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

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| Name of designated centre: | Cill Foireann |
| Name of provider: | Three Steps Limited |
| Address of centre: | Meath |
| Type of inspection: | Unannounced |
| Date of inspection: | 06 February 2020 |
| Centre ID: | OSV-0005201 |
| Fieldwork ID: | MON-0025874 |

## About the designated centre

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

Cill Foireann, Le Cheile is a detached house in a quiet housing estate that caters for up to three residents, both male and female over the age of 18 years. There are a total of two large double bedrooms and one single bedroom in the centre. One of the double bedrooms has its own ensuite and there is a main bathroom located upstairs with the other bedrooms. There is a separate communal bathroom downstairs. There is a private back garden. Cill Foireann, Le Cheile is located in a small residential estate within a quiet community and is ideally located to promote the development of independence, a sense of integration into the community and the growth of the residents into active citizens of their community. Residents are supported 24 hours a day, seven days a week by a person in charge and social care workers.

**The following information outlines some additional data on this centre.**

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| Number of residents on the date of inspection: | 3 |

## 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 6 February 2020 | 09:40hrs to 17:40hrs | Marie Byrne | Lead |

## What residents told us and what inspectors observed

The inspector of social services had the opportunity to meet and spend some time with the three residents who lived in the designated centre during the inspection.

On several occasions during the day, laughter could be heard in the house while residents spent time with staff having cups of tea and getting ready for the next activity they had planned. On return from day services and college, residents were observed to go straight to staff members to share the events of the day. This included one resident asking staff for advice in relation to a dilemma they had during the day.

The residents described to the inspector how they were supported to transition to the centre and to share their home with other people. They described difficulties they encountered during their transitions and the supports which staff put in place to help them to settle into their new home. They also described all of the things they were doing to develop their independence or to prepare to move to semi-independent living. These included cooking, cleaning, money management and shopping.

Residents described how they had been involved in decorating their home and how they were being supported to make choices in relation to their day-to-day lives and to develop their independence. For example, one resident described one of their goals in relation to public transport and how they were now travelling on public transport to get to college and to see their friends. Another young person talked about using public transport to meet a friend they used to live with on a regular basis.

The inspector heard one resident discussing the upcoming election with the staff team. They described how they had logged on to see if they were registered to vote, as they hadn't received their polling card. They discussed what information they were going to use to base their vote on, including watching an upcoming television debate.

The inspector observed friendly and respectful interactions between staff and residents throughout the day. Staff who spoke with the inspector were motivated to ensure each resident was happy, safe and spending their day the way they wanted to. They were also motivated to encourage residents to be independent and to gain new skills. They were very familiar with each residents' likes, dislikes and preferred methods of communication.

One resident discussed the process for accessing advocacy services with the inspector. They also described what they would do if they had any complaints in relation to their care and support in the centre. They described areas where they would like to make improvements in the centre. They stated that the vehicle in the centre was not reliable and described how sometimes the engine wouldn't start.

They also stated that there were not enough regular staff in the centre and that they did not like having someone like an agency staff who didn't know them, in their home looking after them. They stated they had discussed these concerns with staff in the centre and they also stated that they knew the provider was trying to recruit new staff, but that this process was taking too long.

## Capacity and capability

Overall, there were systems in place to ensure residents were safe and in receipt of a good quality service. There were clearly defined management systems and structures that identified lines of authority and accountability. Staff had clearly defined roles and responsibilities and there were systems in place to ensure they were trained and supported to carry out their roles and responsibilities to the best of their ability.

Through discussions with the team and a review of documentation in the centre, it was clear that the provider was identifying areas for improvement in line with the findings of this inspection. They had identified these in their reviews and plans were in place to make the necessary improvements. Some of these improvements were not being completed in a timely manner but the inspector viewed evidence and heard from the person in charge and the person participating in the management of the centre (PPIM), that these improvements would be made in the coming months. The person in charge and PPIM facilitated the inspection and were found to be knowledgeable in relation to their responsibilities and residents care and support needs. They outlined the areas for improvements which had been identified during the providers reviews and their own audits. These included, the need to fill staffing vacancies in the centre, the requirement to review documentation in the centre to ensure that it was clear, concise and clearly guiding staff to support residents and the need to source a new vehicle for the centre. They showed the inspector documentary evidence that they were in the process of sourcing a new vehicle.

There had been a change in personnel in the management team in the months proceeding the inspection and some periods of leave which had resulted in a reduction in the availability of support and supervision for some members of the team. This was discussed with the inspector during the inspection and plans were in place to ensure this support and supervision were occurring regularly moving forward.

The provider's systems for monitoring the quality of care and support for residents included, the annual review and six monthly reviews, audits and regular management meetings. There was evidence that the majority of actions were being completed following these reviews and audits, and that these were positively impacting residents' experience of care and support in the centre. Staff meetings were held regularly and the agenda items were resident focused. There was evidence of the review of incidents and the sharing of learning across the team

following these reviews.

The inspector reviewed the latest annual review for 2018 and last two 6 monthly visits by the provider in 2019. Plan were in place to complete the 2019 annual review and the inspector viewed the resident/representative/staff/stakeholder feedback which would be contributing to this review. The feedback in these reviews were mostly positive but did refer to problems with the service vehicle and the impact of the staffing vacancies for residents in the centre. Key performance indicators were being completed regularly in the centre. These key performance indicators were reviewing significant events, post incident reviews, complaints, safeguarding, medication errors and staff supervision.

There were two staffing vacancies at the time of this inspection. The inspector viewed evidence and heard from one resident that this was negatively impacting on their experience of care and support in the centre. The provider had recognised the need to recruit staff and had also recognised that continuity of care had been affected for young people in line with the high volume of shifts being covered by relief and agency staff. They were in the process of recruiting to fill these vacancies and two new staff were due to start their induction training in the weeks following the inspection. The provider was attempting to reduce the impact of these vacancies for residents. However, this was not always proving possible and during the month of January 2020, 19 shifts had been covered by a number of different relief and agency staff.

Staff employed in the centre had the necessary qualifications and skills to meet the residents' needs. Staff records, including valid Garda vetting disclosures, were kept by the person in charge as required under Schedule 2 of the regulations. However, there were gaps in some documents required under the regulations. This was discussed with the person in charge and PPIM and they had plans in place to source the necessary information.

Staff had access to mandatory training in fire safety, first aid, manual handling, medication management, Safeguarding Vulnerable Adults, and management of actual or potential aggression. A training needs analysis had been completed in the centre and a number or site specific trainings were planned in line with residents' needs. The person in charge was completing regular formal staff supervision. During these meetings there was evidence of discussions relating to staff's strengths and contributions and relating to areas for further development.

There were admissions policies and procedures in place which were also outlined in the centre's statement of purpose. Each resident had a care agreement and contract of care. These contained information relating to the care and welfare and services available for residents, the fees and the additional fees they were responsible for such as luxury items. However, one residents' contract of care required review to ensure it was reflective of the arrangements in place for them in relation to fees.

Residents were protected by the complaints policies, procedures and practices in the centre. There were procedures in place to record, address and resolve complaints raised by residents or their representatives. These included an appeals process and

the satisfaction level of the complainant being recorded on the complaint record. Residents were made aware of the process through information on display in the centre and the process was also discussed during residents' meetings.

All of the policies and procedures required under schedule 5 of the regulations were available in the centre. However, a large number of these policies had not been reviewed within the timeframe identified in the regulations. The provider was aware of this and there was a policy planning group in the organisation in the process of reviewing and where necessary updating these policies and procedures.

## Regulation 15: Staffing

There were two whole time equivalent staffing vacancies in the centre. At the time of the inspection the provider was in the process of recruiting to fill these vacancies. In the interim, they were attempting to provide continuity of care for the residents by using regular relief and agency to cover the required shifts. However, this was not always proving possible due to the volume of shifts which required to be covered. All of the required information was not available in a number of staff files reviewed.

Judgment: Not compliant

## Regulation 16: Training and staff development

Staff had access to training and refreshers in line with residents' needs and plans were in place to complete additional area specific trainings in line with their needs. Staff were in receipt of regular formal supervision to support them to support them to carry out their roles and responsibilities.

Judgment: Compliant

## Regulation 23: Governance and management

There were clearly defined management structures that identified lines of accountability and responsibility and systems in place to monitor the quality of care and support for residents. There were a number of areas for improvement identified by the provider during their reviews and they had plans in place to make these improvements. However, some of these improvements were not being made in a timely manner. Although, the inspector acknowledges that plans were in place to address them in the coming months. There had been changes in the management team in the months preceding this inspection and during this changeover of staff

there had been a gap in supervision and support for members of the management team. The provider had recognised this and plans were in place to further strengthen the management systems in place.

Judgment: Substantially compliant

## Regulation 24: Admissions and contract for the provision of services

There were admissions policies and procedures in the centre and care agreements and contracts of care were in place for each resident. However, one residents' contract of care required review to ensure it was reflective of the arrangements in place for them in relation to fees.

Judgment: Substantially compliant

## Regulation 34: Complaints procedure

Residents were protected by the policies, procedures and practices relating to complaints. Complaints raised were reviewed, recorded and followed up on.

Judgment: Compliant

## Regulation 4: Written policies and procedures

The policies required by schedule 5 of the regulations were in place. However, a large number of these had not been reviewed in line with the timeframe identified in the regulations. The provider was aware of this and had a policy planning group in place who were reviewing them with a date for completion of their review identified as the end of March 2020.

Judgment: Substantially compliant

## Quality and safety

Overall, the inspector found that residents were in receipt of a good quality service and that the provider and person in charge was making every effort to keep them safe. They lived in a nice house and were making choices in relation to how they

wanted to spend their day. The provider and person in charge were recognising areas for improvement in line with the findings of this inspection and had plans to complete the required actions to make these improvements.

The premises were warm, comfortable and well maintained. It was designed and laid out to meet the needs of young people and each young person had their own bedroom. They also had access to adequate private and communal space within their home. Systems were in place to report and fix maintenance issues in they house as they arose.

Each resident had an pre-admission assessment of need completed and then their personal plan was developed with their input. There was evidence of regular review and update of their personal plans in line with their changing needs. Each resident had access to the support of a keyworker to develop and achieve their goals. There was evidence that each resident was being supported to develop and achieve goals relating to both life skills and activities. The inspector found that due to the volume of documentation for each resident, it was difficult to source some information. In addition, there were inconsistencies across some documents reviewed relating to residents' care and support needs. There was no documentary evidence that young peoples' assessments of need were reviewed annually to inform any necessary changes to their personal or care plans. However, there was evidence of regular review of young peoples care and support needs by the multidisciplinary team. The provider had recognised the need to review documentation and had developed new systems and documents to streamline the assessment and personal plan process. They had piloted the use of these systems and documents within the organisations and plans in place to roll these out across the organisation in March 2020.

Residents were supported to enjoy best possible health. They had their healthcare needs assessed and had access to allied healthcare professionals in line with these assessed needs. Plans were in place to review documentation relating to health action plans as part of the organisation's review of documentation, to ensure that they were reflective of residents' assessed needs and clearly guiding staff to support them.

Residents were protected by the policies, procedures and practices in relation to safeguarding and protection in the centre. Safety plans were developed and safeguards put in place as required. Allegations or suspicions of abuse were reported and escalated in line with requirements of the organisation's and national policy. Staff who spoke with the inspector were knowledgeable in relation to their responsibilities in the event of a suspicion or allegation of abuse. Residents had intimate care plans developed as required which clearly outlined their wishes and preferences.

There were risk management polices and procedures in the centre. The risk management policy in the centre was under review to ensure it contained the information required by the regulations. There was a risk register in place 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 in the centre. There was an emergency plan for the centre which included where resident could relocate to in the event of an emergency.

The centre had appropriate systems in relation to the detection, containment and extinguishing of fires. There was a fire alarm system, emergency lighting and fire fighting equipment, which were regularly checked by staff and serviced by an external company. Fire doors were in place throughout the centre. Clear signage was on display indicating fire evacuation routes and the fire assembly point. Fire exits were marked by lit signage. Fire safety training was provided to staff.
Each resident had a personal emergency evacuation plan in place. There were regular fire drill held with a night time drill planned for the evening of the inspection.

## Regulation 17: Premises

The premises was homely and designed and laid out to meet the number and needs of residents in the centre. It was well maintained and there were plans in place to complete works to increase accessibility in one of the bathrooms in line with recommendations following and assessment completed by an allied health professional. In the interim, risk assessments and arrangements were in place to meet this residents' needs.

Judgment: Compliant

## Regulation 26: Risk management procedures

Residents were protected by the policies, procedures and practices relating to risk management and emergency planning in the centre. There was a risk register which was updated regularly and general and individual risk assessments were developed and reviewed as necessary. There were systems in place to review and learn from incidents in the centre. The provider had identified that the needed to replace the vehicle in the centre and were in the process of sourcing a new vehicle.

Judgment: Compliant

## Regulation 28: Fire precautions

There were suitable arrangements in place to detect, contain and extinguish fires. Residents had personal emergency evacuation plans and fire drills were being

completed regularly in the centre.

Judgment: Compliant

## Regulation 5: Individual assessment and personal plan

Each resident had a pre-admission assessment of need completed and a personal plan in place. Residents' personal plans were person-centred and their involvement in the development and review of their personal plans was evident. The provider had recognised the need to review some documentation in the centre to improve ease of retrieval of information and to ensure consistency across documentation. They had plans in place to introduce a new folder and documentation system in March 2020.

Judgment: Substantially compliant

## Regulation 6: Health care

Residents were being supported to enjoy best possible heath. They had access to allied health professionals in line with their assessed needs and staff were knowledgeable in relation to their care and support needs.

Judgment: Compliant

## Regulation 8: Protection

Residents were protected by the policies, procedures and practices relating to safeguarding in the centre. Allegations and suspicions of abuse were reported, followed up on and escalated in line with the organisation's and national policy.

Judgment: Compliant

## Appendix 1 - Full list of regulations considered under each dimension

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

| Regulation Title | Judgment |
|---|---|
| **Capacity and capability** | |
| Regulation 15: Staffing | Not compliant |
| Regulation 16: Training and staff development | Compliant |
| Regulation 23: Governance and management | Substantially compliant |
| Regulation 24: Admissions and contract for the provision of services | Substantially compliant |
| Regulation 34: Complaints procedure | Compliant |
| Regulation 4: Written policies and procedures | Substantially compliant |
| **Quality and safety** | |
| Regulation 17: Premises | Compliant |
| Regulation 26: Risk management procedures | Compliant |
| Regulation 28: Fire precautions | Compliant |
| Regulation 5: Individual assessment and personal plan | Substantially compliant |
| Regulation 6: Health care | Compliant |
| Regulation 8: Protection | Compliant |

# Compliance Plan for Cill Foireann OSV-0005201

## Inspection ID: MON-0025874

## Date of inspection: 06/02/2020

**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** |
|---|---|
| Regulation 15: Staffing | Not Compliant |
| Outline how you are going to come into compliance with Regulation 15: Staffing:<br>The Senior Area Manager, working with the HR department are currently recruiting care team members to ensure that the number, qualifications and skills mix of the staff is appropriate to the number and assessed needs of the residents, the statement of purpose and function and promote a continuity of care and support to the residents.<br><br>The PIC holds a planned and actual staff roster at the Centre. This specifies staff on duty during the day and night. Each month the PIC and the Senior Area Manager review the roster, if there is insufficient numbers of staff scheduled to meet the staff requirements, a plan is put in place to ensure number, qualifications and skills mix of the staff is appropriate to the needs of the residents. If agency staff members are required, the PIC will ensure the induction process is completed prior to the agency staff member coming in duty.<br><br>On the 24.02.2020, The PIC updated Care team files to ensure that files contain all information as set out in Schedule 2 of the regulation.<br><br>The PIC maintains staff personnel file for each member of the Centre Care Team that contains information specified in schedule 2 of the regulation. | |
| Regulation 23: Governance and management | Substantially Compliant |
| Outline how you are going to come into compliance with Regulation 23: Governance and management:<br>The Senior Area Manager has line management and supervisory responsibility for the | |

PIC. Supervision between the PIC and Senior Area Manager will take place every four weeks. This process will be supported by a comprehensive written report in the form of a Centre Manager Report, which is completed monthly including supporting documentation being provided by the Centre Manager in advance of supervision ensuring that all reported issues are discussed and addressed.

The PIC has responsibility for performance management and supervision of care team members. Both will be completed in line with organisation policy. Care team members will be facilitated to exercise their personal and professional responsibility for the quality and safety of the service they are delivering, while also being facilitated to raise concerns about quality and safety of the care and support provided to residents.

An annual review of quality and safety of care and support is currently in process. Residents and their representatives have been consulted and asked for feedback on the quality and safety of care and support at the Centre. A written report detailing the outcome and recommendations from the review will be available to residents and the Chief Inspector.

A Senior Area Manager reporting directly to the CEO has been assigned to carry out twice yearly audits in the Centre. The Senior Area Manager will prepare a report on the safety and quality of care and support provided to the residents. This report will include an action plan to address any concerns regarding the standard of care and support in the centre.

The Director of Care and Senior Area Manager are clear that all recommendations made in finalised audit reports must be implemented within the timeframes specified to bring about any/all changes needed to improve the quality of care and support.

The Senior Area Manager will regularly visit the Centre, oversee SEN and review audit reports that are now scheduled to be carried out twice a year by a dedicated Senior Area Manager.

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| Regulation 24: Admissions and contract for the provision of services | Substantially Compliant |

Outline how you are going to come into compliance with Regulation 24: Admissions and contract for the provision of services:
The PIC provides each resident/ representative with a contract for the provision of services that outlines the support, care and welfare to the resident in the Centre and details of the services to be provided for that resident and where appropriate, the fees to be charged. The agreement provides for and is consistent with the resident's needs.

On the 28.02.2020, The PIC updated the contract for the provision of services to reflect the fees charged and has provided the resident with a copy

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| Regulation 4: Written policies and procedures | Substantially Compliant |

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
The organisation has commenced an internal review of all policies and procedures. A review committee has been established to complete this piece of work. Committee members are currently reviewing and updating all the organisations policies and procedures, as set out in schedule 5. This is due to be completed by 31.03.2020.

The organisation will then commence a role out of written policies and procedures as set out in schedule 5 to all Care Team members.

The organisation will review the policies and procedures as often as required and in accordance with best practice but no longer than three years.

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| 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:
The PIC completes a comprehensive assessment of the health, personal and social care needs of each resident prior to admission.

On the 28.02.2020, the PIC reviewed and updated all assessments of health, personal and social care needs and circumstances.

In line with the introduction of a complete program of care, the individualised personal plans for all residents are currently being updated to reflect all health, personal and social care needs of each resident. The personal plans will outline the supports required to maximise the residents personal development in accordance with their wishes. This will be completed by 20.03.2020

The PIC completes regular reviews of the personal plan if there is a change of needs or circumstances and on an annual basis. The reviews include a multidisciplinary review whilst ensuring maximum participation of each resident or their representatives in accordance with the resident's wishes.

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| The resident's and their representatives where appropriate are provided with an accessible format of their personal plans. |

## 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 | 30/04/2020 |
| Regulation 15(3) | The registered provider shall ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis. | Not Compliant | Orange | 30/04/2020 |
| Regulation 15(5) | The person in charge shall ensure that he or she has obtained in respect of all | Substantially Compliant | Yellow | 24/02/2020 |

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| | staff the information and documents specified in Schedule 2. | | | |
| 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 24(4)(a) | The agreement referred to in paragraph (3) shall include the support, care and welfare of the resident in the designated centre and details of the services to be provided for that resident and, where appropriate, the fees to be charged. | Substantially Compliant | Yellow | 28/02/2020 |
| Regulation 04(3) | The registered provider shall review the policies and procedures referred to in paragraph (1) as often as the chief inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with | Substantially Compliant | Yellow | 31/03/2020 |

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| | best practice. | | | |
| Regulation 05(1)(b) | The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health, 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. | Substantially Compliant | Yellow | 28/02/2020 |
| 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 | 20/03/2020 |
| Regulation 05(6)(c) | The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall assess the effectiveness of the plan. | Substantially Compliant | Yellow | 20/03/2020 |