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:	Hortlands
Name of provider:	Gheel Autism Services Company Limited by Guarantee
Address of centre:	Dublin 16
Type of inspection:	Short Notice Announced
Date of inspection:	25 May 2021
Centre ID:	OSV-0003507
Fieldwork ID:	MON-0032464

About the designated centre

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

Hortlands designated centre is located in a suburb in Co. Dublin and can cater for nine residents, both male and female, over the age of 18 years. The centre is comprised of three buildings. Hortlands house has seven bedrooms, two bathrooms, a kitchen and a living area. Adjacent to this is Hortlands flat which has two bedrooms, a kitchen, bathroom and living room. There is a prefabricated wooden building at the end of the garden that contains two additional communal rooms for residents. Phoenix house is located in a different suburb. This is a semi-detached two story home that accommodates one resident. The designated centre specialises in providing residential services in a personalised and homely atmosphere. The designated centre has a low arousal philosophy, which is used to support adults with a diagnosis of Autism. Residents are supported by a team of social care workers and care workers. These staff are directly overseen by a location manager and a person in charge.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	7

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 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 25 May 2021	10:00hrs to 15:00hrs	Maureen Burns Rees	Lead

What residents told us and what inspectors observed

From what the inspector observed, there was evidence that the residents in the house visited had a good quality of life in which their independence was promoted. Appropriate governance and management systems were in place which ensured that appropriate monitoring of the services provided was completed by the provider, in line with the requirements of the regulations. The inspector observed that the residents and their families were consulted with regarding the running of the centre and played an active role in decision-making within the centre. Some areas for improvement were identified in relation to the maintenance and upkeep of the premises and the arrangements for personal plan reviews.

The centre comprised of three separate homes, Hortland house, Hortland flat and Phoenix house. Hortand house could accommodate up to six residents but there were only four residents at the time of inspection. Hortland flat could accommodate up to two residents but there was only one resident living there at the time of inspection. Both Hortland house and Hortland flat were located on the same site. Finally, phoenix house was located in a different geographical location and could accommodate one resident. Residents living in the centre were older than 50 years and had been living in the centre for a long period.

For the purpose of this inspection, the inspector visited Hortland House. The inspector met briefly with each of the four residents living there. Warm interactions between the residents and staff caring for them was observed. A number of the residents met with were unable to tell the inspector their views of the service but appeared in good form and comfortable in the company of staff. Two of the residents told the inspector that they were happy living in the centre and that staff were kind and helpful to them. One of the residents was due to resume visits to their family home the following weekend which it was evident that they were really looking forward to. Two of the residents were observed to separately enjoy spending time in the outdoor rooms in the back garden.

There was an atmosphere of friendliness in the house visited. Residents were observed to happily converse with staff who responded to their verbal and non verbal cues. Numerous photos of residents were on display. Pieces of art work completed by one of the residents were framed and on display. Staff were observed to interact with residents in a caring and respectful manner. For example, a behaviour of one of the residents was observed to be supported in a kind and respectful manner. It was evident that a low arousal environment was promoted in the centre. One of the residents had created a small alter in one of the outdoor rooms which they enjoyed visiting whilst another resident was observed to enjoy listening to music in the other outdoor room.

The house visited was found to be comfortable and homely. However, the paint on the walls and woodwork in the hallway and a number of the rooms was observed to be worn and chipped in areas. In addition, the carpet and flooring in a number of

areas appeared worn. A number of areas and pieces of furniture had been identified to be in need of replacement or refurbishment. The communal area in the house visited was limited considering the number of residents that it was intended to accommodate. Each of the residents had their own bedroom which had been personalised to their own taste. This promoted residents' independence and dignity, and recognised their individuality and personal preferences. There was a small patio area and garden to the rear of the house. One of the residents was in the process of painting a wall with a specific theme. There was a small table and three chairs for outdoor dining but it was reported that a larger table and chairs had been ordered which could accommodate all of the residents. A significant number of flowers and plants were on display in pots in the garden.

There was some evidence that residents and their representatives were consulted with and communicated with, about decisions regarding their care and the running of their home. Each of the residents had regular one-to-one meetings with their assigned key workers. Residents were enabled and assisted to communicate their needs, preferences and choices at these meeting in relation to activities and meal choices. There were also also regular 'voice and choice' forum meetings in each of the units. One of the residents was responsible for writing on the notice board each day the staff members on duty. This had been identified as the residents' preferred approach versus using staff photos. The inspector did not have an opportunity to meet with the relatives or representatives of any of the residents but it was reported that they were happy with the care and support that the residents were receiving. The provider had completed a survey with relatives across the service which was complementary and indicated that they were happy with the care being provided to their loved ones.

Residents were actively supported and encouraged to maintain connections with their friends and families through a variety of communication resources, including video and voice calls. All visiting to the centre had restricted in line with national guidance for COVID-19. One of the residents was due to make a visit to their family home in the days following the inspection. This resident had been unable to visit their family for an extended period so it was evident they were really looking forward to the visit. A quality of life support plan had been put in place for individual residents in respect of COVID-19 and its impact on their life.

Residents were supported to engage in meaningful activities in the centre. In line with national guidance regarding COVID-19, the centre had implemented a range of restrictions impacting residents' access to activities in the community. It was reported that a number of the residents were suitably adhering to national guidance in terms of social distancing and wearing a face mask while in the community. Overall, it was reported that residents had coped well with the calmer pace of life during the pandemic. Each of the residents were engaged in an individualised programme coordinated from the centre which it was assessed best met the individual residents' needs. A daily activity schedule was led by each of the residents. Examples of activities that residents engaged in included, walks to local scenic areas, drives, arts and crafts, cooking, baking, recycling, listening to music, board games and gardening. A number of residents also engaged in activities via video conferencing, such as exercise classes 'nifty fifty', on-line concerts and a social

club 'Golden Gheels'.

The majority of the staff team had been working in the centre for an extended period. This meant that there was consistency of care for residents and enabled relationships between residents and staff to be maintained. The inspector noted that residents' needs and preferences were well known to staff, the location manager and the person in charge.

The next two sections of this report present the inspection findings in relation to governance and management in the centre, and how governance and management affects the quality and safety of the service being delivered.

Capacity and capability

There were management systems and processes in place to promote the service provided to be safe, consistent and appropriate to residents' needs. Some areas for improvement in relation to the premises and personal plan reviews are outlined in the Quality and Safety section.

The centre was managed by a suitably qualified and experienced person. She had a good knowledge of the assessed needs and support requirements for each of the residents. The person in charge held a diploma in systematic instruction and a certificate in front line management. She had more than 30 years management experience. She was in a full time position but was also responsible for one other centre and a community outreach service which was located a relatively short distance away. She was found to have a good knowledge of the requirements of the regulations. The person in charge reported that she felt supported in her role and had regular formal and informal 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 was supported by a location manager in this centre and in the other centre for which she held responsibility. The person in charge reported to the director of operations who in turn reported to the interim chief executive officer. The person in charge and director of operations held formal meetings on a regular basis. In addition the person in charge had regular formal meetings with the location managers which promoted effective communication across the centre.

The provider's quality auditors had completed an annual review of the quality and safety of the service and unannounced visits, to review the safety of care, on a six monthly basis as required by the regulations. The person in charge and location manager had undertaken a number of audits and other checks in the centre on a regular basis. Examples of these included, medication, finance and health and safety. There was evidence that actions were taken to address issues identified in these audits and checks. There were monthly staff meetings via a video

conferencing medium and separately there were management meetings with evidence of communication of shared learning at these meetings. Quarterly quality and safety reports were compiled which considered trends in incidents and their management, and key performance indicators.

The staff team were found to have the right skills, qualifications and experience to meet the assessed needs of the residents in the house visited. At the time of inspection, the full complement of staff were in place but one part-time staff member was on long term leave. This vacancy was being covered by a small number of regular relief staff. This provided consistency of care for the residents. The actual and planned duty rosters were found to be maintained to a satisfactory level. The provider had completed formal dependency assessments to determine the level of supports required by residents.

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 and coordinated by the location manager. There were no volunteers working in the centre at the time of inspection. Suitable staff supervision arrangements were in place. This was considered to support staff to perform their duties to the best of their abilities.

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

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

The staff team were found to have the right skills, qualifications and experience to meet the assessed needs of the residents in the house visited. At the time of inspection, the full complement of staff were in place but one part-time staff member was on long term leave. This vacancy was being covered by a small number of regular relief staff.

Judgment: Compliant

Regulation 16: Training and staff development

Training had been provided to staff to support them in their role and to improve outcomes for the residents. All staff in the house visited had attended mandatory training. Suitable staff supervision arrangements were in place.

Judgment: Compliant

Regulation 23: Governance and management

There were suitable governance and management arrangements in place. The provider had completed an annual review of the quality and safety of the service and unannounced visits to review the quality and safety of care on a six-monthly basis as required by the regulations. There was a clearly defined management structure in place that identified lines of accountability and responsibility.

Judgment: Compliant

Regulation 31: Notification of incidents

Notifications of incidents were reported to the Chief Inspector in line with the requirements of the regulations.

Judgment: Compliant

Quality and safety

The residents living in the house visited, appeared to receive care and support which was of a good quality, person centred and promoted their rights. However, some improvements were required regarding the upkeep of the premises, and procedures in place to review individual residents' personal plans.

Overall the residents' well-being and welfare was maintained by a good standard of evidence-based care and support in the house visited. However, there was no evidence that an annual review of the personal plan had been completed for a number of the residents as per the requirements of the regulations. Daily living support plans reflected the assessed needs of individual residents and outlined the

support required to maximise their personal development in accordance with their individual health, personal and social care needs and choices. A risk assessment and 'priority determinations' had been completed to determine required supports in relation to COVID-19 for individual residents. There was evidence that person centred goals identified for some of the residents had been paused due to COVID-19 restrictions. It was proposed that with the easing of restrictions that more community based activities would be engaged in.

The health and safety of the residents, visitors and staff were promoted and protected. There were individual and environmental risk assessments in place that were subject to review at regular intervals. This showed that appropriate measures were in place to control and manage the risks identified. There was a risk register in place. 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 the residents. Trending of all incidents was completed on a regular basis. This promoted opportunities for learning to improve services and prevent incidences. Suitable precautions were in place against the risk of fire.

There were procedures in place for the prevention and control of infection. A COVID-19 contingency plan had been put in place which was in line with the national guidance. The inspector observed that areas in the house visited appeared clean. However, as referred to separately in the report, a number of surfaces were worn and broken which could impact on effectiveness of cleaning these surfaces. A cleaning schedule and COVID-19 cleaning checklist was in place which was overseen by the person in charge and location manager. Colour coded cleaning equipment was in place. Sufficient facilities for hand hygiene were observed and hand hygiene posters were on display. There were adequate arrangements in place for the disposal of waste. Specific training in relation to COVID-19, proper use of personal protective equipment and effective hand hygiene had been provided for staff. Disposable surgical face masks were being used by staff whilst in close contact with residents in the centre, in line with national guidance. The location manager was the identified COVID- lead and was supported by two nominated health and safety representatives.

There were measures in place to protect residents from being harmed or suffering from abuse. There had been no allegations or suspicions of abuse in the preceding period. The provider had a safeguarding policy in place. Intimate care and support plans were on file and these provided sufficient detail to guide staff in meeting the intimate care needs of the individual residents. User friendly information on safeguarding was available. Staff had received appropriate training on safeguarding. Finance management capacity assessments had been completed for residents and systems to manage residents finances were being reviewed.

Residents were provided with appropriate emotional and behavioural support and their assessed needs were appropriately responded to. On occasions the behaviours of a small number of the residents could be difficult for staff to manage in a group living environment. However, it was found that residents were suitably supported and overall the residents were considered to get on well together. Behaviour 'how to

support me' plans were in place for residents identified to require same. These provided a good level of detail to guide staff in supporting residents. There were no restrictive practices in use in the house visited. Trends of incidents and their management were reviewed on a regular basis so as to manage any such incidents and prevent re-occurrence.

Regulation 17: Premises

The house visited was found to be comfortable and homely. However, the paint on the walls and woodwork in the hallway and a number of the rooms was observed to be worn and chipped in areas. In addition, the carpet and flooring in a number of areas appeared worn. A number of areas and pieces of furniture had been identified to be in need of replacement or refurbishment.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

The health and safety of the residents, visitors and staff were promoted and protected. Environmental and individual risk assessments were on file and subject to regular review. There was a risk register in place. There were arrangements in place for investigating and learning from incidents and adverse events involving the residents.

Judgment: Compliant

Regulation 27: Protection against infection

There were suitable procedures in place for the prevention and control of infection which were in line with national guidance for the management of COVID-19. A cleaning schedule was in place and the house visited appeared clean. A COVID-19 preparedness and contingency plan was in place which was in line with the national guidance.

Judgment: Compliant

Regulation 28: Fire precautions

There was documentary evidence that fire fighting equipment, emergency lighting and the fire alarm system were serviced at regular intervals by an external company and checked regularly as part of internal checks in the house visited. There were adequate means of escape and a fire assembly point was identified in an area to the front of the house visited. A procedure for the safe evacuation of residents in the event of fire was prominently displayed. Each of the residents had a personal emergency evacuation plan which adequately accounted for the mobility and cognitive understanding of the individual resident. Fire drills involving the residents had been undertaken at regular intervals and it was noted that the centre was evacuated in a timely manner.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

Overall the residents' well-being and welfare was maintained by a good standard of evidence-based care and support in the house visited. However, there was no evidence that an annual review of the personal plan had been completed for a number of the residents as per the requirements of the regulations.

Judgment: Substantially compliant

Regulation 6: Health care

Residents' healthcare needs appeared to be met by the care provided in the centre. Individual health assessments and plans were in place. There was evidence residents had regular visits to their general practitioners (GPs). There was evidence that a healthy diet and lifestyle was being promoted for the residents.

Judgment: Compliant

Regulation 7: Positive behavioural support

Residents appeared to be provided with appropriate emotional and behavioural support. Behaviour support plans were in place for residents identified to require same and these were subject to regular review. There were no restrictive practices in use in the centre. Overall, the residents living in the house visited were considered to be compatible.

Judgment: Compliant

Regulation 8: Protection

There were measures in place to protect residents from being harmed or suffering from abuse. There had been no allegations or suspicions of abuse in the preceding period. Intimate and personal care plans in place for residents identified to require same, provided a good level of detail to support staff in meeting individual resident's intimate care needs. Safeguarding information was on display and included information on the nominated safeguarding officer

Judgment: Compliant

Regulation 9: Residents' rights

Residents' rights were promoted by the care and support provided in the centre. Residents had access to advocacy services should they so wish. There was information on rights and advocacy services available. There was evidence of active consultations with residents regarding their care and the running of the house. Residents' 'voice and choice' forum meetings were completed on a monthly basis. Residents' rights were noted to be discussed at these meetings. Each resident had their own bank account and finance management capacity assessments had been completed for each resident.

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 - 2015 as amended and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	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
Regulation 9: Residents' rights	Compliant

Compliance Plan for Hortlands OSV-0003507

Inspection ID: MON-0032464

Date of inspection: 25/05/2021

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 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises: Premises.
Whilst the premises within the designated center is comfortable and homely, it is fully acknowledged that some updating and refurbishment is required, this work has been delayed due to the Covid 19 Pandemic, whereby the wellbeing of our residents has been the priority. In line with our Covid 19 procedures and practice's all external visitors/staff have not been approved to visit our resident's homes.
Following our most recent Hiqa inspection, there has been liaison with the relevant Maintenance Manager from the HSE, and full discussion with regard to the identified items requiring updating/refurbishment within the premises on the 28/05/2021 and on the 21/06/2021.

A full list has been discussed , compiled and submitted to the HSE on the 28/06/2021.

Further to this, significant consideration has been given to further upgrading the premises ie replacement of existing wardrobes, which should facilitate a more updated presentation of the interior of the building at the time of our next Re registration Inspection. There is a plan in place for the refurbishment work to commence following the HSE approval process which includes securing quotes for all required refurbishment works, and agreed timescales for the completion of the same. This process can take some time to complete, therefore it is not currently possible to confirm a date for the refurbishment work to be completed. However an initial timescale that has been discussed is for a schedule of refurbishment to commence in the Autumn period 2021. This Action plan will be updated accordingly to reflect progress and keep our Hiqa Inspector fully informed.
The Pic, has made telephone contact with our Hiqa Inspector on the 24/06/2021, prior to submission of this report, and it has been agreed that the PIC will keep our Inspector fully informed of progress in the Autumn period 2021.
It is estimated that full refurbishment will be completed by the end of November 30/11/2021 – Full Compliance will be achieved.

Updating/renewal of furniture.

The plan to purchase new items of furniture had been delayed due to the Covid 19 pandemic. In line with our person centered approach, all residents have been consulted individually and through our Person Centered Resident's forum, and shared their view's and choices regarding the type of furniture they would like purchased for their home. There is a plan of action in place and all residents are currently being facilitated to visit furniture stores and garden centers so that they can view a variety of options ,styles and colors of their preferred furniture items.
This activity is current and will be completed by the end of August - 31/08/2021

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:
In response to the findings of our Hiqa Inspector , our absolute priority is on ensuring that the documentation in place reflects the quality of life in place for each resident, and demonstrates their active engagement within their local community. A plan is in place which will engage every individual team member in taking full responsibility for ensuring all the documentation is accurate and fully updated within each individual's Support Plan. The plan will be implemented week commencing the process 28/06/2021, and the necessary updating of documentation will be completed by the end of July 31/07/2021

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(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	30/11/2021
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	31/07/2021
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	Substantially Compliant	Yellow	31/07/2021

	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.			
Regulation 05(6)(c)	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 assess the effectiveness of the plan.	Substantially Compliant	Yellow	31/07/2021
Regulation 05(6)(d)	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 take into account changes in circumstances and	Substantially Compliant	Yellow	31/07/2021

	new developments.			