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:	The Birches Services
Name of provider:	Ability West
Address of centre:	Galway
Type of inspection:	Unannounced
Date of inspection:	20 June 2023
Centre ID:	OSV-0001500
Fieldwork ID:	MON-0040544

About the designated centre

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

The designated centre provides a residential service to eight residents who have an intellectual disability. All residents attend day services and the centre is staffed by both social care workers and care assistants. There is additional staff deployed in the evenings and at weekends to meet residents' needs and two staff support residents during night time hours on a sleep in arrangement. Each resident has their own bedroom and there is a sitting room and kitchen/dining room for residents' use. The centre is located in a housing estate and is within walking distance of the local town. Transport is provided on a shared basis and residents also have access to public buses and taxis.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	8

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 (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
Tuesday 20 June 2023	11:30hrs to 16:30hrs	Ivan Cormican	Lead

What residents told us and what inspectors observed

This was an unannounced inspection carried out to follow up on non compliance's identified during the previous inspection of this centre, to assess the provider's compliance with specific regulations and also the regulatory compliance plan submitted to the Chief Inspector of Social Services on an organisational level.

Residents were at their respective day services when the inspection commenced and they returned to the centre in the late afternoon. As residents returned there was a pleasant atmosphere and residents were greeted warmly by staff who were on duty. Residents had their own routines to attend to upon their return with some having a rest in their rooms, watching television, knitting and others assisting staff with some household chores.

The inspector met with five residents as they returned from day services and they all appeared relaxed and they chatted freely with the inspector and staff members. One resident showed the inspector their bedroom and they explained that in general they got on well with everyone in their home and that they could go to any staff member if they had a concern. They explained that they liked going out for meals and trips and they were very happy that the centre had got their own bus which meant they could go out at a time of their choosing. This resident explained to the inspector that they couldn't chat for long as they were going to their general practitioner for an appointment. They explained that staff members supported them to attend appointments and they were also awaiting a separate review with a surgical consultant.

The inspector met with the other four residents in the centre's reception room. These residents interacted on their own terms with some verbal interactions exchanged. One resident smiled as they were asked about a recent trip with a family friend another resident sat and knitted as they watched television and they appeared relaxed and content throughout the late afternoon. One resident went about their own routine which they enjoyed and they had free access to all areas of their home including an upstairs relaxation room which they used to complete arts and crafts.

There were three staff members supporting residents on the evening of inspection and the inspector spoke with two staff members and observed their interactions with residents. The centre had a very pleasant atmosphere and staff chatted in casual and encouraging manner with residents as they returned to their home. One staff member explained that they were assisting a resident to attend an appointment that evening and they resident they were supporting told the inspector that they liked that this staff was going with them and that they were very nice. The other staff member discussed the residents' collective needs and also the changing needs of a resident who was experiencing a cognitive decline. They explained how this resident liked to be around staff and how keeping the resident busy with small household chores appeared to keep them relaxed and promoted positive interactions

with fellow residents and staff members.

Although the centre appeared relaxed and a pleasant place in which to live, this inspection highlighted issues in relation to its governance and management, personal planning and the capacity of the person in charge to fulfill the duties of their role. These issues will be discussed in the subsequent sections of this report.

Capacity and capability

This designated centre is run by Ability West. Due to concerns in relation to Regulation 23 Governance and management, Regulation 15 Staffing, Regulation 14 Person in Charge, Regulation 5 Individualised assessment and personal plan, and Regulation 26 Risk management procedures, the Chief Inspector of Social Services is undertaking a targeted inspection programme in the provider's registered centres with a focus on these regulations. The provider submitted a regulatory compliance plan to the Chief Inspector in April 2023 highlighting how they will come into compliance with the regulations as cited in the Health Act 2007 (as amended). As part of this regulatory compliance plan the provider has outlined an action plan to the Chief Inspector highlighting the steps they will take to improve compliance in the registered centres. These regulations were reviewed in this inspection and this report will outline the findings found on inspection.

The inspection was facilitated by a senior manager who participated in the centre's management and also partly by the centre's person in charge. Both managers had a good understanding of the service, residents' needs and also of the resources which were in place to meet these identified needs. Both managers were aware that the chief inspector had engaged with the provider entity in regards to the management and delivery of care in centres which they operated and that concerns were raised in relation to the quality and safety of services which were provided to residents.

The senior manager outlined the provider's response to these concerns which were occurring in this centre and included a quality enhancement plan (QEP) which aimed to drive improvements in regards to care and oversight arrangements. The QEP for this centre had been completed and examined areas such as personal planning, complaints, internal audits and adverse events. The QEP outlined some areas that required attention including a potential safeguarding concern. This concern had also been raised on a separate internal audit however, the provider was unable to demonstrate if this concern had been fully investigated and on the day of inspection the associated incident could not be found on the provider's incident reporting system which raised concerns in regards to the management and oversight of care in this centre. In addition, this inspection highlighted a significant issue in relation to personal planning which had not been identified as part of internal reviews.

There were some positive movements in regards to providing support for the centre's person in charge with monthly meetings scheduled to occur which gave a platform for shared learning and examination of issues which were impacting upon

care. The senior manager also explained that the provided was in the process of recruiting a new person in charge who would be based in the centre and provide an enhanced management presence. However, on the day of inspection the person in charge held responsibility for three designated centres and based on the findings of this inspection the provider failed to demonstrate that they had the capacity to fulfill the duties which were assigned to this role.

Although there had been some movement towards providing additional oversight of care in this centre, this inspection identified that governance and management arrangements were not robust at the time of inspection with deficits found in relation to personal planning and the quality of internal review and monitoring systems.

Regulation 15: Staffing

The residents were supported by a familiar staff team and staff members who were on duty during the inspection were observed to be kind and considerate in their approach to care. The person in charge facilitated scheduled team meetings which gave staff a platform in which to discuss care practices and any concerns which they may have. However, this inspection found that improvements were required in regards to the staff rota as the copy which was reviewed was incomplete and did not include the full staffing arrangement for one of the days which was sampled

Judgment: Substantially compliant

Regulation 23: Governance and management

Robust governance and management arrangements assist in ensuring that residents receive a good quality service and that the care which is provided is maintained to a satisfactory standard at all times. Internal review and audit mechanisms are an essential aspect of governance with comprehensive implementations of these mechanisms assisting in ensuring that the quality and safety of care is held to a good standard. However, this inspection highlighted these internal mechanisms had drawn attention to a potential safeguarding concern; however two reviews failed to highlight an urgency in terms of a suitable and timely response.

In addition, the provider's assessment of resident's individual needs required review in relation to suitability of the assessment tool and also in regards to the sharing of relevant information with the centre's management with regards to the outcome of these assessments. This assessment also failed to take into consideration the resident's own views on the service they received including their goals or aspirations for the future. Furthermore, the actions form the last inspection in regards to infection prevention and control had not been fully implemented with issues

remaining on this inspection in regards to maintenance and completion of cleaning and hygiene records.

Judgment: Not compliant

Regulation 14: Persons in charge

The person in charge held responsibility for three designated centres. However, the provider failed to demonstrate that they had the capacity to fulfill their duties. In addition, a scheduled rota for their attendance in the centre was incomplete and the provider was unable to show the frequency or duration of their presence in the centre.

Judgment: Substantially compliant

Quality and safety

The inspector found that residents enjoyed living in this centre and they were supported to engage in a good range of activities. They were also active in their local communities with some residents assisted to access local facilities independently. Although residents reported that they were happy in the centre, levels of support which they received in regards to personal planning and assessments of need were not maintained to a good standard and required improvements. In addition, the provider failed to demonstrate how a resident was involved in the decision making process in relation to a proposal for them to move to a care of the elderly service.

Personal planning is an integral aspect of care,with effective personal planning outlining each resident's personal, social and health needs. Residents in this centre had recently had an assessment of need completed on their behalf which had been completed by an allied health professional with the assistance of the centre's person in charge. This assessment of need gave each resident a dependency score; however, management of the centre were not able to account on how this score was to be used. In addition, the inspector found that although this assessment was comprehensive, it failed to consider residents' thoughts on the service, their aspirations for the future or their satisfaction with the care they received. In addition, the inspector reviewed a sample of personal plans and found that they had not been reviewed as required by the regulations. For example, a resident had experienced cognitive decline and staff reported significant changes in their personal care needs and also the support which they required throughout the day and night; however, relevant areas of their personal plan had not been updated since 2021 which had the potential to impact upon the continuity of care which this resident

received.

Of the regulations which were inspected, some aspects of risk management were found to be well maintained with the provider outlining clear risk assessments in relation to issues which may impact upon the quality and safety of care which residents received. However, as mentioned earlier in the report, there was some confusion on the day of inspection with regard to a potential safeguarding incident which was identified in two internal audits of care but the provider failed to demonstrate how this incident was recorded and initially responded to by the centre's management. The provider had outlined specific risk in relation to issues such as cognitive decline, falls, COVID 19 and behaviours of concern. These risk assessments were comprehensive in nature and set out the controls to mitigate against the impact upon care which these issues may have. Some improvements were required in regards to the review of risks as one risk assessment had not been reviewed as recommended following a resident leaving the centre momentarily without the support of staff.

Although residents had a good social life and they appeared to enjoy living in the centre and the company of staff, this inspection found that personal planning and the process for the assessment of resident's individual needs required significant improvements to ensure that both processes were robust and lead to positive outcomes for residents.

Regulation 26: Risk management procedures

Effective risk and incident management procedures are essential aspect of safety and promote the welbeing and welfare of residents. Although risk assessments were in place, a recommended review and update to a risk assessment for a resident who was undergoing a significant changes in their needs did not occur following an incident which had the potential to impact upon their safety.

Responding to incidents is a critical function of the provider. The provider had identified a potential safeguarding concern over two separate audits; however, the provider failed to demonstrate if this incident had been captured on the internal incident management system and also if this incident had been fully investigated.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Personal planning is central to the quality of care which residents receive. Robust assessments of need assist in determining the residents' requirements to live a fulfilling life and examines key areas in regards to their health, social and personal well being. Assessments of need which were recently completed in this centre were

not found to be person centred and key information in regards to the outcome of the assessments had not been shared with the residents, their representatives are senior management of the centre. In addition personal planning which was in place on the day of inspection had not been reviewed as required by the regulations which had the potential to impact upon continuity of care.
Judgment: Not 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 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 14: Persons in charge	Substantially compliant
Quality and safety	
Regulation 26: Risk management procedures	Substantially compliant
Regulation 5: Individual assessment and personal plan	Not compliant

Compliance Plan for The Birches Services OSV-0001500

Inspection ID: MON-0040544

Date of inspection: 20/06/2023

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

This document is divided into two sections:

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

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

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • The service roster is amended to incorporate the staffing resources as set out in the service Statement of Purpose. Completed 03.07.2023 • The roster now reflects improved staffing detail including full names and work grades and is kept clear and legible. The roster includes full staffing arrangements for each day and shift. completed date 14.07.2023 • The roster is printed and available within the service each month for staff allocating the shifts as required. Completed 03.07.2023 • The Person in Charge of the service maintains and reviews the roster each week as part of their service oversight audits to ensure that adequate staff are available to support the Residents within the service. • The Person in Charge attends each service as outlined in a specific PIC roster for 12 hours each week with each service clearly having access to the PIC attendance within the service each week. • The Person in Charge maintains an administrative role within the service with a Team Lead working directly within the service undertaking front line management responsibilities and reporting directly to the Person in Charge. Work Plan completed 14.07.2023	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • The Person in Charge has commenced a series of internal service audits which are completed each week incorporating many aspects of effective service delivery including quality safety aspects for example Infection Prevention and Control, Incident reporting and follow up, Medication management, Risk Review, Financial checks, Quality Improvement plan and report updates, Working file audits and Roster review. These audits are completed weekly by the service Team Lead and Person in Charge as set out in ongoing regular weekly meetings. A working schedule of meetings is in place.	

• The Service Area Manager will undertake regular service review meetings with the Person in Charge to ensure that all required actions from the weekly audits are followed up and actioned as required. A working schedule of dates is in place.

• The Audit tool designed includes all Statutory Instrument areas of responsibility for the Centre's Person in Charge in order to ensure consistent and continuous service regulation compliance.

• The Person in Charge will complete weekly FLEX submissions to ensure all premises repairs and maintenance matters are reported to the appropriate departments for appropriate response actions and within timelines. This is also included under the Centre risk register.

• The person in Charge will review staff training records each week to ensure that all relevant training and refresher training is undertaken as required. Discussion at team meetings each month.

• The Person in Charge will update the service Quality Enhancement Improvement plan on a monthly basis providing updates to the Service Area manager on the identified actions and status of regulation areas within the service, which will evidence actions being undertaken and completed for internal and external audits. This update will in turn then be collated and discussed with the Quality and compliance Dept. and the Person Participating in Management each month for oversight and review.

• Ability West are also receiving support from an external company to improve our knowledge and compliance with regulations and ensure we meet all quality and compliance standards. Training is currently taking place delivered by external agency.

• The Person in Charge will ensure that all Safeguarding queries or concerns are escalated to the Designated Officer after completion of a QMIS record and will follow up with direct contact upon receipt of the QMIS with the Designated Officer to ensure the safety of all service Users. They will in addition complete all required documentation and ensure all appropriate notifications occur as required and within the required timeframes. Any outstanding concerns will be actioned as required. New development of auditing templates within the Centre will ensure a timely and appropriate response going forward. Concerns in relation to the identification of QMIS records on the day of the inspection have been communication with the external company and actions taken to rectify the issues. Completed 26.06.2023.

• At the Team meeting of June 29th 2023 Safeguarding was discussed with the staff team and their responsibilities under Ability West policy and procedures outlined and re-visited for clarification and execution purposes by the Person in Charge, Person Participating in Management was also in attendance.

• The Designated Officer is scheduled to attend the next service Team Meeting to support current staff team Safeguarding training and outline the appropriate actions on September 8th 2023, timeframes upheld of follow up actions to be completed on foot of

any safeguarding query or concern within the service. To be completed 03.08.2023

• The Person in Charge and Person Participating in Management will review Infection Prevention and Control documentation and practices as part of their service review meetings with any improvement plans agreed within time framed perimeters for implementation by September and discussed at staff meetings monthly.

• The Person in Charge and Team Leader will undertake an immediate IPC audit within the Centre and establish any actions to be completed in order to establish a consistent and robust review system within the service to ensure a high standard of IPC is maintained within the service at all times. Completed 30.06.2023

• The Person in Charge and Team Lead will carry out service IPC spot checks within the service weekly to check on the consistent and continuous adherence to the cleaning guidance set out. These checks will ensure that effective cleaning practices by all staff across the service as outlined.

• At the time of the inspection, a supplementary Service Assessment template was in place alongside the "My All About Me" Assessment document. This has now been removed and the "My All About Me Document" is the only needs assessment document on file. It has been completed by the Person in Charge and the Keyworker and will be reviewed regularly as required, it can be located in the Residents personal plan for the purpose of review. Information within this plan is shared with the Residents and their representatives. Completed 30.03.2023.

Regulation 14: Persons in charge	Substantially Compliant

Outline how you are going to come into compliance with Regulation 14: Persons in charge:
• Discuss supports Area Manager / Team Leaders what is the current staffing arrangements. Activity of PIC in each Centre.
The Person in Charge attends the service as clearly outlined in the service Rota each week for 12 hours each week. The Person in Charge is supported by a Team Leader with 12 hours' administration weekly within the Centre and they will together undertake specific audit tasks as set out in the service weekly to evidence effective oversight within the Centre. The Person in Charge and the Team Leader will meet on a weekly basis to review audits and agree follow up action required to maintain effective governance within the Centre. This will be reviewed by the Person Participating in Management at scheduled Service Review Meetings.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
• All incidents occurring within the Centre are reported by way of the QMIS reporting system. Each staff member within the service is given access to the reporting system and guidance on how to complete and submit QMIS reports. Concerns in relation to the

identification of QMIS records on the day of the inspection have been communicated with the external company and actions taken to rectify the issues.

• Once reviewed the Person in Charge will follow up on any required actions including referral on to any Multi-disciplinary departments for example Physiotherapy relating to mobility issues

• These reports are reviewed weekly by the Person in Charge, amendments to risk assessments and risk register as required and further action of escalation to the Area Services Manager and other relevant stakeholders for review and actions.

• The Person in charge has developed a visual training guide for staff in support of Safeguarding "query" or "concern" and trained all staff in the guide at the Team Meeting of June 29th 2023. The guide document is available now within the service for staff support.

• The Designated officer attended a service Team Meeting in 2022 in order to offer staff Team training, guidance and support in the area of identification and follow on actions in relation to peer to peer incidents and safeguarding plan inputs.

• The Designated Officer is attending another meeting on September 8th 2023 with the staff team to revisit the area of safeguarding and to outline the Organizations policy and procedures within Ability West and staff's responsibility to follow up on any incidents of safeguarding query or concern and report as required. 03.08.2023.

• The service risk register has been updated in line with a review of each individual Risk assessment to reflect all current identified risks for persons within the Designated Centre and QMIS records. Completed 30.06.2023

• The Centre's top 5 Risks are updated on a monthly basis in conjunction with a review of incidents within the Centre for that period and all identified actions are put in place. Incidents and the top 5 risks are discussed at monthly staff meetings to ensure shared learning and shared with the Quality and Compliance Dept. and Person Participating in Management weekly. This identifies trends within the Centre. Last submitted 30 June 2023, next review 30.07.2023.

• The Person in Charge reviewed all safeguarding QMIS reports and undertook required follow up action with the Designated Officer and completed all relevant documentation as required. 30.06.2023

• One Residents safeguarding plan has been updated upon review with the Designated Officer. Completed 30.06.2023

• All safeguarding concerns within the Centre were reviewed 19.07.2023 with the Designated Officer to ensure that they are fit for purpose.

Regulation 5: Individual assessment and personal plan	Not Compliant

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

• At the time of the inspection, a supplementary Service Assessment template was in place alongside the "My All About Me" Assessment document. This has now been removed and the "My All About Me Document" is the only needs assessment document on file. It has been completed by the Person in Charge and the Keyworker and will be reviewed regularly as required, it can be located in the Residents personal plan for the purpose of review. Information within this plan is shared with the Residents and their representatives. Completed 30.03.2023.

• The Person in Charge will ensure that this document is reviewed quarterly or when an emerging/ changing need is identified.

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 14(4)	A person may be appointed as person in charge of more than one designated centre if the chief inspector is satisfied that he or she can ensure the effective governance, operational management and administration of the designated centres concerned.	Substantially Compliant	Yellow	27/06/2023
Regulation 15(4)	The person in charge shall ensure that there is a planned and actual staff rota, showing staff on duty during the day and night and that it is properly maintained.	Substantially Compliant	Yellow	27/06/2023
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the	Not Compliant	Orange	30/07/2023

	designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.			
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Substantially Compliant	Yellow	30/07/2023
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.	Not Compliant	Orange	30/07/2023
Regulation 05(6)(d)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there	Not Compliant	Orange	30/07/2023

	is a change in needs or circumstances, which review shall take into account changes in circumstances and new developments.			