Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Name of designated centre:	Designated Centre 7
Name of provider:	Cheeverstown House CLG
Address of centre:	Dublin 6w
Type of inspection:	Unannounced
Date of inspection:	18 and 19 September 2018
Centre ID:	OSV-0004130
Fieldwork ID:	MON-0021873

About the designated centre

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

The service provided was described in the providers statement of purpose, dated September 2018. The centre provided residential care and support to adults with a diagnosis of an intellectual disability. The centre consisted of four separate houses in the community within the geographical area of Tallaght, Dublin 24. There were three two story houses and 1 bungalow. In total 13 residents lived in the centre within the age range of mid thirties to mid seventies. There were nice sized gardens to the rear of each of the houses. Each of the residents had their own bedroom which had been personalised to their own taste.

The last inspection in the centre had been completed in February 2017. Registration for this centre was granted on the 30 May 2017 but subject to a condition which required the centre to implement and adhere to the action plan response submitted by the provider in respect of the inspection in February 2017. The purpose of this inspection was to monitor the providers adherence to the latter action plan and to monitor compliance with the regulatory requirements.

The following information outlines some additional data on this centre.

Current registration end date:	30/05/2020
Number of residents on the date of inspection:	13

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
18 September 2018	09:00hrs to 17:30hrs	Maureen Burns Rees	Lead
19 September 2018	09:00hrs to 16:00hrs	Maureen Burns Rees	Lead

Views of people who use the service

As part of the inspection, the inspector met with nine of the thirteen residents living in the centre and observed elements of their daily lives at different times over the course of the inspection. Although, a number of these residents were unable to tell the inspector about their views of the service, the inspector observed warm interactions between the residents and staff caring for them and that the residents were in good spirits. Other residents told the inspector that they enjoyed living in their respective houses and that staff were very good to them. A number of the residents had completed a HIQA questionnaire regarding the quality of the service with the assistance of a staff member. Overall, these suggested that the residents were satisfied with the service and the care being provided. Two of the residents had moved out from the providers campus based setting within the last two years and it was evident that the move had significantly improved their quality of life.

The inspector found that residents were enabled and assisted to communicate their needs, wishes and choices which supported and promoted residents to make decisions about their care. One of the residents was a member of a leaders group and an advocacy group within the wider service and shared with her peers information from these groups. Residents were actively supported and encouraged to maintain connections with their families through a variety of communication resources and facilitation of visits. The inspector did not have an opportunity to meet with the relatives of any of the residents but it was reported that they were happy with the care and support their loved ones were receiving.

Capacity and capability

There were management systems in place to ensure that the service provided was safe, consistent and appropriate to the resident's needs. However, some improvements were required to ensure that staffing levels were sufficient to meet the needs of residents living in the centre.

This centre was registered in May 2017, subject to a non standard condition which required the provider to adhere to an action plan submitted in respect of non compliances identified in a February 2017 inspection. On this inspection, the inspector found that the provider had adhered to the action plan and consequently was in compliance with all of the conditions of the centres registration.

The centre was managed by a suitably qualified, skilled and experienced person. The person in charge had taken up the position in April 2016 but had more than 10 years management experience. She is a registered nurse in intellectual

disabilities and held a degree in social science and a diploma in management. She was found to have a sound knowledge of the care and support requirements for each of the residents. She was in a full time post and was not responsible for any other centre. Staff members spoken with told the inspector that the person in charge supported them in their role and supported a culture of openness where the views of all involved in the service were sought and taken into consideration. The person in charge reported that she felt supported in her role and that she had regular contact with her manager.

There was a clearly defined management structure in place that identified lines of accountability and responsibility. This meant that all staff were aware of their responsibilities and who they were accountable to. The person in charge reported to the interim community manager who in turn reported to the chief executive officer. The interim community manager had been in position for the past two months but the position had been unfilled for a short period before that.

The provider had completed an annual review of the quality and safety of care in the centre and six monthly unannounced visits to assess the quality and safety of the service as required by the regulations. A small number of other audits had been undertaken and there was evidence that actions had been taken to address issues identified.

There were appropriate arrangements in place for the admission and discharge of residents to and from the centre. At the time of the last inspection, some contract care agreements in place did not clearly outline the services to be provided and the fees to be charged. On this inspection, the inspector found that contracts of care had been revised to clearly list the services provided and fees payable. However, it was noted that contracts on some residents files had not yet been signed by the identified resident and or their representative.

There were effective staff recruitment and selection arrangements in place. However, there was one whole time equivalent staff vacancy at the time of inspection. It was noted that a bank of regular relief staff were used to cover absences. This ensured some consistency of care for the residents. A formal staff support needs assessment to determine required staffing levels based on dependency requirements had not been completed. The inspector found that in one of the units, there were periods when additional staffing could be required should a dependent resident require support. Overall, the staff team were found to have the right skills, qualifications and experience to meet the assessed needs of the residents. On-call arrangements were in place for staff.

An actual and planned staff roster was in place and maintained manually. However, it was noted that the roster in place for the week of inspection did not reflect staffing changes which had been made. It was proposed that the provider would introduce a computerised staff roster system in the centre to mirror the system introduced in other centres.

Training had been provided to staff to support them in their role and to improve outcomes for the residents. There was a staff training and development policy. A

training programme was in place which was coordinated by the providers training department. Training records showed that staff were up-to-date with mandatory training requirements. Other training to meet specific needs of residents had been sourced.

Formal staff supervision arrangements were only in the early stages of being developed in the centre. This had been highlighted in previous inspections as meant that staff might not be appropriately supported so as to ensure that they performed their duties to the best of their abilities. A draft supervision policy had been developed. Formal supervision had not yet been rolled out for staff.

There was an effective complaints procedure in place which met the requirements of the regulations. Overall there were a low number of complaints in the centre. At the time of the last inspection, some arrangements for the management of complaints were found not to fully comply with the requirements of the regulations with some complaints not investigated promptly. Since that inspection, a person was nominated to ensure that all complaints were appropriately responded to and that complainants were kept informed of the progress and outcomes.

Regulation 14: Persons in charge

The person in charge was found to be competent, with appropriate qualifications and management experience to manage the centre and to ensure it met its stated purpose, aims and objectives.

Judgment: Compliant

Regulation 15: Staffing

There was one whole time equivalent staff vacancy at the time of inspection.

A formal staff support needs assessment to determine required staffing levels based on dependency requirements had not been completed. The inspector found that in one of the units, there were periods when additional staffing could be required should a dependent resident require support.

Judgment: Not compliant

Regulation 16: Training and staff development

Training had been provided for staff to improve outcomes for residents. Formal staff

supervision arrangements were only in the early stages of being developed in the centre.

Judgment: Substantially compliant

Regulation 23: Governance and management

The governance and management systems in place promoted the delivery of a high quality and safe service

Judgment: Compliant

Regulation 24: Admissions and contract for the provision of services

There were appropriate arrangements in place for the admission and discharge of residents to and from the centre. Contracts of care which clearly listed the services provided and fees payable had been put in place. However, it was noted that contracts on some residents files had not yet been signed by the identified resident and or their representative.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

A record of all incidents occurring in the centre were maintained and where required, notified to the Chief Inspector and within the timelines required in the regulations.

Judgment: Compliant

Regulation 34: Complaints procedure

There was an effective complaints procedure in place which met the requirements of the regulations.

Judgment: Compliant

Quality and safety

Overall, the residents living in the centre received care and support which was of a good quality, safe, person centred and which promoted their rights.

The residents' well-being and welfare was maintained by a good standard of evidence-based care and support. Care plans and personal support plans reflected the assessed needs of the individual residents and outlined the support required to maximise their personal development in accordance with their individual health, personal and social needs and choices. Personal plans in place had been reviewed. However, reviews undertaken did not always involve members of the multidisciplinary team or the residents family. Overall, reviews did not assess the effectiveness of the plans in place.

Residents were supported to engage in meaningful activities in the centre and within the community. The majority of the residents attended a day service. Staff facilitated and supported the residents to travel to and from their day service and to participate in activities that promoted community inclusion such as, football training with residents from other centres, zumba class, meals out and shopping trips, music class, afternoon tea experience in various hotels, beautician visits, the cinema, nature walks and garden festivals. The residents in one of the houses were noted to have a keen interest in gardening and had grown their own vegetables and flowers. Personalised weekly activities schedules were in place for residents. Visual timetables of activities were observed in some residents bedrooms for their ease of reference.

Overall, the processes in place for the handling of medicines were safe and in accordance with current guidelines and legislation. However, assessments had not been completed to assess the ability of individual residents to self manage and administer their own medications as required by the regulations. A medication management policy was in place. There was a secure cupboard for the storage of all medicines in each of the houses. All staff had received appropriate training in the safe administration of medications. Individual medication management plans were in place. There were systems in place to review and monitor safe medication management practices which included regular counts of all medications and periodic audits of practices.

The centre comprised of four separate houses located a short distance by car from each other. Each of the houses were found to be suitable to meet the resident's individual and collective needs in a comfortable and homely way. It was noted that the needs of residents in two of the houses were changing as they aged which would require further assessment so as to ensure that their home continued to meet their needs.assessments had not been completed to assess the ability of individual residents to self manage and administer their own medications as required by the regulations. A small amount of chipped paint was observed on the walls and woodwork in two of the houses. The tile grouting in the bathroom of one of the

houses appeared stained and bathrooms in two of the houses had been identified by the provider to be upgraded. Each of the residents had their own bedrooms which had been personalised to their tastes and choices. This promoted the resident's independence, dignity and respect.

Residents' communication needs were met. Individual communication requirements were highlighted in residents' personal plans and reflected in practice. There was a communication policy dated July 2015. Communication passports were on file for residents who required same. A small number of residents were non-verbal. Staff were observed to communicate well with these residents using visual cues such as, picture exchange and object of interests. These were noted to assist the residents to choose food choices, activities, daily routines and journey destinations.

The residents were provided with a nutritious, appetizing and a varied diet. There was a food, nutrition and hydration policy, dated October 2016. The timing of meals and snacks throughout the day were planned to fit around the needs of the residents. A weekly menu was agreed with residents at a weekly meeting in each of the houses. Two of the residents had been supported to engage in a healthy eating programme and had achieved significant success.

The health and safety of residents, visitors and staff were promoted and protected. There were risk management arrangements in place which included a detailed risk management policy. Individual risk assessments and safety plans had been completed for residents identified to require same. Environmental risk assessments had also been completed. However, it was noted that some of the environmental risk assessments had not been reviewed for an extended period. Health and safety audits were undertaken on a regular basis with appropriate actions taken to address issues identified.

There were arrangements in place for investigating and learning from incidents and adverse events involving residents. This promoted opportunities for learning to improve services and prevent incidences. The providers risk management department provided an analysis report of incidents on a periodic basis, which facilitated trends to be identified.

Precautions were in place against the risk of fire. However, keys for a side gate in one of the houses, which was identified as an evacuation route, were not readily available in the event of fire. Otherwise, adequate means of escape from each of the houses were observed and a fire assembly point was identified. There was documentary evidence that fire fighting equipment, emergency lighting and the fire alarm system were serviced at regular intervals by an external company. A procedure for the safe evacuation of residents in the event of fire was prominently displayed in each of the houses. Resident's had a personal emergency evacuation plan in place which adequately accounted for the mobility and cognitive understanding of the resident. Staff who spoke with the inspector were familiar with the fire evacuation procedures and had received appropriate training. Fire drills involving residents had been undertaken at regular intervals.

Residents were provided with appropriate emotional and behavioural support. There

was a policy on promoting positive approaches, meeting needs and reducing distress. The inspector found that the assessed needs of residents were being appropriately responded to. In general residents presented with minimal behaviours that challenge. Compatibility issues were identified in one of the houses but these were being managed at the time of inspection. Suitable information was provided within residents personal support plans to guide staff in meeting the needs of individual residents. There were no restrictive practices in use in any of the houses.

There were measures in place to keep residents safe and to protect them from abuse. The provider had a safeguarding policy and procedure, dated April 2018. Staff members spoken with, were knowledgeable about the signs of abuse and what they would do in the event of an allegation, suspicion or disclosure of abuse. All staff had attended appropriate safeguarding training. There had been a small number of safeguarding concerns which were appropriately managed. There were safeguarding plans in place for a small number of residents identified to require same. Intimate care plans were in place for individual residents and found to contain a good level of detail to guide staff in meeting the intimate care needs of individual residents.

Appropriate arrangements were in place for the management of complaints. There had been a low number of complaints but these had been appropriately responded to.

Regulation 10: Communication

The communication needs of residents had been appropriately assessed with appropriate supports put in place where required.

Judgment: Compliant

Regulation 17: Premises

The centre comprised of four seperate houses. Each of the houses were found to be homely, accessible and promoted the privacy, dignity and safety of each resident. However, a small amount of chipped paint was observed on the walls and woodwork in two of the houses. The tile grouting in the bathroom of one of the houses appeared stained and bathrooms in two of the houses had been identified by the provider to be upgraded.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

Residents were provided with a nutritious, appetizing and varied diet.

Judgment: Compliant

Regulation 26: Risk management procedures

The health and safety of residents, visitors and staff were promoted and protected. However, some of the environmental risk assessments had not been reviewed for an extended period.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Suitable precautions were in place against the risk of fire. However, keys for a side gate in one of the houses, which was identified as an evacuation route, were not readily available in the event of fire.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

There were systems in place to ensure the safe management and administration of medications. However, assessments had not been completed to assess the ability of individual residents to self manage and administer their own medications as required by the regulations.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Each resident's well-being and welfare was maintained by a good standard of

evidence-based care and support. However, reviews undertaken did not always involve members of the multidisciplinary team or the residents family. Overall, reviews did not assess the effectiveness of the plans in place.

Judgment: Substantially compliant

Regulation 6: Health care

The healthcare needs of residents were being met.

Judgment: Compliant

Regulation 7: Positive behavioural support

Residents were provided with appropriate emotional and behavioural support.

Judgment: Compliant

Regulation 8: Protection

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

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Compliant
Regulation 24: Admissions and contract for the provision of services	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Designated Centre 7 OSV-0004130

Inspection ID: MON-0021873

Date of inspection: 18 and 19 September 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 Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: Support needs assessment for all residents will be completed by 30/11/2018 The needs assessment will ensure that the number qualification and skill mix of staff is appropriate to the number and assessed needs of the residents in DC7. The Statement of Purpose and function will be updated to reflect the outcome of the assessment. Time frame: Support needs assessment to be completed by 30/11/2018 Review of staffing to consider assessed needs to be completed by 30/01/2019	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: Draft supervision policy will be approved and then rolled out across DC7 Supervision from CNM3 for PIC will take place quarterly, with a focus on support of the PIC in carrying out regulatory function and Cheeverstown policy and practice. Formal supervision will be rolled out across DC7 with the frequency to be every quarter with the focus during one of these sessions to be on performance management. Timeline Formal supervision was carried out between PIC and CNM3 on 24/10/18. All staff in DC7 will be scheduled for formal supervision by31/12/2018 Scheduled plan will be in place for 2019 which will identify one formal meeting every quarter. This schedule will compose of one performance development planning meeting and 3 formal supervision meetings.	

Regulation 24: Admissions and contract for the provision of services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 24: Admissions and contract for the provision of services:

Letters re Contracts of Care and fee sent to all representatives July 2018 advising of new fee to be charged from Sept 18.

Timeline
Letters have been reissued to families on 28/09/18 regarding unsigned documentation and advising families of revised long stay contribution giving representatives information of revised fees to be charged. PIC will follow up on the four outstanding documents by 30/11/2018

Regulation 17: Premises	Substantially Compliant

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

Maintenance work (chipped paint on walls and woodwork) will be completed
Stained tile grouting in bathroom will be re grouted
Bathroom in Old Court to be upgraded

Timeframe
Painting and woodwork to be commenced on week commencing 05/11/18 with completion date of within 2 weeks
Stained tile grouting to be regrouted week commencing 05/11/18
Upgrading of bathroom will be applied for by through the office of CEO to be considered for 2019 maintenance budget.

Regulation 26: Risk management procedures	Substantially Compliant

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

The review of the environmental risk assessments to be completed in each house in DC7 with support from the Health & safety committee representative.

Timeframe
14/12/2018

Regulation 28: Fire precautions	Substantially Compliant

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

Adequate arrangements are in place for means of escape as keys for side gate in this location are now readily available in the event of a fire. External emergency lighting has been installed in this location

Completed 28/09/2018

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant

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

Cheeverstown House Self Medication Assessment Tool will be reviewed and updated. This tool will be used to assess for capabilities of each resident for self-medication.

Residents will be supported to take responsibility for his or her own medication, in accordance with his or her wishes and preferences and in line with his or her age and the nature of his or her disability.

Timeframe

30/01/2019

Regulation 5: Individual assessment and personal plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:

Personal Plan Review form developed to be utilized by MDT for individual personal plan. The review which will be carried out annually or more frequently if there is a change of needs or circumstances.
These reviews will be multi disciplinary and will assess the effectiveness of the plans in place.

Timeframe

MDT next review scheduled 14/11/18 for each resident in DC7

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 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Not Compliant	Orange	30/01/2019
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	31/12/2018
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Substantially Compliant	Yellow	16/11/2018

Regulation 24(3)	The registered provider shall, on admission, agree in writing with each resident, their representative where the resident is not capable of giving consent, the terms on which that resident shall reside in the designated centre.	Substantially Compliant	Yellow	30/11/2018
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Substantially Compliant	Yellow	14/12/2018
Regulation 28(2)(c)	The registered provider shall provide adequate means of escape, including emergency lighting.	Substantially Compliant	Yellow	Completed 28/09/2018
Regulation 29(5)	The person in charge shall ensure that following a risk assessment and assessment of capacity, each resident is encouraged to take responsibility for his or her own medication, in accordance with his or her wishes and preferences	Substantially Compliant	Yellow	30/01/2019

	and in line with his or her age and the nature of his or her disability.			
Regulation 05(6)(a)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall be multidisciplinary.	Substantially Compliant	Yellow	14/11/2018
Regulation 05(6)(b)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall be conducted in a manner that ensures the maximum participation of each resident, and where appropriate his or her representative, in accordance with the resident's wishes, age and the nature of his or her disability.	Substantially Compliant	Yellow	14/11/2018
Regulation 05(6)(c)	The person in charge shall ensure that the personal plan is the subject of a	Substantially Compliant	Yellow	14/11/2018

	review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall assess the effectiveness of the plan.			