also operated by the provider in addition to administration buildings. This centre consists of two houses. Both of the premises are on the main site close to the administrative offices. Each house has a sitting room, dining room and kitchen, as well as single-occupancy bedrooms for all residents. Residents had personalised their bedrooms to suit their individual preferences. In general, the houses appeared homely however, some improvements were required in the upkeep of the property. This included upgrading bathrooms and replacement or repair of flooring, windows and doors.

During the inspection, the inspector met with four residents. Each resident with the exception of two residents were attending day services when the inspector arrived. One resident was in their bedroom and choose not to meet the inspector. The inspector had the opportunity to view the area where they lived which had been individualised to the resident's individual needs and preferences. For example, the resident had access to a small kitchenette if they choose to prepare snacks away from the main kitchen. A second resident was in hospital at the time of inspection. Regular contact had been maintained with the hospital and a review of the rota reflected familiar staff supported the resident while in hospital. On return from day services residents did not directly engage with the inspector however, they were observed to be comfortable and content in their home and in the company of the staff who supported them.

The staff team comprised of nursing staff, social care workers and care staff. The centre had a team leader and the team leader was supported by a full time person in charge. There was a regular management presence in the centre and the staff team appeared consistent. The numbers of staff on duty and skill mixes in place were appropriate to meet the resident's needs. Some residents also accessed further multi-disciplinary support when required and this was supported and facilitated by management and the staff team. This included behavioural therapy, dietican and psychiatric input where required.

The staff who spoke to the inspector were knowledgeable regarding residents' needs. Staff spoke about residents' individual needs and preferences and how they as staff respond. Staff described the social interactions which the residents engaged in, examples included shopping for items for their home, walks in the local area and

visits with family.

In summary, based on information reviewed and what was observed, it was evident that the residents for the most part received a good quality of care and support. However, there were areas for improvement which included, governance and management, risk management, staff training, medication and pharmaceutical practices, premises and some aspects of infection prevention and control practices.

The next two sections of the report present the findings of this inspection in relation to the the overall management of the centre and how the arrangements in place impacted on the quality and safety of the service being delivered.

Capacity and capability

There was a clearly defined management system in place which ensured the service provided a good quality of safe care. However, some areas for improvement were required in staff training and development and governance and management.

There was a clear management structure in place. The centre was managed by a full-time, suitably qualified and experienced person in charge. The person in charge reported to the service leader. To help support the person in charge in their role, a team leader had been appointed. Both the team leader and the person in charge facilitated the inspection and they both demonstrated knowledge about residents' preferences and assessed needs. There was evidence of regular quality assurance audits taking place to ensure the service provided was effectively monitored. These audits included both local audits such as safety audits and also provider audits for the time that the centre was operational in 2022. The quality assurance audits identified areas for improvement and action plans were developed in response. However, some improvement was required in the effective monitoring of medication and pharmaceutical practices as issues found on inspection had not been identified in the medication audit completed within the centre.

On the day of inspection, there were appropriate staffing levels in place to meet the assessed needs of the residents. From a review of the roster, there was an established staff team in place. Throughout the inspection, staff were observed treating and speaking with the residents in a dignified and caring manner. There was regular formal supervision and support provided to staff.

There were systems in place for the training and development of the staff team. However, improvement was required to ensure all staff had up to date training and skills to support the residents. Staff had not completed refresher training within the time frame recommended by the provider's policy. For example, a number of staff had not completed refresher training in epilepsy awareness and rescue medication, fire, safe administration of medication and first aid. While training had been sought training dates had not been confirmed and dates were scheduled for time frames

beyond the recommended date set by the provider in their policy.

Regulation 14: Persons in charge

The registered provider had appointed a full-time, suitably qualified and experienced person in charge to the centre. On review of relevant documentation there was clear evidence the person in charge was competent, with appropriate qualifications and skills to oversee the centre and meet its stated purpose, aims and objectives. The person in charge demonstrated good understanding and knowledge about the requirements of the Health Act 2007, regulations and standards. The person in charge was familiar with the residents' needs and could clearly articulate individual health and social care needs on the day of the inspection.

Judgment: Compliant

Regulation 15: Staffing

The staff team comprised of nursing staff, social care workers and care staff. At the time of inspection a team leader had been appointed to support the person in charge in their role. There was a staff rota in place that was well maintained and reflective of staff on duty. Support requirements were determined by the residents assessed needs and the inspector found that there were appropriate staffing levels in place to meet these needs. On-call arrangements were in place and communicated to staff to ensure access to managerial support at times when this may be required.

Judgment: Compliant

Regulation 16: Training and staff development

There was systems in place for the training and development of the staff team. However, improvement was required to ensure all staff had up to date training and skills to support the residents. Staff had not completed refresher training within the time frame recommended by the provider's policy. For example, a number of staff had not completed refresher training in epilepsy awareness and rescue medication, fire, safe administration of medication and first aid. While training had been sought, training dates had not been confirmed and dates were scheduled for time frames beyond the recommended date set by the provider in their policy.

Judgment: Not compliant

Regulation 23: Governance and management

The registered provider ensured there was a clearly defined governance structure within the centre . The registered provider had appointed a full-time, suitably qualified and experienced person in charge who was knowledgeable around residents' specific needs and preferences. A team leader was also in place.

Audits and reviews as required by the regulations were taking place and identifying areas of improvements. However, some improvement was required in the effective monitoring of medication as discussed under regulation 29.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The provider had prepared a statement of purpose which accurately outlined the service provided and met the requirements of the regulations.The statement of purpose clearly described the model of care and support delivered to residents in the service. It reflected the day-to-day operation of the designated centre. In addition a walk around of the property confirmed that the statement of purpose accurately described the facilities available including room size and function.

Judgment: Compliant

Quality and safety

Overall, the inspector found that the provider and local management team were striving to ensure residents were in receipt of a good quality and safe service. The inspector reviewed a number of areas to determine the quality and safety of care provided, including visiting both premises, review of risk management, safeguarding and infection control systems. The provider was for the most part identifying and responding to areas that required improvement. Some improvements were required in areas such as premises, fire, medication and pharmaceutical practices and infection prevention and control.

The inspector reviewed a sample of residents' personal files which comprised of a comprehensive assessment of residents' personal, social and health needs. Personal support plans reviewed were found to be up-to-date and to suitably guide the staff

team in supporting the residents with their personal, social and health needs.

Overall, the designated centre was decorated in a homely manner however, improvements were required in the upkeep of some areas of the property. For example, bathrooms and floors were in need of upgrade works.

The systems in place for the prevention and management of risks associated with infection required improvement. For example, wooden surfaces surrounding toilets and wooden floors in the dinning area were also worn which prevented adequate cleaning. In addition, while cleaning schedules were in place there were aspects of the centre not identified on the schedules. For example residents' equipment and unused areas of the centre were not included and therefore schedules did not appropriately guide the staff team.

There were systems in place to ensure residents were protected from abuse. This included staff training and care plans for personal and intimate care.

Relevant risks were discussed with the inspector on the day of inspection. A risk register was in place to provide for the ongoing identification, monitoring and review of risk. A number of individual risk assessments required review to ensure measures in place to mitigate the risk were current.

Regulation 17: Premises

Overall, the designated centre was decorated in a homely manner. The staff team had supported residents to display their personal items and in ensuring that their personal possessions and pictures were available to them throughout the centre. All residents had their own bedrooms which were decorated to reflect their individual tastes. Some facilities were in need of renovation but there was a plan in place for the necessary work. For example, bathroom areas had been identified as a priority for upgrade works along with flooring to the entrance of one of the buildings. On the day of the inspection gaps were evident under external doors, this had been identified by the provider and was included in additional works planned for 2023.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

There were systems in place for the assessment, management and ongoing review of risks in the designated centre. General risks were managed and reviewed through a centre-specific risk register. The residents had number of individual risk assessments on file so as to promote their overall safety and well-being, where required. Some individual risk assessments required review to ensure they were up to date and reflective of the controls in place to mitigate the risks. For example, the

risk of absconsion during evacuation for one individual and a healthcare risk for another resident.

Judgment: Substantially compliant

Regulation 27: Protection against infection

There were systems in place for the prevention and management of risks associated with infection. There was evidence of contingency planning in place for COVID-19. There were infection control guidance and protocols in place in the centre. Overall, frequently used areas of the premises were observed to be visibly clean. The staff team were observed wearing PPE as appropriate. Good practices were in place for infection prevention and control including laundry management and a color-coded mop system. However, some areas required review as they posed a barrier to effective infection prevention and control. Cleaning schedules in place did not appropriately guide the staff team on areas of the centre to clean such as residents equipment or rooms that were not in daily use. In unused areas, high levels of dust and insects were observed in emergency light covers.

Judgment: Not compliant

Regulation 28: Fire precautions

There were systems 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.

The training matrix reviewed indicated that a number of staff required training in fire, while training had been sought dates for completion were yet to be confirmed.

One fire door had a hole where a lock had been removed. Additional containment measures were in place to mitigate the risk. The provider confirmed the fire door was repaired the day following the inspection.

There was evidence of regular fire drills taking place. However, improvement was required in the arrangements in place for the safe evacuation of all persons in the event of a fire, particularly at night-time. For example, from a review of fire drills completed in the six months, the inspector found that the fire drills did not demonstrate that all residents could be safely evacuated at night time with the lowest number of staffing.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

The administration of medication policy and procedure available on the day of inspection noted a revision date of 12/01/2023. The provider advised the inspector that a policy was in draft and soon to be ratified. There were systems in place for the ordering, receipt, prescribing, storing, disposal and administration of medication. However, the inspector found that some practices in the management of medication required review. For example, one medication had not been recorded as administered on a number of occasions between December 2022 and the day of the audit. Rational for the omission had not been recorded. One medicine had not been stored as directed, it had been stored in a locked cupboard as opposed to a fridge as indicated on the directions. It was also observed that some medicines did not have a date of opening documented, to ensure they were disposed of as specified on the medicine. On the day of inspection, over the counter medicines were listed on a Kardex however, were not signed by a GP, medical practitioner and or a nurse as indicated in the providers policy. An assessment had not been completed in order to determine the level of support residents required in the administration and management of medicines. Medicine audits completed in January and March had not identified any of the discrepancies found on inspection which raised concern regarding the quality of this auditing.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

Each resident had a comprehensive assessment of need completed which identified their health, personal and social care needs. These assessments were used to inform the development of their personal plans. Residents' personal plans reflected their assessed needs and outlined any support they may require to maximise their personal development and independence.

Judgment: Compliant

Regulation 6: Health care

Each residents' healthcare supports had been appropriately identified and assessed. The inspectors reviewed a sample of healthcare plans and found that they appropriately guided the staff team in supporting residents with their healthcare needs. The person in charge had ensured that residents were facilitated to access appropriate health and social care professionals as required.

Judgment: Compliant

Regulation 7: Positive behavioural support

Residents were supported to manage their behaviours and positive behaviour support guidelines were in place as required.

There were systems in place to identify, manage and review the use of restrictive practices. There were a number of restrictive practices in use in the designated centre which had been appropriately identified as restrictive practices and reviewed by the organisation's restrictive practice committee.

Judgment: Compliant

Regulation 8: Protection

Residents were protected by the policies, procedures and practices relating to safeguarding and protection. Staff had completed training in relation to safeguarding and protection and were found to be knowledgeable in relation to their responsibilities should there be a suspicion or allegation of abuse. Residents had intimate care plans in place which detailed their support needs and preferences.

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 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Ballytobin Services Orchard View OSV-0008301

Inspection ID: MON-0038070

Date of inspection: 07/03/2023

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: • All staff have completed all online trainings that are available on HSEland available and certs have been sent to the service leader/training department. • The scheduling of all outstanding mandatory training is being organized with the Training Department • The training matrix for the centre has been reviewed and updated to ensure it is an accurate reflection of all staffs current training needs	
	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • The management team in Orchard view will implement audits on a fortnightly basis to ensure adequate oversight of the medication management systems in place. This audit will ensure that the management team are aware of any discrepancies, to ensure timely responses and to prevent similar errors which arose in the recent inspection.	
Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: • Leachare house has been put on the major works list for 2023. This will include; new windows & doors (both internal and external) and upgrades completed to the floor in the dining area. • Quotations have been sought for works to be carried out in the bathrooms upstairs, it is envisaged that works will commence over the coming number of weeks to update and modernize the bathroom areas. • The living area requires new flooring and we are awaiting quotes from the suppliers on these works.	
Regulation 26: Risk management procedures	Substantially Compliant
Outline how you are going to come into compliance with Regulation 26: Risk	

management procedures:
• All Risk assessments in Leachare were reviewed on 15.03.2023 in conjunction with the MDT and will continue to be reviewed on a regular basis. It has been agreed with the MDT recently that timely night time fire drills will be carried out at a more suitable time which will prevent heightened anxiety for individuals whom use our services, with the minimum staff rostered for night shift participating in the fire drill.

Regulation 27: Protection against infection	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
• The PIC has introduced a cleaning schedule with additional guidance for staff to ensure all individuals equipment is cleaned appropriately. This is signed off by staff daily- this will also be audited on a fortnightly basis.
• All unused rooms have also been added to the cleaning schedule
• All emergency exit lights have been cleaned out.
• Required premises works are being scheduled as detailed under Regulation 17. This will ensure that areas identified are conducive to effective cleaning

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• The Management Team and the Training department are in the process of organizing Fire Safety training for all staff in Orchard View.
• Risk assessments in Leachare have been updated as per previous feedback in relation to the simulated fire drills.
• The fire door in Leachare has been repaired
• A review of current restrictive practices in place to mitigate the risk of an individual absconding during a fire drill has been undertaken and measures have been introduced to gradually reduce this restrictive practice with the intent of discontinuing it long term if it no longer poses a risk.

Regulation 29: Medicines and pharmaceutical services	Not Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
• Team leaders/ identified persons will implement checks on a fortnightly basis on medication practices completed by staff to ensure there is adequate oversight over the administration and storage of medication. The PIC as part of their governance will check and sign the audit fortnightly and bring any issues of concern, which may arise to the attention of the Service Leader.
• The new updated medication policy has been reviewed and circulated to all houses in Orchard View for staff teams to read and sign.
• The recording of the opening date for required medications has been implemented in both houses. Staff have been reminded of this requirement at staff meetings and this will be subject to increased monitoring at a local level by PICs and Team Leaders in addition to the increased auditing systems being introduced.
• An assessment for all residemts in Orchard View has been completed in order to determine the level of support residents required in the administration and management of medication.

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	31/07/2023
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Substantially Compliant	Yellow	31/12/2023
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Substantially Compliant	Yellow	31/07/2023
Regulation 23(1)(c)	The registered provider shall ensure that management	Substantially Compliant	Yellow	28/03/2023

	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 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	28/03/2023
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.	Not Compliant	Orange	30/04/2023
Regulation 28(2)(b)(i)	The registered provider shall make adequate arrangements for maintaining of all	Not Compliant	Orange	28/03/2023

	fire equipment, means of escape, building fabric and building services.			
Regulation 28(4)(a)	The registered provider shall make arrangements for staff to receive suitable training in fire prevention, emergency procedures, building layout and escape routes, location of fire alarm call points and first aid fire fighting equipment, fire control techniques and arrangements for the evacuation of residents.	Not Compliant	Orange	31/07/2023
Regulation 28(4)(b)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Not Compliant	Orange	31/03/2023
Regulation 29(4)(b)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt,	Not Compliant	Orange	31/03/2023

	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.			
Regulation 29(4)(c)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that out of date or returned medicines are stored in a secure manner that is segregated from other medicinal products, and are disposed of and not further used as medicinal products in accordance with any relevant national legislation or guidance.	Not Compliant	Orange	28/03/2023
Regulation 29(5)	The person in charge shall ensure that following a risk assessment and assessment of capacity, each resident is	Not Compliant	Orange	28/03/2023

	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.			