Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	Broadleaf Manor
Name of provider:	Nua Healthcare Services Limited
Address of centre:	Kildare
Type of inspection:	Short Notice Announced
Date of inspection:	24 September 2020
Centre ID:	OSV-0003397
Fieldwork ID:	MON-0030135

About the designated centre

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

Broadleaf Manor is a large detached residence located in a rural setting close to a small village in Co. Kildare. The property is subdivided into six separate living areas, four of which are self-contained apartments. The property is homely, well maintained, spacious and clean. The centre provides care and support to both male and female adults, all of whom require support around their mental health needs. The provider has supplied a number of vehicles in order to transport residents to their day services and to access local amenities. Residents are support by the staff team 24 hours a day seven days a week in line with their assessed needs. The staff team comprises of a person in charge, team leaders, deputy team leaders, social care workers and assistant social care workers. Residents have access to a range of allied health professionals in line with their assessed needs.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	7

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Thursday 24 September 2020	11:00hrs to 16:50hrs	Marie Byrne	Lead

What residents told us and what inspectors observed

There were seven residents living in the designated centre on the day of the inspection. During the inspection, the inspector briefly met one resident and observed as they interacted with a staff member and the person in charge. They excitedly told the person in charge about a recent shopping trip and showed them the items they had purchased. They discussed how much the items cost and what a bargain they were, and then counted how many items they had purchased, and then counted the money left in their wallet. They talked about celebrating a big birthday last year and how much they enjoyed their party. They told staff members that it was only three months until Christmas, which was also close to their birthday. They looked at photos on the wall of past events which were important to them, and they discussed how they were planning upcoming events. They also talked about recent improvements in their apartment such, the window in the kitchen being fixed and getting a new cooker. Throughout the visit to their apartment, the resident appeared happy and comfortable, and they were engaging positively with the staff member and the person in charge.

The inspector reviewed seven questionnaires about the care and support in the centre, which residents had completed, or were supported by staff to complete, prior to the inspection. The majority of responses in these questionnaires were positive, with the majority of residents indicating they were happy, comfortable and safe in the centre. The majority of residents indicated in the questionnaires that they were happy with the food and mealtimes, visiting arrangements, and the supports they received to achieve their goals. All residents indicated they were happy with the amount of choice they had about how they spent their time, the care and support they received, the amount of privacy they had, how they were respected, and how their dignity was protected whilst living in the centre. Overall, residents were complimentary towards the staff team, with two residents indicating they were happy with the support of most of the staff. Some residents described staff as kind, helpful and amazing. One resident stated in the questionnaire that they were particularly happy when staff who were familiar to them and who knew their plans and appointments, were supporting them.

A number of residents identified areas for improvement in the designated centre such as; the food in the centre, the levels of comfort and warmth, access to the garden, and fencing in one of the gardens. Two residents indicated that they would like to move from the centre in the future, with one resident indicating their wish to move to independent living. Residents indicated they were aware of the complaints process, with a number of them indicating they were happy with how their complaints had been dealt with in the past.

In the questionnaires residents described their favourite things to do, such as; dancing, listening to music, going for coffee and walks, spending time in the games room, tennis, cycling, going to the gym, attending day services, attending work, and

going shopping.

A number of residents were engaging in activities in the community with the support of staff during the inspection. At the end of the inspection, the inspector observed one resident returning to the centre with the support of two staff members. They appeared happy to be home and with the support offered by staff members.

Capacity and capability

Overall, the registered provider and person in charge had systems in place for the oversight and monitoring of the quality of care and support for residents. There was evidence that the provider was identifying areas for improvement in their audits and reviews in the centre, and that they were developing plans to bring about the required improvements.

This inspection was completed following receipt of a number of notifications relating to allegations of abuse and the use of restrictive practices, from the designated centre. Prior to the inspection, a provider assurance report was issued in relation to a number of these notifications. In this provider assurance report, the provider identified a number of areas for improvements and included an action plan to bring about these improvements within a specified timeframe. These improvements included, supporting residents to develop their knowledge, self awareness and understanding and skills needed for self-care and protection. They also included the requirement for staff to complete safeguarding refresher training, and for reviews relating to residents' care and support including their medication routines and day service placements. Following a review of documentation and discussions with the person in charge, the inspector found that all of the actions outlined in the provider's assurance report, had been implemented.

There was a clearly defined management systems and structures in place in the designated centre. Staff had specific roles and responsibilities in relation to the day-to-day running of the centre, and the reporting structures within the organisation were clear in relation to authority and accountability. The provider had completed an annual review, and was completing six monthly reviews of care and support for residents in the centre. These reviews were identifying areas of good practice, as well as areas for improvement. The majority of the actions from these reviews were being completed in line with the timeframes identified by the provider. However, a number of actions had not been completed and these related to the review and update of documentation. The provider was consulting with residents and their representatives in relation to the quality of care and support for the centre. For example, they were sending out satisfaction surveys. The inspector viewed one of these surveys, which indicated that the resident who completed it was happy living in the centre, felt safe and loved the centre. The provider had not included the findings of these surveys or other engagements with residents and their representatives in their annual review.

A new person in charge had commenced in post since the last inspection. They had been working in the centre for a number of years prior to taking up this post and were very familiar with residents' needs and the systems to monitor the quality of care and support for residents. They had systems in place to identify areas for improvement such as audits and were implementing the required actions from the providers audits and reviews, to bring about positive outcomes for residents in relation to their environment and their care and support. They were working full-time and had the qualifications and experience to fulfill the role. They were supported by a director of operations (DOO) who was meeting with them and visiting the centre regularly. The person in charge was completing a monthly report and submitting this to the DOO. This report reviewed notifications and safeguarding concerns, medication errors, the use of restrictive practices, accidents and incidents, and staff turnover. This document was identifying trends and then actions were developed to ensure that control measures were identified and implemented to reduce the occurrence of accidents and incidents. They were also used to identify any increase in the use of restrictive practices and then leading to review meetings to ensure the least restrictive measures were used for the shortest duration.

Staff meetings were occurring regularly and the agenda items were found to be residents focused. There were discussions relating to the day-to-day running of the centre such as a review of; incidents, accidents, learning following incidents, safeguarding, health and safety, audits, policies and procedures and admissions. COVID-19, the use of PPE, hand washing, cough and sneeze etiquette, and visiting were also regularly discussed during recent staff meetings. In addition, there was a daily handover meeting where discussions were held in relation to residents' care and support needs, and staff members roles and responsibilities for the day. During handover meetings accidents, incidents and safeguarding concerns and plans were discussed, as was learning following these events. There was also discussions and opportunities for staff to practice de-escalation and intervention techniques detailed in residents' support plans.

There were no staffing vacancies in the centre at the time of the inspection. There was a regular relief panel available to cover the required shifts in the event of staff's planned or unplanned leave. There were contingency plans in place for staffing in the event that staff needed to isolate during the pandemic. Through discussions with staff, a review of rosters, audits and staff records, it was evident that there was good continuity of care for residents. A sample of rosters reviewed, showed that all the required shifts were covered during the period reviewed. During the inspection, the inspector observed staff engaging with residents in a supportive and respectful manner. Residents appeared comfortable in the presence of staff and with the levels of support offered to them.

Residents were protected by the complaints policies, procedures and practices in the centre. There was a complaints and compliments log maintained and each resident had a complaints log in their personal plan. Residents also had an accessible version of the complaints process and form available to them in their personal plan. The complaints policy contained information in relation to the complaints procedure, the nominated complaints officers, accessing advocacy services, the appeals process and independent reviews by the Ombudsman. The complaints form allowed for the

satisfaction level of the complainant to be captured and for details of all actions taken as a result of the complaint to be captured. Complaints were discussed monthly with each resident during their keyworker sessions and at weekly residents' meetings. The inspector reviewed a sample of complaints and there was evidence that they had been recorded and followed up on in line with the organisation's policy. They had been referred to the complaints officer, who had replied to the complainants. The satisfaction level of the complainants were recorded on the complaints forms and in the complaints logs.

Regulation 14: Persons in charge

There was a full time person in charge who had the qualifications, skills and experience to manage the centre. They were familiar with residents' care and support needs and had systems in place to ensure they were monitoring the quality and safety of care for residents.

Judgment: Compliant

Regulation 15: Staffing

There were the right number of staff to meet the assessed needs of residents in line with the centre's statement of purpose.

The provider had reviewed the skill mix in the centre and identified the need to provide additional nursing support in the centre. They had then recruited and filled this nursing post.

Rosters were well maintained and showing evidence of continuity of care for residents.

Judgment: Compliant

Regulation 23: Governance and management

The centre was resourced to ensure effective delivery of care and support for residents.

The provider had systems in place to monitor the quality of care and support for residents including regular audits, an annual review and six monthly visits by the provider or their representative. These reviews were identifying areas for improvement and the majority of these actions were being followed up on and

leading to improvements for residents, both in their home and in their care and support.

The provider was consulting with residents and their representatives in relation to the annual review of the centre. However, they did not include details of these consultations in the annual review.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

The Chief Inspector was given notice in writing of incidents occurring in the centre in line with the requirements of the Regulations.

Judgment: Compliant

Regulation 34: Complaints procedure

Residents were protected by the complaints and compliments policy and procedure in the centre.

There was information available and on display in the centre, in relation to the complaints process, the complaints officers and accessing advocacy services.

A sample of complaints reviewed had been investigated and the measures required for improvement recorded. The complainant was informed of the outcome of the complaint, and their satisfaction level was recorded. The appeals process was detailed in the centre's policy.

Judgment: Compliant

Quality and safety

The provider had systems in place to monitor the quality of care and support for residents and through a review of documentation and discussions with staff it was evident that residents were in receipt of a good quality and safe service. Staff who spoke with the inspector were motivated to ensure residents were safe and supported to make choices in relation to their day-to-day lives. The provider was identifying areas to further improve residents' lived experience in the centre. For example, in the latest annual review they identified a need to support residents to

get involved in decorating the house and garden in line with their likes and preferences. Other actions related to working with residents to reduce restrictive practices, and to improve documentation such as care plans and healthcare plans.

Residents were protected by the risk management polices, procedures and practices in the centre. There was a risk register and general and individual risk assessments were developed as required. There were systems in place for recording, investigating and learning from serious incidents and adverse events. These were discussed at staff meetings and during daily handover. The monthly reports completed by the person in charge and sent to the DOO, were being used to track and trend incidents and the use of restrictive practices in the centre. Following this controls were developed and implemented and the inspector viewed evidence of learning and follow up from these reviews.

During the inspection, the premises was found to be clean. There were cleaning schedules in place, which had been adapted in line with COVID-19. Staff's responsibilities were outlined at handover and cleaning was regularly discussed at staff meetings. Accessible information was available for residents in relation to COVID-19 and infection prevention and control. The provider had developed policies, procedures, guidelines and contingency plans for use during the pandemic. They had also updated existing polices, procedures and guidelines. There had systems for ensuring adequate supplies of PPE were available at all times and staff had completed additional training in relation to infection prevention and control including hand hygiene training and training relating to the use of PPE.

There were a large number of restrictive practices in place in the centre. Residents' individual risk management plans, personal plans and multi-element behaviour support plans were detailed in relation to the use of restrictive practices. Restrictive practices were also detailed in the restrictive practice register. There were regular meetings held to review the use of restrictions in the centre. These reviews included, a review of the rationale for the restrictions, and details of the considerations given to the use of the least restrictive practices for the shortest duration. In line with the centre's annual review, there were plans in place to reduce and eliminate some restrictions in the centre.

Incident reviews and trending were completed and used to inform changes to residents' support plans. Residents had access to allied health professionals and multi-element behaviour support plans were developed and reviewed as required. A behaviour specialist was available to support residents and staff. They were meeting with residents and staff regularly and using information gathered to amend residents' support plans to ensure they were effective and clearly guiding staff to support residents. Staff who spoke with the inspector were knowledgeable in relation to residents' support plans. Staff had access to training to support residents and area specific training was facilitated as required.

From reviewing documentation and speaking with staff, it was evident that residents were being supported to develop and achieve their goals. These goals were being regularly evaluated and updated. This was then leading to the development of new goals. Residents were being supported to have meaningful experiences and to

develop and maintain friendships and relationships. Each resident had an assessment of need and a personal plan which outlined their care and support needs. However, some residents' assessments and care plans required review to ensure they were consistent and reflective of residents' care and support needs. The inspector found that these gaps in documentation were not leading to a high risk for residents but required review to ensure they were consistent and accurate.

Overall, residents were being supported to enjoy best possible health. Systems were in place to ensure residents could be supported to access a general practitioner and other allied health professionals during the pandemic. They had assessments in place and care plans were developed as required. A number of residents' assessments and plans required review to ensure they were accurate and reflective of residents' current assessed needs. For example, in a number of residents' assessments it did not identify that they has a specific healthcare concern or condition, but they had care plans in place for these conditions. In addition, a number of residents' assessment of need had conflicting information to that in their personal plan and care plans. Residents were being supported to access National Screening Programmes in line with their age profile and wishes, but the system in place to record how residents were supported to make decisions in relation to accessing these services, required review.

Residents were protected by the policies, procedures and practices relating to safeguarding and protection in the centre. Residents had detailed intimate care plans in place and allegations or suspicions of abuse were reported and escalated in line with requirements of the organisation's and national policy. There was a safeguarding register in place which was regularly reviewed by the management team. Safeguarding plans were developed and implemented as required. From reviewing documentation relating to allegations of abuse in the centre it was evident that the provider and the staff team were responding appropriately to these allegations and completing the required actions to keep residents safe while investigating them.

There had been an increase in the number of allegations of abuse in the centre over a number of months. From reviewing the documentation associated with these allegations, most of them once screened by the designated officer, were returning with no grounds for concern. The provider had recognised this trend and was reviewing the centre specific safeguarding plan regularly. In addition, a number of residents' individual risk management plans and support plans had been updated to clearly guide staff in relation to what to do in the event of an allegation of abuse. In addition, protocols had been developed in a number of residents' personal plans to clearly guide staff what to do and how to support residents should they disclose and allegation of abuse. A number of residents had been supported to develop their knowledge in relation to safeguarding and protection. This was facilitated through educational sessions for residents, discussions at keyworker sessions and residents' meetings. In addition the designated officer and complaints officers had made themselves available to meet and speak to residents. In addition, additional area specific safeguarding training had been provided for staff in August.

Residents were being supported to make decisions in relation to their care and

support and in relation to the day-to-day running of the centre. Choice and menu boards were available to support residents to make these choices. Residents were meeting with their keyworkers regularly. A number of documents were available for residents in a format accessible to them, such as; the complaints procedures, information relating to advocacy services, information relating to residents' rights and information relating to COVID-19. Posters were available in relation to hand washing, cough and sneezing etiquette. A number of residents were accessing independent advocates.

Regulation 26: Risk management procedures

Residents were protected by the risk management polices, procedures and practices in the centre.

The risk policy contained the information required by the Regulations. There were arrangements in place to identify, record, investigate and learn from incidents and systems in place for responding to emergencies.

Judgment: Compliant

Regulation 27: Protection against infection

The provider was ensuring that residents who may be at risk of healthcare associate infections were being protected.

They had developed COVID-19 contingency plans, and risk assessments were developed and reviewed as required.

The centre was found to be clean during the inspection and there were cleaning schedules in place to guide staff in relation to their daily duties.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

Each resident had an assessment of need and personal plan in place. Overall, residents' assessments clearly recognised and identified their health, personal and social care needs. However, a number required review to ensure they were consistent, accurate and reflective of residents' care and support needs.

The inspector found that staff were familiar with residents' needs and that gaps in

documentation were not leading to high risks for residents.

Judgment: Substantially compliant

Regulation 6: Health care

Overall, residents were supported to enjoy best possible health. Residents' healthcare needs were assessed and care plans were developed as required.

However, a number of residents' assessments and care plans required review to ensure they were consistent and reflective of residents' needs. These gaps in documentation were not found to be contributing to a significant risk for residents but required review to ensure they were consistent and accurate.

Staff who spoke with the inspector were knowledgeable in relation to residents' assessed needs.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

Residents had support plans developed and reviewed as necessary and had access to the support of allied health professionals in line with their assessed needs.

Staff had completed training to support residents and staff who spoke with the inspector were knowledgeable in relation to residents' support needs.

Restrictive practices were reviewed regularly to ensure the least restrictive measures were used for the shortest duration. Plans were in place to further reduce or eliminate some restrictive practices in the centre.

Judgment: Compliant

Regulation 8: Protection

Residents were protected by the policies, procedures and practices relating to safeguarding residents.

Staff had completed training and those who spoke with the inspector were familiar with their roles and responsibilities in relation to reporting and escalating allegations

or suspicions of abuse in line with the organisation's and national policy.

In line with an increase of allegations of abuse in the centre, residents had been supported to increase their knowledge, self-awareness and understanding in relation to self-care and protection. A number were being supported by allied health professionals in line with their changing needs. In addition, staff had completed additional safeguarding training, and there had been a review of a number of documents in the centre.

Judgment: Compliant

Regulation 9: Residents' rights

Residents' meetings and keyworker sessions were occurring regularly in the centre. There was evidence that residents were participating in the day-to-day management of the centre and making choices in relation to how they wished to spend their day.

Information was available in relation to advocacy services should residents wish to access them. A number of residents were accessing the support of independent advocates.

Residents were kept up to date in relation to the pandemic in a format accessible to them.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 as amended and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Substantially compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Broadleaf Manor OSV-0003397

Inspection ID: MON-0030135

Date of inspection: 24/09/2020

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
Outline how you are going to come into compliance with Regulation 23: Governance and management: 1. Annual Review for the Designated Centre will be reviewed and updated by the Person in Charge and shall include consultation with the Resident and their Representatives. 2. An updated 'Easy Read Version' of the Designated Centre's Annual Review will be made available to all residents.	
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: 1. The Person in Charge shall review all Resident's Comprehensive Needs Assessments and Personal Plans to ensure that they are consistent, accurate and reflective of the Residents' care and support needs. 2. All updated Personal Plans shall be communicated to Staff at the Monthly Team Meeting which will take place on 26 November 2020.	

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
1. The Person in Charge shall review all Resident's Comprehensive Needs Assessments and Personal Plans to ensure that appropriate health care supports are reflective of their assessed needs.

2. All updated Personal Plans shall be communicated to Staff at the Monthly Team Meeting which will take place on 26 November 2020

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 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Substantially Compliant	Yellow	30/10/2020
Regulation 23(1)(e)	The registered provider shall ensure that the review referred to in subparagraph (d) shall provide for consultation with residents and their representatives.	Substantially Compliant	Yellow	30/10/2020
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	30/10/2020

	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	30/10/2020
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 circumstances, which review shall assess the effectiveness of the plan.	Substantially Compliant	Yellow	30/10/2020
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	30/10/2020