



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

Issued by the Chief Inspector

Name of designated centre:	Villa Maria
Name of provider:	Sunbeam House Services Company Limited by Guarantee
Address of centre:	Wicklow
Type of inspection:	Unannounced
Date of inspection:	05 November 2019
Centre ID:	OSV-0001686
Fieldwork ID:	MON-0024816

About the designated centre

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

Villa Maria designated centre is located in a town in Co. Wicklow. The designated centre can provide residential care for up to six male or female residents over the age of 18 years. The centre provides services for residents who are dependent in many areas of their daily life and require staff support to maintain and increase independence as much as possible. Staff also support residents to manage personal risks and provide health-care supports. The centre is managed by a full-time person in charge who also has responsibility for another designated centre. They are supported in their role by a deputy manager. A senior services manager is also assigned to the centre and provides supervisory support to the person in charge. The whole-time-equivalent staffing for this centre is 12.8, as per the provider's statement of purpose. The provider has identified, in the statement of purpose, that at least one male staff is required to work in this designated centre during the day and at night time. The provider has also identified in the statement of purpose that Villa Maria cannot accept new admissions should a vacancy arise in the future.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	6
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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
05 November 2019	10:05hrs to 18:30hrs	Louise Renwick	Lead

What residents told us and what inspectors observed

The inspector met all six residents living in the designated centre. Not all residents spoke with the inspector directly, but residents communicated through their own methods.

The inspector observed that residents were content in their home, and appeared very happy in the presence of staff and management. Staff had a good understanding of each resident's communication style and interacted with ease with each resident. During the inspection, the inspector observed there were enough staff to support residents' daily activities and personal choices. For example, residents were seen going out for lunch and coffee, going shopping and attending groups outside of the designated centre during the course of the inspection.

While the centre was pleasant and comfortable, the inspector observed that the communal space was limited. For example, the dining room table was pushed against the wall and the dining room also included couches and a television for residents. When residents who required wheelchairs were sitting for a meal, space was limited and as such staff were observed to try to manage this through staggering the time of meals for different residents and supporting some residents to eat in local restaurants and pubs.

The inspector observed residents making their own choices throughout the day, for example deciding to change their outfit or deciding whether or not they wanted to go out of the designated centre. These choices were encouraged by staff members and resources available supported this.

The inspector observed residents enjoying a music session in their home, singing and dancing to their favourite songs and there was a joyous atmosphere during this time.

Capacity and capability

The provider and person in charge demonstrated the capacity and capability to deliver a person-centred service to the residents living in the designated centre, which was safe and of good quality. Some improvements were required by the provider to ensure adequate resources were in place to address long standing issues with the premises.

In the designated centre, there were clear lines of reporting, accountability and management. The designated centre was managed by a suitably qualified and experienced full-time person in charge, who had support from a deputy manager.

There was a clear management structure in place in the designated centre, with the person in charge reporting to a senior services manager, who reported to the Chief Executive Officer (CEO). At the time of the inspection, a new person had been appointed to the role of interim CEO.

There were monitoring systems in place which reviewed the standard of the care and support delivered to residents in the designated centre. The person in charge demonstrated effective oversight of the individual needs of residents, the care and support they received and the day-to-day operation of the designated centre. The person in charge and deputy manager carried out monthly audits in areas such as housekeeping, documentation, care planning, health and safety and staff knowledge. External audits were also carried out in areas such as medicine management. The provider had made arrangements for an annual review of the centre in addition to six-monthly unannounced visits that assessed the standard of the care and support being delivered. The inspector discussed the findings of the six-monthly review with the person in charge and determined that the local management team had taken appropriate and timely action to bring about improvements.

While the local management and monitoring systems were effective, improvements were required to ensure the provider carried out identified actions that were raised through Health Information and Quality Authority (HIQA) inspections in order to bring about positive changes. The previous inspection of this designated centre in May 2018 identified that communal space for residents was limited. The provider had informed the Chief Inspector of Social Services that works to address this issue would be completed by September 2019. This had not yet occurred due to financial reasons.

The person in charge held responsibility for two designated centres located close to each other. It was noted there were adequate operational management and oversight systems in place for this arrangement, for example, the person in charge was supported in their role by a deputy service manager.

Records of supervision, performance and management meetings between the person in charge and senior manager were maintained. The person in charge held regular staff meetings with the staff team that focused on key areas regarding residents' care and support. Staff were appropriately supervised, both in a day-to-day capacity and through formal one-to-one meetings by the person in charge.

There was a stable and consistent staff team in place, consisting of nurses, social care workers and care assistants. There was an adequate number of staff on duty each day and night to meet residents' assessed needs, in line with the details of the written statement of purpose. Where residents had been assessed as requiring specific staffing support, this was facilitated. For example, one to one staff or male staff support. The local management team had provided staff with additional training in certain areas to increase staff skills in particular areas. For example, social care staff were appropriately trained in the safe administration of medicine.

The inspector reviewed training records and spoke with some staff, and found that

there was a system in place to ensure all staff received training in mandatory fields, as determined by the provider. Refresher training was available for staff, as guided by the provider's policy. Since the previous inspection in May 2018 staff had received training in first aid, the administration of oxygen and seizure management medicine as well as training in autism awareness. Planned and actual rosters demonstrating who was on duty at day and night time were maintained by the person in charge.

The inspector found that there was a policy and procedure in place for the management of complaints in the designated centre. A record was maintained of any complaints or compliments raised by residents, families or other persons. There was a clear process in place for the management of complaints, information was on display in the designated centre and persons identified for managing and reviewing complaints. On review of the complaints log, the inspector noted no complaints had been raised in recent months, and a number of compliments had been made by family members.

Overall, this inspection found that the provider and person in charge were operating the designated centre in a manner that was promoting person-centred care for residents, with some improvements required to ensure adequate resources were in place to address issues with the premises.

Regulation 15: Staffing

The provider has ensured that the number and qualifications of the staff team were appropriate to the number and assessed needs of residents, the statement of purpose and the layout of the centre.

Residents received continuity of care from a stable and consistent staff team employed by the provider.

The person in charge maintained a planned and actual staff roster, which clearly reflected the hours worked in the designated centre, along with any additional responsibilities of the staff team.

Judgment: Compliant

Regulation 16: Training and staff development

Staff had access to appropriate training, including refresher training to enable them to best meet residents' needs.

Mandatory training was identified through the provider's own policies, and staff were offered refresher training after a set period of time.

The person in charge had ensured effective supervision was in place, both informal supervision of the day to day practice along with formal one to one meetings with each staff . Staff meetings were held on a regular basis.

Information on the Act, regulations and standards was available to the staff team in the designated centre.

Judgment: Compliant

Regulation 23: Governance and management

There was a clearly defined management structure in the centre and the organisation overall. Any vacant posts were currently being recruited by the provider.

The inspector found that there was good local oversight in the designated centre and effective systems of reviews and audits to monitor the quality and standard of the care and support being delivered to residents.

The provider had completed an annual review along with six-monthly provider-led visits, which were unannounced, to monitor the safety and quality of the care and support provided. These reviews and visits generated an action plan to address any concerns. While the audits and reviews in general, identified that the centre was providing a good quality and person-centred service, there were outstanding actions that the provider had not yet addressed due to resources.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

The provider had a written complaints policy in place, and details of the procedure to follow and how to raise a complaint were on display in the designated centre.

A record was maintained of any complaints raised in relation to the designated centre, and there were named persons appointed to investigate complaints and ensured they were appropriately reviewed.

Judgment: Compliant

Quality and safety

The provider and person in charge demonstrated that they had the capacity and capability to operate and manage the designated centre in such a way that was resulting in a good quality and person-centred service for the residents living in the designated centre. Some improvements were required however, to ensure adequate communal space was available in the designated centre along with some improvements in residents' assessments and personal plans.

The designated centre offered residents their own private bedroom, communal spaces, such as a living room, living/ dining room, kitchen and adequate bathroom facilities. The designated centre was located within walking distance of a large town and amenities and residents' had use of two vehicles that supported choice for residents, and supported them to have more control over their time out of the designated centre. While the designated centre had been extended in size in recent years, the usable communal space for residents was not adequate in relation to the number and needs of the six residents living there. This had been found as not compliant on the previous inspection in May 2018, and to date had not been addressed by the provider. The dining facilities in the designated centre were not sufficient. The size of the living room at the front of the house was small, and some residents chose not to use this room with their peers. As a way to offer residents a second living space, the dining room also contained a couch, chairs and a television. This resulted in inadequate space for residents to have meals together in their home. The inspector observed a lack of suitable space for the storage of items in the designated centre due to poor lay out of the premises. For example, a weighing scales chair, unused tables or computer monitors and other equipment were located in living spaces and hallways further impacting on the communal spaces available for residents.

Throughout the day, the inspector observed residents coming and going from the designated centre and taking part in activities that were meaningful to them. Through assessments, residents had determined the way that they enjoyed spending their time, and this was facilitated and supported by the staff team working in the designated centre. For example, attending music classes, going for walks, visiting restaurants and coffee shops. Residents were supported to promote relationships with their natural supports, through visiting family members or spending time with them during the week. The person in charge had arranged for thumb turn locks to be installed on some residents bedrooms, this arrangement promoted residents' ability to make the choice to spend time alone in their bedroom, or not to be disturbed by staff or their peers. The inspector observed residents having fun and laughter throughout the day in the designated centre, being responded to kindly when they sought attention from staff and having their requests followed. Residents were seen to be supported in a manner that was important to them.

All staff had received training in safeguarding vulnerable adults and there was a clear pathway to be followed if residents, staff or families had any concerns or

suspensions regarding residents' safety. The person in charge was aware of the reporting responsibilities for safeguarding concerns, in line with National policy and the provider's own procedure. The designated centre was managed in such a way as to offer residents' choice and control over their daily activities, and there was an adequate number of staff to support residents to promote positive relationships between peers.

There was a system in place to assess and plan for residents' health, social and personal needs. From a review of a sample of residents' records, the inspector noted health issues, that were identified through the assessment process, had a relevant personal plan in place to outline the individual supports required to address them. A new assessment tool had been implemented since the previous inspection, which was an improvement on previous assessments and outlined the supports residents required in varying aspect of their lives. Residents' personal and social needs and wishes were identified through the use of an additional validated tool, and residents' had identified goals that they wished to work on. Improvements were required however, to ensure assessments included the type of staffing support that residents required. For example, full-time nursing care, or more community based or drop-in nursing support. Improvements were also required to ensure the review of care plans was inclusive of determining how effective the plan had been.

Residents had access to their own General Practitioner (GP), and were supported to avail of additional allied health professionals through referral to the primary care team or to allied health professionals provided by Sunbeam House, for example, physiotherapy, social work and counselling. Residents had access to psychiatry services as required. Where residents presented with behaviour support needs, behaviour support planning was in place to guide staff in how to positively manage this. However, behaviour support plans were drawn up by the person in charge and staff team, and while they offered guidance on how to manage behaviour, they were not inclusive of advise or review by an allied health professional suitably training in the area. The inspector was informed that the provider had recently employed a psychologist as part of the allied health supports that would be available to residents.

Some restrictive practices were in place in the designated centre such as external doors being locked, and access to the kitchen limited at periods of time during the day, as a means to keep people safe from harm or identified risks. Restrictive practices were recorded and risk assessed. There was a Human Rights committee in place in the organisation that reviewed all restrictive interventions regularly, with an aim to reduce these, if possible. The person in charge had recently completed a self assessment tool on the use of restrictive interventions in the designated centre, and had identified further areas to bring about improvements in line with best practice. For example, to clearly evidence trialling reductions of restrictions in order to continuously promote a restraint free environment.

There was a risk management policy in place and the person in charge maintained a risk register for the designated centre. There was an escalation pathway so that identified risks which were at a particular risk rating was discussed with the senior manager and monitored and reviewed more frequently. From review of the risk

register, and in speaking with the person in charge, overall risk was low in the designated centre, and appropriate measures were in place to manage and alleviate known risks. Similarly, there was a system in place to record, review and respond to any incidents or adverse events that occurred in the designated centre, for example, falls.

The inspector found that there was a fire safety systems in the designated centre. There was a fire detection and alarm system in place, emergency lighting, identified fire exits and fire fighting equipment in place. All systems and equipment were seen to be serviced and checked regularly by a relevant professional, and records were maintained. Emergency evacuation drills were completed routinely and included deep sleep evacuation drills to ensure all residents and staff knew what to do in the event of an emergency. Staff had also completed training in fire safety. Since the previous inspection, fire containment measures were now in place throughout the building.

Overall, the designated centre was being managed and operated in a person-centred manner, with effective systems of oversight to ensure residents were receiving care and support in line with their assessed needs and preferences. Residents appeared happy and content in their home, and were supported to take part in activities that they enjoyed. There did, however remain a requirement for the provider to address issues in relation to the communal space in the designated centre.

Regulation 13: General welfare and development

Residents had access to facilities for occupation and recreation and opportunities to participate in activities in accordance with their interests and preferences.

Residents were encouraged and supported to develop and maintain personal relationships and links with the wider community in accordance with their wishes.

Judgment: Compliant

Regulation 17: Premises

The designated centre accommodated six residents and each resident had their own private bedroom. There were a sufficient number of bathrooms available, along with a separate kitchen to prepare food. Residents had access to a secure garden at the back of the house, and the designated centre was well located within walking distance of local amenities.

However, the provider had not ensured that:

- adequate communal space was available for residents to use
- the kitchen facilities were in good state of repair and decoration
- adequate space for the storage of equipment, aids and other items

Judgment: Not compliant

Regulation 26: Risk management procedures

The provider had put in place a risk management policy which offered clear guidance on the identification, assessment, management and response to risk in the designated centre.

In the designated centre, practice was reflective of the guidance in the risk management policy, with any identified risk assessed, reviewed and controls put in place to alleviate or reduce them.

There was a system in place to record adverse events or incidents and good oversight arrangements in place to ensure patterns or trends were identified, along with actions taken to reduce the likelihood of incidents reoccurring. There was a pathway in place to escalate risk to senior management and the provider, if necessary.

Judgment: Compliant

Regulation 28: Fire precautions

The registered provider had ensured that there were effective fire safety management systems in place. There was a fire detection and alarm system in the designated centre, fire fighting equipment, emergency lighting, emergency exit lighting and fire containment measures. All equipment in place was checked and serviced by a relevant fire professional on a routine basis, and records of this were well maintained.

Staff had received training in fire safety, and this training was refreshed routinely. Evacuation drills were carried out at different times of the day and night to ensure all staff and residents could be safely evacuated in the event of an emergency.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The person in charge had improved the assessment tool that was used to assess residents' health, social and personal needs. There was a system in place to assess and plan for residents' needs and these documents were reviewed regularly. In general, where a need had been identified, there was a written personal plan in place outlining how each resident would be supported in relation to it.

Further improvement was required to ensure that assessments tools encompassed residents' needs in relation to nursing care support and input.

There was a lack of input from allied health professionals in the creation and review of support plans for residents with behaviour of concern, and where advice had been sought for some residents, this had not been included into written plans.

Improvement was required to clearly document and evidence progress being made on supporting residents to achieve their own goals and develop skills.

While care plans were regularly reviewed, this review did not determine the effectiveness of the plan itself and if it achieved the desired positive outcome for residents.

Judgment: Substantially compliant

Regulation 6: Health care

Residents were provided with appropriate health care as outlined in their personal plans.

Residents had access to their own General Practitioner along with access to allied health professionals through referral to the primary care team, or to allied health professionals made available by the provider.

Judgment: Compliant

Regulation 7: Positive behavioural support

The person in charge had ensured that staff had the knowledge and skills to respond to behaviour that is challenging, and to support residents to manage their own behaviour positively. Staff had received training in de-escalation and intervention techniques.

Restrictive interventions that were in place were well documented and reviewed regularly by the person in charge and the human rights committee.

The person in charge was continuing to self- assess the use of restrictive practices in the centre to further improve practice.

Residents that required support in relation to their behaviour had written support plans in place.

Judgment: Compliant

Regulation 8: Protection

Staff had received training in safeguarding residents and the prevention, detection and response to abuse.

The person in charge was aware of their responsibilities to investigate any safeguarding concerns, and how to report any suspicions, allegations or concerns in line with national policy.

Any safeguarding concern had been recorded, responded to and reported in line with best practice.

Resources available, and the manner in which the designated centre was operated was resulting in the promotion of residents' safety.

Judgment: Compliant

Regulation 9: Residents' rights

The designated centre was operated in a manner that was respectful of residents' rights. It was observed that interactions between residents and staff were warm, kind and person-specific.

Residents were encouraged to exercise choice and control in their daily lives, and the resources in place in the designated centre supported this.

Some residents living in the designated were reliant on members of the staff team to advocate on their behalf. Staff were aware of how to support residents in a person-focused manner, and information on an independent advocate was available should staff feel they could not advocate for residents for particular issues or concerns. Where restrictions were in place in the designated centre, this was referred to the internal human rights committee for review and scrutiny.

Residents' privacy and dignity were upheld in the designated centre. Each resident had their own bedroom and some residents chose to lock their rooms when they wanted time alone, or to demonstrate that they did not wish to take part in activities or appointments.

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 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	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 Villa Maria OSV-0001686

Inspection ID: MON-0024816

Date of inspection: 05/11/2019

Introduction and instruction

This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This document is divided into two sections:

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

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

A finding of:

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 23: Governance and management	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 23: Governance and management:</p> <p>The Provider acknowledges that Communal space for residents is limited. Business Plan has been submitted to HSE for Funding to do the required work. The Provider is unable to set a date for this work to be completed until confirmation of Funding is received from the HSE. This is currently in discussions with the HSE.</p> <p>In the interim additional space will be made available upstairs to facilitate some residents to have quiet time to relax alone under the supervision of staff. This will be completed by the end of the 31st March 2020.</p>	
Regulation 17: Premises	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 17: Premises: Adequate communal space for Residents to use kitchen facilities and decoration,</p> <p>The Provider acknowledges that Communal space for residents is limited. Business Plan has been submitted to HSE for Funding to do the required work. The Provider is unable to set a date for this work to be completed until confirmation of Funding is received from the HSE.</p> <p>In the interim additional space will be made available upstairs to facilitate some residents to have quiet time to relax alone under the supervision of staff. This will be completed by the end of the 31st March 2020.</p> <p>Adequate space for the storage of equipment, aids and other items</p>	

- The Provider has ensured adequate space and storage of personal equipment and aids by storing resident's equipment in their bedrooms whilst still providing sufficient space in each resident bedroom.
- All hallways are clear of any other equipment.
- Unused items have been removed. Completed 2nd December 2019.

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

- Individual assessments will be conducted to determine the type of staffing supports that residents require. 31st March 2020.
- Care plans will be reviewed and will show the effectiveness and the achieved outcome for the Residents. . 31st March 2020.
- A Clinical Psychologist reviewed six Positive Behavior Support Plans and directed the use of ABC charts to be included as part of the PBSP. This has been completed. Completed 4th December 2019.

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)(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.	Not Compliant	Orange	31/12/2025
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.	Substantially Compliant	Yellow	31/03/2025
Regulation 05(1)(b)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health,	Substantially Compliant	Yellow	31/03/2020

	personal and social care needs of each resident is carried out subsequently as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.			
Regulation 05(4)(a)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which reflects the resident's needs, as assessed in accordance with paragraph (1).	Substantially Compliant	Yellow	31/03/2020
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	31/03/2020
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	Substantially Compliant	Yellow	31/03/2020

	circumstances, which review shall assess the effectiveness of the plan.			
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