Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Office of the Chief Inspector

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

Name of designated centre:	Cork City North 5
Name of provider:	COPE Foundation
Address of centre:	Cork
Type of inspection:	Unannounced
Date of inspection:	27 February 2019
Centre ID:	OSV-0003291
Fieldwork ID:	MON-0023356

About the designated centre

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

The designated centre is located on the north side of Cork City.The designated centre comprises of three individual houses that are interlinked to form one designated centre. The service provided is reflective of a retirement home for males and females with intellectual disability who are advancing in age. Some residents live independently within the service, some attend activation and recreation services off site while some are in receipt of total nursing care within the centre. House 1 consists of a sitting room, a family room, a dining room, an art room, a kitchen, a sluice room, a nursing office, a utility room and an oratory. There are 9 single bedrooms and 1 double bedroom. It also has a basement floor comprising of one single bedroom, a water closet, a staff room, an activity room and a sluice room. House 2 consists of a sitting room, dining room, kitchen, multipurpose room and an office. It has 8 single bedrooms. House 3 has a sitting room, cleaning store, kitchen, office and 3 bathrooms. It has 7 single bedrooms.

The following information outlines some additional data on this centre.

Current registration end date:	04/01/2021
Number of residents on the date of inspection:	28

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 as amended. To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
27 February 2019	09:00hrs to 17:00hrs	Michael O'Sullivan	Lead

Views of people who use the service

The inspector met with 23 of the residents during the course of the inspection. Many residents were non verbal but appeared happy, well cared for and comfortable. Residents who did speak with the inspector stated that they were happy and that they liked their home and their friends. They also said that staff were very good and kind. This view was articulated by two relatives who spoke with the inspector. The facility, service and kindness of staff was mentioned in feedback.

Capacity and capability

Overall the inspector found that the registered provider and staff were responsive to the identified needs of each resident who had complex presentations relating to physical, mental health, intellectual disability and dementia. Staff were committed to promoting residents' independence, choice and voice as much as possible within the designated centre. The inspector found that residents were very comfortable with their surroundings and with staff.

The inspector found the service delivered a good standard of care to the residents. The inspector found that the governance and oversight arrangements in place supported the good standard of care delivered.

The inspector found that the capacity and capability of the provider to deliver a safe and quality service was supported by a management team and governance structure that included evidence of regular staff supervision, the full time employment of a person in charge, the delegation of operational responsibility to an on site clinical nurse manager. The person in charge was employed in a full time capacity and had direct access and supervision from the person participating in management. The person in charge had extensive knowledge and experience of both the disability sector and the residents within the service. Daily operational management was delegated and discharged through two clinical nurse managers. The clinical nurse manager present the day of inspection had extensive nursing experience, had additional qualifications specific to gerontology and had an indepth knowledge of all the residents. A clinical nurse manager had only recently departed the service and the provider was actively seeking to fill this vacancy.

The provider's statement of purpose was up to date and reflected the operation of the centre on the day of inspection. The details for the fire evacuation procedure in relation to the designated centre required inclusion in the statement of purpose. Minor alterations of floor plans were required to reflect current room designations.

The inspector met all staff that were on duty during the course of the inspection. All staff present were as per the planned roster for the designated centre. The staff comprised of one clinical nurse manager 1, four qualified nurses and two care assistants. Additionally, there was one full time member of staff employed in the kitchen and two student nurses on placement. External contractors provided cleaning services to the designated centre. Since the last inspection, the provider had employed a staff member in the role of activation. This person and the role had improved the availability of activities to residents and had enhanced activities that were structured and also provided additional meaning to the residents day. Of the 28 residents residing in the designated centre, three were attending day services and one was on an excursion to the city centre. Staff were observed to engage residents in foot massage, nail art and physical education while a volunteer provided music and singing which residents and their family members took an active part in. In light of the high dependency needs of the resident group, the registered provider required activation staff in addition to the existing staff resource employed for that purpose.

Mandatory training records for fire safety, safeguarding of residents and managing behaviours that challenge were reviewed by the inspector. Staff attendance at mandatory training was monitored and recorded and renewal of training dates were monitored within the service. Of the 42 staff listed as employed in the designated centre, 33% required updated training in managing behaviours that challenge as well as safeguarding residents. Fire and safety training refreshers were required by 12% of staff. Staff had also undertaken training in food safety and food hygiene, first responder and anaphylaxis, phlebotomy, medication management and venepuncture, feeding eating drinking swallowing which were all relevant to the presenting needs of residents. There were two registered nurses and three care assistants employed at night as listed on the roster.

The provider had undertaken an unannounced review / six-monthly audit of the service as well as an annual review on 12th November 2018. While the review was extensive, comprehensive and detailed, no actions or the persons responsible were recorded. While some matters had been addressed, staff informed the inspector that the findings were in dispute. In light of three months elapsing since the review, it was necessary for the provider to ensure the matters outstanding and disputed be addressed without further delay.The clinical nurse manager 1 had overseen staff conducted audits relating to individual care plans, continence, directory of residents, environmental, protected mealtimes, privacy and report writing.

All notifications of incidents arising per regulation 31 were notified to the Authority in a timely manner. Appropriate safeguarding actions were implemented by the provider. The provider had a volunteer policy in place, all volunteers were suitably subject to garda vetting and each volunteer had a written job and role description, with a supervisory framework in place.

A residents guide and an easy to read format of the complaints procedure was on display. The provider had a current and up to date detailed complaints policy also available. The designated centre had three separate complaint logs, one for each house. Very few complaints were recorded. Many residents were an only child of

parents now deceased. Some relatives who agreed to speak with the inspector were very complimentary of the staff, the care and the overall service provided to their family member. The current registration certificate was displayed in the main hallway as per regulatory requirements. The directory of residents was up to date and contained accurate information on the movement of residents between the designated centre and when in the care of their families / relatives.

Regulation 14: Persons in charge

The registered provider had in place a full time suitably experienced and qualified person in charge.

Judgment: Compliant

Regulation 15: Staffing

The registered provider ensured that the qualifications and skill mix of staff were appropriate to the assessed needs of some residents, however the greater proportion of residents could not leave the designated centre for recreation and occupation provision. The registered provider required activation staff in addition to the existing staff resource employed for that purpose. A clinical nurse manager vacancy was unfilled at the time of inspection.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Mandatory training as prescribed by the Authority in the areas of fire and safety and managing behaviours that challenge was required.

Judgment: Not compliant

Regulation 19: Directory of residents

The registered provider had in place a directory of residents that accurately reflected the information required for residents and those availing of respite services.

Judgment: Compliant

Regulation 23: Governance and management

The registered provider had management systems in place to ensure that the services were consistently and effectively monitored, however the findings of the annual review of the quality and safety of care remained un-actioned.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The registered provider had a statement of purpose in place that required updating in relation to the fire evacuation procedure.

Judgment: Substantially compliant

Regulation 30: Volunteers

The person in charge ensured that volunteers had current garda vetting, a written description of their roles and responsibilities as well as the necessary support and supervision.

Judgment: Compliant

Regulation 31: Notification of incidents

The person in charge had provided to the chief inspector notice in writing within 3 working days of all adverse incidents.

Judgment: Compliant

Regulation 34: Complaints procedure

The registered provider had in place an effective complaints procedure for residents

that was prominently displayed and in an easy to read format.

Judgment: Compliant

Quality and safety

The inspector observed that the quality and safety of the service provided to residents was of a good standard. The designated centre presented as bright and welcoming, was warm and clean. 22 residents had their own bedroom with adequate storage facilities. Six residents shared three twin rooms and one bedroom was available to respite residents. Residents were consulted in relation to room sharing.

There was adequate storage in bedrooms for personal items and clothing. Residents had personal effects on display in their bedroom and their living areas. Each resident could avail of a laundry service within the centre if they so wished and were supported by staff with this task. Some residents bedrooms required painting and upgrading due to normal wear and tear as did some of the floor coverings. These works were scheduled.

The centre layout promoted independence, privacy and individual space determined by residents ability. One resident was supported to live independently in a basement floor and had the freedom to come and go, which they did. There was good evidence on work done by staff to assist this resident make an informed decision regarding relocating to a community dwelling and the support and respect afforded to the resident when they decided to remain living in the designated centre.

The designated centre was separated into three distinct living areas depending on a residents assessed level of ability and vulnerability. The inspector observed a lot of meaningful engagement between residents and staff, all of which was respectful and person centred. Staff were observed to maintain a high level of resident supervision and safety through direct contact and proximity.

The fire evacuation plan for the centre reflected the nature of the service comprised of three interlinked buildings. This plan reflected the dependency needs of residents and was consistent with the personal emergency evacuation plan for each resident. The fire alarm panel and all fire detection systems were inspected and serviced by a registered contractor and in date. All fire extinguishers had been serviced, as was the water sprinkler system, emergency lighting, gas detection systems, door closures and fire blankets. All fire exits were clear and suitably labelled. Staff fire and safety training was in date but 12% of staff required updated training. Staff conducted and recorded fire evacuation drills by day which recorded 3 minutes as the total evacuation time. The inspector was assured with the existing staffing ratio in place, all residents could be evacuated safely by day. It was necessary for the provider to demonstrate that such an evacuation time could be replicated at times of lower staffing numbers. The services fire and safety policy of 2016 and the fire

evacuation notices on walls differed. Fire assembly points for notices and for each residents personal emergency evacuation plan, were blank.

Each resident had an individual care plan and personal plan in place. This included current risk assessments and multi-element behavioural support plans. It was evident that the action plans and personal plans for residents were not always linked. Due to residents current capacity to make their wishes and goals known, this area required greater support from key staff. Documents were not always in date and goals were repeated and brought forward without evidence of review. While staff had gone to great lengths to support a resident choose to remain living in the designated centre, the goals set by the resident to have their bedroom redecorated and toilet facilities upgraded had remained unrealised since 2016. The inspector was informed that the request had failed to pass at annual budgetary meetings. The provider was in the process of implementing new templates and paperwork to improve overall care planning. While this paperwork was in place, in many instances it was blank.

Residents had healthcare plans in place, however, pertinent health information did not relate back to the residents individual care plan. Some residents had hospital passports that did not contain documented diagnosed conditions. Some residents had very exact details of vital signs and observations that were recorded, however, some did not. While some residents were awaiting falls assessments, there was no documentary evidence to demonstrate the plans or actions to be undertaken by staff in the intervening period. Residents were subject to an internal waiting list of three to six months for allied health professional assessment.

The residents' guide was in place and available on the day of inspection. The updated guide was available to the residents and the inspector. The guide was easy-to-read and provided a clear summary of the choices for residents. Each resident had a contract in place with the terms and conditions relating to their residency. This was signed by the resident or their representative.

Each resident had access to a television in their living area with access to multiple channels. Residents were assisted to use telephones and the internet with staff assistance. Food was prepared centrally on campus and distributed in thermal boxes to a smaller kitchen within each house. One kitchen had been recently extensively renovated through the financial assistance of donations. Food was observed to be varied, balanced and nutritious. Food times were protected times and residents were observed to eat or be assisted to eat at their own pace with staff in attendance.

Infection control measures within the centre were to a good standard and hand sanitation solution was available throughout the unit. The provider had an open visiting policy in place and families indicated to the inspector that they were made very welcome by staff who would often give them a lift home afterwards.

The risk management policy was in date. The risk register was up-to-date and subject to regular review. Restrictive practices in the form of environmental and physical controls were recorded in a restrictive practices log dated September 2018 and subject to review. There was evidence that the least restrictive form of practice

was employed by staff and that restrictive practices were as recorded. Staff had received training in the safeguarding and protection of residents, however 33% of staff required updated training. Each resident had an intimate care plan in line with the providers intimate care policy.

The person in charge ensured that the designated centre had appropriate and suitable practices in place relating to the ordering, receipt, prescribing, storage and administration of medicines. Medication was stored securely in individual medication trolleys, cupboards and secure refrigerators. Opened, in use bottles, contained a date of opening.

Regulation 11: Visits

The registered provider facilitated residents to receive visitors and there were suitable private areas for that purpose.

Judgment: Compliant

Regulation 12: Personal possessions

The person in charge ensured that residents had access to their own personal property and residents had furnished and decorated their own bedrooms.

Judgment: Compliant

Regulation 13: General welfare and development

The registered provider ensured that each resident had the appropriate care and support based on their assessed needs and wishes.

Judgment: Compliant

Regulation 17: Premises

The registered provider ensured that the designated centre was designed to meet

the needs of residents.

Judgment: Compliant

Regulation 18: Food and nutrition

The person in charge ensured that each resident had adequate food and drink that was properly and safely prepared, wholesome and nutritious.

Judgment: Compliant

Regulation 26: Risk management procedures

The registered provider ensured that there were systems in place for the assessment, management and ongoing review of risk in the designated centre.

Judgment: Compliant

Regulation 28: Fire precautions

The registered provider had adequate fire safety systems in place, however all fire evacuation instructions needed to be consistent and to state the designated assembly point. Fire drills needed to reflect drills undertaken at times of minimum staffing levels.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

The person in charge ensured that the designated centre had appropriate and suitable practices relating to the ordering, receipt, prescribing, storage, disposal and administration of medicines.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

While the person in charge ensured that residents' individual care plans were updated, many required greater detail relating to goal reviews that demonstrated a proper review.

Judgment: Substantially compliant

Regulation 6: Health care

The registered provider provided appropriate healthcare to each resident, however there were gaps in information recorded and significant waiting times for some allied health professionals.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

The registered provider ensured that restrictive practices were for the shortest duration possible and were always the least restrictive means.

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
Views of people who use the service	
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Not compliant
Regulation 19: Directory of residents	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 30: Volunteers	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Compliant
Regulation 18: Food and nutrition	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Substantially compliant
Regulation 7: Positive behavioural support	Compliant

Compliance Plan for Cork City North 5 OSV-0003291

Inspection ID: MON-0023356

Date of inspection: 27/02/2019

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 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: A review of current staffing levels will be completed with PPIM and HR. An activation role will be identified through the current staffing allocation once the review has been completed	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: Fire (Annual) – 3 staff currently require Fire Training – Dates booked for 01/05, 06/06. Safeguarding every 3 Years – 100% compliant Manual Handling every 2 years – 22% non-compliant Dates booked for 21/03/2019, 26/03/2019, 11/04/2019, 23/04/2019, 21/05/2019, 28/05/2019, 18/06/2019, 25/06/2019 CFR (Non Mandatory) - 21 staff due training, courses will run Mon-Fri 20/05/2019, 22/07/2019, 16/09/2019, 18/11/2019 all 21 staff have dates booked MAPA every 2 Years - 21 staff due training .Training needs arranged for 10 with places booked with available dates.20/03/2019, 28/3/2019, 29/03/2019, 10/04/2019, 22/05/2019,17/07/2019, 21/08/2019, 18/09/2019, 23/10/2019, 20/11/2019, 04/12/2019.	

Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The Action plan from the annual review was completed by the person in charge. The action plan continues to be implemented within the centre.	
Regulation 3: Statement of purpose	Substantially Compliant
Outline how you are going to come into compliance with Regulation 3: Statement of purpose: The Fire Evacuation procedure has been updated in the SOP.	
Regulation 28: Fire precautions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: A fire evacuation drill with minimum staff levels took place on the 11/04/2019 at 07:45hrs. Another Fire evacuation drill with minimum numbers staff levels is scheduled for 18/04/2019 07:45hrs. All personal evacuation plans have been updated and now include a picture and descriptions of the fire assemble point.	
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:	

An audit was completed to assess the goal reviews / Keyworker meetings. In line with nursing metrics a review of the care plan content was completed. A keyworker meeting was held with ALL staff on the 12/04/2019, 15/04/2019 and 16/04/2019. The meetings identified to staff their role in ensuring keyworker documentation, goal review sheets and meaningful moments / butterfly moments are completed with residents. A comprehensive audit was completed to guide staff when they are completing or updating documentation within care plans. This was presented at the meetings. A detail of the keyworker role and responsibilities was also completed.

Regulation 6: Health care	Substantially Compliant
Outline how you are going to come into compliance with Regulation 6: Health care: An audit of referrals to multi-d team professionals has commenced by the person in charge and clinical nurse manager 1. A scheduled meeting will be held with the PPIM and individual MDT discipline present.	

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.	Substantially Compliant	Yellow	27/05/2019
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.	Not Compliant	Orange	08/04/2019
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre	Substantially Compliant	Yellow	08/04/2019

	is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.			
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 care and support.	Substantially Compliant	Yellow	17/12/2019
Regulation 28(4)(a)	The registered provider shall make arrangements for staff to receive suitable training in fire prevention, emergency procedures, building layout and escape routes, location of fire alarm call points and first aid fire fighting equipment, fire	Substantially Compliant	Yellow	05/04/2019

	control techniques and arrangements for the evacuation of residents.			
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	18/04/2019
Regulation 28(5)	The person in charge shall ensure that the procedures to be followed in the event of fire are displayed in a prominent place and/or are readily available as appropriate in the designated centre.	Substantially Compliant	Yellow	05/04/2019
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	15/04/2019
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	07/06/2019

	circumstances, which review shall assess the effectiveness of the plan.			
Regulation 05(7)(a)	The recommendations arising out of a review carried out pursuant to paragraph (6) shall be recorded and shall include any proposed changes to the personal plan.	Substantially Compliant	Yellow	07/06/2019
Regulation 05(7)(b)	The recommendations arising out of a review carried out pursuant to paragraph (6) shall be recorded and shall include the rationale for any such proposed changes.	Substantially Compliant	Yellow	07/06/2019
Regulation 05(7)(c)	The recommendations arising out of a review carried out pursuant to paragraph (6) shall be recorded and shall include the names of those responsible for pursuing objectives in the plan within agreed timescales.	Substantially Compliant	Yellow	07/06/2019
Regulation 06(1)	The registered provider shall provide appropriate health care for each resident, having regard to that resident's personal plan.	Substantially Compliant	Yellow	07/06/2019

Regulation 06(2)(d)	The person in charge shall ensure that when a resident requires services provided by allied health professionals, access to such services is provided by the registered provider or by arrangement with the Executive.	Substantially Compliant	Yellow	31/05/2019