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:	Arranmore
Name of provider:	St John of God Community Services Company Limited By Guarantee
Address of centre:	Dublin 8
Type of inspection:	Announced
Date of inspection:	19 February 2020
Centre ID:	OSV-0003591
Fieldwork ID:	MON-0022967

About the designated centre

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

The designated centre is operated by St. John of God services and is situated on a campus based setting in South Dublin. It is a large one storey property that provides residential services for a maximum of 13 residents. There is one dining area, kitchen, 13 bedrooms, a staff office, a medication room, a family room and a TV lounge. There are two accessible bathrooms, two shower rooms and two toilets. There is a small grassy and paved area to the back of the building where residents, staff and family members can sit. There is also access to a swimming pool, day services, an oratory, gymnasium and multisensory room located on the campus. Residents are supported 24/7 by nursing staff, healthcare assistants and social care workers. Resident's have access to multidisciplinary supports in the organisation such as; social workers, physiotherapists, occupational therapists, speech and language and psychology, as required.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	12

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
Wednesday 19 February 2020	09:00hrs to 19:00hrs	Sarah Mockler	Lead

What residents told us and what inspectors observed

The inspector had the opportunity to meet and spend a brief period of time with six of the 12 residents currently residing in the centre. Residents used a range of communication styles from verbal communication, to using gestures and facial expressions to indicate and express their needs. On arrival to the centre on the morning of inspection, a number of residents were getting ready to go to their day service. Staff were observed to assist residents with feeding and putting on suitable outside clothes. Interactions at this time were noted to be patient and kind. Residents were observed to smile towards staff and look towards the staff when they spoke to them. Residents who spoke with the inspector stated they were happy and felt safe.They were familiar with the staff providing care and readily requested that their needs were met.

Documentation review and staff discussions were also utilised to ascertain residents' views on the service that was being provided. The six monthly unannounced visit reports completed by the provider, contained a section around views of residents and their families or representatives. The views expressed in these reports indicated that families were happy with many aspects of care, however improvements were required around access to community and activities for residents. Staff spoken with stated that residents were well cared for and were happy in their home.

Capacity and capability

The inspector found that the registered provider and the person in charge were effective in assuring a safe service was provided to the residents. Improvements were required across a number of regulations to ensure that a quality driven service was maintained. The inspection established that improvements were required in staffing, training and development, and the improved managerial oversight and monitoring.

Historically, there had been a period of substantial management changes in this designated centre. Although, now there was a clear management structure in place with clear lines of accountability, there had been recent change to the person in charge of this centre in the last year. A new person in charge was appointed in the last quarter of 2019 and replaced a person in charge that had been in the role for approximately nine months. The person in charge reported to the residential coordinator who in turn reported to the programme manager. The person in charge was a clinical nurse manager (CNM2) and spoke about the comprehensive handover

that had been completed with them to help them settle into the role effectively.

The provider had been carrying out annual reviews and unannounced visits for this designated centre as required by the regulations. These reviews were identifying areas of improvement in the service. However, there was no action plan in place to address the required areas of improvement. The actions identified in the unannounced visit report in June 2019 and Dec 2019 had not been placed on the provider's Quality Improvement Plan (QEP). The timeliness of adding actions to the QEP was identified by the provider in June 2019 unannounced report however, this still had not been rectified. Therefore, actions identified in the June 2019 unannounced report were also evident in the December 2019 report indicating a lack of timeliness in addressing identified issues. These reviews were not driving areas of improvement in the service.

On the day of inspection there was a full staffing compliment. Residents were supported by nurses, care assistants and social care workers. The inspector found that the skill mix and number of staff was appropriate to meet the residents' needs. There was an actual and planned rota in place. However, improvements were required to address the continuity of staffing within the centre. Although there was a regular relief panel of staff utilised to cover staff absences, there was no such panel to replace nursing staff when absent. The provider relied on agency staff to cover such absences. The system in place to cover staff vacancies meant that the person in charge was given at times, minimal notice, of who was coming on duty to cover staff absences. There were no systems in place to ensure that familiar agency staff were utilised. This meant that induction for agency staff into the service was required on a frequent basis which in turn impacted the time other staff members had to care for residents or perform other duties. In addition to this some residents plans stated that continuity of care in the form of familiar staff was essential. This could not always be guaranteed.

Schedule 2 documentation was reviewed by the inspector. A requirement of the regulations is that the person in charge has access to this documentation. When the inspector requested this information from the person in charge on the day of inspection, they did not have access to this for the agency staff on duty that day. This information was provided at later time by the residential coordinator. The systems in place in relation to the person in charge accessing this information required improvement.

The majority of staff had received the necessary training to deliver safe and evidence based care, to ensure this training was kept up-to-date staff also completed refresher training as required. Recently the service was now providing home cooked meals from the kitchen in the centre, this was a very positive change as previous to this meals were provided to residents from a centralised kitchen that was not located in the designated centre. However, not all staff had completed the necessary training in relation to this. A supervision schedule of 2020 had been devised by the person in charge and the majority of staff had completed one formal supervision session in the new calendar year. Staff spoken with stated they felt supported in their role, both formally and informally.

Registration Regulation 7: Changes to information supplied for registration purposes

The inspector identified that some outstanding information required from the provider for change of person in charge in line with registration requirements had not been submitted in a timely manner.

Judgment: Substantially compliant

Regulation 15: Staffing

An appropriate number and skill mix of staff was available to support residents. Nursing staff was available in line with the provider's statement of purpose. Planned and actual rosters were maintained. Continuity of staffing required improvement as there was a reliance on agency staff to provide nursing care to cover nursing staff absences. In addition to this the systems in place for access to Schedule 2 documentation required improvements.

Judgment: Not compliant

Regulation 16: Training and staff development

Arrangements were in place to staff to receive both formal and informal supervision. Training was provided in a wide range of areas, however, some staff still needed to complete mandatory training in one area.

Judgment: Substantially compliant

Regulation 22: Insurance

The centre was insured against accidents or injury to residents.

Judgment: Compliant

Regulation 23: Governance and management

Management systems were in place to ensure that the service provided was safe and appropriate to residents' needs. However, the monitoring and oversight of identified actions from reviews by the provider required improvements. Actions identified from unannounced provider visits, to drive improvements in service provision, had not been placed on the provider's quality improvement plan. This resulted in many actions not been completed in a timely manner.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The statement of purpose was amended and sent to the inspector following the inspection. The amended statement of purpose contained the required information as set out in the regulations.

Judgment: Compliant

Quality and safety

Overall, the inspector found that the person in charge and provider were aiming to provide a quality based, safe service. Residents appeared happy on the day of inspection and there was evidence of good care being provided.
However, improvements were required across a number of regulations to ensure that a quality driven service was being maintained. Improvements were required in relation residents accessing the community and activities, premises, individual personal plans, healthcare plans and fire drills.

The premises was a very large bungalow located within the St. John of God service. On arrival to the front door the area was well maintained with fresh flower beds and pots on display. The inspector completed a walk around of the premises and it was found to be very clean. The inspector was invited to view one of the residents bedroom. They had many personalised items on display and it was evident that the room was individualised. Paintwork was required in a number of areas in the building, such as bathrooms and residents' bedrooms.

A sample of residents' personal plans were reviewed. There were assessments in place to identify the individual health, personal and social care needs of the residents. There was an associated plan of care. Keyworkers identified social care needs and goals with consultation from the resident. However, the identification of these goals required improvements. For example in one resident's plan three goals were chosen which were similarly defined so the range and effectiveness of these goals was limited. Also, there was limited evidence that the personal plan was

subject to an annual review where by the resident and their representative were consulted. This had been identified by the provider in their unannounced visit in December 2019.

There was some evidence of residents accessing their community, maintaining family contact and engaging in meaningful activities such as going swimming, day trips to relevant places of interest, and access to activities in the community. A number of residents access to community and activities required significant improvements. Recently two residents were unable to leave the designated centre in the last three to five weeks due to accessibility issues. In addition to this, the provider had identified access to a range of activities as an issue and stated the the range of activities needed to be broadened to offer more choice and wider service experience. Families had also identified this as an area of improvement.

Nursing care was provided on a daily basis to the residents in line with some complex assessed needs. A sample of healthcare plans were reviewed and although the majority guided staff practice effectively there was areas of improvement identified. There was some evidence of health care plans not being updated to reflect changing needs in terms of allied professional access. Also, some recent visits to allied professionals and subsequent recommendations had not been documented in the personal plans. Currently the gaps in the documentation had not impacted on the residents but it was an area that required addressing to ensure no risks around presenting healthcare needs emerged.

The residents has good supports in place in terms of positive behaviour support plans as required. Positive behaviour support plans were found to be based on evidence based approach, with a functional assessment used to determine the possible cause of certain behaviours. Plans were detailed and would effectively inform staff practice. In addition to the plans, the Clinical Nurse Specialist in behaviour attended staff meetings to discuss changes in relevant plans. A restrictive practice register was in place and all restrictive practices had been referred to the rights committee in 2018. The provider and person in charge were still awaiting a response from this committee.

As stated in the previous report in May 2019, a long standing issue in terms of the suitability of the current environment for the assessed needs of all residents remained. The environment was not suitable for any resident that had been assessed to need a low arousal environment and therefore the environment was impacting on the assessed needs of some residents. This issue had been identified in 2017 and continued to have no time bound plan to sufficiently address this.

Suitable fire equipment was provided and there was adequate means of escape including emergency lightning. Staff spoken to were knowledgeable on what to do in the event of an outbreak of a fire. All staff had completed training in relation to fire safety. All escape routes were clear from obstruction and were sufficiently wide to enable evacuation, taking account residents' individual needs. The mobility and cognitive understanding of residents had been considered and appropriate emergency plans had been developed and reviewed regularly. However, fire drills were not reflective of possible fire scenarios, as drills were not taking into account

times were minimum numbers of staff were present.

The inspector found that residents were protected by appropriate risk management procedures and practices. There was a risk register in place and evidence that general and individual risk assessments were developed and reviewed as necessary. Arrangements were in place to ensure risk control measures were relative to the risk identified.

The provider and person in charge had put appropriate safeguarding measures in place. There was a policy in place and reviewed on a regular basis. Staff had received suitable training and could discuss aspects of the same on the day of inspection. Appropriate actions had been taken where incidents had occurred. For example, the person in charge and provider completed the necessary investigations and reporting as well as ensuring the continued safety of the residents following any incidents.

Regulation 13: General welfare and development

Some residents had limited access to participate in activities in their community for a period of time. Also the range of activities available to residents needed improvement to ensure they were in accordance with the residents interests, capacities and developmental needs.

Judgment: Not compliant

Regulation 17: Premises

The environment continued not to be suitable for any resident that required a low arousal approach as this was a large building with 12 residents residing in it. This meant the assessed needs of all residents could not be met. In addition to this, parts of the centre required paintwork and general maintenance to ensure it was kept in good structural repair.

Judgment: Not compliant

Regulation 20: Information for residents

The residents' guide contained all the required information as set out in the relevant

regulation.

Judgment: Compliant

Regulation 26: Risk management procedures

Arrangements were in place to ensure risk control measures were relative to the risks identified.

Judgment: Compliant

Regulation 28: Fire precautions

Staff showed sufficient knowledge and understanding of what to do in the event of a fire, however, fire drills were not reflective of possible fire scenarios.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

Residents personal plans had limited evidence to indicate how they had been involved in the review of their plans. The effectiveness of social care goals was not always possible due to how these goals were defined in their individual personal plans.

Judgment: Substantially compliant

Regulation 6: Health care

There were some gaps evident in the maintenance of documentation, for example a heathcare plan had not been updated following a visit to an allied professional. However, care was delivered to a good standard.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

An evidence-based approach to devising positive behaviour support plans was in place for residents that required this support. These plans were reviewed on a regular basis and staff completed the necessary training to deliver the recommendations in the plan effectively.

Judgment: Compliant

Regulation 8: Protection

The person in charge had initiated and put in place an investigation in relation to any safeguarding incidents that had occurred in the centre. Staff had received suitable training.

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	
Registration Regulation 7: Changes to information supplied for registration purposes	Substantially compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Quality and safety	
Regulation 13: General welfare and development	Not compliant
Regulation 17: Premises	Not compliant
Regulation 20: Information for residents	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Not 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

Compliance Plan for Arranmore OSV-0003591

Inspection ID: MON-0022967

Date of inspection: 19/02/2020

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**
Registration Regulation 7: Changes to information supplied for registration purposes	Substantially Compliant
Outline how you are going to come into compliance with Registration Regulation 7: Changes to information supplied for registration purposes: All relevant documentation has been provided to the regulator. Any future changes will be notified in accordance to the specified timelines	
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: There is ongoing recruitment for relief staff nurses for this designated centre. The PIC is full time and possess the relevant qualifications, skills, knowledge and experience to manage the DC. Garda Vetting is has been updated and forwarded to the Authority. There is an appropriate skill mix of nurses and social care staff to meet the needs of the residents. There is also a relief panel to supplement the staffing levels when required for annual leave or sick leave. The centre operates a rolling roster to ensure continuity of staff for the residents. One resident has a dedicated team to support their needs. There is a shared folder which is updated weekly by the agencies who provide staff to the unit with all their Schedule 2 documentation. PIC and CNM1 are aware of how to access Schedule 2 information in the shared folder to ensure all relevant documentation is available for agency staff on duty. Where agency staff are used, the same agency staff are requested to return to cover shifts in the DC where possible.	

Regulation 16: Training and staff development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
There is a training schedule which the PIC has access to. This enables PIC / CNM1 to monitor training and schedule refreshers as they come due. The training matrix is maintained by CNM1 on a monthly basis.

All food safety training has been completed.
All mandatory training is monitored and scheduled as it falls due.

Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The DC has clearly defined management structures in place with management support available in the evening and at weekends.
An annual review is carried out each year and includes feedback from residents and their representatives. This is available for viewing to families and residents. The annual review is completed by end of February each year. All actions arising from this review will be compiled and put into the Quality Enhancement Plan (QEP).
The registered provider provides regular audits and there is an internal audit system in place. All audit outcomes are recorded on the QEP which is maintained by the PIC and reviewed monthly to drive continuous quality improvement in the DC.

Regulation 13: General welfare and development	Not Compliant

Outline how you are going to come into compliance with Regulation 13: General welfare and development:
The DC provides access to day service for residents. There is also opportunities for activation within the community which are planned in conjunction with the resident's wishes. A social activity schedule will also be put in place to support the residents to have more involvement in their community outside of day service activities.

The DC has a visitor's policy which supports residents in maintaining close relationships with family and friends. There are facilities for residents to meet visitors outside of their bedroom.
The team will develop an activation plan for those residents who cannot attend day service to ensure they have an opportunity to have a meaningful day.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
The areas requiring some maintenance issues and paint work will be reported to the new maintenance manager and a schedule of works will be issued.
One resident has been identified as requiring a low arousal environment. There have been many attempts made to support this resident outside of the current DC but to no avail. The residents has been put forward and discussed at the Admission, Discharge and Transfer meeting to see if there was any suitable alternative placement across the region, however this has not been successful to date. Alternative accommodation through local authority social housing or CAS funding has been attempted, however due to the residents high support needs, this has not been accepted. This resident has been raised through local case review meetings with the HSE and a letter was issued to CH07 requesting support to find alternative more suitable placement for the resident, however they responded to say that they have nothing suitable to offer at present, please see attached. A further alternative application will be made to the housing authority requesting to increasing capacity in an alternative property or converting the use of a building to support the resident. The Provider will also continue to advocate for the resident to the HSE.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
The PIC has a schedule for fire drills in place that will be reviewed with all staff at staff meetings. Deep sleep simulation to be carried out by 31.03.2020 with the lowest number of staff on duty.
All staff will maintain current fire safety training and will be scheduled for refresher as it falls due.

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:
A schedule has been formulated whereby CNM2/PIC will carry out audit on each personal plan with keyworkers on a one to one basis to outline areas in plan that require improvement and to set out goals to amend and improve each plan to comprehensively reflect suitable goals. These goals will be reviewed by the keyworker to ensure they are SMART and annual circle of support meetings will be held to review the effectiveness of each residents plan, including the important people in their lives. A schedule will be drafted for these meetings and reviews.

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
During scheduled one to one supports for personal plans as mentioned in response to Reg 5, CNM2/PIC will outline on an individualised basis the need for all relevant and salient information to be filed, retained and communicated effectively so that plans can be formulated to address the healthcare need or indication as required. This one to one schedule for staff support will also include a review of all appointments and related information and recommendations form allied health professionals so that same can be updated as required for the benefit of the resident and their healthcare needs

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
Registration Regulation 7(2)(b)	Notwithstanding paragraph (1) of this regulation, the registered provider shall in any event supply full and satisfactory information, within 10 days of the appointment of a new person in charge of the designated centre, in regard to the matters set out in Schedule 3.	Substantially Compliant	Yellow	18/03/2020
Regulation 13(2)(b)	The registered provider shall provide the following for residents; opportunities to participate in activities in accordance with their interests, capacities and developmental needs.	Not Compliant	Orange	30/05/2020
Regulation 15(3)	The registered provider shall ensure that	Not Compliant	Orange	30/05/2020

	residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.			
Regulation 15(5)	The person in charge shall ensure that he or she has obtained in respect of all staff the information and documents specified in Schedule 2.	Substantially Compliant	Yellow	31/03/2020
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	31/03/2020
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	28/02/2021
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound	Substantially Compliant	Yellow	31/08/2020

	construction and kept in a good state of repair externally and internally.			
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	30/04/2020
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.	Not Compliant	Orange	31/03/2020
Regulation 05(6)(b)	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 conducted in a manner that	Substantially Compliant	Yellow	31/07/2020

	ensures the maximum participation of each resident, and where appropriate his or her representative, in accordance with the resident's wishes, age and the nature of his or her disability.			
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	31/07/2020
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	31/07/2020