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:	Lake House Nursing Home
Name of provider:	Sheephaven Properties Limited
Address of centre:	Portnablagh, Dunfanghy, Donegal
Type of inspection:	Unannounced
Date of inspection:	05 July 2018
Centre ID:	OSV-0000353
Fieldwork ID:	MON-0022258

About the designated centre

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

Lake House nursing home is located by the coast in Portnablagh in Donegal. It provides full-time nursing care to 49 residents, male and female who require long-term and short-term care. Residents assessed as having dementia can be accommodated. There are single, twin and triple bedded rooms.
The ground floor contains a number of communal spaces and dining areas. Household facilities including the kitchen and sluice room, clinical room and offices are also located on the ground floor. Bedroom accommodation is located on both floors. There are suitable sanitary facilities on each floor. The laundry is located nearby in a separate building.

The following information outlines some additional data on this centre.

Current registration end date:	14/04/2020
Number of residents on the date of inspection:	49

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
05 July 2018	12:30hrs to 17:30hrs	Leone Ewings	Lead
06 July 2018	10:00hrs to 14:30hrs	Leone Ewings	Lead

Views of people who use the service

Residents gave very positive feedback to the inspector about their experiences of the service they were receiving. Residents told the inspector that meals were of a good standard, and they enjoyed the variety and choices on the menu.

The staff team were described by residents as friendly, caring and available to meet their needs. Residents confirmed they were happy with their bedrooms, and had been encouraged to bring in items to personalise them.

Residents confirmed staff communicated well with them, and they were involved in any decisions about their daily routines, and activity plans.

Residents reported enjoying reading daily newspapers, watching television, music sessions, singing and religious services. Residents expressed satisfaction with their access to activities that suit their preferences. They enjoyed the range of activities available, and also had access to an outdoor garden, and outings. They also confirmed their individual choices to engage (or not engage) in any activity were respected.

The complaints procedure was said to be accessible, and residents confirmed who they could speak to in order to raise any issues. Visitors confirmed they received a warm welcome and were offered refreshments.

Residents did not relay any concerns or advise the inspector of any areas for improvement or changes and were happy with the current service level in place.

Capacity and capability

This was a well-organised and managed service with clear governance and management arrangements in place. Sufficient resources were in place to ensure residents needs were being met and staff were skilled in carrying out their role. Residents were positive about the service they were receiving. While there were quality assurance and oversight arrangements in place they required improvement to ensure all areas of practice were safe and effective, specifically in relation to fire safety. The statement of purpose required review and two policies required updating.

Clearly defined governance and management arrangements were in place with the provider, a person in charge and persons participating in management responsible for running the centre. Weekly reports were made to the provider by the person in

charge. Supervision of the delivery of care to residents was in place. There was clear evidence of a learning culture in the organisation and this was evidenced through a review and audit system established by the person in charge. Training opportunities for staff enhanced the quality and safety of care of residents, and systems of staff appraisal and analysis of training needs were in place. A detailed annual report had been prepared with feedback from resident and relative surveys. However the inspector identified an area of risk in relation to fire safety in the centre that had not been picked up through the management arrangements and so they required review.

Effective planning and staff supervision measures were in place. Overall, staff turnover was low, and safe recruitment practices were found to be in place. There were sufficient staff available to meet residents needs.

A clear complaints policy was in place and its implementation was overseen by the person in charge. No written complaints had been made and any verbal complaints were recorded and managed by her and overseen by the provider. The procedure was on display in the centre and residents who gave feedback to the inspector confirmed they understood the process, and felt any issues raised would be addressed. Where improvements were required following feedback from residents, this was discussed and addressed at staff and management meetings, and changes made where possible.

A range of documentation was reviewed and seen to be in place, including the directory of residents, recruitment records and the policies and procedures. The statement of purpose was available and contained most of the information required, but updates were required to ensure it reflected the service being provided in the centre.

Regulation 15: Staffing

Safe recruitment practices were in place. There was suitable provision of staff on the day of the inspection and the skill-mix was appropriate to the needs of the residents.

Judgment: Compliant

Regulation 16: Training and staff development

Staff mandatory training in safeguarding, fire safety and moving and handling was up to date. Staff appraisals identified areas for staff development, and a training plan was in place for 2018. All staff were supervised and care practices were reviewed by the person in charge.

Judgment: Compliant

Regulation 19: Directory of residents

The directory of residents was up to date and contained all of the information required by legislation.

Judgment: Compliant

Regulation 21: Records

All records reviewed were clear and kept up to date.Records were maintained on an electronic record-keeping system, staff were familiar with its use. The person in charge audited and reviewed records and policies. Records of Garda vetting disclosures were in place for all staff working at the centre.

Judgment: Compliant

Regulation 22: Insurance

The provider had insurance in place for the provision of the service.

Judgment: Compliant

Regulation 23: Governance and management

The provider had a clear management structure in place, and systems to ensure that the service was provided in line with statement of purpose. He visited the centre on a weekly basis and met with the person in charge formally to review management of the service. Management systems required review to ensure all areas of risk were identified and responded to.

Judgment: Substantially compliant

Regulation 24: Contract for the provision of services

Each resident had a signed contract of care in place. The additional details of any terms and conditions of services provided was included.

Judgment: Compliant

Regulation 3: Statement of purpose

There was statement of purpose dated 6th October 2016. It, required review. to meet the requirements of Schedule 1. It required up-to-date conditions of registration and staffing details.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

The person in charge had notified HIQA of all incidents in line with the regulatory requirements.

Judgment: Compliant

Regulation 34: Complaints procedure

An accessible and effective complaints procedure was in operation at the centre. The policy and procedure around making complaints identified the complaints manager, and the option of an independent review.

Judgment: Compliant

Regulation 4: Written policies and procedures

Overall, policies and procedures in place were found to be evidence-based and were in place in line with regulatory requirements. However, a policy on the use of intermittent catheterisation had not been developed to guide staff practice and the complaints policy required updating to include the revised procedures.

Judgment: Substantially compliant

Quality and safety

Residents' needs were being met through good access to health care services, opportunities for social engagement and suitable premises. Improvements were required in relation to fire safety evacuation procedures, the emergency lighting certification was not available, and also storage of equipment required review.

The premises offered a range of communal and private spaces that were bright and airy. There was open access to a courtyard through the centre, and the communal areas were flexible to support large and small groups, those engaged in practical activities, and there was also progress in creating a sensory room for relaxation. The ground floor of the centre was laid out well and contrasting colours were used to assist the identification of handrails, doors to bathrooms and bedrooms, and safety features in the toilets and showers. A weekly religious service and rosary took place this took place in a sitting room. There was a mix of triple, double and single bedrooms that were well presented and had sufficient furniture for residents to store their private belongings. As noted on previous inspections any admission to triple bedrooms needed to be monitored closely, to ensure there was adequate space to meet residents assessed needs. While the centre was spacious and had a good selection of rooms, it was noted that storage of larger items such as hoists and wheelchairs was not being adequately managed in the centre.

There were arrangements in place to manage fire safety in the centre, for example the centre had fire detection arrangements that included doors in circulation areas being fitted with magnetic door releases, there were fire extinguishers through the centre, and staff had completed training in fire safety. While there were arrangements in place for evacuation in the centre improvements were needed. On the first floor a number of residents had high needs and some had reduced mobility, and there was only a single escape route. While fire drills were being carried out they did not include the procedure to evacuate a full compartment in the case of a fire. Certification for the emergency lighting was not available on the day and the person in charge said they would submit a copy to the inspector

There were risk management arrangements in place that included environmental walk rounds, staff being aware of their responsibilities to report any issues to management, a safety statement, and risk register were maintained and updated yearly or as required. However, the system required review to ensure all areas of risk were being identified and monitored, including fire safety arrangements.

Comprehensive assessments were carried out to identify resident's health and social care needs on their admission to the centre. The care provided was regularly reviewed by the nursing staff, making use of a range of assessments and information to identify if their needs remained the same or whether there were changes. Where there were changes referrals were made to relevant healthcare

professionals for example the general practitioner (GP) dietitian, or speech and language therapist. There was also information gathered from the resident and, where appropriate, their family about their life experience, achievements, and individual preferences. This information supported staff to provide support that ensured residents maintained a good quality of life.

Nursing staff were knowledgeable about the needs of residents and the processed to following in the centre in relation to medication management, however improvement was needed in record keeping to ensure practice was fully in line with the centres medication policy. For example examples were seen where records of medicines awaiting disposal or transfer to pharmacy were not fully maintained and medicines requiring crushing not individually prescribed ,and some times of administration not recorded. Examples were also seen where medicines which required additional checks were not consistently signed for by two staff.

Activities staff completed assessments that identified the approach that would best suit each resident, for example whether they preferred individual or sensory activities or group participation. The activities programme was then developed to include the approaches that were most effective for residents. There were group activities, and also the opportunity for some one-to-one engagement where residents enjoyed that. Activities equipment was available to support staff giving close support during practical tasks, for example there were tables that supported the resident to have close access and for the staff member to be close enough to provide hand-over-hand support.

One of the sunrooms overlooking the courtyard had been identified as an area for residents who smoked. This area had been risk assessed and was fully equipped for residents to use, including the provision of smoking aprons or fire blankets to reduce risks associated with accidents while smoking.

The provider had clear processes in place to protect residents' finances. Residents had the option of retaining a small amount of cash for safekeeping within the centre, and this was secured with a countersigned balance book for withdrawals and deposits. The provider did not act as a pension agent for any resident. Residents reported that they felt safe in the centre, and staff were found to have appropriate skills and knowledge to respond to allegations of abuse if they were made.

Regulation 10: Communication difficulties

Staff communication skills were strong and the ability to communicate in both Irish and English was observed by the inspector. Residents with any identified communication difficulties had an appropriate care plan in place to guide practice.

Judgment: Compliant

Regulation 13: End of life

Overall, there was good access to palliative care and end of life care was managed well. Records were found to include the expected information and details of each resident's wishes and preferences were recorded within their assessments.

Judgment: Compliant

Regulation 17: Premises

While the centre provided a range of communal areas that met the needs of residents, and it was well decorated and maintained, improvements were required to conform with Schedule 6 of this regulation in relation to storage of equipment.

Judgment: Substantially compliant

Regulation 20: Information for residents

The resident's guide included the required information, including details of the right to appeal to the Ombudsman in the case of making a complaint.

Judgment: Compliant

Regulation 26: Risk management

There were arrangements to identify and manage risk in the centre, however inspectors identified risk in relation to fire safety during the inspection that had not been picked up.

Judgment: Not compliant

Regulation 28: Fire precautions

While there were arrangements for detecting, containing and extinguishing fires improvement was required to ensure there was adequate means of escape from the first floor as a number of residents with high dependencies were accommodated on

this floor.

There was no certification for the emergency lighting system available during the inspection, and while evacuation drills were taking place on a regular basis they had not practiced evacuating a full compartment from the first floor.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

Overall medication practice was found to be safe but improvement was required to ensure the medication policy was applied in practice, and that records were correctly maintained in relation to storage, administration and return of medication.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

Residents care records included initial assessments and care plans that provided advice and guidance for how residents' needs were to be met. Reviews were carried out every four months and any changes were reviewed with the resident, and where relevant their relatives.

Judgment: Compliant

Regulation 6: Health care

Appropriate medical and healthcare was being provided to residents, in line with their identified health and social care needs.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

Arrangements were in place to ensure that where any restrictive practice was used in the centre that they were individually assessed as being appropriate and the least restrictive option.

Judgment: Compliant

Regulation 8: Protection

Measures were in place to protect residents from abuse, including effective recruitment practices and access to advocacy service. Staff had received mandatory training in relation to detecting, preventing and responding to allegations of abuse. Residents confirmed to the inspector that they felt safe living at the centre.

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	Compliant
Regulation 19: Directory of residents	Compliant
Regulation 21: Records	Compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 24: Contract for the provision of services	Compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 10: Communication difficulties	Compliant
Regulation 13: End of life	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 20: Information for residents	Compliant
Regulation 26: Risk management	Not 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	Compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Lake House Nursing Home OSV-0000353

Inspection ID: MON-0022258

Date of inspection: 05/06/2018 and 06/07/2018

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 23: Governance and management	Substantially Compliant

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

1. A safety and service officer has been nominated to carry out an audit once a month on the building. He will then compile a list of his findings which will be given to the maintenance man and the PIC.

   The maintenance man will be responsible to sort out any issues and this then will be checked and signed off in the maintenance log book, which will be audited by the PIC

   The provider will work closely with the Safety and Service officer to ensure that the Lake house is a safe environment for both residents and staff.

   The Safety and Service officer will be allocated hours to do this job.

   The PIC has informed all staff and residents who the safety and Service officer is so they can report any issues to him.

   The PIC will develop a policy to outline the responsibility of the Safety and Service Officer and the Maintenance man in conducting safety checks and audits and maintaining a safe environment at all times. This will also determine any risks that need to be addressed by the Provider.

2. During monthly management meetings areas of risk will be identified and responded to by the Registered Provider and the PIC. During Monthly management meetings there will be time allowed in order for the Registered provider to review all issues and if the PIC contacts the Registered Provider concerning any issues these will be logged in a journal and dealt with at the meeting also.

To be completed and implemented by the 01/10/2018.

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:

1. The Registered Provider with the PIC will review and update the Statement of Purpose and shall prepare them in writing containing the information set out in schedule 1.

2. The Statement of Purpose will be reviewed and revised in the future on a six month basis by both the Registered Provider and the PIC.

To be completed by the 31/10/2018

Regulation 4: Written policies and procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:

1. The PIC has prepared in writing a policy on the use of an intermittent catheterization to guide staff practice. This is complete.

2. The PIC will review and update the complaints policy to include the revised procedures.

3. All policies are continually reviewed on a two yearly basis or if any change occurs, the PIC continues to do this on an ongoing process.

To be completed by the 01/10/2018

Regulation 17: Premises	Substantially Compliant

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

1. The registered Provider will provide storage space in the form of a storage container for larger equipment and for equipment that is not always in use. This storage container will be placed the laundry and the side door in order for staff to have easy access to transport equipment when needed.

2. A person has been authorized by the Registered provider to put this container in place and it will be completed by the 1/11/2018

Regulation 26: Risk management	Not Compliant

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

1. The risk assessment policy will be reviewed by the Register Provider and the PIC.

2. The Risk Register will be updated on a monthly basis

3. The risk Register will be checked and signed by the Register Provider

4. Any issues relating to risk will be discussed at management meetings.

5. Safety meetings will be held on a three monthly basis with the safety and service office, PIC, Maintenance man and the Registered Provider.

6. Staff training to be provided in the area of risk assessment.

7. A computerized risk assessment to be installed and the PIC to have training provided for same

To be completed by 01/2/2019

Regulation 28: Fire precautions	Not Compliant

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

1. An Emergency Lighting Certificate has been compiled and has been sent to HIQA,.

The certificate recommended that a CTU be installed and this will be carried out by the 31/10/2018.

2. Five additional smoke detectors will be installed on the ground floor beneath the first floor.

   To be completed by the 31/10/2018

3. All areas of risk regarding the fire safety of the first floor in the Lake House Nursing Home have been commissioned by the registered Provider to a Fire Consultant who has prepared a fire check and risk assessment.

4. The Register Provider will follow instruction to ensure these works are completed to ensure safety for all residents.

5. The PIC will continue to assess all residents on their dependency levels on the first floor.

6. The plan is to remove any non-ambulant residents from the first floor to the ground floor.

   To be completed by 24/12/2018

7. An extra care assistant has been employed on the night shift in order to assist with evacuation if the need arises while the work to upgrade the compartments on the first floor and the ground floor are carried out. That is the escape route at ground floor to be upgraded which involves replacement of 3 sets of double doors being changed from 30 min fire check doors to 60 min fire check doors. There will also be the provision of additional fire protection to the glazed screen between the corridor and the stair to provide minimum of 60 minutes fire resistance.

   The attic space on the first floor will be upgraded by fitting a suitable cavity barrier in line with the wall in the attic level to upgrade the compartments on the first floor.

   To be completed by the 30th of November 2018.

8. The Admission Policy has been updated that clearly states that no person will be accommodated on the first floor if they are not ambulant.

   To be completed by 17/09/2018

9. The PIC will continue to update the Hiqa Inspector of all changes on a fortnightly basis. This will include the resident's assessments of mobility who are accommodated on the first floor with the results of their Personal Evacuation Plans.

10. In the meantime there have been procedures put in place to decrease the risk of fire, or in the event of a fire that there are procedures in place to evacuate all residents safely.

11. Every bed has an evacuation sheet under the mattress of each bed.

12. Each section of the corridor on the first floor is provided with an evacuation Ski Pad, which is hung on the wall outside the triple bedroom at one side of the corridor and on the wall outside the opposite bedroom of the corridor on the first floor

13. Additional extinguishers a Co2 extinguisher and a foam extinguisher have been provided outside both bedrooms on the first floor also.

14. All staffs training records have been checked and are up to date.

15. Fire evacuation training is planned for all staff.

    To be completed by 30/12/2018

16. A member of staff from each day shift and night shift will be appointed to act as a fire warden for the shift, they will receive a refresher course on fire safety as soon as possible.

17. Half hourly fire checks will be carried out and documented by these fire wardens each day.

18. Any surplus of materials or equipment will be removed from the first floor to reduce the potential fire load and to also leave a clear pathway to evacuate if the need arises.

19. All staff are being made aware at report every morning and evening that there is a risk associated with the first floor and the PIC has asked them to be extremely vigilant at all times.

20. Evacuation drills of full compartments are being carried out on the first floor with staff on an ongoing basis. The time it is taking to evacuate has improved greatly with continued drills.

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant

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

pharmaceutical services:

1. A full review of medication practice will be reviewed by the PIC.

2. A second drugs trolley has been ordered and the nursing home will be divided into two sections, where two nurses will administer the drugs in their own sections.

3. A nurses meeting will be held to discuss and plan changes.

4. The medication policy will be reviewed and revised in accordance with An Bord Altranais Guidelines in relation to storage, administration and return of medication.

5. A meeting is to be organized with the Pharmacist, GP and the nursing staff to discuss changes.

   To be completed by 01/05/2018

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 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.	Not Compliant	Yellow	01/11/2018
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Substantially Compliant	Yellow	01/10/2018
Regulation 26(2)	The registered provider shall ensure that there is a plan in place for responding to major incidents likely to cause death or injury,	Not Compliant	Orange	01/2/2019

	serious disruption to essential services or damage to property.			
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Orange	31/10/2018.
Regulation 28(2)(iv)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, of all persons in the designated centre and safe placement of residents.	Not Compliant	Orange	30/11/2018 and 24/12/2018
Regulation 29(5)	The person in charge shall ensure that all medicinal products are administered in accordance with 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.	Substantially Compliant	Yellow	01/05/2018
Regulation 29(6)	The person in charge shall ensure that a medicinal product which is out of date or has been dispensed to a resident but is no	Substantially Compliant	Yellow	01/05/2018

	longer required by that resident shall be stored in a secure manner, segregated from other medicinal products and disposed of in accordance with national legislation or guidance in a manner that will not cause danger to public health or risk to the environment and will ensure that the product concerned can no longer be used as a medicinal product.			
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose relating to the designated centre concerned and containing the information set out in Schedule 1.	Substantially Compliant	Yellow	31/10/2018
Regulation 03(2)	The registered provider shall review and revise the statement of purpose at intervals of not less than one year.	Substantially Compliant	Yellow	31/10/2018
Regulation 04(1)	The registered provider shall prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.	Substantially Compliant	Yellow	01/10/2018

National Quality Standards for Residential Care Settings for Older People in Ireland (2016). Health Information and Quality Authority: Dublin