Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Older People

Name of designated centre:	Heather House Community Nursing Unit
Name of provider:	Health Service Executive
Address of centre:	St Mary's Health Campus, Bakers Road, Gurranabraher, Cork
Type of inspection:	Unannounced
Date of inspection:	26 & 27 June 2018
Centre ID:	OSV-0000714
Fieldwork ID:	MON-0022370

About the designated centre

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

Heather House Community Nursing Unit is a purpose built, two storey premises, which opened in April 2011. It is located on the grounds of St. Mary's Health Campus on the north side of Cork City. The centre is registered to accommodate 50 residents in two 25 bed units, Primrose, which is on the ground floor and Daisy, which is on the first floor. Each unit has 17 single bedrooms, two twin bedrooms and one four bedded room. All of the bedrooms are en suite with shower, toilet and wash hand basin. Each unit has its own sitting room, dining room and quiet room. The centre offers both short and long term care to persons requiring 24 hour nursing care.

The following information outlines some additional data on this centre.

Current registration end date:	13/04/2020
Number of residents on the date of inspection:	48

How we inspect

To prepare for this inspection the inspector or inspectors reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
26 June 2018	08:30hrs to 17:00hrs	John Greaney	Lead
27 June 2018	08:30hrs to 13:00hrs	John Greaney	Lead

Views of people who use the service

The inspector met and spoke with a number of residents during the two days of inspection either in the sitting room, dining room or in their bedrooms.
Residents said they felt safe and well cared for and generally knew the names of the staff looking after them. Residents were complimentary about staff saying they were very caring and approachable.

Residents spoke of their privacy being protected and having choice about when they get up in the morning, retire at night and where to eat their meals. There was general approval expressed with laundry services, however, clothes did periodically get misplaced.

Residents were complimentary of the food and were happy with the menu and the quantity of food provided at mealtimes. Most residents spoken with said they were happy with the programme of activities. Some talked about going on outings to areas of interest in the community.

Capacity and capability

Overall, the service provided to residents ensured that they were safely cared for and their health care needs were met to a good standard. However, improvements were required to the governance and management arrangements as there were significant deficits in staff training on fire safety and on responsive behaviour. An Garda Síochána (police) vetting disclosures were not available for all staff in the centre as required by the regulations and the annual review of the quality and safety of care required significant work to ensure it reflected the actual quality and safety of care delivered to residents.

There was a clearly defined management structure with defined lines of accountability and responsibility for the service. There was a commitment to provide quality care that promoted people's independence and autonomy. Previously the person in charge of this centre was also person in charge of another designated centre. The Chief Inspector was not satisfied that this arrangement provided adequate oversight in both centres, due to the distance between the centres, the complexity of the needs of residents in both centres and the numbers of residents accommodated in each of the centres. A new person in charge had been appointed to this centre in January 2018 and was not responsible for managing any other centre. The person in charge was supported by a clinical nurse manager in each of the two units.

The quality of care was monitored through a comprehensive programme of audits. The programme of audits included audits of staff training, the use of restraints, accidents and incidents, hygiene, medication management and care planning. There was also an annual review of the quality and safety of care. The review, however, comprised a series of statements under various headings rather than an actual assessment of the quality and safety of care provided. Neither the audits or the annual review identified required improvements, such as deficits in training.

There were adequate numbers and skill mix of staff on duty to meet the needs of residents. The number of staff required each day, however, could not be maintained from within the centres' own staff complement. In order to maintain adequate staffing levels, the centre relied on agency staff for both nurses and healthcare assistants. Every effort was made to ensure continuity of care to residents by requesting that only staff members that have worked in the centre previously are sent by the agency. This, however, was not always possible, and on the day of the inspection, one agency staff member had not worked in the centre previously.

A sample of personnel records were reviewed to determine if they contained the information required by the regulations, such a photographic identification, verified employment references, An Garda Síochána (police) vetting disclosures, full employment history and current registration for nursing staff. From the sample of four personnel records reviewed, none contained An Garda Síochána (police) vetting disclosures in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012. The inspector was informed that these are held centrally by the HSE and would be delivered to the inspector subsequent to the inspection, however, the requirements of the regulations are that they are kept in a designated centre. While the personnel record for each member of staff in the sample of records reviewed contained a full employment history, there were gaps in employment for some, for which a satisfactory explanation had not been recorded.

Staff were facilitated to attend training relevant to their role. A number of staff had completed training on cardiopulmonary resuscitation (CPR), infection prevention and control and falls prevention. Training records indicated that most, but not all, staff had attended training in areas such as manual and people handling and in safeguarding residents from abuse. Significant improvements were required in mandatory training in other areas. A large number of staff were overdue attendance at annual fire safety training. Additionally, a significant number of staff had not attended training in responsive behaviour (also known as behavioural and psychological signs and symptoms of dementia).

Residents and staff said they could raise any concerns regarding the quality and safety of care delivered and felt their views were listened to and considered. Complaints made were investigated by the person in charge and the records of each complaint, the investigation and satisfaction of the complainant were recorded.

In the feedback meeting, the person in charge and clinical nurse managers acknowledged and accepted the findings and the inspector noted a willingness to ensure that issues would be addressed to bring the centre into full compliance with

the regulations.

Regulation 15: Staffing

There were adequate numbers and skill mix of staff on duty to meet the needs of residents. The number of staff required each day, however, could not be maintained from within the centres' own staff complement. In order to maintain adequate staffing levels, the centre relied on agency staff for both nurses and healthcare assistants. Every effort was made to ensure continuity of care to residents by requesting that only staff members that have worked in the centre previously are sent by the agency. This, however, was not always possible, and on the day of the inspection, one agency staff member had not worked in the centre previously.

Judgment: Compliant

Regulation 16: Training and staff development

Staff were facilitated to attend training relevant to their role. A number of staff had completed training on cardiopulmonary resuscitation (CPR), infection prevention and control and falls prevention. Training records indicated that most, but not all, staff had attended training in areas such as manual and people handling and in safeguarding residents from abuse. Significant improvements were required in mandatory training in other areas. A large number of staff were overdue attendance at annual fire safety training. Additionally, a significant number of staff had not attended training in responsive behaviour (also known as behavioural and psychological signs and symptoms of dementia).

Judgment: Not compliant

Regulation 21: Records

An Garda Síochána (police) vetting disclosures in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012 was not available in the designated centre for each member of staff. While the personnel record for each member of staff ,in the sample of records reviewed, contained a full employment history, there were gaps in employment for some for which a satisfactory

explanation had not been recorded.

Judgment: Not compliant

Regulation 23: Governance and management

There was a clearly defined management structure. The person in charge reported to a general manager and met formally on a monthly basis. They were also in contact via phone and email on a regular basis. The quality of care was monitored through a comprehensive programme of audits. The programme of audits included audits of staff training, the use of restraints, accidents and incidents, hygiene, medication management and care planning. There was a Safety of Quality of Care and Support Report. This report, however, required significant improvement. The report predominantly contained a series of statements under various headings, rather than an actual review of the quality and safety of care delivered to residents over a particular time frame. Additionally, some of the information in the report was inaccurate, such as the number of residents admitted in a particular time frame.

Judgment: Not compliant

Regulation 24: Contract for the provision of services

Each resident had a contract of care, which was signed and dated. The contract included the amount payable by or on behalf of each resident.

Judgment: Compliant

Regulation 31: Notification of incidents

Most notifications required to be submitted to HIQA were submitted as required. However, not all notifications whereby residents required immediate medical attention following an injury were submitted as required.

Judgment: Compliant

Regulation 34: Complaints procedure

The complaints procedure was on prominent display in the centre. A review of

the complaints log demonstrated that complaints were recorded, acted upon and satisfaction or otherwise with the outcome of the complaint was recorded.

Judgment: Compliant

Quality and safety

The inspector found that a good standard of care was delivered to residents. Staff and management made efforts to maintain and improve residents' quality of life through access to the community and through a programme of activities within the centre.

Residents were usually admitted to the centre following an assessment by a placement coordinator. The placement coordinator had good knowledge of the centre and its suitability to meet the needs of proposed residents. A common summary assessment report (CSAR) was usually provided to nursing management in advance so they could plan for the admission. Comprehensive assessments were completed following admission and updated at regular intervals. Care plans were personalised based on the assessed needs of each resident to support staff to meet those needs.

Residents had timely access to medical services. Records indicated that residents were regularly reviewed by their general practitioner (GP). Residents had good access to dietetics through a nutritional supply company. Speech and language therapy was available through referral to the HSE and there was good access. Based on discussions with the person in charge access to physiotherapy and occupational therapy was limited. These services were available through referral to an outpatients clinic. However, the occupational therapist and physiotherapist did not routinely visit the centre to assess residents that could not or did not wish to attend the outpatients department. The inspector was informed that one resident that required a physiotherapist assessment did not wish to leave the centre to attend the outpatients clinic, therefore the resident did not have this assessment completed. A mobile optician services was present in the centre on the day of inspection to carry out an assessment of residents' vision. There was also good access to psychiatry and to palliative care.

The inspector observed that residents were supported to be as independent as possible and facilitated to exercise their autonomy both within the centre and externally. They were actively encouraged to participate in the organisation of the centre and they gave positive feedback regarding opportunities available to them. There was a comprehensive programme of activities. The programme included poetry reading, puzzles, bingo, arts and crafts, music, boschia. Residents were seen to be enthusiastically participating in the activities on both days of the inspection. The centre also had access to transport that could take five residents on outings to

the community. The transport could accommodate one resident with a wheelchair on each trip. Recent trips included a visit to Kinsale and Youghal. Residents usually had their lunch in a restaurant on these trips. This transport was also used to take residents to medical appointments and on shopping trips.

There were procedures in place for fire safety management, however, they required improvement. Training records indicated that a significant number of staff were overdue attendance at fire safety training. Fire drill records provided to the inspector indicated that the most recent fire drill was conducted in August 2017 but prior to that had been conducted approximately every two months. Fire drill records indicated that the drill usually involved the evacuation of one bedroom and not an entire compartment. It was therefore not possible to ascertain if all residents in a compartment could be evacuated in a timely manner. There were daily checks of the means of escape to ensure they were not obstructed. The fire alarm was sounded monthly and not weekly as per guidance. Maintenance records indicated that fire safety equipment was serviced annually and the fire alarm and emergency lighting were serviced quarterly. Improvements were also required in relation to signage. A map was on display in the nursing station of each of the units showing the layout of the centre and emergency escape routes. There was, however, no signage at other areas in the units to identify for residents, visitors and staff where they were in relation to the nearest place of relative safety.

The premises was generally suited to its stated purpose. There was adequate communal space that included a sitting room, a dining room and a quiet room.Thirty four resident were accommodated in single bedrooms, eight residents were accommodated in twin bedrooms and there were two four-bedded rooms. One of the beds in each of the four bedded rooms is usually unoccupied due to the design and layout of the rooms. If a resident was to be accommodated in the fourth bed their privacy could be compromised due the the proximity of the bed in relation to the bathroom. The centre was generally bright and clean throughout. The paintwork on some of the walls was scuffed, particularly in some of the bedrooms. There was good access to outdoor space with two enclosed gardens. The gardens were nicely landscaped and had raised mature shrub beds and one of the gardens had a water feature. There was garden furniture to allow resident spend some time outside in good weather.

Regulation 17: Premises

The premises was generally suited to its stated purpose. There was adequate communal space and adequate secure outdoor space. Thirty four resident were accommodated in single bedrooms, eight residents were accommodated in twin bedrooms and there were two four-bedded rooms. One of the beds in each of the four bedded rooms is usually unoccupied due to the design and layout of the rooms. If a resident was to be accommodated in the fourth bed their privacy could be compromised due the the proximity of the bed in relation to the bathroom. The centre was generally bright and clean throughout, however, the paintwork on some

of the walls was scuffed, particularly in some of the bedrooms.

Judgment: Substantially compliant

Regulation 26: Risk management

The risk management policy addressed the risks specified in the regulations. The person in charge was very familiar with the risk policy and and risks identified. The minutes of the monthly health and safety meetings showed a significant list of standard items discussed and acted upon at each meeting demonstrating a broad-ranging overview of the centre.

Judgment: Compliant

Regulation 28: Fire precautions

There were procedures in place for fire safety management, however, they required improvement. Training records indicated that a significant number of staff were overdue attendance at fire safety training. Fire drill records provided to the inspector indicated that the most recent fire drill was conducted in August 2017 but prior to that had been conducted approximately every two months. Fire drill records indicated that the drill usually involved the evacuation of one bedroom and not an entire compartment. It was therefore not possible to ascertain if all residents in a compartment could be evacuated in a timely manner. There were daily checks of the means of escape to ensure they were not obstructed. The fire alarm was sounded monthly and not weekly as per guidance. Maintenance records indicated that fire safety equipment was serviced annually and the fire alarm and emergency lighting were serviced quarterly. Improvements were also required in relation to signage. A map was on display in the nursing station of each of the units showing the layout of the centre and emergency escape routes. There was, however, no signage at other areas in the units to identify for residents, visitors and staff where they were in relation to the nearest place of relative safety.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

Improvements had been made to medication management practices since the last inspection. The design of the medication administration record had been changed to allow for the recording of the times that PRN (as required) medications were

administered. A review of a sample of prescriptions, however, indicated that the time of administration of PRN medicines was not always recorded.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

Residents were usually admitted to the centre following an assessment by a placement coordinator. The placement coordinator had good knowledge of the centre and its suitability to meet the needs of proposed residents. A common summary assessment report (CSAR) was usually provided to nursing management in advance so they could plan for the admission. Comprehensive assessments were completed following admission and updated at regular intervals. Care plans were personalised based on the assessed needs of each resident to support staff to meet those needs.

Judgment: Compliant

Regulation 6: Health care

Residents had timely access to medical services. Records indicated that residents were regularly reviewed by their general practitioner (GP). Residents had good access to dietetics through a nutritional supply company. Speech and language therapy was available through referral to the HSE and there was good access. Physiotherapy and occupational therapy were available through referral to outpatients but did not routinely visit the centre for residents that could not or did not wish to attend the outpatients department. A mobile optician services was present in the centre on the day of inspection to carry out an assessment of residents vision. There was also good access to psychiatry and to palliative care.

Judgment: Not compliant

Regulation 7: Managing behaviour that is challenging

The inspector observed staff interacting with residents in a kind and caring manner. Staff were knowledgeable of each resident's communication needs. A considerable number of staff had not attended training in responsive behaviour or in dementia care.

Judgment: Compliant

Regulation 8: Protection

Residents stated that they felt safe in the centre. Training records indicated that most, but not all staff, had attended training in safeguarding residents from abuse. Efforts had been made to minimise the use of restraint with the use of alternative to bedrails, such as low beds and crash mats . There were records of safety checks while bedrails were in place.

Judgment: Compliant

Regulation 9: Residents' rights

The inspector observed that residents were supported to be as independent as possible and facilitated to exercise their autonomy both within the centre and externally. They were actively encouraged to participate in the organisation of the centre and they gave positive feedback regarding opportunities available to them.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Not compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Contract for the provision of services	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management	Compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 6: Health care	Not compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Heather House Community Nursing Unit OSV-0000714

Inspection ID: MON-0022370

Date of inspection: 26 & 27/06/2018

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

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: Fire Training: Comprehensive Fire Safety Training including evacuation procedures was completed by 56 staff on the following dates, 06/07/18, 11/07/18, 17/07/18 and 18/07/18. There are 3 staff whose last training was completed in February 2017. These will be facilitated with training as soon as possible. Anticipated date for completion: 31/08/18 Responsive Behavior: Training will be facilitated by our In House Trainer every 2 weeks until all staff have completed the training. Anticipated date of completion: 30/09/18 Safeguarding Training: A member of staff has completed Train the Trainer for Safeguarding and is now available to provide in house training. 4 staff completed safeguarding training on 24/07/18 and 5 staff on 01/08/18. The remaining 4 staff will have training completed by 14/09/18.	
Provide Regulation 21: Records	Not Compliant
Outline how you are going to come into compliance with Regulation 21: Records: Garda Vetting Disclosures:	

Cork Kerry Community Healthcare Data Controller has developed a plan to move the Vetting Disclosure documentation to a secure file location in the Centre which can only be accessed by the PIC or delegate. It is expected that this will be completed by 15th September 2018.

Regulation 23: Governance and management	Not Compliant

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

The Annual Safety and Quality of Care and Support report is due for completion on 31/08/18. This will include a comprehensive overview and assessment of the quality and safety of care provided over the past year and will be available for viewing to residents as required.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:

Paint Work: A rolling scheme of painting has been initiated in both the Daisy and Primrose Wards. This will include all bedrooms and common areas that require painting. Anticipated date of completion: 30/09/18

Regulation 28: Fire precautions	Not Compliant

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

As outlined in Regulation 16 above, 56 staff have undergone Fire Safety Training in July 2018.

The Fire Alarm is being sounded weekly and recorded. Date of completion 02/07/18

Additional fire maps have been ordered from Horizon to improve signage. Anticipated date of completion: 14/09/18

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant

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

All Staff Nurses are aware that the date and time must be recorded when administering all PRN medications.

Date of completion: 02/07/18

Regulation 6: Health care	Not Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:

The Community Occupational Health Therapist evaluated all Residents with outstanding referrals the week of 23/07/18.

An Occupational Therapist also completed a sling assessment on all hoisted Residents on 31/07/18 and is scheduled for staff training within the next 3 weeks.

The provision of on-site Physiotherapy services at the Centre is currently being examined by Senior Management.

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 has access to appropriate training.	Not Compliant	Orange	30/9/18
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Substantially Compliant	Yellow	30/9/18
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.	Not Compliant	Red	15/9/18
Regulation 23(c)	The registered provider shall	Not Compliant	Yellow	30/9/18

	ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.			
Regulation 23(d)	The registered provider shall ensure that there is an annual review of the quality and safety of care delivered to residents in the designated centre to ensure that such care is in accordance with relevant standards set by the Authority under section 8 of the Act and approved by the Minister under section 10 of the Act.	Not Compliant	Yellow	30/9/18
Regulation 23(e)	The registered provider shall ensure that the review referred to in subparagraph (d) is prepared in consultation with residents and their families.	Not Compliant	Yellow	30/9/18
Regulation 23(f)	The registered provider shall ensure that that a copy of the review referred to in subparagraph (d) is made available to residents and, if requested, to the Chief Inspector.	Not Compliant	Yellow	30/9/18

Regulation 28(1)(c)(iii)	The registered provider shall make adequate arrangements for testing fire equipment.	Not Compliant	Yellow	2/7/18
Regulation 28(1)(d)	The registered provider shall make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.	Not Compliant	Orange	14/9/18
Regulation 28(3)	The person in charge shall ensure that the procedures to be followed in the event of fire are displayed in a prominent place in the designated centre.	Substantially Compliant	Yellow	14/9/18
Regulation 29(5)	The person in charge shall ensure that all medicinal products are administered in accordance with	Substantially Compliant	Yellow	2/7/18

	the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident's pharmacist regarding the appropriate use of the product.			
Regulation 6(2)(c)	The person in charge shall, in so far as is reasonably practical, make available to a resident where the care referred to in paragraph (1) or other health care service requires additional professional expertise, access to such treatment.	Not Compliant	Yellow	30/9/18