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:	Cork City North 13
Name of provider:	COPE Foundation
Address of centre:	Cork
Type of inspection:	Unannounced
Date of inspection:	15 March 2023
Centre ID:	OSV-0003310
Fieldwork ID:	MON-0032274

About the designated centre

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

Cork City North 13 is comprised of 4 bungalow type town houses which are located in a cul-de-sac in a large residential area on the outskirts of Cork City. The designated centre can provide full residential care for up to nine adult residents. Each bungalow comprises of individual bedrooms, some en-suite, kitchen, dining and sitting room, bathroom and laundry facilities. All the bungalows have individual front entrances with shared open plan garden area to the rear. There is a staff office and visitor room in one bungalow. The centre supports residents with varying levels of intellectual disability with many residents presenting with additional complex needs and behaviours that challenge. Residents are supported by a staff team that comprises of both nursing and social care staff by day and night.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	8

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 15 March 2023	09:30hrs to 16:00hrs	Laura O'Sullivan	Lead

What residents told us and what inspectors observed

This was an unannounced visit to designated centre Cork City North 13. Due to concerns in relation to Regulation 23 Governance and Management, Regulation 15 Staffing, Regulation 16 Training and development, Regulation 5 Individualised assessments and personal plan and Regulation 9 Rights, the Chief Inspector of Social Services is undertaking a targeted inspection programme in the provider's registered centres with a focus on these regulations.

The inspector was greeted by a staff member of one of the houses who welcomed them to the centre. It was observed that this staff member was not wearing a facemask upon opening the door. This was not in adherence to the local policy as the resident was up from bed and was going about their morning routine. When the staff member did put on a mask this was worn incorrectly. This was highlighted to the person in charge, who assured the inspector that this would be reviewed, to ensure the staff had the required training in the correct use of personal protective equipment (PPE) and effective infection control measures.

At the beginning of the inspection, the inspector met with the person in charge to discuss the operations of the centre and the support needs of residents. They had only recently taken up the role and was becoming familiar with the needs of the residents and the centre. Since their commencement the person in charge had identified a number of key areas which required review. This included staff supervision and staff training. They were in the process of reviewing the actions required under the annual review of service provision and most recent six monthly unannounced visit to the centre, and was aware these had yet to be completed to improve the service being afforded to residents.

The inspector spent time visiting with residents living in the centre throughout the day of the inspection. A number of residents had left for their day service by the time the inspectors arrived. One resident was waiting for their bus to collect them to bring them to their day service. They showed the inspector their bedroom where they "liked to chill" and get some peace and quiet. They went to their day service every day and enjoyed this. The resident told the inspector their game console was not working. Staff assured the resident that they would look at this when they returned home in the evening. The resident said it was okay that they could look at their tablet instead. The resident went to the living room to watch TV until their bus arrived.

The resident shared the house with two other residents. These individuals were relaxing in the living room watching morning TV. One resident told the inspector that they had gone for coffee the day before in a local restaurant and enjoyed this. They liked to get to be out and about and the person in charge had been encouraging community activation for all residents since commencing their role in the centre. The residents told the inspector they could look in their rooms. Each residents' bedroom was decorated in accordance with their interests and unique

personality traits. The inspector thanks the residents and said good bye.

The inspector visited with another resident in their house. The resident showed the inspector around their house and showed them their bedroom. They laughed and smiled with the inspector while watching their favourite movie on TV. They told the inspector they were going to the canteen for salad for lunch which was one of their favourite things to do. They showed the inspector their favourite teddy and told them that their goal was to visit Disney land. Staff supporting this resident were very aware of their individual support needs including when the resident displayed anxiety or became upset. They were aware of triggers which could result in escalation and the importance of routine and consistency to reduce the impact of this. This resident was supported by two staff members and appeared very comfortable in their company. They laughed and joked with each when planning the day's activities.

The centre consisted of four terraced houses. Each resident had their own bedroom which they were supported to decorate in accordance with their unique interests and personalities. As the provider had self-identified the buildings did require attention to ensure it was in a good state of repair. This included a new roof, attention to the garden and painting throughout. While the centre appeared clean, it was difficult to ensure effective cleaning of some areas due to raising flooring, dampness and peeling paint.

The inspector had the opportunity to meet with three residents when they returned from their day service. They happily engaged with staff and management on their return to the house and went about their routine of putting their lunch stuff in the dishwasher and getting a cup of tea ready for a snack. They told the inspector they liked living in the centre and enjoyed going out every day. Staff were observed to interact with the residents in a positive manner. Residents were enquiring about a day trip they had planned for the next day and how this was to go ahead. Staff reassured the residents to the plan. The residents said goodbye to the inspector and went about their evening.

The next two sections of the report will review evidence present in the areas or capacity and capability of the provider and the quality and safety of the service provided and how this impacts the life of the residents currently availing of the service within Cork City North 13.

Capacity and capability

Due to concerns in relation to Regulation 23 Governance and Management, Regulation 15 Staffing, Regulation 16 Training and development, Regulation 5 Individualised assessments and personal plan and Regulation 9 Rights, the Chief Inspector of Social Services is undertaking a targeted inspection programme in the

provider's registered centres with a focus on these regulations. The provider submitted a service improvement plan to the Chief Inspector in October 2022 highlighting how they will come into compliance with the regulations as cited in the Health Act 2007 (as amended). As part of this service improvement plan, the provider has provided an action plan to the Chief Inspector highlighting the steps the provider will take to improve compliance in the provider's registered centres. These regulations were reviewed on this inspection and this inspection report will outline the findings found on inspection.

The registered provider had appointed a governance structure to the centre to oversee that a safe and effective service was afforded to residents. A new person in charge had been appointed in the weeks previous to the inspection. This was the third appointment in a twelve month period. The person in charge had governance responsibility over three designated centre and was supported in their role by a clinical nurse manager. Since their appointment the person in charge had identified a number of areas which required attention. This included the area of staff training and the appropriate supervision of staff.

The registered provider had ensured the implementation of the regulatory required monitoring systems. An annual review of service provision had been implemented by delegated persons in December 2022 and an unannounced visit to the centre was completed in November 2022. Both reports had incorporated consultation with residents and their representatives. The reports were utilised to identify areas requiring attention such as staff supervision, review of personal plans and need for premises work. Despite these areas being highlighted to the registered provider within the reports and associated actions plans, limited actions had been taken to address these within the allocated time line. The person in charge, since taking up post in February 2023 had implemented some actions including the introduction of monthly staff meetings to communicate relevant information to the staff team and build professional relationships.

An audit schedule was in place to oversee the day to day operations of the centre. This included specific time lines for audits to be competed. Areas present on the schedule included medication management, fire safety, infection prevention and control and finances. Despite a set time line in place for audits to be completed, this was not consistently adhered to. Also, audits were not used to identify areas for improvement and drive service improvements. For example, in the area of individualised personal plans and infection prevention control, the need for improvement had not been recognised.

Staff within the centre had not been facilitated to access mandatory training that was appropriate to the assessed needs of residents. For example, 23 staff required training in the area of behaviours of concern and 21 staff required training in manual handling. No action plan was in place to address this and to ensure all staff were appropriately trained. There was a level of reliance in the centre in the use of agency staff. The person in charge did not have assurances in place that all agency staff had the mandatory training to complete their duties. This had been requested from the organisational HR department but had yet to be received. Within the centre it was practice to utilise staff from other designated centres to provide supports to

residents of the centre. As per agency staff, assurances were not in place to ensure all individuals had the required mandatory training.

The person in charge had not ensured that staff were appropriately supervised in accordance with the organisational policy. This policy stated that each staff member should be supported to have a performance management review every 12 months completed by their line manager. Adherence to this process was not evidenced on the day of the inspection. Despite the need for appropriate staff supervision being identified within regulatory required auditing systems, no actions had been taken by the provider to address this is a timely manner. Three staff members had returned the completed documentation for their performance management to the management team in January 2023, but no further action was taken to complete their performance review or discuss concerns noted. The concerns noted by the inspector included the impact of lack of familiar staff had on residents and the completion of tasks including cleaning and documentation recording.

The registered provider had not ensured that continuity of care was afforded to the residents currently residing in the centre. From review of the actual and planned staff roster in place shifts were covered on a regular basis by staff from other designated centres, relief staff and agency staff. Staff from Cork City North 13 were also used to cover shifts in other centres with some duties then not being completed in their absence such as personal plan reviews and completion of required health action plans. A number of individualised plans and behaviour support plans identified the need for a consistent staff team to support the resident and the importance of regular staff supports. The lack of continuity of staff was also emphasised to the registered provider within the most recent unannounced visit to the centre, with the requirement of an action to ensure the continuity of supports was promoted.

Regulation 15: Staffing

Practices relating to the implementation of an actual and planned roster did not promote continuity of care within the centre. From review of the roster in place it was difficult to ascertain if the registered provider had appointed an appropriate staffing level to the centre.

Staffing levels reported ot the inspector were not in line with the statement of purpose.

Judgment: Not compliant

Regulation 16: Training and staff development

The person in charge had not ensured that the staff team allocated to the designated centre were supported and facilitated to access appropriate training including manual handling and behaviours of concern.

The person in charge had not ensured effective measures were in place for the supervision of staff. Formal annual appraisals were not completed in accordance with organisational policy.

Judgment: Not compliant

Regulation 23: Governance and management

There had been a recent change in the governance structure of the centre to ensure oversight in the day to day operations of the centre. Clarity was required to ensure the roles and responsibilities of all members of the governance team were clear and monitored. While the provider had ensured the completion of the regulatory required monitoring systems, actions identified in these reviews had not been completed within the allocated time frames. For example:

- Appropriate staff supervision in accordance with organisational policy,
- Continuity of care and supports.
- Premises work.

Where an audit schedule was in place to oversee the day to day operations of the centre, these were not utilised effectively to identity non compliance and drive service improvement. This included the identification of improvements in such areas as:

- Individualised personal plans and
- Infection prevention and control.

Judgment: Not compliant

Quality and safety

Cork City North 13 was a designated centre located on the north side of the city. The centre currently provided supports to 8 residents, with no planned admission in progress. Each resident had been supported to develop an individualised personal plan. It had been highlighted through provider level monitoring systems such as the annual review of service provision that improvements were required to these plans. These improvements were required to ensure personal plans reflect the current assessed needs of the residents. The individualised plans in place were to be utilised to reflect the holistic support needs of residents. This included their social, physical

and emotional supports.

The inspector was informed by staff that an annual multi- disciplinary review had been completed for each resident in January 2023. However, at the time of the inspection the reports for each of these remained outstanding. Therefore, personal plans had not been updated to reflect the current assessed needs of residents as discussed as part of the review taking into account any change in circumstances for the individual or recommendations made. For example, on the day of the inspection, following multi-disciplinary referrals made on the day of the review, responses were received in the centre. One resident was assigned a 12 month wait for physiotherapy with no rationale for this time period assigned. It was also not noted in the resident's personal plan what the referral was in connection with and what the individual's support needs were in this area.

During the inspection, it was highlighted to the inspector that one resident had a recent increase in falls in the weeks previous to the inspection. Upon review of the resident's individual personal plan, the individuals supports required in this area were not present. A risk assessment had been completed however, was found to be generic in nature and not specific to the individual needs of the resident. The assessment also referred to a falls assessment in place, this assessment was not available on the day of the inspection. While personal plans were documented as being updated these updates did not consistently take into account changes in circumstances. For example, in the area of health care, where changes to multi-disciplinary recommendations were made, these were not consistently recorded with the update stating no change in supports.

The inspector was informed that each resident had an appointed keyworker and that regular keyworker meetings were completed in accordance with the statement of purpose, to ensure the ongoing review of the personal plans and individualised goals. There was no evidence on the day of the inspection that these meetings were occurring, with some records showing a meeting had not occurred since September 2021. This did not allow for a consistent review of personal goals in place and to progress actions as required. Where records were maintained of social activities within each plan to monitor resident community involvement in accordance with personal goals, these were also not completed in a consistent manner. For example, two residents had gone for lunch in a local restaurant the day previous to the inspection. This was not recorded.

Resident forum group meetings were held with residents of the centre to discuss the operations of the centre, where they chose to participate. Records of these meetings were very found to be very comprehensive. However, meeting records were not maintained in a manner which was accessible to residents. Should a resident be unable to attend a meeting the records would not allow for their review. A number of items discussed in meetings warranted follow up when the meeting was concluded. For example, one resident expressed interest in attending a sporting event. Despite being told that this would be accommodated there was no evidence that this had been actioned in the resident's personal plan or meeting notes. Also, two resident asked to go out more to the community, again no action or goal was in

place to ensure this was actioned.

Regulation 5: Individual assessment and personal plan

Each resident had been supported to develop an individualised personal plan. However, on the day of the inspection it was not evidenced that these had been consistently updated to reflect the assessed and changing needs of residents. Where it was reported that multi-disciplinary reviews had been completed for each resident in January 2023 there was no documented evidence of this.

There was no evidence of the review of personal plans and individualised goals through key worker meetings, with some records not being updated since September 2021.

Judgment: Not compliant

Regulation 9: Residents' rights

Overall, the registered provider had ensured the centre was operated in a manner that respected their rights. However, while resident meetings occurred these were not documented in an accessible manner fo residents to comprehend. Also, agreement of actions to be completed during these meetings, between staff and residents were not completed.

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	
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Cork City North 13 OSV-0003310

Inspection ID: MON-0032274

Date of inspection: 15/03/2023

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: 15(1): The registered provider is in the process of completing a skill mix review across its services to ensure safe and effective recruitment practices in accordance with standard 7.1. From this the PPIM will highlight shortfalls (if any) to the PIC through monthly meetings. The PIC will provide the PPIM with an escalated risk regarding regulation 15 as needed, this will be escalated by the PPIM through allocation meetings. The PIC and PPIM will review SOP with regards to staffing levels in the centre. 15(3) The PIC ensures that familiar staff work in the centre in so far as possible. The PIC requests familiar agency staff as needed. The PPIM supports the PIC to ensure the centre is operationally effective. In times of staff shortages, due to unforeseen circumstances, the PIC will endeavor to use familiar staff from link centres first and foremost before using unfamiliar staff. 15(4) The PIC has completed a review of current and planned rosters, ensuring adequate cover to provide a safe and effective service in CCN13, rosters reflecting staff complement within CCN13 solely. The PIC ensures continuity of care within the center by making sure that their familiar staff working with the residents and that the skill mix is suitable to the individual resident's needs.	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: 16(1)(a): Actions plans in place to ensure mandatory training is completed in a timely fashion. Training matrix is continuously being reviewed to highlight training gaps. All	

safeguarding and Fire training are completed. All CPI (formally MAPA) training has been prioritized and manual handling training action planned to be completed throughout 2023. Additionally, staff have access to CPD and staff education programs such as Medication management, Diabetes awareness, Report writing for Nurses and Healthcare Assistants. Agencies have provided assurances that all their staff rostered to CCN13 comply with Cope Foundation's Mandatory training schedule and certs are available on request.

16(1)(b) Performance management reviews (PMR's) have been commenced by the PIC relating to staff. Staff are completing the appropriate documentation in line with the Registered Providers Performance Management System Policy. A record will be maintained for staff supervision purposes. The PIC will feedback any concerns or suggestions for service improvements to PPIM during monthly meetings, the PPIM will counter sign the PMR's.
The center has onsite specific induction in place for new employees as well as organizational mandatory induction.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
23(1)(b) PIC has outlined the governance structure to all staff and has discussed roles and responsibilities with senior staff members. Governance structure available to all staff. Regular management meetings held (PIC & CNM1). Fortnightly regional meetings with PIC, PPIM and PIC's of linked centers to engage with shared learning as part of the service improvement plan (SIP) to be in line with Standard 5.2.
23(1)(c) The PIC will support, develop and manage performance of all staff through the PMR policy and staff meetings to promote personal and professional responsibility. The PIC will ensure there is senior staff on duty every day. Audit schedule being adhered to with appropriate action plans in place as needed, audits to be reviewed by PIC and PPIM to include personal plan audit.
23(3)(b) The PIC ensures that staff are facilitated to raise concerns, that staff access to and read the protected disclosure policy and safeguarding policy statement and sign same. All staff are compliant in training in safeguarding the vulnerable adult. PIC ensures time to meet staff is available to raise any concerns. PIC is available via telephone & email if not onsite on rostered days. Quality & Safety meetings have commenced within the center to ensure service being provided is safe and appropriate for resident's needs.

Regulation 5: Individual assessment and personal plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
05(6)(a) All updated Multidisciplinary records are now held in the resident's personal plans, all personal plans are being reviewed to reflect same. 05(6)(b) All PCP meetings are scheduled and have commenced with the person at the centre of the process. All goals to be reviewed on an ongoing basis through keyworker meetings.
05(6)(c) Personal plans will be reviewed and updated annually in consultation with the resident and their support network. The PIC will review all personal plans with each keyworker. All health assessments have been input into individuals' personal plans by nursing staff. The PIC or CNM to regularly review residents notes and escalate any concerns to relevant disciplines and PPIM.
05(6)(d))5(8) The PIC will ensure that as plans are being reviewed they will reflect any changing needs of the residents in accordance with updated assessments and MDT reviews; MDT assessment and CASS referral sheet added to the personal plans to track referrals and need to follow up same.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
09(1) The PIC will include a more user-friendly option suitable for the residents needs to allow residents accessible information regarding the topics discussed at the resident's forum meetings to accommodate all residents within the Centre.
09(2)(e) The PIC ensures that residents forums are in place so that the residents participate in the organization of CCN13, in saying that the PIC will review current resident forums so that if a resident misses a forum or would like to include something in their absence they will be afforded the opportunity to have input or review meeting notes through discussion with staff.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Not Compliant	Orange	31/08/2023
Regulation 15(3)	The registered provider shall ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.	Not Compliant	Orange	24/03/2023
Regulation 15(4)	The person in charge shall ensure that there is a planned and actual staff rota,	Not Compliant	Orange	24/03/2023

	showing staff on duty during the day and night and that it is properly maintained.			
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.	Not Compliant	Orange	30/12/2023
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	30/06/2023
Regulation 23(1)(b)	The registered provider shall ensure that there is a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.	Substantially Compliant	Yellow	30/06/2023
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	Not Compliant	Orange	30/06/2023

	and effectively monitored.			
Regulation 23(3)(b)	The registered provider shall ensure that effective arrangements are in place to facilitate staff to raise concerns about the quality and safety of the care and support provided to residents.	Not Compliant	Orange	31/05/2023
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 frequently if there is a change in needs or circumstances, which review shall be multidisciplinary.	Not Compliant	Orange	30/06/2023
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	Not Compliant	Orange	30/06/2023

	representative, in accordance with the resident's wishes, age and the nature of his or her disability.			
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.	Not Compliant	Orange	30/07/2023
Regulation 05(6)(d)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall take into account changes in circumstances and new developments.	Not Compliant	Orange	30/07/2023
Regulation 05(8)	The person in charge shall ensure that the personal plan is amended in accordance with any changes recommended following a review carried out pursuant to	Not Compliant	Orange	30/07/2023

	paragraph (6).			
Regulation 09(1)	The registered provider shall ensure that the designated centre is operated in a manner that respects the age, gender, sexual orientation, disability, family status, civil status, race, religious beliefs and ethnic and cultural background of each resident.	Substantially Compliant	Yellow	30/05/2023
Regulation 09(2)(e)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability is consulted and participates in the organisation of the designated centre.	Not Compliant	Orange	30/05/2023