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: | Liffey 4 |
| Name of provider: | St John of God Community Services CLG |
| Address of centre: | Dublin 24 |
| Type of inspection: | Unannounced |
| Date of inspection: | 07 February 2023 |
| Centre ID: | OSV-0005781 |
| Fieldwork ID: | MON-0039135 |

## About the designated centre

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

Liffey 4 is a designated centre operated by St. John of God Community Services Company Limited by Guarantee. The designated centre is comprised of two detached community houses based in West Dublin. The service provides residential care and support for up to seven residents with intellectual disabilities. Support is based on identified needs and abilities through relevant assessments. The aim of Liffey 4 is to support residents to live as independently as possible and to enable them to plan for and achieve their goals they set in their lives. Each resident has their own bedroom in each residential unit that makes up the centre. Residents are supported by a staff team of social care workers and a social care leader who holds the role of the person in charge of the centre. Residents in Liffey 4 are supported to avail of meaningful day services. The day service the individual attends depends on the individuals' needs and preferences. The residents are supported to access the community and access work and education opportunities through these day services. Where a resident has chosen not to attend a day service they are supported to avail of a meaningful day from their home through activities in the community.

**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 (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 7 February 2023 | 10:15hrs to 16:45hrs | Jennifer Deasy | Lead |

## What residents told us and what inspectors observed

This inspection was an unannounced risk inspection. It was carried out to verify the representation that the provider had made subsequent to an inspection of the designated centre on 03 November 2022. High levels of non-compliance were identified on that inspection which resulted in a notice of proposed decision to cancel the registration of the designated centre being issued by the Chief Inspector of Social Services under Section 51 of the Health Act (as amended) 2007. The provider submitted representation which detailed the actions that they proposed to take in order to come into regulatory compliance.

The inspection focused on verifying the provider's representation and, in particular, reviewing the safeguarding arrangements in the designated centre. The inspector used conversations with key staff, residents and family members, a review of the documentation and a walk around the premises to inform decision making.

The inspector met the person in charge on arrival to the designated centre. The person in charge showed the inspector around the designated centre and described the actions that had been taken subsequent to the last inspection. The residential programme manager also attended the designated centre during the course of the inspection.

All of the residents had left to attend day service when the inspector arrived. The inspector met one of the residents when they returned from day service in the afternoon. The inspector saw that this resident appeared comfortable in their home and that their interactions with staff were familiar and relaxed. This resident showed the inspector their bedroom and the kitchen, where they supported the inspector to make a cup of tea. This inspection did not focus on the premises of the designated centre. However, the inspector saw that the resident's bedroom was clean and contained their preferred personal photographs and pictures. The inspector saw that the kitchen required maintenance and was informed by the person in charge that this was due to be addressed by the provider in the coming months.

Other residents were not in the designated centre while the inspector was there. All residents had attended day service and were supported by one-to-one staffing on their return to engage in activities of their preference. The inspector saw that there was a clear daily routine protocol which set out measures to reduce the likelihood of peer-to-peer safeguarding incidents from occurring. This protocol included supporting residents to access communal areas of the house and to leave the house to access day services at staggered times. While this was being generally effective, it was restrictive in nature and did not resolve the core issue relating to the incompatibility of residents in this centre.

The inspector had the opportunity to speak to some family members of residents over the phone on the day of inspection. Family members expressed concern that the safeguarding issues had been allowed to go on for a considerable length of time

without intervention by the provider and without the families' knowledge and input. Family members described having verbally expressed concerns over the preceding year regarding residents' behaviours but felt that their concerns had not been responded to.

Family members also expressed that they were not assured that there was sufficient planning and consideration given to the proposed move of one resident to another apartment. Families expressed that they wanted to ensure that all residents' rights were upheld and that all residents were in receipt of the appropriate care and support that they required.

Overall, the inspector saw that the provider had a plan in place and was attempting to resolve the compatibility issues in the designated centre. However, the inspector was not assured that the timeframe, as set by the provider, to transition one resident from the designated centre was sufficient enough to ensure that this transition occurred in a safe manner which was upholding resident's rights and was in line with their assessed needs.

## Capacity and capability

The inspection was an unannounced inspection, the purpose of which was to verify the actions as submitted in the provider's representation received subsequent to a notice of proposed decision to cancel the registration of the designated centre. This section of the report sets out the findings of the inspection in relation to leadership and management of the service and how effective it was in ensuring that a good quality and safe service was being provided.

The inspector saw that the provider was in the process of implementing the actions as set out in their representation. However, some of these actions were outside of the timeframe initially proposed by the provider. In an attempt to resolve the safeguarding concerns in the designated centre, the provider had planned to transition one resident from Liffey 4 to another apartment. However, the provider had not allowed sufficient time to safely plan this transition. The resident's representative had expressed concern regarding this move and the inspector was informed that the resident was also hesitant regarding moving to a new home.

The compatibility issues, as described in the last report of this designated centre, were as a result of a poor admissions process. It was not evidenced that the provider had enhanced their admissions, transition and discharge practices to prevent similar incidents from reoccurring. The inspector saw that transitions continued to be planned in a manner which was not cognisant of residents' rights, preferences and in line with their assessed needs.

The inspector did see that the provider had enhanced the systems in place to support them in having oversight of the designated centre. The provider had effected an enhanced schedule of meetings at all levels of the chain of command in

the designated centre, from the staff through to the board of directors.

Staff were in receipt of regular meetings where they were informed of risks in the designated centre and the actions required to ensure that residents were supported in as safe a manner as possible. A monthly meeting was held between the person in charge and the two service managers above them. The minutes of these meetings showed that issues such as safeguarding concerns and resident updates were discussed and reviewed. Action plans were developed from these meetings.

The residential programme manager also had monthly meetings with the interim regional director and with human resources. These meetings reviewed staffing arrangements and also provided an opportunity to ensure that the regional director was informed regarding the quality and safety of care in the designated centres in the region.

In particular, the provider had enhanced their oversight of safeguarding issues in the region. The inspector was informed that a peer compatibility assessment was in the process of being devised. This would mitigate against the risk of peer compatibility issues on future admissions to designated centres. An enhanced series of meetings had been implemented to ensure that the service managers were informed of safeguarding issues and that safeguarding issues were reviewed by the regional director at monthly intervals.

The provider had enhanced the staffing levels in the designated centre. The roster was reviewed and the inspector saw that the staffing levels were in line with the statement of purpose and were suitable to meet the needs of the residents. Staff were also up -to -date with mandatory training.

Overall, the inspector saw that the provider had enhanced their oversight of the designated centre and that there were sufficient, suitably trained staff in place to support the residents. There were systems in place to ensure that safeguarding risks were regularly reviewed by those at the provider level and that risks could be responded to in a timely manner.

It was evident that the provider was attempting to address the safeguarding risks in the designated centre. However, enhancement was required to the oversight of admissions, transitions and discharges within the region to ensure that residents were compatible and to ensure that the transition or discharge of any resident was planned and carried out in a manner that was in line with the regulations and the provider's own policies and procedures.

## Regulation 15: Staffing

The inspector saw that the staffing levels had been enhanced for the designated centre. There was a full and consistent staff team in place. While there was still a reliance on agency and relief staff to fill gaps in the roster due to unplanned and planned leave, the inspector saw that the frequency of reliance on agency staff and

the number of agency staff had significantly reduced. This was supporting continuity of care for residents.

Judgment: Compliant

## Regulation 16: Training and staff development

A training matrix was maintained in the designated centre however the inspector saw that this required review to ensure that it contained the most up-to-date training records. It was unclear from reviewing the matrix if all staff were compliant with mandatory training. However, evidence was submitted to the inspector within 24 hours of the inspection which demonstrated that all staff were up -to -date with this training.

Judgment: Compliant

## Regulation 23: Governance and management

The provider had committed through their representation to enhance their oversight of the designated centre and to implement systems to ensure that safeguarding risks were identified, escalated to the appropriate responsible person and responded to in a timely manner. The inspector reviewed these arrangements on inspection and found that the provider had implemented them as they had committed to.

There was a series of regular meetings scheduled which occurred at all levels of the reporting structure from the staff on the ground through the chain of command to the provider level. Minutes of these meetings were maintained and were reviewed on the day of inspection. The inspector saw that risks pertaining to the quality and safety of care were reviewed and that actions were identified and were assigned to responsible individuals.

The inspector saw that the oversight by the provider of safeguarding risks in particular had been enhanced. The method for reporting safeguarding incidents had been amended. There was now a requirement for the programme manager to be informed of any safeguarding reports sent from the designated centre to the designated officer. This ensured that the programme manager was informed of safeguarding issues and could respond in a timely manner.

An enhanced schedule of safeguarding meetings had been established. These meetings supported the designated officer to meet with the programme managers regularly to review all safeguarding concerns and to discuss any patterns of safeguarding or compatibility issues. Further oversight was provided through a monthly meeting between the designated officer and the interim regional manager

specifically to discuss safeguarding in this region of the provider's service.

However, the inspector saw that while the provider had enhanced their oversight of the designated centre, there was further work required to ensure that the centre was being carried on in accordance with the regulations. There were a number of regulations which were not compliant on this inspection. Including; ensuring that notifications were submitted in line with the regulations, that admissions and discharges were carefully planned, and that all residents had a comprehensive and up-to-date assessment of need on file.

Judgment: Substantially compliant

## Regulation 31: Notification of incidents

The inspector saw that allegations of abuse were not reported to the Chief Inspector in line with the regulations. Where residents had made allegations of abuse these were reported on an "accusation form" and were reviewed by the designated officer to determine if a safeguarding report was required. However, these incidents of alleged abuse were not notified to the Chief Inspector.

Judgment: Not compliant

## Quality and safety

This section of the report describes the quality and safety of the service for the residents who lived in the designated centre. Overall, the inspector found that, while the provider was attempting to enhance the quality of care in the designated centre, the long-standing and persistent peer compatibility issues meant that residents continued to be in receipt of care that was not upholding their human rights and that placed them at risk of abuse. These issues stemmed from a previous admission to the centre which had not been appropriately assessed and planned to ensure peer compatibility. The inspector found that significant enhancements were required to the provider's policies, procedures and practices in relation to the admissions, transition and discharge of residents in order to ensure that all residents were in receipt of safe, person-centred and rights-informed care.

The provider had enhanced their oversight of the safeguarding risks in the designated centre. Enhanced staffing levels, along with a carefully planned routine for residents overseen by staff, had reduced the instances of peer to peer incidents of abuse. This routine was, however, restrictive in nature and this was acknowledged by the person in charge on the day of inspection. However, the inspector noted that when this routine was not followed, it had resulted in peer -to -

peer incidents, one of which was physical in nature.

The inspector also found that the oversight of restrictive practices in the designated centre required review. There were several restrictive practices in place that had not been reviewed in over a year. It was therefore not evidenced that the least restrictive practice for the shortest duration was in place. The provider had recently identified that an audit of restrictive practices was required and had referred the restrictive practices in the designated centre for review by their restrictive practices committee.

The provider had commenced transition planning in order to move one resident to their own apartment. This action was in line with the provider's representation received subsequent to the issuing of a notice of proposal to cancel the centre's certificate of registration.

The inspector reviewed the transition plan and found that sufficient time had not been allowed to plan for this transition. The inspector was informed by both the person in charge and the resident's representative that the resident was hesitant regarding the move to another location. The provider had imposed a time-frame to transition this resident which was too short and therefore did not allow for sufficient consultation with the resident or for a full and comprehensive review of their assessment of need and care plans.

The inspector found that there was a lack of a current and comprehensive assessment of need on this resident's file. Therefore the inspector could not be assured that the proposed transition to an individualised apartment was in line with the resident's assessed needs.

Overall, the inspector found that there continued to be some levels of non-compliance in the designated centre which were impacting on residents' well-being.

The inspector saw that the provider was attempting to address the peer compatibility and safeguarding risks however, more time and an enhanced admissions practices were required to ensure that this was done in a safe and planned manner. Ultimately, while the provider had committed to addressing the peer compatibility issues, it was found by the inspector that this would take some time and, in the interim, residents were subject to restrictive practices in order to mitigate and manage safeguarding risks in the centre.

## Regulation 5: Individual assessment and personal plan

The inspector saw that residents had an assessment of need which had been updated within the past 12 months. However, the assessment of need was insufficiently detailed and did not clearly set out the residents' assessed needs and the supports required to maximise their personal development in line with their wishes.

The inspector was informed that residents presented with additional needs in the area of mental health. Mental health needs were not clearly described in the assessment of need and there were no care plans available to describe how these needs were being supported.

There was an absence of assessments from relevant multidisciplinary professionals on the residents' files. For example, for one resident, there was no psychological assessment available. Therefore, it was unclear how the resident met the criteria for admission to the centre in line with the centre's statement of purpose.

Judgment: Not compliant

## Regulation 7: Positive behavioural support

The inspector saw that residents had up-to-date positive behaviour support plans on file which detailed proactive and reactive strategies to support residents' behaviour. Staff spoken with were knowledgeable regarding behaviour support plans and the strategies required to support residents.

The inspector reviewed the restrictive practices log in the centre and found that it was out of date and required review. It was last reviewed in 2021. The inspector was informed that there were other restrictive practices in place that were in the process of being reviewed by the provider's restrictive practices committee. It was not evident that all restrictive practices in the designated centre had been reviewed on a frequent enough basis to ensure that they were in place for the shortest duration possible.

Judgment: Substantially compliant

## Regulation 8: Protection

The provider had implemented measures in an attempt to mitigate against the peer compatibility and safeguarding incidents in the centre. While these were being effective in reducing the frequency and the physical nature of peer -to -peer incidents, the inspector found that the measures were restrictive in nature and that residents continued to experience psychological abuse on a regular basis.

The provider had enhanced their staffing complement and provided for individualised staffing for the residents. A strict daily protocol had been implemented to reduce the likelihood of peer to peer incidents from occurring. These measures were found to be somewhat effective as a short-term measure in reducing peer -to -peer incidents. The person in charge acknowledged that they placed restrictions on residents. The provider set out that they planned to transition one resident to their

own apartment in order to resolve the peer compatibility issues.

The provider had also committed to devising a peer compatibility tool in the representation which was submitted. The inspector was informed that the compatibility tool was in the process of being developed at the time of inspection. It was not available to the inspector for review.

Judgment: Not compliant

## Regulation 25: Temporary absence, transition and discharge of residents

Transition planning had commenced for one resident. The provider had planned to discharge this resident to their own individual apartment. This transition was proposed in light of peer compatibility issues and the resident's assessed needs. Consultation had commenced with the resident and their representative regarding this and there was a written transition plan in place which set out a short time frame for this transition to occur.

However, the inspector was not assured that this transition had been planned in a safe manner which was in line with the resident's assessed needs. There was a lack of a comprehensive assessment of need and personal plans on the resident's file. Without a comprehensive assessment of need, assurances could not be provided that the proposed new apartment was suitable to meet the resident's assessed needs.

The inspector also found that the provider had not allowed sufficient time to ensure that this transition was planned in a safe manner which gave sufficient time for consultation with the resident, their representative and multidisciplinary professionals.

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 | Compliant |
| Regulation 16: Training and staff development | Compliant |
| Regulation 23: Governance and management | Substantially compliant |
| Regulation 31: Notification of incidents | Not compliant |
| **Quality and safety** | |
| Regulation 5: Individual assessment and personal plan | Not compliant |
| Regulation 7: Positive behavioural support | Substantially compliant |
| Regulation 8: Protection | Not compliant |
| Regulation 25: Temporary absence, transition and discharge of residents | Not compliant |

# Compliance Plan for Liffey 4 OSV-0005781

## Inspection ID: MON-0039135

## Date of inspection: 07/02/2023

**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 23: Governance and management | Substantially Compliant |
| Outline how you are going to come into compliance with Regulation 23: Governance and management:<br>A protocol has been developed in relation to a resident making allegations. This protocol has been completed in consultation with the Designated Officer and Principal Psychologist.<br><br>A two-bed apartment has been sourced from the local council which will allow the resident to be supported with a funded staff team in a more appropriate home setting.<br><br>All retrospective notifications have been submitted to the Authority and any required notifications will be submitted in the required timeframe.<br><br>All admissions and discharges will be carefully planned going forward with corresponding transition plans to support all new admissions along with a comprehensive support needs assessment.<br><br>Monthly Designated Centre team meeting continue to be held with PIC, Coordinator and Programme Manager in attendance.<br>All staff in the Designated Centre are familiar with the governance and line management structures for the Designate Centre | |
| Regulation 31: Notification of incidents | Not Compliant |
| Outline how you are going to come into compliance with Regulation 31: Notification of incidents: | |

A protocol has been developed in relation to a resident making allegations. This has been completed in conjunction with the Designated Officer and Principal Psychologist. Where an allegation cannot be shown to be unfounded, a PSF1 and NF06 will be completed.

All retrospective notifications have been submitted to the Authority and any required notifications will be submitted in the required timeframe outlined by the Authority.

| Regulation 5: Individual assessment and personal plan | Not Compliant |
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Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
One resident has completed with support from Psychology, a Support Intensity Scale assessment. This will help outline the residents needs and the supports required to maximise their personal development in line with their wishes. All reports will be made available to the inspector. All residents individual assessments and personal plans are reviewed and updated regularly by their staff team.

A mental health care plan has been developed and in place in consultation with their Multidisciplinary team.

| Regulation 7: Positive behavioural support | Substantially Compliant |
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Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
All restrictions in place had been sent to the Restriction Committee prior to inspection and going forward all will be scheduled for review as required by this Committee.

| Regulation 8: Protection | Not Compliant |
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Outline how you are going to come into compliance with Regulation 8: Protection:
HSE safeguarding policy being complied with relating to all safeguarding concerns.
All incidents are escalated to the Designated Officer and the HSE safeguarding team and

are notified to HIQA if necessary. NIMs completed as required.

All restrictions were reviewed by the restrictive practice committee in February 2023 and will be reviewed by this committee going forward as required.

A compatibility assessment tool is currently being developed by disciplines within this service.

All staff trained in Safeguarding of the Vulnerable persons and safeguarding training is rescheduled by the Person in Charge as required for the team.

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| Regulation 25: Temporary absence, transition and discharge of residents | Not Compliant |

Outline how you are going to come into compliance with Regulation 25: Temporary absence, transition and discharge of residents:
The Provider is currently working to develop a robust and comprehensive compatibility tool to enhance the transition and discharge process.

Based upon individual assessed needs, two residents will remain in their home. Going forward an updated compatibility tool will be used to guide the Provider on suitable housemates to fill vacancies following the outlined move, however, all residents will be given a period of stability before admissions are agreed.

The third resident with support from Psychology has completed a Support Intensity Scale assessment. This will help outline the residents needs and the supports required to maximize their personal development in line with their wishes. This resident will be transitioned to an identified new home setting which will meet their individual assessed needs and preferences. The timeframe for this transition will be led by this person in a person centered approach.

## Section 2:

## Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

| Regulation | Regulatory requirement | Judgment | Risk rating | Date to be complied with |
|---|---|---|---|---|
| Regulation 23(1)(c) | The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored. | Substantially Compliant | Yellow | 30/06/2023 |
| Regulation 25(4)(b) | The person in charge shall ensure that the discharge of a resident from the designated centre take place in a planned and safe manner. | Not Compliant | Orange | 30/06/2023 |
| Regulation 25(4)(c) | The person in charge shall ensure that the discharge of a resident from the designated centre is in accordance with the resident's needs as assessed | Not Compliant | Orange | 30/06/2023 |

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| | in accordance with Regulation 5(1) and the resident's personal plans. | | | |
| Regulation 31(1)(f) | The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: any allegation, suspected or confirmed, of abuse of any resident. | Not Compliant | Orange | 15/03/2023 |
| 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 | 30/04/2023 |
| 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, | Not Compliant | Orange | 30/05/2023 |

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| | as assessed in accordance with paragraph (1). | | | |
| Regulation 05(4)(b) | 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 outlines the supports required to maximise the resident's personal development in accordance with his or her wishes. | Not Compliant | Orange | 30/05/2023 |
| Regulation 05(4)(c) | 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 is developed through a person centred approach with 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. | Not Compliant | Orange | 30/05/2023 |
| Regulation 05(6)(a) | The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more | Not Compliant | Orange | 30/05/2023 |

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| | frequently if there is a change in needs or circumstances, which review shall be multidisciplinary. | | | |
| Regulation 07(5)(c) | The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation the least restrictive procedure, for the shortest duration necessary, is used. | Substantially Compliant | Yellow | 30/04/2023 |
| Regulation 08(2) | The registered provider shall protect residents from all forms of abuse. | Not Compliant | Orange | 30/06/2023 |