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:	Inbhear Na Mara
Name of provider:	Health Service Executive
Address of centre:	Donegal
Type of inspection:	Unannounced
Date of inspection:	03 July 2025
Centre ID:	OSV-0002496
Fieldwork ID:	MON-0047412

About the designated centre

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

Inbhear Na Mara provides accommodation for 10 adults over the age of 18 years with an Intellectual disability who have high support and complex needs in terms of their physical and medical needs. The unit was purpose built to accommodate persons with complex needs and all accommodation is at ground level and is suitable for wheelchair users or people with limited mobility. All bedrooms are single occupancy and some have direct access to the garden areas via double doors. Residents have access to a range of communal seating areas, a dining room and quiet room where residents can spend time alone if they wish. In addition to shared toilet and bathing facilities a number of residents have en suite shower and toilet facilities. The centre is located in a small town and is staffed 24 hours with nurses on duty at all times.

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
Thursday 3 July 2025	11:20hrs to 18:40hrs	Alanna Ní Mhíocháin	Lead

What residents told us and what inspectors observed

Residents in this centre received a good quality service. They were supported to meet their health, social and personal care needs. The staff had the appropriate skill-mix and training to support the residents. However, the reliance on high numbers of agency staff impacted on the consistency of staff in the centre. The provider had systems in place to maintain oversight of the service and to progress any service improvement actions that were identified. However, improvement was required to ensure that all service improvement actions were clearly defined to ensure that they were addressed. Improvement was also required to ensure that all assessments of need were up to date and that staff had clear information in relation to the communication supports needed by residents.

The centre consisted of a very large, single-story building on the edge of a town. The centre was registered to accommodate ten residents but, on the day of inspection, there were only eight residents living in the centre. The main entrance to the centre was in the middle of the building. The bedrooms were all located in one wing of the building. Each resident had their own bedroom. Each resident shared an en-suite bathroom with another resident. There was also a large bathroom with a Jacuzzi bath that could be used by all residents. The centre had a very large open-plan living room in the middle of the building. There was a coffee station in the living room with kitchen cupboards and a small fridge. The centre also had a separate activity room with a kitchenette for making coffee and where residents could complete baking activities. There was a sensory room with sensory equipment. The centre had a large dining room with three separate dining tables. The centre's kitchen was not accessible to residents. It was a large, professional kitchen and could not be accessed by residents in order to maintain food safety and hygiene regulations. In addition, there was also a large laundry room and staff offices, staff changing rooms, and store rooms were located throughout the centre.

The building was a congregated setting and institutional in design. However, the provider had made refurbishments to the centre to make it more homely and personal to the residents. Each of the residents' bedrooms were decorated in different styles in line with their tastes. Their rooms were personalised with their photographs and belongings. New cupboard units had been installed in the living room and activity room. The person in charge reported that there were plans to put a tracking hoist in the ceiling of the sensory room so that the room could be used by all residents. One of the unused bedrooms had recently been fitted with a new piece of technology for the residents' use. This device projected games and interactive activities onto a table top and the person in charge reported that residents enjoyed spending time playing games. The person in charge reported that the provider had replaced windows and made structural improvements to the centre to address issues with damp and further works were planned. An external company had been employed to test the air quality in the centre in January 2025. The report that was viewed by the inspector indicated that there were no issues detected. The person in charge reported that there were plans for residents to move to new homes.

However, these plans were in the early stages of development and there was no definite timeline for when this would occur.

The inspector had the opportunity to meet with five resident on the day of inspection. Residents required differing levels of support with their communication. The inspector greeted the residents and spoke about the reason for their visit to the centre. Staff supported the residents when speaking with the inspector. All residents were supported to tell the inspector how they enjoyed spending their time during the day. Two residents told the inspector that they liked living in the centre.

All residents in this centre had high-support needs. Residents included younger adults and older adults and all required support with their health, social and personal care needs. Some residents availed of regular day services during the week and others enjoyed completing activities from home. On the day of inspection, some residents were at day services and met the inspector in the evening when they returned. Others spent the day in the centre relaxing, watching television, reading the newspaper and going for short outings in the community.

In addition to the person in charge, the inspector met with four other members of staff. This included staff who were directly employed by the provider and agency staff. All staff were knowledgeable on the needs of residents and their role in supporting residents to meet their needs. They showed good knowledge of how to support residents to manage their behaviour. When asked about specific care needs of some residents, staff gave clear examples of the supports that they provided. This was in line with the information outlined in the residents' care plans and nursing intervention plans. Staff had completed training in human rights-based care and spoke about the importance of respecting residents. They knew how to respond should a safeguarding incident occur.

The next two sections of this report present the inspection findings in relation to the governance and management in the centre, and describes about how governance and management affect the quality and safety of the service provided.

Capacity and capability

The provider maintained oversight of the service through incident reviews to avoid a reoccurrence. Any incidents that happened in the centre were reported to the Chief Inspector of Social Services, as required. Oversight was also maintained through routine audits and unannounced provider-led audits that were completed every six months. All audits were completed in line with the provider's schedule. Findings from these audits were added to a quality improvement plan. This document was reviewed monthly to ensure that any service improvement actions were progressed and addressed within specific timeframes. However, it was noted that actions on the quality improvement plan and on audit were not always specific. This meant that it was difficult to measure progress towards goals in all cases.

The number of staff on duty and their mix of skills were in line with the needs of residents. Staff had largely up-to-date training in the provider's mandatory modules and in other specific areas that were relevant to the care and support of the residents in this centre. However, there were a number of vacancies in the centre and this meant that there was a large reliance on agency staff. This impacted on the consistency of staff working in the centre.

Regulation 15: Staffing

The number and skill-mix of staff on duty were in accordance with the residents' assessed needs. However, the consistency of staff was impacted by the large number of vacancies in the centre.

The person in charge reported that there was a significant number of vacant posts in the centre. The person in charge reported that there were four vacancies for staff nurses in the centre and three vacancies for healthcare assistants. This meant that there was a large reliance on agency staff to cover shifts. The person in charge reported that posts had been advertised to existing panels in the locality but that this had not resulted in the filling of any posts. The person in charge reported that the posts were due to be expressed to newly qualified nurses in the coming months.

The inspector reviewed the rosters from the beginning of 2025. This showed that the required number of staff was on duty at all times with the required skill-mix between nursing staff and healthcare assistants. However, it was noted that there was a turnover of staff throughout this time period and that some staff covered shifts in the centre on a sporadic basis. This meant that staff were not always consistent and may not be familiar to the residents.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Staff training in this centre was largely up to date in modules that were relevant to the care and support of residents.

The inspector reviewed the training records in the centre. These showed that staff had largely up-to-date training in modules that the provider had identified as mandatory. Where staff required refresher training, this had been identified by the person in charge and staff were booked onto relevant courses. Staff had also completed training in modules that were specific to the needs of residents in this centre. For example, staff had completed training in pressure ulcer prevention and in how to support residents with their feeding, eating, drinking and swallowing needs.

Judgment: Compliant

Regulation 23: Governance and management

There were clear lines of accountability in this service. The provider had systems in place to monitor the quality of the service and actions were taken to address areas for service improvement. However, improvement was required in relation to the goals that were identified for service improvement to ensure that actions were effective and progress could be measured.

The management structure was clearly defined in this centre. Staff knew who to contact should any issues arise. When an incident occurred in the centre, this was recorded, escalated and addressed. The provider maintained oversight of the service through reviews of incidents in the centre. The monthly incident reviews that had taken place in the centre since the beginning of 2025 were reviewed by the inspector. These showed that incidents were trended and actions to avoid a reoccurrence were identified.

Audits also formed part of the provider's system of oversight in the centre. The inspector reviewed the routine audits that were completed in the centre since the beginning of 2025. This showed that audits were completed in line with the provider's schedule and timelines. In addition, the provider completed unannounced audits of the service every six months. The inspector reviewed the two most recent six-monthly audits and found that these were comprehensive. The audits included an overview of the highest risks in the centre and the actions that were in place to reduce those risks.

When the audits identified areas for service improvement, corresponding actions to address these issues were identified. These actions were listed on the centre's quality improvement plan. This gave an overview of all of the service improvement actions that were underway in the centre and included information from routine audits, provider-led audits, and senior management evaluations. However, the actions were not always specific; for example, 'continue to review assessment of need, risk assessments and evaluation'. As the goals were not specific, it meant that it was not always clear that they would be effective at addressing the issues identified and it was not possible to measure progress towards service improvement in all cases.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

The provider reported incidents to the Chief Inspector in line with the regulations.

The inspector reviewed the incidents that had been recorded in the centre since the beginning of 2025 and noted that all incidents that needed to be reported to the Chief Inspector had been submitted accordingly.

Judgment: Compliant

Quality and safety

Residents received a person-centred service in this centre. There was evidence that residents received supports to meet their specific needs. Residents had access to a wide variety of medical and healthcare professionals who provided guidance to staff on how to support residents. However, improvement was required in relation to the documentation of the assessments of the residents' needs to ensure that assessments were up to date, relevant to the resident and available to guide the development of care plans. This was reflected in the residents' communication care plans where documentation from relevant professionals was not included in these plans.

There was clear guidance in relation to the residents' nutritional needs. Meals were prepared in the centre's kitchen by a professional catering service. This was of benefit to the residents as catering staff were also informed of the residents' needs and ensured that the food prepared met their requirements. However, given the institutional nature of the building and the kitchen, residents could not engage in the preparation of their meals.

The safety of residents was promoted in the centre. The risk management systems in the centre identified risks to residents and the control measures to reduce risk were put in place. The provider was found to be responsive when the level of risks to residents increased. Support from the multidisciplinary team was sought to provide additional supports to residents to reduce risk. Staff were trained in safeguarding residents from abuse and the provider had measures in place to monitor staff members' knowledge of safeguarding procedures. Clear guidance was available to staff on how to support residents to manage their behaviour.

Regulation 10: Communication

The provider had made arrangements to support residents to communicate their needs and wishes. However, improvement was required to ensure that there was clear information to staff to ensure that residents received the appropriate supports.

When speaking with the inspector, staff demonstrated good knowledge of residents' individual communication strategies. They could give examples of how to present information to residents and how to interpret the residents' non-verbal communication. Staff demonstrated knowledge of one resident's use of Lámh signs and knew the specific signs that they used. This was in keeping with the information contained within the resident's communication profile.

The inspector reviewed the information available for staff in relation to two residents. The inspector noted that communication profiles that had been developed by a speech and language therapist for both residents. These outlined how to support residents to understand information and how to express their choices and preferences. Residents also had communication care plans that had been developed by key workers to guide staff practice in this area. However, not all plans were reflective of the content of the speech and language therapy reports and they had not been updated following the development of the reports. For example, for one resident had been assessed by a speech and language therapist in October 2024. However, their communication care plan was dated June 2024 and did not contain information for staff in relation to the pictorial communication supports that were outlined in the speech and language therapy report.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

The nutritional needs of residents were well managed in this centre. Residents had access to wholesome and nutritious meals that were in line with their identified nutritional needs. The provider had made arrangements for residents to complete baking activities in the centre's activity room but, due to the nature of the building, residents did not have access to the facilities to cook and prepare their own daily meals.

As outlined in the opening section of the report, the centre consisted of a very-large building and the kitchen was not accessible to residents. Meals were prepared in the centre by a professional catering team. As a result, the kitchen was accessible to a limited number of staff in order to maintain food hygiene and food safety standards. This meant that residents could not partake in the preparation of their daily meals. It must be noted, however, that the provider had installed some facilities in the centre's activity room to facilitate residents to complete baking activities if they so wished.

The inspector reviewed the notes and care plans of two residents. These showed that the nutritional needs of residents had been assessed by relevant healthcare professionals. Guidelines from these professionals were available to ensure that foods and beverages were prepared in line with the residents' needs. The person in charge reported that the chef in the centre had attended meetings with healthcare

professionals to ensure that foods were of the correct consistency to meet residents' needs and were also in line with their nutritional needs.

Judgment: Compliant

Regulation 26: Risk management procedures

The provider had good measures in place to manage risks to residents.

The inspector reviewed the risk assessments that had been completed for two residents. These showed that the risks to residents had been identified, assessed and control measures implemented to reduce the risks. For one resident, a review of their risk assessments had shown an increase in risk in one particular area. This had resulted in a referral to an appropriate healthcare professional to provide additional support to reduce the risk to the resident. This meant that the provider monitored the risks in the centre and was responsive when risk levels escalated.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The provider ensured that information was available for staff in relation to the residents' health, social and personal care needs. However, improvement was required to ensure that all information was up-to-date and relevant.

The inspector reviewed the assessments of needs that had been developed for two residents. These outlined the health, social and personal care needs of residents. However, it was noted that the assessments were not signed or dated. Therefore, it was unclear when the assessments had been completed, if they were still relevant to the residents, and if they had been completed by a suitable individual. Support plans for residents were in place where a need had been identified. All support plans had been developed within the previous 12 months. However, without the corresponding assessment, it was unclear if the plans were in line with the residents' current needs.

The inspector reviewed the annual review that had been completed for one resident. This annual review included input from staff in the centre and a family representative was also in attendance at the meeting. The annual review record included information about the resident's progress in the previous year. However, goals and plans for the coming year were not recorded in the annual review.

Judgment: Substantially compliant

Regulation 6: Health care

The healthcare needs of residents were well managed in this centre.

The inspector reviewed the care notes and support plans for two residents. These showed that residents were supported to attend appointments with a variety of healthcare professionals, as required. Reports and guidelines from these healthcare professionals were available for staff. Where specific healthcare needs were identified for residents, care plans to guide staff had been developed. The inspector also reviewed the daily notes for one resident. This showed that staff had implemented the healthcare supports identified for the resident. For example, specific skin care regimes for the resident had been implemented as outlined in their care plan.

Judgment: Compliant

Regulation 7: Positive behavioural support

The provider had good systems in place to support residents to manage their behaviour.

The inspector reviewed the behaviour support plan that had been developed for one resident. This plan had been developed by a suitably qualified professional. It guided staff in relation to the supports required by the resident to manage their behaviour in specific circumstances. A recent risk assessment review had found that the resident required support with another aspect of their behaviour and a referral had been made to the provider's psychology service to review the plan in light of this. This showed that the provider was responsive to the resident's changing needs.

When speaking with the inspector, staff demonstrated very good knowledge of the specific steps that should be taken to support resident to manage their behaviour.

The inspector also reviewed the minutes of meetings of the restrictive rights committee that had taken place in May and June 2025. These showed that the person in charge had presented the restrictive practices that were in use in the centre to the committee for review and assessment. This showed that the provider had systems in place to review practices and to ensure that they were the least restrictive options in use.

Judgment: Compliant

Regulation 8: Protection

The provider had measures in place to ensure that residents were protected from abuse.

The inspector's review of staff training records showed that all staff had up-to-date training in safeguarding vulnerable adults from abuse. In conversation with the inspector, staff demonstrated good knowledge of the steps that should be taken should any safeguarding incidents occur. The provider completed regular audits of the staff's knowledge of safeguarding procedures. Behaviour support plans were in place and staff were knowledgeable of their contents. There were no open safeguarding plans in the centre on the day of inspection. The inspector's review of the records of incidents that had occurred in the centre since the beginning of 2025 showed that no safeguarding incidents had happened in that time.

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 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 10: Communication	Substantially compliant
Regulation 18: Food and nutrition	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Inbhear Na Mara OSV-0002496

Inspection ID: MON-0047412

Date of inspection: 03/07/2025

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: To ensure compliance with Regulation 15: Staffing the following actions have been undertaken; • The registered provider has undertaken staff nurse interviews to include interviews for interns and offers have been extended specific to Inbhear na Mara. Completed 28/07/2025 • The Person in Charge has completed documentationfor the replacement of further staff nurse and health care assistant vacancies and escalated to the General Manager for approval. These now have been offered out again to the panels to fill four nursing positions and three health care sssistants positions. Completed 17/07/2025 • The Person in charge continues to ensure consistant familiar HSE staff is targareted initially when offering extra/additional hours prior to using agency staff. • The person in Charge continues to restructure HSE staff to meet the needs of residents and reduce the usage of agency staff. • The Person in Charge continues to use consistent and familiar agency staff through the HSE's Service Level Agreement. All shifts including sporadic shifts are covered by familier agency staff when required.	
Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
To ensure compliance with Regulation 23: Governance and Management the following actions have been undertaken;

• The Registered Provider has now a system in place to capture time frames for the completion of Assessments of Needs for all residents in the designated centre. A monitoring system has been established through the center's QIP which is submitted monthly to the Director of Nursing. Completed 07/08/2025
• The Person in Charge has agreed with nursing staff time frames for the completion of the Assessment of Need and this will be closely monitored by the Person in Charge. Completed 29/07/2025
• The Person in Charge has ensured that all staff now document clearly the specific goals, progress, completion and evaluation of goals in a timely manner This has been discussed at staff meetings, and will continue to be discussed monthly to ensure progression of goals is monitored and recorded. Completed 29/07/2025
• The Person in Charge has ensured that all risk assessment have been reviewed and will be reviewed three monthly in line with Policy. Completed 29/07/2025

Regulation 10: Communication	Substantially Compliant

Outline how you are going to come into compliance with Regulation 10: Communication:
To ensure compliance with Regulation 10: Communication the following actions have been undertaken;

• The Person in charge has completed information sessions with all staff in relation to the pictorial communication supports that are outlined in the speech and language therapy report . This has supported staff practices and understanding around communication with residents. Completed 29/7/2025 .
• The person in charge is currently reviewing all residents communication profiles and support plans to ensure that triangulation is completed and information is accurate. To be completed by 13/08/2025

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:

To ensure compliance with Regulation 05: Individual Assessment and Personal Plan the following actions have been undertaken;

• The Person in Charge has now ensured information is now available for all staff in relation to each residents' health, social and personal care needs and this will continue to be monitored through audits, the centres QIP and staff meetings.
• The Person in charge has ensured that one Assessment of Need is now signed and dated by the named nurse for one resident Completed 13/07/2025
• The Person in Charge has assured the provider that all Assessment of Needs are now in line with residents current needs will and preferances.
• The Person in charge has ensured the provider that all goals and plans for the coming year will be recorded in the Annual review of the residents. All Key workers will update person centered plans following reviews to reflect the goals of the residents for the current year. To be completed by 17/08/2025

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 10(2)	The person in charge shall ensure that staff are aware of any particular or individual communication supports required by each resident as outlined in his or her personal plan.	Substantially Compliant	Yellow	14/08/2025
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.	Substantially Compliant	Yellow	17/07/2025
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the	Substantially Compliant	Yellow	07/08/2025

	service provided is safe, appropriate to residents' needs, consistent and effectively monitored.			
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	17/08/2025