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:	JULA
Name of provider:	Saint Patrick's Centre (Kilkenny)
Address of centre:	Kilkenny
Type of inspection:	Unannounced
Date of inspection:	01 May 2018
Centre ID:	OSV-0005694
Fieldwork ID:	MON-0021386

About the designated centre

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

Jula is a residential home located in Co.Kilkenny, catering for four adults with an intellectual disability over the age of 18 years. The service operates 24 hours, seven days a week. The property is a large bungalow which provides a homely environment for the residents. Each resident's private bedroom is decorated to their unique tastes. The person in charge works in a full time capacity with the support of the person participating in management and the staff team. The whole time equivalent of staff, in accordance with the provider's Statement of Purpose document, which is a key governance document, is 13 staff.

The following information outlines some additional data on this centre.

Current registration end date:	18/12/2020
Number of residents on the date of inspection:	4

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 May 2018	09:00hrs to 17:30hrs	Laura O'Sullivan	Lead

Views of people who use the service

The inspector met and interacted with residents at intervals during the inspection ensuring not to impinge on their individual planned activities. As residents had their individual unique means of communication, the inspector communicated with each person respecting this. All residents appeared content and comfortable in their environment which was relatively new to them after having recently moved from a larger living environment on a campus setting. Positive interactions with residents and staff were observed.

Capacity and capability

The inspector found that this was a good service which demonstrated high levels of compliance. The capacity and capability of the provider to deliver a safe, effective and quality service was emulated through the systems and process in place.

A clear governance structure and effective operational systems was in place. As a result there was an emphasis on meaningful activities, participation in the local community and consultation in the running of the centre. This helped to ensure that residents experienced a good quality of life. A strong staff team approach to the service was evident with an inclusive and innovative culture evident throughout. Improving the quality of life of the residents was paramount in the running of the centre. Some improvements were required in the remit of staff training and a service provision agreement.

The registered provider had effective monitoring systems in place to assure themselves that the residents were supported in receiving a high standard of care. A comprehensive annual review of the service had been implemented with action plans developed for any improvements required. The person in charge had reviewed this action plan monthly post the implementation of the review and disseminated this information to the staff team as part of the monthly meetings. This ensured that actions for improvement were met within the set time frame and that all staff were aware of improvement required within the centre.

In conjunction with the annual review the person in charge and person participating in management had implemented a number of audits to ensure that a high standard of care was in place for the residents. This oversight ensured a high level of compliance with regulations and a positive impact for residents.

The registered provider had appointed a person in charge to the centre. The inspector found that this individual had the necessary skills, experience and

knowledge to carry out her role to a high standard. The person in charge had effective systems in place to ensure the safe effective service was afforded to residents. The person in charge implemented staff supervisory meetings 6 weekly. Staff spoken with found these very effective and comprehensive. Along with structured staff supervisory meetings the person in charge carried out informal supervisions on an ongoing manner. As part of monthly staff meetings the person in charge developed an agenda and assigned tasks to staff prior to meetings. This encouraged a team approach and consultation with the staff team in the running of the centre.

The centre was well resourced to meet the needs of the residents. The registered provider had ensured sufficient staffing levels was available at all times within the centre. An actual and planned rota was developed and maintained by the person in charge. this rota was flexible and adapted to meet the needs of the residents.

Some improvements required in the area of staff training. Due to the health care needs of the residents training in a particular area of health supports was paramount to support residents at meal times. The registered provider gave assurances that untrained staff would not partake in supporting the residents during mealtimes to ensure the safety and well being of residents.

The registered provider had ensured the development of a service provision agreement between the organisation and the resident. This document detailed the services to be provided including any fees which may be incurred. This document had as yet not been signed by the resident or their representative. It was evident that the registered provider was working in conjunction with an external advocacy agency to ensure the rights of the resident was upheld within the document.

The person in charge had effective systems in place for the recoding of care and support provided to the resident. The inspector reviewed records such as the directory of residents and statement of purpose. Some improvements were required for the statement of purpose, which is a key governance document, to ensure this contained the required information and was kept under review by the provider.

Regulation 14: Persons in charge

The registered provider had appointed a person in charge to the designated centre in a full time capacity. This person in charge possessed the required attributes and regulatory required skills and knowledge to carry out her role.

Judgment: Compliant

Regulation 15: Staffing

The registered provider had ensured that the necessary staffing levels and skill mix was present within the centre to meet the needs of the residents.

Nursing supports were available to meet the needs of the residents.

Judgment: Compliant

Regulation 16: Training and staff development

The person in charge had ensured that all staff had received mandatory training within the centre. Improvements were required in training to meet specific, individual needs of residents.

Staff supervisions were implemented six weekly by the person in charge.

Judgment: Substantially compliant

Regulation 19: Directory of residents

The registered provider had established and maintained a directory of residents for the centre including information as required under Schedule 3.

Judgment: Compliant

Regulation 23: Governance and management

A defined governance structure was present within the centre to ensure effective operational management systems were in place. The governance structure ensured a safe service was provided appropriate to the residents needs and was consistent and effectively monitored.

The provider had ensured systems were in place for the implementation of a comprehensive annual review of service provision within the centre. A robust action plan was established post audit. Actions were planned and implemented to ensure a safe effective service was provided to residents.

Judgment: Compliant

Regulation 24: Admissions and contract for the provision of services

A service provision agreement between provider and resident had been developed but not yet agreed.

This document had not been signed by the residents and/or their representatives.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The statement of purpose was available within the centre. Some amendments were required to ensure information required under
Schedule 1 was present and accurate.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

All required notifications had been submitted to the chief inspector. The person in charge was aware of her regulatory requirements.

Judgment: Compliant

Regulation 34: Complaints procedure

Effective systems were in place for the reporting and management of complaints within the centre. A complaints log was maintained and reviewed regularly by the person in charge. All complaints were dealt with in a timely fashion ensuring satisfactory outcome for the complainant.

A complaints policy was in place and gave guidance for staff in the area of complaints.

Judgment: Compliant

Quality and safety

The inspector reviewed the quality and safety of supports afforded to the residents currently residing within the designated centre, finding overall-all a high level of compliance. These residents had recently transitioned to their new home and through consultation and resident involvement they now engaged in a plethora of meaningful activities both within the home and their local community. Residents' right, dignity and privacy were respected by all and a positive interactive environment was promoted. Some improvements were required in the area of medication management and individualised personal plans to ensure an effective service was provided on a consistent basis.

The centre was homely and tastefully decorated. Each resident's private bedroom was decorated in line with their personal tastes and interests. All equipment required to support residents was present and serviced accordingly to ensure the supports needs of the residents were met in a safe manner. The provider had made arrangements to ensure the service was accessible and comfortable for residents. Counter top areas had been lowered within the kitchen area to allow wheelchair accessibility and resident participation in kitchen activities.

Care and supports were delivered based on each resident's personal plan. ''Visionary'' meetings were held to assess the needs of the resident and to develop goals through a multi-disciplinary format. Within these meetings social needs of the resident were discussed and actions developed to encourage meaningful activation and community links. Some improvements in the documentation were required to ensure that these goals were clearly recorded to ensure that guidance was available for all staff and progression of the goals occurred. If residents were unable to participate in a planned activity for any reason a ''Barrier for inclusive life'' document was completed by staff and reviewed by the person in charge. This document assisted the person in charge to ensure that the required supports and resources would be sourced and available for planned activities. This demonstrated a positive and concerted effort to ensuring barriers to achieving residents' goals were removed.

All residents' health and well-being was supported through access to health care services and multi-disciplinary review. As part of the monthly review meetings staff ensured that all social and health care supports needs were in place and proportionate to the needs of the residents. Health care plans and health specific standard operating procedures ensured best practice was adhered to by all staff. Regular consultation with the general practitioner had ensured that the need for interventions had reduced since the transition of the residents to the centre with an improvement in residents overall health status. Staff members were proactive and innovative in the development of documents and guidelines to guide colleagues and promote the best possible health and well being for residents.

Overall the person in charge had implemented systems for the safe effective

ordering, receipt, storage and prescribing of medicinal products. Improvement were required in the area of disposal of out of date medication and review of as required medications. The person in charge ensured this was rectified immediately. Following the inspection the person in charge submitted a standard operating procedure to HIQA aimed at addressing this. These adapted procedures would ensure the effective monitoring of all medicinal products including checking of out of date stock and procedures for all staff to adhere to.

The person in charge had implemented systems to ensure the safety and well being of residents was promoted in the area of positive behaviour support. A referral had been submitted for all positive behaviour support plans to be reviewed by a positive behavioural therapist. Whilst awaiting review and to ensure a consistent and effective support network the staff team had implemented interim guidelines for staff to adhere to. Through this implementation the change in residents living environment and supports was noted and there was a decrease in incidents noted.

A limited number of restrictive practices were in use to ensure the safety of residents. Where a restrictive practice was utilised the least restrictive measure was utilised for the shortest duration required. Regular review of restrictive practice was implemented by the person in charge including the assessment of need for its use. Due to this system there was a reduction in the use of restrictive practice within the centre since the residents transition into their new home.

The registered provider had ensured effective systems were in place to safeguard residents from abuse. Comprehensive individualised intimate care plans had been developed for all residents giving clear guidelines to staff on level of support required. These plans were global in their approach to personal care needs of all residents. The organisational policy gave clear guidance for staff on procedures to follow if a concern arose. Staff spoken with clearly articulated this information and through review of safeguarding plans it was evident that staff were proactive in the review and development of safeguarding plans to ensure all residents were protected and safe in their environment.

Risk was managed well within the centre. The risk register was an active document under regular review by both the person in charge and the person in participating in management. Control measures were in place for all identified risk with additional control measures actively being reviewed to promote the reduction of the risk risk rating. The organisational policy gave clear guidance to all staff in the area of risk identification and management.

The inspector found effective systems and procedures were in place for the prevention and detection of fire. Fire evacuation drill had been implemented day and night. Improvements were required in relation to evacuation procedure guidelines and documentation of fire evacuation drills to ensure the effectiveness of same. Each resident had a personal emergency evacuation plan in plan which staff articulated clearly alongside the centre specific evacuation plan. All fire equipment was serviced quarterly including emergency lighting and fire alarm system. The completion of this was reviewed by the person in charge to ensure its

completion.

Regulation 17: Premises

The house presented as a clean, warm and personalised environment. The environment was observed to meet the needs of the resident as set out in the statement of purpose. Each individual bedroom was decorated in line with individual preferences and interests.

The registered provider had ensured all necessary equipment and facilities were present and regularly serviced.

Judgment: Compliant

Regulation 18: Food and nutrition

Residents were afforded a choice of wholesome nutritious meals in line with nutritional recommendations. A choice of snacks was available.

Judgment: Compliant

Regulation 20: Information for residents

A residents guide had been developed in an accessible format.

Judgment: Compliant

Regulation 26: Risk management procedures

A risk register was in place within the centre. This register was regularly reviewed and adapted as required by the person in charge and the person participating in management.

The provider ensured the on-going identification, assessment and management of risk to ensure the safety of residents and staff.

Judgment: Compliant

Regulation 28: Fire precautions

The registered provider had ensured that effective systems were in place for the prevention and detection of fire within the centre. Adequate arrangements had been made for the provision and servicing of fire alarm systems, emergency lighting and fire fighting equipment.

Fire evacuation drill had been implemented day and night with learning from drills evident. Improvements were required in relation to evacuation procedure guidelines and documentation of fire evacuation drills to ensure the effectiveness of same.

Daily checks of fire exits and weekly checks of systems ensured the safety of residents was paramount within the centre.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

All residents had access to a local pharmacy for the dispensing of medications.

Systems were in place to ensure the safe effective ordering, receipt, storage and prescribing of medicinal products. Improvement were required in the area of disposal of out of date medication and review of as required medications.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Each resident had a detailed comprehensive individualised plan in place prior to admission to the designated centre. The person in charge implemented an audit in conjunction with a monthly review to ensure that the plan met the needs of the resident.

Plans were developed and reviewed through a multi disciplinary approach utilising a visionary meeting to plan goals for each resident based on their unique interests, needs and likes. Improvement was required in relation to the documentation of goals to ensure all goals were set out in a clear manner, with supports required to ensure a consistent approach.

Judgment: Substantially compliant

Regulation 6: Health care

The provider had effective systems in place to help the residents achieve the best possible health. Individual health care plans gave staff clear guidance on all supports required to ensure compliance with recommendations from members of the multi disciplinary team. Standard operating procedures had been developed to ensure guidance was available for staff to meet the health care needs of the residents.

Staff facilitated residents to attend all health care appointments and adapted associated documentation to reflect any changes to support needs of the residents.

Judgment: Compliant

Regulation 7: Positive behavioural support

The person in charge had implemented systems within the centre to ensure that staff had the necessary guidance to support residents in the management of behaviours of concern, taking into account the on going changing needs of residents.

Where restrictive practice was utilised this was assessed and reviewed on a three monthly basis to ensure the least restrictive measure was utilised for the shortest duration necessary.

Judgment: Compliant

Regulation 8: Protection

The registered provider had systems to ensure that residents were protected from abuse. The organisational policy gave staff clear guidelines if a concern arose, staff articulated this clearly to the inspector.

Where safeguarding measures were in place, it was evident that these plans were reviewed and updated as required. Following this updated plans were disseminated to all members of the team to ensure implementation of the plan.

An individualised personal and intimate plan had been developed for all residents.

Judgment: Compliant

Regulation 9: Residents' rights

The registered provider had ensured that the residents rights were upheld within the centre. Consultation in the running of the centre was encouraged with skills training underway to promote participation.

House meetings were implemented with the support of communication aids such as i-pads.

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	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 19: Directory of residents	Compliant
Regulation 23: Governance and management	Compliant
Regulation 24: Admissions and contract for the provision of services	Substantially compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 17: Premises	Compliant
Regulation 18: Food and nutrition	Compliant
Regulation 20: Information for residents	Compliant
Regulation 26: Risk management procedures	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
Regulation 9: Residents' rights	Compliant

Compliance Plan for JULA OSV-0005694

Inspection ID: MON-0021386

Date of inspection: 01/05/2018

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 16: Training and staff development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:

Staff have access to training as part of continuous professional development. All staff have completed or are booked in for St. Patrick's Centre (Kilkenny) mandatory training. At a team meeting on 28/06/18 further dates for centre specific training were discussed. *Please find the Training report attached.*

A centre specific training profile, individual staff training profiles and a training schedule are distributed monthly to the PIC and Community Service Manager of the Centre by the Training Department.

There is a Quality Conversations Policy in place. The policy outlines a standardised organisational framework for the implementation, continuing development and maintenance of a system of Quality Conversations for staff. These conversations take place every 6 weeks, aim to support employees and ensure their work practices and development are supported and overseen in a positive way.

Please find attached the Quality Conversations Policy, Form and schedule.

On Wednesday, 13/6/2018, a meeting was held between St. Patrick's Centre (Kilkenny) and the main employment agency providing staff for the designated centres. The training needs for agency staff regarding mandatory and centre specific training and also consistency of staff was discussed at this meeting.

A further meeting will take place on Thursday, 28/06/2018 between the Community Service Managers, Quality & Therapeutic Department and the HR department of St. Patrick's Centre (Kilkenny). This meeting will address the training requirements of all designated centres identified by the training department.
Further to this meeting, the specific training requirements for each centre will be

discussed with the employment agencies working with St. Patrick's Centre (Kilkenny).

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:

The Provision of Service document was reviewed by the advocacy agency SAGE between February and May 2018. The document is being amended and will be available in the designated centre by the end of June 2018. An easy read version will accompany the text version. The supported person will be taken through the document using the easy read version and this process will be signed off by the Team Leader/PIC. The Provision of Service document will be available to the person supported's representative for information purpose only.

A copy of both documents was sent to the inspector at the 29/06/18.

Regulation 3: Statement of purpose	Substantially Compliant

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

The statement of purpose was reviewed immediately after the inspection took place. All necessary amendments were made and the statement was sent to HIQA Registration on the 03/05/2018.

The statement of purpose is reviewed on an ongoing basis. The statement of purpose and the easy read version are available for people supported and their representatives in the designated centre.

Regulation 28: Fire precautions	Substantially Compliant

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

The updated Fire Policy Procedure for the designated centre was sent to the inspector on the 03/05/18, this included:

- An update on the fire assembly point
- An updated fire drill form incorporating the reaction of the people supported during the drill.

A fire drill was held on 25/05/18 and the behavior and reactions of the people supported was documented.

Please find attached the Fire Policy Procedure.

The PIC booked a simulated night fire drill with the fire trainers. The PIC is waiting for a date to be confirmed.

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant

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

After the inspection, the PRN stock check form and the Standard Operation Procedure for the weekly stock check of PRN medications were reviewed by the medication coordinator and the PIC. An expiry date check has been included for each week on the PRN Stock Check form. The PRN stock check form and SOP were sent to the inspector on 08/05/18.

The format for the PRN protocol was reviewed by the medication coordinator and the PIC. The amended PRN protocol now includes a question regarding which PRN medication is the first choice?

Please find attached the amended PRN stock check form, Standard Operating Procedure and amended PRN protocol.

Medication ordering and stock control documentation is audited by the medication coordinator and is continuously monitored and reviewed by the PIC through monthly medication management auditing.

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:

Action plans for all goals identified in the visioning meetings for the people supported are in place. The action plans include identified responsibilities and agreed timeframes.

In a team meeting on the 30/05/2018 the action plans were discussed and guidance was given by the PIC to staff regarding the completion of action plans for the identified goals.

The standard of reviewing these goals is on a three monthly basis. The PIC in the inspected designated centre is supporting the key worker through 6 weekly Quality Conversations to achieve the goals with the supported person.

Visioning meeting reviews are taking place every 6 months.

Within the Person Supported Pathway to MDT each person has a monthly in house review meeting, where current issues and needs are discussed and agreed. The keyworker and PIC attend an annual MDT review meeting.

All these meetings ensure that the supported person's personal plan is not only the subject of a review by the keyworker and PIC, but also by appropriate health care professional to reflect changes in need and circumstances.

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 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	31/08/18
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	05/07/18
Regulation 28(4)(b)	The registered provider shall ensure, by means of fire safety management and fire drills at	Substantially Compliant	Yellow	25/05/18

	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.			
Regulation 29(4)(c)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that out of date or returned medicines are stored in a secure manner that is segregated from other medicinal products, and are disposed of and not further used as medicinal products in accordance with any relevant national legislation or guidance.	Substantially Compliant	Yellow	08/05/18
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose containing the information set out in Schedule 1.	Substantially Compliant	Yellow	03/05/18
Regulation 05(4)(b)	The person in charge shall, no later than 28 days after the resident	Substantially Compliant	Yellow	30/05/18

	is admitted to the designated centre, prepare a personal plan for the resident which outlines the supports required to maximise the resident's personal development in accordance with his or her wishes.			