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:	Elvira
Name of provider:	St John of God Community Services Company Limited By Guarantee
Address of centre:	Co. Dublin
Type of inspection:	Announced
Date of inspection:	01 October 2018
Centre ID:	OSV-0003580
Fieldwork ID:	MON-0021798

About the designated centre

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

The designated centre is based in a suburban area of South County Dublin and is comprised of 11 individual apartments across three single storey buildings. The centre is located on a site shared with a nursing home and is a short walk from a variety of village services. There are four single occupancy apartments, two apartments with four bedrooms, two apartments with three bedrooms, and three apartments with two bedrooms in the centre. 24 hours residential services are provided by the centre and a total of 21 residents can be supported. There are three sleep over staff present overnight to respond to resident needs should they arise. The staff team is comprised of a person in charge, a team leader and a number of social care workers.

The following information outlines some additional data on this centre.

Current registration end date:	05/01/2019
Number of residents on the date of inspection:	20

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
01 October 2018	09:30hrs to 17:10hrs	Thomas Hogan	Lead
01 October 2018	09:30hrs to 17:10hrs	Marie Byrne	Support

Views of people who use the service

The inspectors met with five residents availing of the services and spoke with two residents about their experiences of the centre. Residents communicated that they were satisfied with the services they received and felt safe living in the centre. In addition to meeting and speaking with residents, the inspectors met with a family member of a resident. The family member spoken with outlined that while the service was of a general high standard there were some areas that required improvement which included adequately resourcing and ensuring there was a consistent staff team in place to support residents. The family member outlined that support needs of residents were not accurately assessed on occasions which resulted in minor shortcomings in areas such as personal hygiene, caring for personal possessions, and appropriate follow up with support services such as dental and chiropody. Despite this, the family member stated that they felt their relative was safe while availing of the services of the centre and was confident in the complaints process in place. 21 completed questionnaires were returned to the inspectors and overall it was found that there were high levels of satisfaction identified. Respondents who completed the questionnaires were six residents, four staff members assisting residents, eight staff members on behalf of residents, one family member and two undisclosed persons. The questionnaires asked respondents for their views on areas such as accommodation, food and mealtime experience, arrangements for visitors, rights of visitors, activities, care and supports, staffing, and complaints. Some themes emerging from the questionnaires included requirements for improvement in personal space for residents in apartments, opportunities for engaging in further community activities, security of personal belongings, arrangements for visitors, facilities for laundering clothes, and arrangements for grocery shopping.

Capacity and capability

The inspectors found that there were effective governance structures and arrangements in place in the centre with clear lines of accountability and staff awareness of their responsibilities and to whom they were accountable. Both the person in charge and registered provider demonstrated that they were aware of areas of non-compliance and had systems in place to determine if care and support delivered to residents was of good quality and safe. Six regulations were inspected against relating to *capacity and capability* and the inspectors found mixed levels of compliance with areas of non-compliance identified in both staffing and training and development.

A review of staffing arrangements found that there were shortcomings in the

numbers of staff members employed in the centre to meet the identified needs of residents availing of its services. The inspectors reviewed staff duty rosters and spoke with residents and family members and found that the number of staff members employed in the centre was not sufficient to meet the needs of all residents. There was a notable reliance on a relief staff panel to support the staff team in the centre which varied between 20 and 105 hours on weeks reviewed by the inspectors. There were some minor concerns reported to the inspectors regarding the continuity of care and support provided to residents as a result of the high turnover of relief staff members and this was found to have been compounded by an unfilled staff vacancy in the centre. Staff members met and spoken with by inspectors demonstrated high levels of knowledge of the individual needs of residents and were observed to be respectful and kind in their interactions with residents. A sample of three staff files were reviewed and it was found that all required information as set out in Schedule 2 of the regulations was available.

The inspectors reviewed staff training records and found that deficits existed in four of five mandatory staff training areas. 93 per cent of staff had completed training, and up-to-date refresher training, in the areas of fire safety, manual handling, and safe administration, while 81 per cent of staff had completed training in managing behaviours that is challenging. All staff were found to have completed training in safeguarding vulnerable persons. A plan was in place for addressing the training deficits and this was due to be completed for all staff members by the end of November 2018. Additional non-mandatory areas of staff training included communication, diabetes, personal planning, multi-elemental skills, first aid, and food hygiene. Staff members employed in the centre were found to have been appropriately supervised. There was a full-time team leader employed in the centre on a supernumerary basis who provided both day-to-day supervision of staff and regular one-to-one supervision meetings.

A review of governance and management arrangements found that there were systems in place which assured that care and support delivered was safe and resulted in positive outcomes for residents. There was evidence of a culture which encouraged regular feedback from residents, family members, and staff members and this feedback informing local practices. There was on-going internal audit and monitoring of the performance of the centre. An annual review had been completed for 2017 and a range of six-monthly unannounced visits to the centre by persons on behalf of the registered provider had been completed. The inspectors found that reports of six monthly unannounced visits did not accurately reflect concerns identified at the time of inspection such as the absence of emergency lighting from areas of the centre. Despite this, both the person in charge and programme manager demonstrated appropriate awareness of these concerns during discussions held with the inspectors.

A statement of purpose (dated August 2018) was in place in the centre and was reviewed by the inspectors. It was found that five areas of this document did not fully comply with the requirements set out in Schedule 1 of the regulations. Feedback on this matter was provided to the person in charge and an opportunity to update and revise the document was offered. A revised statement of purpose (dated October 2018) was submitted to the inspectors after the inspection and was found

to satisfactorily meet the requirements of the regulations.

The inspectors reviewed the arrangements in place for the management of complaints and found that there were effective procedures in place. A complaints register was maintained in the centre which clearly outlined the statuses of all complaints received. Complaints were responded to and investigated promptly and all relevant persons were informed of the outcome of same. Easy read explanations of the complaints procedure were on display in the centre and details of available advocacy services were also displayed.

Regulation 15: Staffing

A review of staffing arrangements found that there were shortcomings in the numbers of staff members employed in the centre to meet the identified needs of residents availing of its services. Difficulties were observed in ensuring that there was continuity of care and support for residents due to a high turnover of relief panel staff and an unfilled staff vacancy.

Judgment: Not compliant

Regulation 16: Training and staff development

The inspectors reviewed staff training records and found that deficits existed in four of five mandatory staff training areas.

Judgment: Substantially compliant

Regulation 22: Insurance

There was evidence available to demonstrate that the centre was insured against accidents or injury to residents.

Judgment: Compliant

Regulation 23: Governance and management

Internal auditing and monitoring systems failed to self-identify areas of concern such

as the absence of emergency lighting.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

A revised statement of purpose (dated October 2018) was submitted to the inspectors after the inspection and was found to satisfactorily meet the requirements of the regulations.

Judgment: Compliant

Regulation 34: Complaints procedure

The inspectors found that there were effective procedures in place for the management of complaints.

Judgment: Compliant

Quality and safety

The inspectors found that residents experienced a good quality of life through the care and supports provided. There was evidence available to demonstrate that residents were actively involved in shaping the service they received and were empowered to exercise their rights, personal goals, and aspirations. There was person-centred and resident-led culture present with many examples of meaningful relationships with the local community. There were opportunities for residents to access educational, training and employment opportunities and for the development of independent living skills. Seven regulations were inspected against relating to *quality and safety* and the inspectors found that overall, there were high levels of compliance identified in four of these regulations. Improvements were required in the areas of fire safety, premises and individualised assessments and personal plans.

A review of communication supports found that residents were assisted with their needs to ensure methods for expression were in place. There was evidence available which demonstrated that information was provided to residents in a format that they understood and which enabled informed decision making. Staff members had completed training on communication strategies and residents with identified communication needs had communication plans in place. There was input from relevant allied health professionals in supporting residents with communication

needs and there were visual time tables and accessible documents available throughout the centre. There was internet access for residents in parts of the centre and this was being extended to all areas of the centre through the installation of wi-fi which was underway at the time of inspection.

The inspectors reviewed the arrangements in place relating to the general welfare and development of residents and found there were considerable measures employed to support individuals develop relationships and links with the local community and wider networks. There was evidence in place which demonstrated an organisational culture existed which supported residents to exercise their rights to independence, social integration and participation in valued social roles. Skills building supports such as relationships and sexuality training were provided to residents along with on-going supports such as management of finances training. Some residents met with by the inspectors were employed in the local community and communicated the personal importance of these roles in their lives.

A full walk through of the centre was completed by the inspectors in the company of the person in charge and a maintenance officer. The inspectors found that the centre was constructed in 2004 and was maintained throughout to a high standard. Individual apartments were clean and decorated in accordance with the wishes and tastes of residents. In the case of two four bedroom apartments in the centre, the inspectors found that there were insufficient bathroom, toileting and showering facilities in place to meet the needs of residents. In addition, there was insufficient communal spaces available in all areas of the centre to accommodate residents. For example, the communal space of the kitchen and dining area was similar in apartments which accommodated four individuals to those which accommodated just one person. While there was suitable facilities for storage, the communal spaces of the centre were impacted by the drying and airing of clothes. There was a shared 'common room' space which was used for activities, gatherings and meetings, and there were outdoor seating areas in some individual apartments.

The inspectors found that emergency lighting was not in place in a significant number of areas of the centre which contained emergency exit routes. While there were some fire containment measures in place, there was an absence of evidence or documentation to certify these measures. In some areas where it was required such as doors to attic spaces, there were no fire containment measures in place. In addition, there was an absence of self-closing mechanisms on doors to ensure their closure in the event of a fire. The inspectors found that there was a fire and smoke detection and alarm system in place and a limited number of emergency lights. These were serviced and maintained on a regular basis and records of this was logged locally in the centre. While there were regular fire drills completed, the inspectors were not assured that recent drills completed were reflective of the maximum number of residents and the lowest number of supporting staff members in order to identify any potential shortcomings in the emergency procedures in place. There was evidence of learning from fire drills and appropriate follow up to issues arising including positive behavioural supports. There were personal emergency evacuation plans in place for residents which clearly informed the reader of the supports required to safely evacuate in the event of a fire or emergency.

A review of medication management arrangements found that there were appropriate and suitable practices in place for the ordering, receipt, prescribing, storing, disposal and administration of medications. There were risk and capacity assessments completed for residents regarding the self-administration of medications and there was evidence to demonstrate that residents were consulted with and offered a choice of pharmacy services. Staff members were supported in the administration of medication through the completion of training and competency assessments. Medication management plans were in place for residents and outlined the supports required including the manner in which medications were to be administered.

The inspectors reviewed assessments of need on file which were found to have been completed on an annual basis for all residents. The inspectors found that it was not clear who the person(s) conducting the assessments were and also found that needs identified through the assessment process were not clearly listed. While the assessments covered a variety of areas, the inspectors found that they were not comprehensive in nature. A review of personal plans found that identified needs had corresponding support plans in place. These provided guidance to the reader on how to support residents appropriately. The inspectors found that while plans were reviewed on a regular basis, there was an absence of evidence to demonstrate that allied health professionals were involved in the review process and that plans were reviewed for their effectiveness.

Protection and safeguarding measures were reviewed by the inspectors and it was found that residents were appropriately supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection. While there were reports of incidents which had occurred in the centre which met the definitions of abuse, these were found to have been appropriately investigated and followed up on by the registered provider. Incidents of this nature were logged on a local safeguarding register and had been reported to the Health Service Executive safeguarding and protection team. Residents spoken with stated they felt safe while availing of the service of the centre and a family member spoken with stated they felt their relative was safe also.

Regulation 10: Communication

The inspectors found that residents were appropriately assisted with their needs to ensure methods for expression were in place.

Judgment: Compliant

Regulation 13: General welfare and development

Residents were found to have been provided with access to facilities for recreation, for participation in activities in accordance with their interests, and were supported to develop and maintain personal relationships and links with the wider community.

Judgment: Compliant

Regulation 17: Premises

In the case of two four bedroom apartments in the centre, the inspectors found that there were not sufficient bathroom, toileting and showering facilities in place to meet the needs of residents. In addition, there was insufficient communal spaces available in all areas of the centre to accommodate residents. While there was suitable facilities for storage, the communal spaces of the centre were impacted by the drying and airing of clothes.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Emergency lighting was not in place in a significant number of areas of the centre which contained emergency exit routes. There was an absence of evidence or documentation to confirm there were some fire containment measures in place. There were no fire containment measures in place in areas such as attic doors and there was an absence of self-closing mechanisms on doors. The inspectors were not assured that recent drills completed were reflective of the maximum number of residents and the lowest number of supporting staff members in order to identify any potential shortcomings in the emergency procedures in place.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

The inspectors found that there were appropriate and suitable practices in place for the ordering, receipt, prescribing, storing, disposal and administration of medications.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

Assessments of need were not comprehensive in nature. It was not clear who the person(s) completing assessments were. Needs identified through the assessment process were not clearly outlined to the reader. There was an absence of evidence to demonstrate that allied health professionals were involved in the review of personal plans and that the plans in place were reviewed for their effectiveness.

Judgment: Substantially compliant

Regulation 8: Protection

The inspectors found that residents were appropriately supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 8: Protection	Compliant

Compliance Plan for Elvira OSV-0003580

Inspection ID: MON-0021798

Date of inspection: 01/10/2018

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: A review of the purpose and function of Elvira is currently being conducted by the Programme Manager, the person in charge and all stakeholders. One of the terms of references is to review the roles and responsibilities of the social care workers in Elvira. The aim is to streamline the supports that are being offered and enable the social care workers to concentrate on areas such as skills teaching and community integration. There are currently additional staff working in Elvira alongside the three sleepover staff and these staff will remain in place until the review is complete. Timeline: December 22nd 2018 Person Responsible: Person in Charge The vacancy within the centre will be filled by December 2018 which will reduce the amount of relief staff currently being used. Regular relief staff, which the residents are familiar with, are used within the centre. All relief staff have supervision every three months, have completed their mandatory training and are offered additional training as required. Timeline: December 22nd 2018 Person Responsible: Social Care Leader	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development:	

All staff have now completed all of their mandatory training – some of these staff are currently awaiting appraisals for training which will be completed by the 30th of November 2018

Timeline: 30th November 2018

Person Responsible: Social Care Leader

Regulation 23: Governance and management	Substantially Compliant

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

The Person in Charge shall ensure that internal audits relating to Fire Safety are in line with national policy relating to the designated Centre. This information will also be fed to our internal auditing team to ensure they are also auditing in lines with best practice in this area. This will ensure that we are correctly self identifying areas of risk and non compliances within the regulations.

Timeline: 2nd November 2018

Person Responsible: Person in Charge

Regulation 17: Premises	Substantially Compliant

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

A review of the purpose and function of Elvira is currently being conducted by the Programme Manager, the person in charge and all stakeholders. One of the terms of references is to liaise with the housing association to identify ways to increase the communal spaces available to the residents and reduce the number of residents living in the four bedroom apartments. Following the review and with agreement from the housing association the person in charge shall ensure that the recommendations of the review and put in place.

Timeline: December 30th 2019

Person Responsible: Person in Charge

Regulation 28: Fire precautions	Not Compliant

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

It was found that there was not emergency lighting in place that lit the area to the emergency exit. The person in charge will ensure that adequate lighting is put in place in all areas.

Timeline: March 7th 2019

Person Responsible: Person in Charge

Certificates confirming that doors in the apartments are fire doors were sourced (sent as an attachment to this plan)

Timeline: 22nd October

Person Responsible: Person in Charge

A qualified Fire Engineer will be sourced to assess current fire containment measures in place in this designated Centre and to advise as to what additional fire containment measures are needed. This will include assessing what is needed to protect the attic space. The person in charge will ensure this assessment is carried out by December 22nd 2018 and will act on recommendations as appropriate.

Timeline: December 22nd 2018

Person Responsible: Person in Charge

A review of all self-closing mechanisms on fire doors will be carried out in Elvira. Due to mobility issues there are a number of doors that would prove disabling to a resident if there was a self-closing mechanism on them. The person in charge will consult with the fire engineer and seek his recommendations in relation to these doors and act appropriately on his recommendations.

Timeline: March 31st 2019

Person Responsible: Person in Charge

A fire drill will be completed with all residents of Elvira Close present. To assess the effectiveness of the fire protocol the person in charge shall ensure that the lowest number of supporting staff present (i.e. the three sleepover staff) are supporting this fire drill.

Timeline: 22nd December 2018

Person Responsible: Person in Charge

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:

The Personal Plan is currently being revised by the service to ensure that they are comprehensive in nature. The following revisions will be made:

- The personal plan will identify all people, including health professionals, who were involved in the review of the plan and who completed assessments.
- The support needs of the residents will be written at the front of the plan so the reader can clearly see what the needs of the resident are.
- The effectiveness of the plans will be conducted , in conjunction with health care professionals, on an annual basis at a minimum or sooner as required. This will be recorded in the individuals personal plan.

This new revised Personal Plan will be implemented for each resident before their next annual review. All staff will receive training in how to complete these personal plans with their key client.

Timeline: 30th September 2019

Person Responsible: Social Care Leader and Person in Charge

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	22/12/18
Regulation 15(3)	The registered provider shall ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.	Substantially Compliant	Yellow	22/12/18
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to	Substantially Compliant	Yellow	30/11/18

	appropriate training, including refresher training, as part of a continuous professional development programme.			
Regulation 17(1)(a)	The registered provider shall ensure the premises of the designated centre are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.	Substantially Compliant	Yellow	30/12/19
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Substantially Compliant	Yellow	30/12/19
Regulation 23(2)(a)	The registered provider, or a person nominated 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	Substantially Compliant	Yellow	02/11/18

	care and support.			
Regulation 28(2)(c)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Orange	07/03/19
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	31/03/19
Regulation 28(4)(b)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Substantially Compliant	Yellow	22/12/18
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	Substantially Compliant	Yellow	30/09/19

	basis.			
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	30/09/19
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	30/09/19