# Report of an inspection of a Designated Centre for Disabilities (Adults).

# Issued by the Chief Inspector

| Name of designated centre: | The Grange |
|---|---|
| Name of provider: | Peter Bradley Foundation CLG |
| Address of centre: | Dublin 24 |
| Type of inspection: | Announced |
| Date of inspection: | 17 January 2024 |
| Centre ID: | OSV-0001524 |
| Fieldwork ID: | MON-0033580 |

## About the designated centre

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

The Grange is a designated centre operated by The Peter Bradley Foundation CLG. The centre is a four bed residential neuro-rehabilitation service. It follows a non-nursing model of care and supports a bio-psycho-social model. The service provides individualised, community based supports, designed to maximise the quality of life for each person living with an Acquired Brain Injury (ABI). This service is based in the community and can accommodate four adults with an ABI. The Grange is a five bedroom detached home located in Co. Dublin close to many local amenities and public transport links. Each resident has their own bedroom with access to a kitchen, dining room, living room, bathrooms and a garden area. The service is staffed 24 hours, seven days a week by Neuro Rehabilitation Assistants and a Team Leader. The team receives supports from a Person in Charge.

**The following information outlines some additional data on this centre.**

| Number of residents on the date of inspection: | 4 |
|---|---|

## 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 17 January 2024 | 14:00hrs to 17:40hrs | Jennifer Deasy | Lead |
| Thursday 18 January 2024 | 10:45hrs to 16:45hrs | Jennifer Deasy | Lead |

## What residents told us and what inspectors observed

This inspection was scheduled to inform decision making in respect of the provider's application to renew the centre's certificate of registration. The inspection was completed over two days. On the first day, the inspector visited the premises of the designated centre, completed a walk-around and had the opportunity to meet with and talk to residents and staff. On the second day, the inspector visited the provider's head office and reviewed documentation and paperwork relating to the centre.

The inspector used conversations with residents and staff, a walk-around of the premises and review of documentation to inform judgments on the quality and safety of care in the centre. Overall, the inspector saw that residents were supported by a familiar staff team and that they felt safe and happy in their home. However, there were some enhancements required to certain aspects of service delivery, including for example, the provider's ability to complete required premises works in a timely manner.

The inspector saw that the centre was clean and generally homely and welcoming. The inspector was greeted by a staff member who checked that the inspector did not have any symptoms of a transmissible infection. An opening meeting was completed with the person in charge and the team leader who outlined the current profile of residents living in the centre and their assessed needs.

Each resident in this centre had their own bedroom. Residents shared a communal kitchen, a bathroom, accessible shower room, utility and sitting room. Residents also had access to a back garden. The inspector saw that the sitting room was furnished with comfortable and well-maintained furniture and that it was decorated with residents' photographs. There was ready availability of activities for relaxation including a television, DVDs and board games.

Residents' bedrooms were personalised, comfortable and had adequate storage facilities. Repairs or replacement were required to two items of furniture in residents' bedrooms as they were damaged and could not be effectively cleaned. This will be discussed further in the quality and safety section of the report.

The centre's kitchen was in need of upkeep. Some of the cupboards were water-damaged and other cupboards were missing doors. The laminate counter-top had also been damaged in places. This was impacting on the homeliness of the centre and on the ability of staff to effectively clean the kitchen. This issue had been known to the provider for some time but had not been addressed in a timely manner. This will be discussed in more detail in the capacity and capability section of the report.

Downstairs, there was an accessible shower room which was used by all of the residents in the centre. It was clean and well-maintained. Two residents had their bedrooms upstairs and also had access to a bathroom with a bath and over-bath

shower. However, these residents told the inspector that they did not use this bathroom as the shower was inaccessible for them. One resident told the inspector that they sometimes had to wait to use the shower room downstairs if another resident was using it.

Painting was required throughout the centre, including to windowsills, doors and skirting boards. The provider was aware of this but did not have a time-bound plan in place to complete this upkeep.

The inspector had the opportunity to meet three of the residents over the course of the first day. The inspector saw residents coming and going freely from the centre to go for walks or to complete errands in the locality. The centre was located in a busy suburb of Dublin and had ready access to many community facilities. Residents were familiar with these facilities and spoke about walking to them or travelling independently on public transport.

Two residents, who had lived in the centre for some time, said that they felt well-supported by the staff team and were happy living there. One of the residents told the inspector that their long-term goal was to get their own home. They said that staff were supporting them in progressing towards that goal. Another resident showed the inspector the new gaming device that they had set up in their bedroom as well as their art work and personal possessions. They were proud of their bedroom and of their work.

A third resident had lived in the centre for a shorter period of time. They told the inspector that they were settling in well. They said that they knew the staff now and were familiar with them. This resident described making connections in the local community and getting to know people locally. They told the inspector that they were cooking dinner for everyone that evening and described the meals that they enjoyed cooking. They spoke of how everyone contributed to the running of the house.

Overall, the inspector saw that residents were happy and comfortable in their home. Residents were supported by a familiar staff team who they said listened to them and supported them to achieve their goals. Residents were informed regarding the day-to-day running of the house and were supported to make decisions and choices regarding their daily activities. However, there was upkeep required to parts of the premises to ensure that it was homely, accessible and could be effectively cleaned.

## Capacity and capability

This section of the report sets out the findings of the inspection in relation to the leadership and management of the service, and how effective it was in ensuring that a good quality and safe service was being provided. Overall, the inspector found that there were effective local management arrangements, however enhancements were required at the provider level to effectively implement policies and to track and

progress all actions across the provider-level audits.

There were clear lines of authority and accountability at local level in the centre. The centre was staffed by a stable staff team who were in receipt of regular training, support and supervision. The staff team reported that they felt well-supported in their roles and were aware of the oversight arrangements including the on-call arrangements.

A person in charge had been employed in a full-time capacity. They also had oversight of another designated centre located a short distance away. The person in charge was suitably qualified and experienced. A team leader had been appointed in each of the centres that the person in charge had responsibility for in order to support them in their role.

The inspector found that, while staff were in receipt of regular support through staff meetings and formal supervision, the provider had failed to ensure that the person in charge was also in receipt of adequate supervision. The provider's supervision policy set out that all employees should have the opportunity for individual, in-depth supervision regarding their performance, progress and specific work needs. However, the person in charge had not received an individual supervision session in over 12 months. While the person in charge could contact a senior manager for queries regarding specific issues in the day-to-day running of the centre, they did not have a forum through which to escalate issues relating to the quality and safety of care in the centre, or to seek support regarding their regulatory responsibilities.

There were a suite of audits in place including six-monthly unannounced visits by the provider's quality and safety team, as well as an annual review of the quality and safety of care of the service. While the six-monthly audits were comprehensive, the inspector found that there was a failure to track action plans across these audits and to ensure that actions set out in previous audits had been achieved. For example, the kitchen in this centre had been identified as requiring upkeep on a number of the six monthly audits reviewed. However, works to refurbish the kitchen remained outstanding at the time of the inspection.

The provider had submitted an application to renew the centre's certificate of registration in a timely manner and had paid the required fee. They had submitted the required documentation however there were amendments required to some of these documents in order to meet the criteria as set out by the Chief Inspector.

Overall, the inspector was assured that there were effective local management systems, however enhancements were required at the provider level to ensure that all staff were adequately supported and supervised, and to use audits effectively in in order to drive service improvement.

## Registration Regulation 5: Application for registration or renewal of registration

An application to renew the centre's certificate of registration was made within the

time frame as prescribed by the Regulations and the appropriate fee was paid. However, while all of the required documentation was submitted, there were several changes required to the statement of purpose and to the floor plans to ensure that these were in line with the guidance as set out by the Chief Inspector.

Judgment: Substantially compliant

## Regulation 14: Persons in charge

There was a suitably qualified and experienced person in charge appointed to have oversight of the designated centre. They were employed in a full-time capacity.

The person in charge also had responsibility for another designated centre located a short distance away. There were local arrangements in place to support the person in charge in having oversight of both designated centres. These arrangements included the appointment of a team leader in each centre to act up when the person in charge was not present.

Judgment: Compliant

## Regulation 15: Staffing

The provider had ensured that there were adequate staffing levels in the centre. The staffing arrangements were maintained in line with the statement of purpose. There were no vacancies in the centre at the time of inspection and there was generally a very low reliance on the use of relief and agency staff. This was supporting continuity of care for the residents.

The inspector saw that there were sufficient staff to meet the needs of the residents and to be able to support residents in an individualised manner.

Residents spoken with were familiar with the staff team and informed the inspector that they were happy with the level of support that they received from the staff team.

Judgment: Compliant

## Regulation 16: Training and staff development

A training matrix was maintained in the centre and was reviewed by the inspector. The inspector saw that there was a high level of compliance with mandatory and

refresher training. All staff were up-to-date with training in key areas such as safeguarding, managing behaviour that is challenging and infection prevention and control.

Staff in this centre were in receipt of regular supervision and support. Staff meetings were held monthly. Records of these were maintained and were reviewed by the inspector. The inspector saw that the content of these was sufficient to support staff in fulfilling their day-to-day responsibilities in the centre.

Staff reported to the inspector that they felt well supported and were familiar with the oversight arrangements including the on-call arrangements for out-of-hours support.

Judgment: Compliant

## Regulation 22: Insurance

The provider submitted a copy of their certificate of insurance along with their registration renewal application. The inspector saw that the provider had effected a contract of insurance against injury to residents.

Judgment: Compliant

## Regulation 23: Governance and management

The provider had effected a series of audits including six monthly unannounced visits and annual reviews of the quality and safety of care. The annual review was completed in consultation with key stakeholders, including the residents.

However, the inspector saw that these audits were not wholly effective in driving service improvement. Actions plans derived from these audits were not specific and did not set out clear time-frames for addressing known risks. For example, it was identified across several six monthly audits that the kitchen cupboards were damaged however there was no SMART action plan implemented to address this risk.

While staff in this centre were in receipt of regular supervision and support from the team leader, the provider had failed to implement their staff supervision policy in respect of the person in charge. The person in charge had not received individual support or supervision in over 12 months at the time of the inspection. This required enhancement to ensure that all staff working in the centre were supported and developed to exercise their professional responsibility for the quality and safety of services that they were delivering.

Judgment: Substantially compliant

## Regulation 3: Statement of purpose

A statement of purpose was submitted by the provider along with their application to renew the centre's certificate of registration. The inspector reviewed the statement of purpose prior to the inspection and noted that there were several omissions and areas that required further detail and clarification. These amendments were made by the provider prior to the inspection of the centre. The statement of purpose was reviewed on inspection and was found to meet the requirements of the Regulations.

Judgment: Compliant

## Quality and safety

This section of the report details the quality of the service and how safe it was for the residents who lived in the designated centre. Overall, the inspector saw that residents were living in a warm and clean house however there was upkeep required to aspects of the premises. Additionally, some residents had not been supported to access all of the health-care interventions as required in line with their assessed needs.

The centre was found to be clean and warm and residents told the inspector that they felt safe and well-supported in their home. Howveer, there was upkeep required in a number of rooms in the centre, including the kitchen and residents' bedrooms. These issues were known to the provider however they had not been effectively addressed. Additionally, the inspector was told by residents that the upstairs bathroom was not accessible for them and, as a result, all of the residents relied on one bathroom for showers and bathing.

The inspector saw that the provider had effected measures to detect, contain and extinguish fires. Fire equipment was regularly serviced and maintained in good working order. Regular fire drills were held in line with the provider's policy and all residents were able to evacuate the centre in a timely manner.

All residents in this centre had an individualised assessment available on their file. The inspector reviewed a sample of these assessments. It was found that, while the assessment was updated annually, the care plans were insufficiently detailed and did not allow staff to track if health care outcomes had been achieved. For example, a gap was identified whereby a resident had been referred for physiotherapy number of years ago, however this referral had not been followed up on and the

resident had not accessed physiotherapy since the initial referral. This required review to ensure that residents were supported to avail of all of the health care services required in order to meet their assessed needs.

Overall, the inspector saw that residents were happy in their home and generally were in receipt of supports that were in line with their preferences and day-to-day needs. However, enhancement was required to ensure that care plans were comprehensive and guided staff to support residents in accessing to all of the multi-disciplinary professionals as required by their assessed needs. Additionally, enhancement was required to the premises to enable staff to effectively clean in line with IPC standards.

## Regulation 17: Premises

The designated centre was seen to be clean, warm and welcoming. The centre was decorated with photographs and communal furniture was generally well-maintained. However, there were some areas of the premises which required upkeep. Some of this required upkeep had been known to the provider for a number of years however it had not been addressed in a timely manner.

The inspector saw that the kitchen cabinets and counter-top required repairs. Some of the cabinets were water-damaged and the laminate counter-top had worn away in places. This was impacting on the infection prevention and control (IPC) measures in the centre.

The upstairs bathroom was not accessible to residents. Residents told the inspector that they could not access the shower in this bathroom and so all four residents used the accessible shower room which was located downstairs. Residents told the inspector that this sometimes impacted on them, for example, they may be required to wait to use the shower room if another resident was using it.

Painting was required throughout the centre including to kitchen windowsills, skirting boards, door frames and a resident's bedroom.

The bed base in one resident's bedroom was ripped which posed an IPC and falls risk.

One chair in a resident's bedroom required replacement as the seat pad was ripped and the seat could not be effectively cleaned.

Judgment: Not compliant

## Regulation 28: Fire precautions

There were effective procedures in place to allow for the detection, containment and extinguishing of fires in the centre. The inspector saw that the fire panel, emergency lighting and fire extinguishers were regularly serviced. Fire doors and automatic door closers had been fitted throughout the centre.

Fire drills were completed in line with the provider's policy. Records of these drills showed that all residents could evacuated in a safe time frame. Person evacuation plans were in place which detailed the supports that residents required to safely evacuate.

Judgment: Compliant

## Regulation 5: Individual assessment and personal plan

A sample of residents' files along with their individualised assessments and care plans were reviewed by the inspector. The inspector saw that all residents had an individualised assessment which was used to inform care plans. However, some of these care plans were insufficiently detailed to guide staff in managing the assessed health care needs of residents. For example, a swallowing care plan did not detail control measures to ensure that the resident was supported to eat, drink and swallow safely. The person in charge was aware of these control measures however they were not set out in the care plan. This care plan was updated by the second day of the inspection.

Care plans also required enhancement to ensure that they consistently tracked any proposed changes to personal plans, and set out a responsible person to implement care plan objectives within a defined time-frame. A deficit was identified whereby a resident was referred to physiotherapy in 2019, however due to a failure to clearly define who was responsible for following up on this referral, it was found that the resident had not received a physiotherapy appointment by the time of the inspection.

Judgment: Not compliant

## Regulation 8: Protection

Residents in this centre reported that they got on well and that they felt safe. There were no safeguarding concerns at the time of inspection or in recent months in the centre.

Staff were up to date in safeguarding training and were knowledgeable regarding their safeguarding roles and responsibilities.

Residents had up to date intimate care plans detailed on their files. These care plans

were written in a person-centred manner and detailed steps that staff should take to ensure residents' autonomy was upheld while supporting them with intimate care.

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** | |
| Registration Regulation 5: Application for registration or renewal of registration | Substantially compliant |
| Regulation 14: Persons in charge | Compliant |
| Regulation 15: Staffing | Compliant |
| Regulation 16: Training and staff development | Compliant |
| Regulation 22: Insurance | Compliant |
| Regulation 23: Governance and management | Substantially compliant |
| Regulation 3: Statement of purpose | Compliant |
| **Quality and safety** | |
| Regulation 17: Premises | Not compliant |
| Regulation 28: Fire precautions | Compliant |
| Regulation 5: Individual assessment and personal plan | Not compliant |
| Regulation 8: Protection | Compliant |

# Compliance Plan for The Grange OSV-0001524

## Inspection ID: MON-0033580

## Date of inspection: 17/01/2024

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

This document is divided into two sections:

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

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

A finding of:

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

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

## Section 1

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

**Compliance plan provider's response:**

<table>
<tr><th>Regulation Heading</th><th>Judgment</th></tr>
<tr><td>Registration Regulation 5: Application for registration or renewal of registration</td><td>Substantially Compliant</td></tr>
<tr><td colspan="2">Outline how you are going to come into compliance with Registration Regulation 5: Application for registration or renewal of registration:<br>Statement of purpose to be updated - Completed</td></tr>
<tr><td>Regulation 23: Governance and management</td><td>Substantially Compliant</td></tr>
<tr><td colspan="2">Outline how you are going to come into compliance with Regulation 23: Governance and management:<br>Service audits were not wholly effective in driving service improvement – the provider is rolling out a new auditing process and it has been agreed that all PICs nationally will be provided with a SMART action plan following the audit. This will set clear time frames for the completion of same. Local management will then add these SMART actions to their on-going quality improvement plan, progress of QIP will be monitored by provider (National Service Manager) during 1:1 meetings with PIC.<br><br>Lack of supervision for PIC and direct support from Senior Management -<br>Supervision is scheduled for the 28th of February and every 6 weeks thereafter for 2024 to provide protected one to one time to the PIC</td></tr>
<tr><td>Regulation 17: Premises</td><td>Not Compliant</td></tr>
<tr><td colspan="2">Outline how you are going to come into compliance with Regulation 17: Premises:<br>Kitchen cabinets and counter top need to be replaced – this will be completed by June 2025<br><br>Upstairs bathroom needs to be transformed into an accessible wet room - Funding will need to be sourced to transform bathroom, this will be completed by June 2025.<br><br>Painting is needed on kitchen windowsills, skirting boards, door frames and a residents bedroom. –this will be completed by June 2025.</td></tr>
</table>

| New bed base to be purchased for a resident – purchased on the 6/03/2024. Delivery imminent.<br><br>New chair to be purchased for a resident's bedroom – completed Jan 2024 | |
|---|---|
| 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:<br>Care Plans are insufficiently detailed – TL has updated the keyworker checklist to ensure that care plans are to be reviewed and updated monthly. TL completes quarterly audits of individual rehab plans; the TL highlights any changes or updates that need to be made to the keyworker. – Completed and ongoing<br><br>Full review of risk assessments and care plans to be discussed with clinical psychologist re client in question and further clinical input will be provided for all changing needs of clients in future to update BSPs. – to be completed by 15/03/24<br><br>Team Leader (TL) works with keyworkers to ensure care plans are updated monthly, or as necessary. These care plans are reviewed regularly by PIC and feedback provided to TL and keyworkers around same. This has been prioritised since the HIQA visit so is underway and ongoing. The TL and PIC complete quarterly audits of each service user's individual rehabilitation plan and amends where necessary. Keyworkers hold monthly meetings with the person served to get their input on all parts of the care plan. PIC oversees all care plans and attends annual IRPs with person served and whoever else they want to attend (family member(s)/friend(s)). PIC will also attend some of the monthly keyworker meetings, with the keyworker and the person served, where possible. All progress or problems with goals set will be documented on iPlanit and discussed in the relevant residential team meetings and the clinical team meetings. | |

## 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 |
|---|---|---|---|---|
| Registration Regulation 5(2) | A person seeking to renew the registration of a designated centre shall make an application for the renewal of registration to the chief inspector in the form determined by the chief inspector and shall include the information set out in Schedule 2. | Substantially Compliant | Yellow | 22/02/2024 |
| 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. | Not Compliant | Orange | 30/06/2025 |
| Regulation 17(6) | The registered provider shall ensure that the designated centre adheres to best practice in | Not Compliant | Orange | 31/12/2024 |

|  |  |  |  |  |
|---|---|---|---|---|
|  | achieving and promoting accessibility. He. she, regularly reviews its accessibility with reference to the statement of purpose and carries out any required alterations to the premises of the designated centre to ensure it is accessible to all. |  |  |  |
| Regulation 23(2)(a) | 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 prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support. | Substantially Compliant | Yellow | 30/06/2024 |
| Regulation 23(3)(a) | The registered provider shall ensure that effective arrangements are in place to support, develop and performance | Substantially Compliant | Yellow | 28/02/2024 |

| | | | | |
|---|---|---|---|---|
| | manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering. | | | |
| Regulation 05(4)(b) | The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which outlines the supports required to maximise the resident's personal development in accordance with his or her wishes. | Not Compliant | Orange | 15/03/2024 |
| Regulation 05(7)(a) | The recommendations arising out of a review carried out pursuant to paragraph (6) shall be recorded and shall include any proposed changes to the personal plan. | Not Compliant | Orange | 15/03/2024 |
| Regulation 05(7)(c) | The recommendations arising out of a review carried out pursuant to paragraph (6) shall be recorded and shall include the names of those responsible for pursuing objectives | Not Compliant | Orange | 15/03/2024 |

| | | | | |
|---|---|---|---|---|
| | in the plan within agreed timescales. | | | |