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:	Rathmuck
Name of provider:	KARE, Promoting Inclusion for People with Intellectual Disabilities
Address of centre:	Kildare
Type of inspection:	Unannounced
Date of inspection:	18 January 2023
Centre ID:	OSV-0008047
Fieldwork ID:	MON-0033827

About the designated centre

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

Rathmuck 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 18 January 2023	10:50hrs to 18:00hrs	Gearoid Harrahill	Lead
Wednesday 18 January 2023	10:50hrs to 18:00hrs	Karen Leen	Support

What residents told us and what inspectors observed

The inspectors had the opportunity to meet and speak with both residents living in the centre and with their support staff team during this inspection, as well as reviewing documentation on their routines and support structures to observe the lived experience of residents in the centre.

On arrival, residents were in their morning routines and having their breakfast, being assisted with making their plan for the day. Residents were supported to pursue their routines and activities at home and in the community based on their choices and pace. Accessible and visual guides where available to residents to assist in the planning aspects of their day such as activities, meal plan and support staff working with them for the day. Support staff were observed to offer alternatives and choice within residents activities. Resident who changed their mind from the pre-planned activities of the day were supported to do so. Staff had a friendly, positive rapport with the residents, and residents were comfortable with staff. Some staff members had supported these residents since they were children and had worked with them in previous settings.

The centre was comprised of a bungalow house divided in two halves, with each resident having their own bedroom, living room and kitchen and dining area. The residents had access to a large garden with patio space, swing, trampoline and sets of planter boxes for growing herbs. There was a large ancillary building to the rear of the garden which was used by residents as a relaxing alternative activity space. Inspectors found this space to be spacious for residents to relax and participate in an activity of their choosing. The space was furnished with couches and bean bags. While overall the house was suitable in its design and layout, some areas required work to maintain a clean environment and address cosmetic maintenance issues.

The team had use of two suitable vehicles which supported residents to participate in activities or trips to the community as and when they wished. As each resident had their own support team, their preferred routine was not impacted by the choices of their housemate.

From speaking with residents' support staff and observing interactions between residents and staff during the day, the inspectors found that staff were knowledgeable of residents' individual support needs. The inspectors met and spoke with several staff members during the inspection including social care workers and direct support workers. The inspectors observed staff engaging with residents in a kind and respectful manner and staff spoken to had a good understanding and knowledge of the residents and were focused on providing good quality support and care.

Residents told inspectors that they were happy in their home and the activities that were provided. Residents showed inspectors their communication systems and talked inspectors through their plan for the day through their individualised supports

and through the support of staff members. Resident informed the inspectors that staff would help them change their plan for the day due to poor weather and that this would be decided together after their breakfast. Residents' personal tastes had been taken into consideration in the décor of the house, including photos of family, pictures of activities and events, and residents' artwork.

Residents spoke with inspectors about the important people in their lives and how they liked to keep in touch and spend time with their family and friends. One resident spoke about their family members and how they were looking forward to meeting up with them just after the inspection. One of the residents went out shopping with their support staff and showed off their new runners when they got back.

Overall, it was found by the inspectors that residents were in receipt of good quality and person-centred care. It was evident that residents' preferences and personal choice were considered in the day-to-day running of the centre. There was evidence of regular staff meetings in which residents' support quality was a key item of discussion. However, aspects of the quality and safety of the service required improvement such as the fire safety arrangements, governance and management, the procedures for making complaints and individualised assessment and personal plans.

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

Inspectors found evidence to indicate that the service was appropriately resourced by staff who were competent, appropriately supervised by the person in charge, and aware of their out-of-hours supports. Improvement was required in systems of oversight and record-keeping of matters related to the routine operation of the designated centre, as well as how the registered provider was working to address deficits in regulatory compliance.

Inspectors could not be provided evidence of the registered provider's quality and safety inspections as the report for this was not available for review. A number of regulatory gaps from the previous inspection were found again on this visit with no evidence of what action had been taken per the provider's compliance plan and timeline. Some of the oversight processes were found to not be effective in addressing service improvements or in assuring the person in charge of service compliance. This included training gaps reports, maintenance schedules and fire drills.

The complaints log for the designated centre indicated a number of entries made in

recent months, however the details of what had been raised, the actions taken by the provider, and information of how they were resolved with their respective complainants, could not be accessed for review by management. This did not provide assurance on how these matters were being reviewed for future reference and learning for the centre operation and to prevent reoccurrence.

The centre had an appropriate complement of staff to support residents, and staff who spoke with inspectors had a good knowledge of their support needs, interests, communication styles and personal preferences. The inspectors observed a good rapport and encouraging interactions from staff in supporting residents to go about their day, choose their activities, and travel with them into the community. Some staff had worked with these residents for a long time, and the inspectors observed examples of the team working well together. Appropriate contingency arrangements were in place to mitigate the impact that staff absences may cause on continuity of support by familiar persons.

Staff felt supported in their role, both from their colleagues and their manager. Inspectors reviewed a sample of team meetings and one-to-one performance management reviews which demonstrated how staff were supported to fulfil their duties, develop in their respective roles and address areas for improvement. Staff were confident in their support arrangements if they required management or clinical advice during the night or out of hours.

Regulation 16: Training and staff development

The provider had identified training and skills which were required for team members working in this designated centre. Overall staff were up to date in their attendance at training required under regulations, however there was a small number of staff members who had not attended refresher courses in subjects such as fire safety, infection control, safeguarding, positive behaviour support and safe moving and handling of people in accordance with provider policy. The report provided to the person in charge was not effective in providing assurance of staff being up to date in some of the skills identified as mandatory for this designated centre.

Judgment: Substantially compliant

Regulation 23: Governance and management

The designated centre was appropriately resourced with sufficient personnel, vehicles and equipment. The inspectors found evidence of the front-line team being subject to suitable supervision and performance management with the person in charge, including staff who had progressed through the process for induction and

probation.

Some of the management systems in place were not effective in ensuring that the service provided was safe and effectively monitored. This included records and oversight of staff training, complaints management, premises maintenance and assurances related to fire safety infrastructure and procedures. Some of the regulatory findings from the previous inspection were found again on this inspection.

During this inspection, inspectors could not be provided a report of findings from a six-monthly unannounced visit by a person nominated by the service provider, on the safety and quality of care and support. This did not provide assurance that these findings were readily available in the designated centre for the person in charge, front-line team and residents and used to inform quality improvement planning.

Judgment: Not compliant

Regulation 24: Admissions and contract for the provision of services

A written and signed agreement between the registered provider and the residents and their representatives had been completed.

Judgment: Compliant

Regulation 3: Statement of purpose

The registered provider had prepared a written statement of purpose containing the information set out in Schedule 1 of the regulations. The statement of purpose had been recently revised and was readily available to residents and their representatives.

Judgment: Compliant

Regulation 34: Complaints procedure

Details of complaints were not held within the centre and could not be made readily available to inspectors during the course of the inspection.

Judgment: Not compliant

Regulation 4: Written policies and procedures

The provider had a suite of policies and procedures for the designated centre per requirement of Schedule 5 of the regulations.

Judgment: Compliant

Quality and safety

Overall, residents were supported in their daily lives and to pursue their preferred routines in a safe, homely and restraint-free environment, with a team of staff who were provided person-centred, evidence-based guidance on support delivery. Fire safety issues previously raised remained outstanding, as well as some improvement in the general maintenance of the living environment and furnishings.

The inspectors conducted a walk of the premises during this inspection and found it to be homely, comfortable and appropriately furnished. Some areas of the house were in need of attention to address areas which were stained, damaged or in need of re-painting or re-plastering. The upholstery of some furniture was torn and held together with tape which was peeling, impacting on the ability to properly clean and sanitise surfaces.

The majority of the house was appropriately equipped to detect and contain flame and smoke in the event of fire. However, a number of fire safety deficits identified on the previous inspection, which the provider had set out a time bound plan to address, remained outstanding on this visit with no evidence to indicate work done or scheduled. One evacuation route was not equipped with emergency lighting. Fire escape routes which included doors locked with keys did not have features which would allow someone not carrying keys to use them. Inspectors also observed some fire protection doors propped open using a means which would not allow them to close in the event of fire. It was not evident how the provider could be assured of a safe and efficient evacuation of the designated centre under high risk circumstances, as there was some inconsistency with staff procedures in the event of a fire, and evacuation drill records did not accurately reflect night time scenarios.

Inspectors found evidence to indicate how residents were being protected from suspected or alleged instances of abuse, including protection measures in response to risks related to unexplained injuries, residents finances, and intimate support arrangements. Where relevant, the provider had notified or referred to outside bodies in response to incidents and concerns. Staff were provided guidance on supporting residents who were anxious or distressed, including protecting them where there existed a risk of harm to themselves or others.

Inspectors reviewed a sample of personal support plans which were overall detailed,

person-centred, and sufficient in providing guidance to staff on supporting health, personal and social support needs. Some improvement was required to ensure that the assessments informing these personal plans were conducted at least annually or as circumstances changed.

Residents were supported to pursue their interests, activities and community involvement with regard to their choices, preferred routines and assessed level of independence. Residents used planning tools and were supported to change their mind during the day. The inspectors were provided evidence of how residents were supported to explore new and meaningful social ,educational and community opportunities with their keyworking team.

Regulation 12: Personal possessions

Residents were supported to maintain control over their belongings and finances in accordance with their assessed level of capacity and understanding. Inspectors found evidence to demonstrate how key working staff were working with residents and their families to establishing financial accounts in the residents own name.

Judgment: Compliant

Regulation 13: General welfare and development

Residents were provided with opportunities to participate in activities in accordance with their interests, capacities and developmental needs. Residents were provided with support to develop and maintain personal relationships and links with the wider community in accordance with their wishes. Residents were seen to have access to online education courses with the support of staff.

Judgment: Compliant

Regulation 17: Premises

Overall the premises was suitable for the number and needs of residents, including spacious and personalised living, dining and bedroom areas and large safe garden grounds. Inspectors observed some areas of the house requiring cleaning, repair, repainting or cosmetic upkeep, with many of the observations not identified and logged for the attention of maintenance personnel.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

The provider had composed a register of risks in this centre and a log of adverse incidents occurring in the service. In the main, the provider had set out control measures and actions addressing the majority of risks in the service. However some risks had not been identified on this register, including risks related to frequent false fire alarms, and gaps in fire safety features on the premises.

Judgment: Substantially compliant

Regulation 27: Protection against infection

Inspectors observed the upholstery and padding of some furniture including mattresses and changing benches to be worn and torn with peeling sticky tape, compromising the ability to properly clean and sanitise surfaces.

Some improvement was required in the ready availability of hand towels and pedal-operated bins at some hand hygiene sinks.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Improvement was required to evidence how the provider was assured that an efficient evacuation could take place during high risk scenarios, for example when staff and residents were asleep. The inspector discussed with multiple staff members how they would safely evacuate a resident whose bedroom was on the opposite side of a kitchen from the staff bedroom. There was some inconsistency on how this would be achieved, including staff entering through the kitchen before confirming it was safe to do so, or staff going outside and around the rear of the house, a procedure which had not been tested or assessed as safe and effective. The provider had conducted a number of fire drills in the designated centre, including four drills representing a night-time scenario. It was not clear, however, how the provider could be assured of a timely evacuation in this event as three of these drills were carried out with double the number of staff members as would typically be working on a night shift in this house.

Following the findings of the previous inspection, the provider had committed to addressing deficits in one fire evacuation route, including installing emergency

lighting, and equipping key-locked final exit doors with a means of emergency escape by people not carrying keys. These deficits had not been addressed on this inspection.

Inspectors observed that some fire doors were propped open instead of using a mechanism which allowed doors to remain open by choice or necessity without compromising their ability to contain flame and smoke in the event of fire.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

Individual assessment of each residents' health, personal and social needs had been carried out within the centre, however these assessments had not been reviewed on an annual basis in line with the provider's policy.

The person in charge and support workers had ensured that personal plans were developed for residents. These plans were reflective of the supports required to meet the residents' needs. The plans viewed by the inspectors were up to date and readily available to guide staff in the appropriate delivery of care and support for residents.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

Staff had completed training in the area of positive behaviour supports and demonstrated the skill and knowledge in supporting residents who may express anxiety or frustration in a manner which may harm themselves or others.

Residents had access to allied health professionals for support in the area of responsive behaviours. A positive behaviour support plan was reviewed on inspection and it was found to detailed, kept under regular review, and developed with input from an appropriate qualified person.

Judgment: Compliant

Regulation 8: Protection

The provider had followed their procedures in response to alleged or suspected incidents of abuse, and had involved the appropriate external parties such as the

Health Service Executive or the Gardaí where relevant as part of their investigation. Appropriate supports were in effect related to sensitive matters such as intimate support and protection of finances.

Judgment: Compliant

Regulation 9: Residents' rights

Inspectors found evidence indicating how residents' choices and wishes were respected. Staff were observed supporting residents in a manner which protected their privacy and dignity, and allowed residents to have their voice heard in how they went about their daily routine and preferred community activities.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Admissions and contract for the provision of services	Compliant
Regulation 3: Statement of purpose	Compliant
Regulation 34: Complaints procedure	Not compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 12: Personal possessions	Compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Rathmuck OSV-0008047

Inspection ID: MON-0033827

Date of inspection: 18/01/2023

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 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: All staff who require refresher training have been booked into the relevant trainings and will be completed by the end of April 2023. The training records will be reviewed by the training department to identify improvement opportunities and these improvements actioned by the end of May 2023.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: An audit was conducted on the 28th of July 2022 and the next 6 monthly audit was in the process of being finalized on the 18th of January 2023. This audit report will be available to the leader by the end of February 2023. Other gaps identified in this area are documented below as actions under other regulations.	

Regulation 34: Complaints procedure	Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
All complaints are recorded on KARE CID database, for new leaders access to this system has been enabled for all previous adverse advents including complaints for that location on the 18th January 2023 which is now standard practice for every leader in every location.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
All actions identified as an issue have been completed by 31st January 2023. This includes paint work, cleaning and repair to cracks.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
The location risk register ratings have been updated to include false alarms and gaps in fire safety by 23rd February 2023.

Regulation 27: Protection against infection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
The armchair, mattress and changing bench will be repaired/replaced by the end of June 2023.

Hand towels, bins are ordered and will be in place by the end of February 2023.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions: PEEPs for each individual will be reviewed and updated by the end of February 2023 and all staff will be informed of the changes at the same time.

The emergency response plan has been reviewed and communicated to all staff by the end of February 2023.

Fire drills, including simulated fire drills will be conducted with all staff after the PEEPs have been updated using night time conditions by the end of June 2023.

5 Emergency lighting external to the building were installed on the 31st January 2023.

Emergency light inside the building lobby was installed on the 31st January 2023.

The key box was installed at the front door in January 2023 to use in the event of staff not having the key on them in the event of an emergency at night.

External key boxes will be installed outside by the end of February 2023.

Thumb locks were reviewed for use and were deemed a safety risk and therefore not installed in January 2023.

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 plans which are overdue a review will be reviewed and updated with the relevant people and include all necessary information to effectively review and document the effectiveness of the plan as required by the end of March 2023.

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 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	31/05/2023
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Substantially Compliant	Yellow	31/01/2023
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Substantially Compliant	Yellow	31/01/2023
Regulation 23(1)(c)	The registered provider shall	Not Compliant	Orange	28/02/2023

	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.			
Regulation 23(2)(b)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall maintain a copy of the report made under subparagraph (a) and make it available on request to residents and their representatives and the chief inspector.	Not Compliant	Orange	28/02/2023
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	Substantially Compliant	Yellow	23/02/2023

	responding to emergencies.			
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.	Substantially Compliant	Yellow	30/06/2023
Regulation 28(2)(c)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Orange	31/01/2023
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	28/02/2023
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	28/02/2023
Regulation 28(4)(b)	The registered provider shall	Not Compliant	Orange	28/02/2023

	ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.			
Regulation 34(2)(f)	The registered provider shall ensure that the nominated person maintains a record of all complaints including details of any investigation into a complaint, outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.	Not Compliant	Orange	18/01/2023
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.	Substantially Compliant	Yellow	31/03/2023