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:	Ennis Adult Respite Service
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Clare
Type of inspection:	Unannounced
Date of inspection:	24 January 2023
Centre ID:	OSV-0004895
Fieldwork ID:	MON-0035127

About the designated centre

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

In this centre a respite service is provided for up to a maximum of four residents at any one time; residents are over the age of 18 years. Approximately fourteen residents currently avail of the respite service. The centre is located in a residential area of the busy town and comprises of one detached two-storey dwelling. Each resident is provided with their own bedroom with en-suite facilities. In addition there is a shared kitchen and dining area, utility room, staff office, sitting room and garden space. There is one bedroom at ground floor level allocated to residents who needs preclude them from using the first-floor facilities. The model of care is social and there are staff on duty at all times to support residents. Management and oversight responsibility is delegated to the person in charge supported by a social care worker.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	0

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 24 January 2023	10:15hrs to 17:15hrs	Mary Moore	Lead

What residents told us and what inspectors observed

This inspection was completed to monitor the provider's ongoing level of compliance with the regulations. The last HIQA (Health Information and Quality Authority) inspection of this service was completed in December 2021. Again, the inspector found that many areas of the service were well managed. Improvement was noted in the management of complaints and in the oversight of fire safety arrangements. However, based on the sample of residents' personal plans reviewed by the inspector on this inspection and discussions with the management team of the service, the arrangements in place for assessing residents' needs, planning their support and updating their assessments and plans as needed were not satisfactory. This meant that not only was the provider not in compliance with the requirements of the regulation but risk was created to the appropriateness, quality and safety of the service provided to residents.

On arrival at the centre the inspector saw that infection prevention and control measures were in place to reduce the risk of accidentally introducing infection to the service. Resident wellbeing was also established prior to their respite stay and staff monitored residents for any possible signs of infection during their respite stay.

This respite service is not open every day and while registered to accommodate four residents the service continues to operate at a somewhat reduced capacity with a maximum of two residents availing of respite together at times. There was no resident availing of respite on the day of inspection. The person in charge and the social care worker described how the planning of the respite service endeavored to meet the needs and requirements of the 14 residents and their families who availed of this respite service. The provider continued to engage with their funding body in relation to expanding the availability of respite in the region.

The person in charge had issued questionnaires to families and residents seeking feedback on the service to inform the 2022 annual review. The feedback on file was relevant to the 2021 annual review and had been received in early 2022. This feedback was positive with families describing staff as supportive and respectful. The resident feedback on file was limited but these residents had said that they felt safe in the centre and could make their own choices and decisions when availing of respite. There was an articulated desire for more access to respite and other suggestions were made as to how the service could be improved. This feedback, such as changing some transport arrangements in place was included in the current service quality improvement plan.

However, while the provider had consistent quality assurance systems and these were identifying areas that needed to improve such as these transport arrangements and the process of personal planning, these matters were not resolved so as to improve the appropriateness, quality and safety of the respite service. The need to address and improve the process of assessment and planning was a repeat finding

of internal reviews; an action had also issued from the last HIQA inspection.

While agreement was outstanding on how the respite service supported residents to pursue their personal goals and objectives, a transition document was in use and each resident was asked what it was they would like to do during their brief respite stay. The person in charge reported that having a meal out was a particular favourite while residents might also choose to go to the cinema, bowling, shopping or simply choose to relax in the house. This was reflected in narrative notes seen by the inspector as was respect for resident choice to decline offered activities and outings.

In summary, the current arrangements for assessing and planning for how to best support each resident's holistic needs were not adequate and meant that staff working in the respite service did not consistently have up-to-date-information for each resident. This created a risk that the support provided and the arrangements in place may not be appropriate, safe or of the best quality. This risk was mitigated somewhat by the attentiveness of staff to changed needs that they noted, reported and escalated and controls put in place to manage these risks. This did not however result in an update of the assessment or personal plan prior to the next planned respite stay.

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

Capacity and capability

There were areas that were effectively managed and overseen. However, there was also a deficit of oversight and proactive management in other areas and this impacted on the quality and safety of the service provided and, the level of compliance with the regulations achieved by the provider. There were repeat failings such as the failure to submit notifications to HIQA.

The person in charge was responsible for the day to day management and oversight of the service with support from the social care worker. The social care worker had allocated administration time but was also a member of the frontline staff team. The wider governance structure participated in the management and oversight of the service for example, in the review of accidents and incidents and any complaints received and, their participation in the completion of the unannounced six-monthly reviews of the quality and safety of the service.

Based on these inspection findings areas that demonstrated improvement and effective management and oversight included the management of complaints and oversight of fire safety. There was good oversight of risks that presented and their control. However, this oversight did not ensure for example that incidents and

restrictive practices that required notification to HIQA had been submitted and were submitted within the required timeframe.

There was inadequate accountability and responsibility demonstrated for ensuring each resident had an up-to-date assessment of their needs and an up-to-date plan of support. This meant that staff working in the respite service did not consistently have up-to-date information in relation to the residents that they supported. This will be discussed again in the next section of this report but is relevant here in the context of governance, lines of authority, accountability and responsibility. The provider had, through its own quality assurance systems identified the improvements needed in the process of personal planning but it was a repeat finding from these internal reviews and not resolved.

There had been staffing challenges in 2022 and this had had some impact on the availability of respite due to unplanned staff absence. This was reflected in the record of complaints received. The person in charge described an ongoing process of staff recruitment and the utilisation of day service staff as needed as a staffing contingency. Staffing levels were at the time of this inspection appropriate to the current occupancy levels of the service. Good oversight was maintained of staff attendance at training.

Regulation 15: Staffing

Staffing challenges were reported but there was an ongoing process of recruitment and staff members had been recruited by the provider to work in the respite service. Based on the inspectors review of the staff rota staffing levels were responsive to the current occupancy levels of the respite service. For example, two staff members were on duty up to approximately 21:00hrs when two residents were availing of respite. The person in charge described how they had access to day service staff as needed on a relief basis and this ensured continuity for residents who attended local day services. A planned and actual staff rota was in place and it was well maintained.

Judgment: Compliant

Regulation 16: Training and staff development

The training matrix recorded the mandatory, required and desired training that staff had attended. When refresher training was due was highlighted on the matrix so that it was planned and booked. The staff members listed on the training matrix were consistent with the staff members on the staff rota. The training completed by staff included mandatory training such as training in safeguarding and fire safety but also training such as in falls prevention and infection prevention and control. Regular

staff meetings were convened. The person in charge and the social care worker confirmed that staff supervisions and appraisals for more recently recruited staff were all up to date.

Judgment: Compliant

Regulation 23: Governance and management

From these inspection findings it was evident that aspects of the service were well managed and overseen. Improvement was noted in the management of complaints and in oversight of the provider's fire safety arrangements. The provider had quality assurance systems such as the annual review and the six-monthly reviews required by the regulations. However, while the provider was collecting data about the service this did not identify all failings such as the failure to submit notifications to HIQA. Monitoring and quality assurance also did not always bring about the improvement that was necessary. For example, deficits in the personal planning process were a repeat finding of internal reviews and quality improvement plans with the provider itself stating the matter may require escalation if not resolved. The inspector found there was an absence of clear lines of accountability and responsibility for ensuring the appropriate assessment and personal planning for and with residents was completed. Records seen by the inspector reflected regular and consistent correspondence between respite and day service staff teams in relation to residents' personal plans but no defined accountability and responsibility for ensuring these deficits were addressed. This absence of appropriate accountability and responsibility impacted on the quality and safety of the respite service and created a risk that residents' needs would not be appropriately met.

Judgment: Not compliant

Regulation 31: Notification of incidents

Based on the records seen by the inspector good oversight was maintained of existing and new risks. Incidents that occurred were recorded and reported by staff; these reports were reviewed by the person in charge. However, this reporting and oversight did not ensure HIQA was notified of all incidents or notified within the required time-frame. This included minor injuries sustained by residents such as bruising and broken skin (as seen on body maps completed by staff members) and, the use of environmental restrictions such as the locking of the main front door and the use of listening devices at night to manage risks.

Judgment: Not compliant

Regulation 34: Complaints procedure

The inspector reviewed the management of a complaint that had been received since the last HIQA inspection. Detailed records were maintained of the complaint received and the circumstances that had led to the complaint. The complaint was made following two occasions where changes were made to planned respite due to staffing matters. Based on the inspectors reading of these records, reasonable efforts had been made by the provider to prevent the disruption of the planned respite breaks. The provider acknowledged the impact of this and apologised for its failings in this regard. The complaint was escalated to the complaints officer due to ongoing dissatisfaction. Further action was taken by the provider to address the complainants concerns and it was recorded that they were currently satisfied with this.

Judgment: Compliant

Quality and safety

The last HIQA inspection of this service had identified the need for improvement in the process of personal planning particularly in relation to residents' personal goals and objectives. This was not addressed but what was of concern on this inspection was the quality and accuracy of the assessment of residents' overall needs, the plans of support and care in response and not just the personal outcomes aspect of the plans.

The assessment of residents' needs, the preparation, maintenance and update of their personal plans was, based on records seen and discussed delegated to the day services. The person in charge was responsible for the management and oversight of some of these day services. There were also processes in use such as the transition document that sought updated information and requests prior to each respite admission. However, these arrangements did not ensure that respite staff had access to a personal plan for all residents who availed of respite or access to updated and current plans of support and care. This meant that regulatory requirements were not met but it also created an inherent risk to the appropriateness, quality and safety of the service provided to residents.

Some parts of the personal plans reviewed were current such as medication capacity assessments, seizure management plans, health passports if hospital admission was required and, plans in the event that a resident was missing from the service.

The respite staff team were attuned to and reported any changes in resident overall wellbeing and any increased risks that they noted during the respite stay. These changes were communicated to the person in charge, the day service, family members and, health professionals as appropriate such as the general practitioner

(gp). These changes may have resulted in further clinical review and a change of care such as in prescribed medicines that benefited residents but the personal plan was not updated to reflect these changes in needs and supports.

When the respite service took accountability for an area of service provision this was managed well. For example, good oversight was maintained of risk and its management and clear up-to-date risk assessments and protocols were in place to guide staff in the management of certain scenarios. For example, where a resident struggled with transitions between home and the respite service. Practices identified by the provider itself as restrictive practices such as listening devices were in use in response to some identified risks. There were protocols in place to guide their use and their ongoing use was regularly reviewed. As discussed in the previous section of this report, their use was not however reported to HIQA.

There were improved arrangements in place for maintaining oversight of the centres' fire safety arrangements including the procedures for evacuating each resident if necessary from the designated centre.

Regulation 26: Risk management procedures

There were arrangements in place for identifying risks, controlling risks and for regularly reviewing the ongoing level of risk and the effectiveness of the controls in place. Staff created detailed records of any incidents or events arising and of the actions that they took in response.

Judgment: Compliant

Regulation 28: Fire precautions

The fire safety register was well maintained. There was documentary evidence that the fire detection and alarm system, the emergency lighting and fire-fighting equipment were inspected and tested at the required periodic intervals. Staff were undertaking simulated evacuation drills with residents and the majority of residents had participated in two simulated drills in 2022. Each resident who attended for respite had a personal emergency evacuation plan (PEEP). Since the last HIQA inspection simulated drills that replicated and tested the night-time evacuation scenario had been completed such as residents in bed or the requirement for staff to use an evacuation device as provided for in one PEEP. These were timed and completed by staff within an appropriate time-frame. The person in charge described how the learning from this exercise had been shared with the senior management team. The inspector saw that the space under the stairs was empty and not used for storage.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

Notwithstanding the nuances of respite provision adequate and appropriate arrangements were not in place for assessing and re-assessing residents needs and for updating their personal plans on a routine basis and in response to changes in their needs. This meant that not only was the provider not in compliance with this regulation but staff working in the respite service did not always have access to the information and the most up-to-date information that they needed to ensure the provision of appropriate care and support. This created a risk to the appropriateness, the quality and safety of the service provided. For example, the inspector reviewed one incident record completed by staff in August 2022 where staff had noted when a resident arrived for respite, a marked deterioration in the overall wellbeing and abilities of the resident since their previous respite stay. While a detailed report was made by staff of their findings and concerns and of the increased support needed by the resident, the inspector saw that the personal plan had not been subsequently updated to reflect these changed needs to ensure that their needs could be safely met by the respite service. The person in charge confirmed that a further respite stay for this resident was planned. The inspector was advised that a personal plan was not in place in the respite service for a resident who had recommenced accessing the service in December 2022 having spent some years away for the service. In general, while there was much stand-alone correspondence between the person in charge, respite staff, day service staff and families about residents needs, changed needs and increased needs and risks, this did not result in an update of the assessment of needs or the personal plan. As discussed in governance and management there was no clear sense of who was responsible for ensuring this ongoing deficit was addressed.

Judgment: Not compliant

Regulation 6: Health care

Records such as the daily narrative notes and incident reports demonstrated that staff were attentive and attuned to any changes in residents needs. Staff reported their concerns and took action such as seeking nursing or medical advice and care as needed. Respite staff liaised with families so that they could seek further clinical care as needed once the resident returned home. For example, staff were attuned to changes such as declining mobility and an increased risk for falls. Staff did have access to current prescriptions for prescribed medicines and the administration records seen by the inspector reflected the instructions of the prescriptions. There were protocols in place guiding the administration of emergency medicines and these were also in date. However, the gaps in and the failure to update the personal plan as described above created a risk to the continuity and appropriateness of the

care provided. This is addressed in Regulation 5.

Judgment: Compliant

Regulation 7: Positive behavioural support

Plans were in place to guide staff on the prevention and management of behaviours that challenged. The plans seen by the inspector were relatively current and referrals seeking review by the behaviour support team had been made. Staff had completed training both in positive behaviour support and in de-escalation and intervention techniques. Interventions that had a restrictive dimension such as their impact on resident privacy and freedom of movement were in use as risk controls; for example the use of listening devices to alert staff to possible seizure activity at night. The provider had procedures for reviewing the ongoing use of these devices.

Judgment: Compliant

Regulation 8: Protection

The provider had safeguarding policies and procedures. All staff had completed safeguarding training. Staff recorded how they used safeguarding media and easy-to-read materials to develop resident understanding of safeguarding and their safeguarding skills. The inspector was advised that there were no active safeguarding risks or plans. The designated safeguarding officer was available as needed for advice and support.

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 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Ennis Adult Respite Service OSV-0004895

Inspection ID: MON-0035127

Date of inspection: 24/01/2023

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 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: 1. A meeting was arranged by the PIC on 30 January 2023 for all day service managers and supervisors. The manager for the area was also in attendance. The agenda and purpose of the meeting was to address the need for good communication between the day services, families and the respite service to ensure that relevant information (IPPs and Health Care Plans) is shared on a timely basis with the respite service. At the meeting, it was emphasized that the Day Services Managers are responsible for the completion of IPPs and Health Care Plans for each person in their day service that is also availing of the respite service. The deadline of 1st March was outlined for receipt of completed Individual Personalised Plans. The plans will be saved on secure channels on MS Teams and when updated or amended, both the Respite and Day Service will be able to see the same version of the documents. 2. The PIC sent a letter to all the families on 20th January 2023 with a one page document entitled "Your priorities for your visit to Respite". The families were asked to complete the document for the resident on each separate admission to the respite service. 3. The use of restricted practises such as use of listening monitors and use of lap belts were recommended by health care professionals and recorded internally by the BOCSI. However, these were not notified to HIQA in the mistaken belief that as they were part of the recommended care plan for the resident it wasn't required. These were subsequently notified to HIQA on 2/2/2023. 4. All future internal BOCSI 6 month audits will include evidence checking that the Restricted practices logged internally are also notified to HIQA. Internal auditors will also check that OLIS AIRS quarterly reports match those notified to HIQA on a quarterly basis. This will be communicated to the Quality Committee and Quality Officer for dissemination to internal auditors for the next schedule of visits.	
Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents: 1. Restricted practises such as use of listening monitors and use of lap belts for residents using wheelchairs were recommended by health care professionals and recorded internally by the BOCSI. However, these were not notified to HIQA by the PIC in the mistaken belief that as they were part of the recommended care plan for the resident it wasn't required. These were subsequently notified to HIQA on 2/2/2023. 2. The PIC did not submit notifications for all incidents where body maps were completed for residents. An internal record is kept on the computerised system OLIS for all incidents and accidents but not necessarily bodymaps. The PIC has now requested to all staff working in the respite service to complete an incident record for all bodymaps (minor injuries or bruises) recorded in future. All incidents (OLIS AIRS) are reviewed by the PIC and area manager on a quarterly basis. The PIC will submit notifications to HIQA to match these going forward. 3. The main front door is locked as a security measure as the house is located in a residential housing estate in the town. The key of the front door is hanging beside the door so that residents may unlock the door if they wish.	
Regulation 5: Individual assessment and personal plan	Not Compliant
Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan: • A meeting was arranged by the PIC on 30 January 2023 for all day service managers and supervisors. The manager for the area was also in attendance. The agenda and purpose of the meeting was to address the need for good communication between the day services, families and the respite service to ensure that relevant information (IPPs and Health Care Plans) is shared on a timely basis with the respite service. At the meeting, it was emphasized that the Day Services Managers are responsible for the completion of IPPs and Health Care Plans . The deadline of 1st March was outlined for receipt of completed Individual Personalised Plans for each person availing of the respite service. The plans will be saved on secure channels on MS Teams and when updated or amended, both the Respite and Day Service will be able to see the same version of the documents. • The PIC and respite staff will add observations and progress notes to the documents and continue to communicate with both day service managers and families in the interest of the residents. Any priority goals identified by the resident or their family/day service as important for each separate admission,30/06/2023 will be communicated to the Respite Service on the document entitled "Your priorities for your visit to Respite"	

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 23(1)(b)	The registered provider shall ensure that there is a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.	Not Compliant	Orange	31/01/2023
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	01/03/2023
Regulation 23(2)(a)	The registered provider, or a person nominated	Not Compliant	Orange	30/06/2023

	by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.			
Regulation 31(3)(a)	The person in charge shall ensure that a written report is provided to the chief inspector at the end of each quarter of each calendar year in relation to and of the following incidents occurring in the designated centre: any occasion on which a restrictive procedure including physical, chemical or environmental restraint was used.	Not Compliant	Orange	01/04/2023
Regulation 31(3)(d)	The person in charge shall ensure that a written report is provided to the chief inspector at	Not Compliant	Orange	01/04/2023

	the end of each quarter of each calendar year in relation to and of the following incidents occurring in the designated centre: any injury to a resident not required to be notified under paragraph (1)(d).			
Regulation 05(1)(b)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out subsequently as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.	Not Compliant	Orange	01/03/2023
Regulation 05(4)(a)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which reflects the resident's needs, as assessed in accordance with paragraph (1).	Not Compliant	Orange	01/03/2023
Regulation 05(6)(d)	The person in charge shall ensure that the personal plan is	Not Compliant	Orange	01/10/2023

	the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall take into account changes in circumstances and new developments.			
Regulation 05(7)(c)	The recommendations arising out of a review carried out pursuant to paragraph (6) shall be recorded and shall include the names of those responsible for pursuing objectives in the plan within agreed timescales.	Not Compliant	Orange	01/10/2023
Regulation 05(8)	The person in charge shall ensure that the personal plan is amended in accordance with any changes recommended following a review carried out pursuant to paragraph (6).	Not Compliant	Orange	01/10/2023