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:	Kare DC19
Name of provider:	KARE, Promoting Inclusion for People with Intellectual Disabilities
Address of centre:	Kildare
Type of inspection:	Announced
Date of inspection:	13 March 2024
Centre ID:	OSV-0008047
Fieldwork ID:	MON-0033819

About the designated centre

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

Kare DC19 provides a residential service for up to two adults with a primary diagnosis of intellectual disability, who may have a range of support requirements including physical support needs. The objective of the service is to support residents with their activities of daily living as well as identifying and encouraging involvement in meaningful social, leisure and personal development activities underpinned by a model of person-centred support. The designated centre consists of a bungalow house in a rural area of County Kildare with each resident having a private bedroom, a living room, dining area, kitchen and garden. The centre is staffed by social care personnel, with access to clinical services when required.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	2

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
Wednesday 13 March 2024	10:40hrs to 18:00hrs	Gearoid Harrahill	Lead
Wednesday 13 March 2024	10:40hrs to 18:00hrs	Carmel Glynn	Support

What residents told us and what inspectors observed

During this inspection, the inspectors met with the residents and their direct support staff, as well as observing interactions in their day, their living environment and support structures, as part of the evidence indicating experiences living in Kare DC19. This inspection was announced in advance, in part to afford residents the opportunity to prepare for the visit and to fill out written surveys to express their experiences and commentary on the service. The families of both residents filled these on their behalf, and provided positive commentary on the service and the staff support. The survey commented where residents would benefit from changes to their home to optimise accessibility, such as with the size and height of chairs and kitchen appliances.

The inspector met both service users in the morning, who were up and ready for their day. One resident was planning to go shopping with their support staff and later visited a nearby farm. They used pictures to explain what they were doing and staff provided support to facilitate the resident and inspectors to communicate with each other. One resident used objects and props to communicate what they wanted to do during the day. One resident spent the day in the house or walking in the local area, as they had not been engaging with their vehicle or wider community in recent months. Inspectors observed examples of residents being supported to engage in meaningful activities and continuing to offer fun and interesting ideas in the community, while also respecting their choices.

The residents were observed moving about their separate living spaces and spending their time in the house listening to music, relaxing in their bedroom or socialising with staff. One resident was having their breakfast and inspectors observed them using their kitchen to help themselves to a second bowl of cereal per their wishes. Residents had plans in effect to support them to engage in activities of daily life such as laundering their clothes, washing dishes and participating in meal preparation to develop their own skills and independence. Support plans around subjects such as personal and intimate hygiene guided staff on which tasks residents could carry out without assistance. One resident had recently been supported to access and independently use items without staff support, including their mobile phone, hair dryer and contactless debit card.

The provider had captured some of the residents' achievements and successes in their annual report. This included attending classes and social events, going on holiday, and attending shows and carnivals. The service summary also reflected on areas with which the residents' support structure is being or had been changed to facilitate independence and autonomy, with referrals to speech and language and occupational therapy where required.

The inspectors observed kind, patient and supportive interactions between residents and their support teams. The inspector also found good examples of staff advocating for the rights of residents including using the complaints and

safeguarding processes where residents had been upset or dissatisfied with their experience in the service, such as with continuity of staff support and reliability of transport on which residents relied to access their community.

The next two sections of the report present the findings of this inspection in relation to the governance and management arrangements in place in the centre, and how these arrangements impacted on the quality and safety of the service being delivered.

Capacity and capability

This designated centre was resourced with a staff team who demonstrated good knowledge of residents' support structures, interests and preferred routines. Front-line staff felt supported in their day-to-day role and duties by their colleagues, and by the person in charge who had commenced in their role in February 2024. However, staff commentary and the findings of the provider's audits reflected on challenges which had been posed by a high turnover of local management in this centre in the past year, including the timeliness of quality improvement actions and initiatives being implemented. Inspectors also found that due to a lack of records of meeting minutes and development plans available to the person in charge, they were required to start over with formal supervision cycles, probation reviews and performance management for all front-line staff.

Staff were overall up to date in mandatory training such as fire safety, safeguarding of adults at risk of abuse, and safe administration of medicines. The provider had identified training to be completed by staff in 2024 to optimise support for the assessed needs of residents including communication needs, epilepsy and autism.

Staff had supported residents to communicate with the provider on matters which affected their routines and the quality of their service. Staff commented to inspectors that a centre vehicle required for safe community access had broken down or required repairs a number of times, which resulted in activities not occurring and plans for days being interrupted. Senior management personnel advised inspectors that there were plans to replace both service vehicles with ones which could be used by either resident to mitigate service interruption, though did not have an anticipated timeframe for this to happen as of the day of this inspection.

Registration Regulation 5: Application for registration or renewal of registration

The registered provider had submitted their application and associated documents to renew the registration of this designated centre.

Judgment: Compliant

Regulation 14: Persons in charge

The person in charge worked full-time in the designated centre and was appropriately qualified and experienced in the management of a health and social care setting.

Judgment: Compliant

Regulation 16: Training and staff development

The registered provider had identified training which was mandatory for staff working in this designated centre and had a means of identifying where staff were overdue or scheduled to attend refresher courses. As part of the provider's quality improvement and development plan, staff were planned to attend training in 2024, including supporting residents with specialist communication needs, epilepsy, autism and nutrition.

As referenced elsewhere in this report, the newly-appointed person in charge was required to restart all staff supervision cycles, however inspectors found examples of this having already commenced for some members of the team.

Judgment: Compliant

Regulation 21: Records

Records of staff supervision and performance management and development meetings were not available for inspection, nor were they available to the person in charge of the designated centre.

Judgment: Substantially compliant

Regulation 23: Governance and management

This designated centre was suitably resourced with a staff team, premises and equipment required to support the number and assessed needs of residents. Through speaking with staff and reviewing service commentary, inspectors observed

evidence to indicate that there had been challenges in the past year in ensuring that transport resources were reliable and suitable to meet resident requirements.

The provider had composed their annual report for the designated centre, dated November 2023, which reflected on the key achievements and challenges of the past year and areas on which the provider will focus in 2024. The content of this report indicated that it had been written in consultation with residents and their families, and included areas for learning based on complaints, incidents, allegations and residents' changing support needs in the centre.

The provider had had four people in role of person in charge of the centre since the start of of 2023, and had acknowledged challenges which had arisen in effective centre governance and completion of actions with this high turnover. Inspectors found that the performance management systems in effect had not facilitated the current person in charge to continue support and development plans which had been in progress with their staff. As there were no records available, the person in charge was required to restart all staff members' supervision, performance management and probation reviews.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The statement of purpose for this centre was updated in February 2024 and contained all information required by the regulations. An easy-read version was also available for use by residents.

Judgment: Compliant

Regulation 34: Complaints procedure

A record of complaints raised in or about the services of the designated centre was available for review along with evidence of actions and learning taken from the matters raised, and how these were communicated back to the complainant. The inspector observed staff supporting residents to make complaints where they had been upset or adversely affected by events and quality deficits in their support.

Judgment: Compliant

Quality and safety

In the main, each resident's wellbeing and welfare was maintained by a good standard of evidence-based care and support. Support was directed by guidance with which staff were familiar, and to which they had contributed based on working with service users and knowing their preferences, presentations and risks. However, it was not always clear if the effectiveness of the plans was assessed as part of a review as required by the regulations, and in some instances, plans were not specific, measurable or time-bound in actions required to achieve the objective.

The premises were suitably designed, homely, clean and in an overall good state of repair. Residents were supported to personalise their living spaces and to access communal areas, their belongings, their kitchen and their garden as required. Where required, equipment and features were present to facilitate good infection control measures, accessibility, and safety from injury.

There had been some improvement in fire safety compliance following previous inspections, including installation of emergency lights and being assured that practice evacuation drills were carried out during times of minimal staffing levels. However a repeat finding was identified in a fire exit which was locked and not equipped with a feature to open it in an emergency. Some risk assessments related to fire had not been carried out to mitigate risks related to storage of flammable items, detection of fire and smoke, and staff knowledge of recent changes to the alarm system.

Inspectors observed examples of residents' rights, autonomy and independence being developed through support plans and routines. This included supporting residents to enhance their independence in personal care and daily life skills, exploring opportunities to develop communication skills, attaining supported access to finances, and encouraging varied and meaningful community and social engagement.

Residents appeared content and comfortable in their home and with their staff teams and returned positive feedback on their staff, meals and personal supports through surveys. Where residents had indicated that they were anxious, frustrated or scared in the service, the provider had conducted investigations to determine the facts and take action to improve their lived experience. Staff were trained and familiar in identifying and responding to suspected or alleged safeguarding concerns.

Regulation 10: Communication

Inspectors observed communication techniques in effect in the centre to support residents to be informed and make choices. This included techniques to support residents who communicated by means other than speech, such as use of pictures

and objects of reference. A referral had been submitted to support the introduction of assistive technology to further enhance communication.

Judgment: Compliant

Regulation 12: Personal possessions

The provider had plans in progress to work with outside parties to ensure residents, either independently or with support from their staff, have access to their finances and associated statements and cards. Interim arrangements were in place to ensure that residents had cash available to them for their own use. Residents were supported to use their money as they wished and to decorate their living space and launder clothes in line with their skills and preferences.

Judgment: Compliant

Regulation 17: Premises

The premises was generally clean, in a good state of repair and suitably laid out for the number and support needs of residents. While some works were required in cosmetic maintenance such as walls requiring painting, this work was scheduled to take place in the coming weeks.

Judgment: Compliant

Regulation 26: Risk management procedures

The provider maintained a policy on risk management and a register of risks associated with the operation of the designated centre. Some risks related to resources, governance structures and fire safety had not been formally identified and risk assessed, or did not feature in the service's risk register to outline actions or risk controls to reduce the identified risk in the future.

Judgment: Substantially compliant

Regulation 27: Protection against infection

Staff were trained in infection prevention and control procedures and could describe appropriate practices for hand hygiene, use of personal protective equipment, management of soiled items, and food safety. The premises overall was clean, and where required was equipped with paper towels, hand sanitiser dispensers and hands-free waste bins. Cleaning tools were designated based on room types, and routine or as-required laundering of mops heads was included in the cleaning schedule for the centre.

Judgment: Compliant

Regulation 28: Fire precautions

Following the findings of the previous two inspections, the provider had committed to addressing deficits in fire safety procedures, evacuation plans and escape routes in this designated centre. Some elements of this had been addressed, such as ensuring that evacuation routes were equipped with emergency lighting, and ensuring that a timely evacuation could be carried out at night.

One evacuation route required staff to unlock a door to get to a resident as part of their evacuation plan, and this final exit was not equipped with a break-glass unit to allow someone to open this door in an emergency. This was a repeat finding from the previous two inspections. The inspector brought this to the attention of management, and before the end of the inspection was advised that an emergency key was put at this final exit.

Some fire safety risks in this centre had not been identified and formally risk-assessed, including storage of flammable items and a part of the premises not equipped with a means of detecting smoke or fire. Staff knowledge of emergency and evacuation procedures was overall good, but required improvement in how staff could identify where in the centre a fire had been detected.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

In the main, medicines were dispensed, recorded, administered, stored and disposed of in line with good practice, and staff were knowledgeable on the purpose and precautions for medicines used. Some improvement was required to ensure that where some medicines were being modified, this was included in the prescription with individual authorisation signed by the prescriber.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Inspectors reviewed a sample of support plans for the assessed health, personal and social care needs of residents. In the main these plans were evidence-based, person-centred and composed with input from the relevant healthcare professionals. Many of the support plans were comprehensive in detailing guidance for staff, and highlighting areas in which residents did not require support or were being supported to develop their own self-care skills. Plans were observed being implemented in practice, such as the use of objects of reference, mood charts and behaviour support observations. While plans were reviewed for accuracy or to reflect changes in circumstances, there was limited evaluation of the effectiveness of the plans as part of these reviews. It was not clear from review notes how the resident or their representatives participated in the review of their support plans.

Some resident support plans related to social or recreational pursuits did not contain specific, measurable or time bound steps or actions to achieve the intended objective, or to capture any actions done already towards progressing same. For one resident, a need was identified for developing a plan around using technology to enhance the resident's ability to communicate, with a referral or same submitted in August 2023, however there had been no progress on this support structure as of the time of this inspection.

Judgment: Substantially compliant

Regulation 8: Protection

Staff were familiar with what to do in response to alleged, witnessed or suspected instances of abuse of service users. Where there had been suspected or alleged safeguarding concerns, these were promptly reported to the designated officer and Health Service Executive Safeguarding and Protection Team. Where relevant, interim actions were taken to ensure residents were safe, such as not having relevant staff work with particular residents pending the outcome of an investigation. The inspectors observed investigation methodology and evidence-gathering procedures used by the provider to come to an informed conclusion and to identify where practices could be improved. The records of some safeguarding records required improvement to ensure that there was clear rationale for not informing family members or An Garda Síochána, or closing investigations prior to them being agreed by the HSE Safeguarding Team.

Residents were protected from potential financial abuse through appropriate oversight and checks of how residents' cash and bank accounts were being used. These records were accurate and complete on review. However the staff could not

perform these checks for both residents as they lacked access to records accounting for income and expenses.
Judgment: Substantially 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	
Registration Regulation 5: Application for registration or renewal of registration	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 12: Personal possessions	Compliant
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 8: Protection	Substantially compliant

Compliance Plan for Kare DC19 OSV-0008047

Inspection ID: MON-0033819

Date of inspection: 13/03/2024

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 21: Records	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records: Records of staff supervision as well as performance management and development meetings completed in 2024 will be saved in a secure file which will be accessible only by leaders of that location as of the 26th of March 2024. This will be accessible to any future leaders of this location. The performance management policy will be reviewed, updated and launched to staff prior to the end of December 2024.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: Repeat action from Regulation 21 - Records of staff supervision and performance management and development meetings completed in 2024 will be saved in a secure file which will be accessible only by leaders of that location as of the 26th of March 2024. This will be accessible to any future leaders of this location. The transport for this location is in good working order at present. Repairs have been completed as required. New transport is on order for this location which should eliminate future issues as both buses will need the required needs for individuals living in this location. It is envisaged that this will be in place by the 31st of July 2024.	

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
Two of these three actions have been identified in other regulations as actions required.
Risks related to resources – Reg 21 re buses actioned above.
Fire safety – Reg 28 re flammable items storage actioned below.
Governance structures – PIC abseentism is captured on adult supports risk register and was reviewed in March 2024.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
There are two control measures in place in the event of a fire which are to be used firstly. A third additional control measure as per individuals PEEPs was documented to be in place. The emergency key was put at this final exit on the day of the inspection 13th March 2024.
Fire safety risks in this centre had been reviewed, identified and formally risk-assessed and documented on the risk register as of the 28th of March 2024.
The cabin at the back of the house will be equipped with a means of detecting smoke or fire by the end of April 2024.
Staff knowledge of emergency and evacuation procedures was reviewed at the staff team meeting on the 20th of March 2024.
Flammable items storage has been identified and risk assessed, and features in the service's risk register to outline actions and risk controls to reduce the identified risk in the future.

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
The kardex will reflect and instructions for modifying any medication going forward where required as of the 13th of March 2024.
The medication noted as not compliant was a short term medication and is no longer

prescribed. This was caputured in the medication management plan and appointment log and notes from prescribing clinician on day of the medical visit.

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:
All support plans have a section that there is an evaluation of the effectiveness of the plans as part of these reviews. It is documented in the review notes how the resident or their representatives participated in the review of their support plans. All support plans will be updated to ensure this is captured by the end of June 2024.

Support plans will be also reviewed to ensure that goals contain specific, measurable or time bound steps or actions to achieve the intended objective. They will also capture any actions done already towards progressing same.

A referral for a review using technology to enhance the resident's ability to communicate, will be reviewed with the relevant department and plans to progress on this support structure implemented prior to the end of August 2024.

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
The Safeguarding policy for Kare will be updated to ensure that the Will and Preference of the individual is respected and adheered to in relation to informing their family or representatives.
Guidance for staff in the event of an immediate safety risk for an individual will be clarified in the next policy review which will be completed by the end of December 2024.
The safeguarding and protection team link with Kare when they are informed of an allegation. Safeguarding incidents on Kare CID database are only closed in Kare when the safeguarding and protection review or close the plan.
Kare will complete a review of financial policy for service users to ensure that their will and preference as well as the family responsibilities are outlined within the policy. This will be completed by the end of December 2024. If required each individuals financial support plan will be updated to reflect any changes required.

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 21(1)(c)	The registered provider shall ensure that the additional records specified in Schedule 4 are maintained and are available for inspection by the chief inspector.	Substantially Compliant	Yellow	31/12/2024
Regulation 21(5)	Records kept in accordance with this section and set out in paragraphs (7), (8), (9), and (10) of Schedule 4, shall be retained for a period of not less than 7 years from the date of their making.	Substantially Compliant	Yellow	31/12/2024
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with	Substantially Compliant	Yellow	31/07/2024

	the statement of purpose.			
Regulation 23(3)(a)	The registered provider shall ensure that effective arrangements are in place to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.	Substantially Compliant	Yellow	31/07/2024
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	30/04/2024
Regulation 28(2)(c)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Orange	30/04/2024
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	30/04/2024

Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.	Substantially Compliant	Yellow	30/04/2024
Regulation 29(4)(b)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine which is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.	Substantially Compliant	Yellow	13/03/2024
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.	Substantially Compliant	Yellow	31/08/2024

Regulation 05(6)(b)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall be conducted in a manner that ensures the maximum participation of each resident, and where appropriate his or her representative, in accordance with the resident's wishes, age and the nature of his or her disability.	Substantially Compliant	Yellow	31/08/2024
Regulation 05(6)(c)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall assess the effectiveness of the plan.	Substantially Compliant	Yellow	31/08/2024
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Substantially Compliant	Yellow	31/12/2024