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:	Stewarts Care Adult Services Designated Centre 18
Name of provider:	Stewarts Care Limited
Address of centre:	Dublin 20
Type of inspection:	Unannounced
Date of inspection:	12 December 2019
Centre ID:	OSV-0005852
Fieldwork ID:	MON-0028015

About the designated centre

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

This centre aims to provide long stay residential care to no more than 10 men and women with complex support needs. It consists of two wheelchair accessible homes located on the Stewart's Care campus in Palmerstown. Each resident has their own bedroom. Nursing support is provided within the centre, and the staff team is made up of staff nurses and care staff. Residents can avail of services from a range of allied health professionals such as psychiatry, psychology, occupational therapy, speech and language therapy, dietitian services, dental services, General Practitioner and social workers.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	9

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 - 2015 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 12 December 2019	10:30hrs to 16:00hrs	Louise Renwick	Lead
Thursday 12 December 2019	10:30hrs to 16:00hrs	Amy McGrath	Support

What residents told us and what inspectors observed

Inspectors met all nine residents living in the designated centre and spent time in each of the two homes observing residents' daily activities.

On arrival to the designated centre, a resident was sitting at a height adjustable table doing art. Inspectors observed that residents' choice to stay in bed late was facilitated, with some residents resting in their rooms on the morning of the inspection.

Inspectors observed person-centred care being delivered by the staff team throughout the day, and respectful interactions which were warm and friendly. Residents' needs and requests were responded to kindly by staff and residents' choices were respected. For example, a resident who uses a wheelchair was moved close to the window to watch birds feeding in the garden, as this was something that he enjoyed.

Residents' personal care was attended to in a timely manner and residents were well dressed in clothing suitable to their age and preferences. Residents were supported appropriately at mealtimes.

Inspectors observed staff making arrangements for some residents to leave campus during the day to go shopping, and a vehicle was available that certain staff could drive.

Inspectors observed the majority of activities for the day of inspection were limited to activities at home, or on campus.

Capacity and capability

This inspection found a deterioration in compliance with the regulations and standards since the previous inspection in February 2019. This was linked to a reduction in resources earlier in the year, which had impacted on the person in charge's ability to maintain improvements previously achieved. The provider was operating and managing this designated centre in a manner that was safe, residents' healthcare needs were met and there was a stable and consistent staff team in place who were delivering kind and person-centred care. However, the provider had not demonstrated that they had the capacity to resource the designated centre in a manner that was fully in line with residents' comprehensive needs and ensured meaningful and engaging lives for all residents.

There was a clear management structure in place in the designated centre and

wider organisation. The person in charge was a clinical nurse manager who reported to a programme manager. The programme manager reported to the the acting Director of Care of Residents. At the time of the inspection, the person in charge was on leave, and the programme manager was holding responsibility during this absence. Staff were aware of who was in charge of the centre and the lines of reporting. The person responsible during the absence of the person in charge visited the centre daily and staff felt there was appropriate support and guidance in place during this absence.

There were clear lines of information and escalation regarding this designated centre, with regular meetings and reports to the care management team and executive management team on behalf of the provider. Information gathered about this designated centre was well maintained, and used to improve the quality of the care and support being delivered.

The provider had implemented governance oversight systems and processes in order to monitor and improve the quality and safety of care and support across the designated centres. An annual review had been completed by the provider along with six-monthly visits which generated a report and action plan. However, improvement was required to ensure the designated centre had an unannounced visit on a six-monthly basis. At present, each home was being visited separately and this resulted in a longer period between visits and less timely follow up on areas identified in need of address. For example, one unit of the designated centre had its last unannounced visit and report in April 2019, and the second unit in December 2019.

Earlier in the year, the provider had reduced the number of staff working in the designated centre, based on a dependency assessment. This also included the removal of an activity staff member identified to work in this centre. On the day of inspection there were a also a number of vacancies for staff roles in the designated centre, which had resulted in a high amount of temporary agency usage during the previous month.

In addition to the reduction of staff on duty, the inspector found that there were a high number of days in the previous month where the staffing numbers were below this revised, assessed amount. This was due to sick leave absences. Given the restrictions on the person in charge to replace staff who were on paid leave, and the complex needs of residents in this designated centre, this needed to be addressed by the provider to ensure adequate staffing was put in place at all times. Furthermore, the provider's decision to remove a day activation staff member had impacted on opportunities for residents to engage in meaningful activities, both in and outside of their home.

There was evidence that residents were negatively impacted by these decisions, for example it was not currently possible to support residents to go swimming. It was noted that staffing had increased slightly in the previous weeks in order to ensure residents at risk of dehydration, and at risk of other health-related issues, had sufficient supervision and support. Overall, the staffing required review to ensure it could adequately meet the health, social and personal needs of residents, along with

ensuring the safe requirement of staff was in place at all times even during times of unexpected leave.

While the staffing resources needed to be addressed by the provider, inspectors found that the staff team were promoting meaningful activation and social inclusion for residents to the best of their abilities. Staff were observed to be eager to offer residents meaningful days, were possible and interactions between residents and staff were friendly, respectful and person centred.

There was a system in place in the designated centre to monitor training of staff in key areas such as fire safety and safeguarding vulnerable adults. While there was good oversight of these training needs by the person in charge, some mandatory training was in need of refreshing for a number of staff at the time of the inspection. For example, six staff required refresher training in safeguarding vulnerable adults. There was a formal system of staff supervision in place in the designated centre along with regular and effective team meetings by the person in charge.

There were arrangements in place to manage complaints, including a specific policy and associated procedures. There was a named person responsible for the management of complaints. It was found that complaints made in the centre were recorded and responded to in line with the provider's policy, and records of measures to address complaints were available for review. In one premises, the complaints procedure was not displayed as required by the regulations.

Overall, inspectors found that the provider and person in charge had the capacity and capability to managing this designated centre in a manner that was safe, comfortable and met residents' health care needs. However, the manner in which the centre was resourced had not ensured that the care and support being delivered was fully in line with residents' comprehensive needs and offered meaningful and engaging lives for all residents.

Regulation 15: Staffing

The registered provider had not ensured that the number of staff on duty in the designated centre was in line with the number and assessed needs of residents, most notably at times of unexpected staff leave.

This designated centre had a staff team of nurses and care staff to support residents. There was a stable and consistent staff team available to work in the designated centre, and staff knew residents well and some had supported residents for a number of years. However, there were vacancies on the staff team, and there had been a high amount of temporary staff working in the designated centre in the previous month. This did not promote continuity of care and support.

There was a planned and actual staff roster available in the designated centre.

However, this required review to ensure it was a clear reflection of staff on duty during the day and night time.

Judgment: Not compliant

Regulation 16: Training and staff development

While the provider had arrangements in place for staff in the designated centre to access training, including refresher training,not all staff had up-to-date training in mandatory areas as identified in the provider's own policies.

For example, out of 25 staff members:

- Two staff required refresher training in safe manual handling

- Six staff required refresher training in fire safety

- Six staff required refresher training in safeguarding vulnerable adults

- While nine staff had completed risk and incident management training, 14 required this as per the provider's written improvement plan.

Some staff had completed additional training specific to this designated centre and the needs of residents. For example, training in diabetes awareness, care planning, venapuncture, malnutrition assessment and replacement of feeding tubes.

Staff working in the designated centre were appropriately supervised, both informally and formally through recorded one-to-one meetings with the person in charge.

Information on the Health Act 2007 (as amended), regulations and standards were available in the designated centre.

Judgment: Not compliant

Regulation 23: Governance and management

There was a clear governance structure in place in the designated centre, along with defined lines of reporting, responsibility and accountability.

The manner in which the designated centre was resourced required review, to

ensure all resources were available in line with residents' needs.

There were effective management systems in place to monitor the safety and quality of the care and support in the designated centre. An annual review had been completed and a schedule of six-monthly visits was in place. However, the timeliness of the six-monthly visits required review to ensure they were in line with the regulations.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

It was found that the procedures in place to address complaints were being effectively implemented. Improvement was required to ensure that the complaints procedure was displayed in a prominent position in each premises.

Judgment: Substantially compliant

Quality and safety

This inspection found that residents were in receipt of a service that was safe, quite person-centred and meeting their individual health needs. That being said, the manner in which the provider had resourced the centre had some negative impacts on the opportunities for residents to engage in more activities in line with their needs and preferences. Some improvements were required to promote the quality of care and support through improved assessment and planning tools and increased access to meaningful activities.

The staff team in the designated centre were promoting a person-centred approach to care and support. For example, interactions were kind and conversations were specific to each person being supported. The provider had ensured residents lived in a pleasant and homely environment. Each resident had their own private bedrooms which was uniquely decorated. Some residents had a bell to call upon staff for assistance, and mirrors were positioned at suitable levels so residents could attend to their own appearance each morning. Residents' bedrooms were filled with photographs of their lives and important people to them.

While the environment was homely and comfortable for residents, the manner in which the provider was managing staffing resources in the designated centre was limiting residents' opportunities for recreation outside of the centre and campus. For example, in the previous month, some residents had only engaged in activities

outside of Stewarts Care services two or three times. Some residents enjoyed swimming and the positive impact this had on their health and mobility. However, this activity was not facilitated at present due to staffing resources. While a vehicle was available for staff to use to support choice in activities, not all staff could drive and opportunities to use the vehicle were limited to the times that certain staff were on duty.

The provider had a risk management policy in place which was available in the designated centre, and the person in charge maintained a risk register which identified all known risks for residents and the centre in general. Staff were familiar with the risks and their control measures and, in general, risk within the designated centre was low and well managed through appropriate staff support and intervention. There were escalation pathways in place to ensure any increase in incidents, newly identified risks or an increase in risk overall was brought to the attention of the executive management team and provider.

The provider had adequate processes in place to promote residents' safety and protect residents from harm. There was a policy in place to guide the management of safeguarding concerns, allegations or suspicions, and the process for responding and recording safeguarding concerns was in line with national policy. Residents had access to a social work department, if required, and there was a named designated officer for the designated centre. Inspectors found that safeguarding incidents was screened and responded to appropriately, a safeguarding plan was put in place and additional control measures were implemented to prevent a similar situation from happening again.

Staff were knowledgeable on their duties to respond and report any safeguarding concerns and had been provided with training. Some staff required refresher training in safeguarding vulnerable adults. Overall, the inspector found that there were strong safeguarding process in place in the designated centre, with clear recording and review of incidents to ensure measures were taken to protect residents from harm.

Some improvements were required with regards to residents' assessment of needs and personal planning. Residents' healthcare needs were assessed and planned for, information was kept up to date and there was a plan in place for any assessed healthcare need. However, there was an absence of a formal system of assessing residents' personal and social needs in order to maximise their opportunities for new experiences and personal development. The provider had outlined in their previous action plan response that a new assessment tool would be put in place by June 2019. These were not yet in place at the time of inspection, and the inspector was informed that this was currently in development, with plans for the new assessment to be put in place in January 2020. This would guide staff in identifying residents' individual needs in a more comprehensive manner.

Residents had access to their own general practitioner (GP), and access to this service had improved recently through the introduction of an assessment system prior to an appointment. Residents had access to a range of allied health professionals employed by the provider such as psychology, occupational therapy,

clinical nurse specialists and physiotherapy. The person in charge and staff nurses had good oversight of residents' healthcare needs and residents had the choice to avail of national screening programmes if they wished. Residents' wishes in relation to their healthcare were respected, and there was evidence that residents were supported to make their own decisions around refusing treatment once they were fully informed, and if they so wished. The person in charge had ensured residents' needs and wishes for end-of-life care had been recorded into written plans. Residents' wishes and decisions about their future needs were noted and respected, and supports put in place, where necessary to enable residents to make their own decisions.

There were a range of appropriate fire precautions in place. Staff had received training in fire safety management, and supported residents to engage in evacuation drills. The support needs of residents had been considered in the development of individual evacuation plans, and there was a centre specific plan available also. There was a schedule of maintenance in place for fire safety equipment, including extinguishers and fire blankets; however, some items had not been serviced in the time frame outlined. The provider was aware of this issue, and had plans in place to address it.

Inspectors found that residents had a pleasant place to live, with a staff team supporting them in a person-centred and kind manner. Residents' healthcare needs were well supported and risk was well managed. However, some improvements were required to promote the quality of care and support through improved assessment and planning tools and increased access to meaningful activities.

Regulation 13: General welfare and development

While residents had opportunities to take part in activities that were meaningful to them, this was limited by the resources available in the designated centre. Residents could not attend some activities that would benefit their health, such as swimming due to staffing resources. Some residents' activities were quite limited to campus based activities, and their opportunities to engage in activities outside of the provider's service had reduced in recent months.

While residents were supported to develop links with the wider community by the staff team, this was dependent on adequate resources being put in place by the provider each day.

There was evidence that residents were encouraged and supported to maintain relationships with their families and natural support networks.

Judgment: Not compliant

Regulation 26: Risk management procedures

The provider had written and implemented a risk management policy in the designated centre which met the requirements of the regulations.

There was good oversight of risk through a well-maintained risk register and risk assessments, and there was an escalation pathway in place.

Control measures in place, were not found to be overly restrictive and were proportionate to the risks identified.

Judgment: Compliant

Regulation 28: Fire precautions

There were established fire safety arrangements in place, including appropriate measures to detect fire, fire fighting equipment and containment measures. Residents took part in planned emergency evacuations drills, and there were individual evacuation plans in place for each resident. Some fire fighting equipment had not been monitored for servicing in over a year, and outside of the required time indicated by records from the previous service. The provider acknowledged that they were due for servicing imminently and that scheduled services were delayed due to changing contractors.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Residents' healthcare needs were assessed and planned for in the designated centre. Assessments were multidisciplinary, and advice from allied health professionals was included in health care plans.

There was an absence of comprehensive assessments of residents' needs to continue to guide the care and support in relation to their personal and social needs and preferences.

Judgment: Substantially compliant

Regulation 6: Health care

Residents had access to a general practitioner (GP) and a multidisciplinary team which consisted of a psychiatrist, psychologists, occupational therapist, physiotherapist, speech and language therapist, clinical nurse specialist in behaviour, social workers and dietitians. Residents also had access to dental services, optician services and chiropody services.

Residents were informed of national screening programmes in an accessible format, and supported to avail of these programmes if they so wished.

Judgment: Compliant

Regulation 8: Protection

There was a policy in place to guide the management of safeguarding concerns, allegations or suspicions and the process for responding and recording safeguarding concerns was in line with national policy.

The provider had appointed a designated officer in the centre to ensure all safeguarding incidents were responded to and investigated, and residents had access to a social work department if required.

Residents had intimate care plans in place to guide their needs and preferences.

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 - 2015 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	Substantially compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 13: General welfare and development	Not compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Stewarts Care Adult Services Designated Centre 18 OSV-0005852

Inspection ID: MON-0028015

Date of inspection: 12/12/2019

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: New workforce planner in place since 27th of January. Weekly roster management meetings are taken place between programme managers, workforce planner. This meeting identifies areas that are short due to annual leave and relief staff or overtime staff fill the deficit. Since the 1st of January there has been no staff deficit in DC 18. There is also a new PIC that has commenced in this area as .5.	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: All staff have been instructed by the director of care to complete risk management training. All staff throughout DC 18 will be fully compliant with risk management training before June 2020. New person in charge has been instructed by programme manager to review all staff training records through staff member's supervisions and ensure all staff are fully compliant with their mandatory training before June 2020.	
Regulation 23: Governance and	Substantially Compliant

management	
Outline how you are going to come into compliance with Regulation 23: Governance and management: Register provider audit had been completed on the 2nd of December 2019. Next register provider audit to be completed before the 2nd of June 2020. Programme manager will ensure all register provider audits are completed every 6 months.	
Regulation 34: Complaints procedure	Substantially Compliant
Outline how you are going to come into compliance with Regulation 34: Complaints procedure: Person in charge to ensure complaints procedures are displayed in a prominent position throughout the DC before 15/02/2020.	
Regulation 13: General welfare and development	Not Compliant
Outline how you are going to come into compliance with Regulation 13: General welfare and development: An organization group have been developed to visit areas that require additional activities. DC 18 has been highlighted as one of these areas. An adapted physical activity program has been implemented by sports Centre, Staff from sport center will support staff in DC 18. An additional task force is to be implemented by the GP service starting on the 12th of February in training staff in areas about the health benefits of physical activity. Programme manager attended staff meeting on the 29th of January and spoke with staff about their responsibilities in ensuring residents participate in activities within the community. PIC will ensure transport driver is available to support DC18 in helping residents access the community.	
Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions: All fire equipment was serviced in January 2020.

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: A full review has been completed by Programme manager and person in charge. The assessments of need will be completed for each resident before the 31st March 2020. Keyworkers have been instructed to review personal plans and make them current and guide the care and support in relation to resident's social needs and preferences.

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 13(2)(b)	The registered provider shall provide the following for residents; opportunities to participate in activities in accordance with their interests, capacities and developmental needs.	Not Compliant	Orange	12/02/2020
Regulation 13(2)(c)	The registered provider shall provide the following for residents; supports to develop and maintain personal relationships and links with the wider community in accordance with their wishes.	Substantially Compliant	Yellow	10/02/2020
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the	Not Compliant	Orange	29/02/2020

	number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.			
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	27/01/2020
Regulation 15(4)	The person in charge shall ensure that there is a planned and actual staff rota, showing staff on duty during the day and night and that it is properly maintained.	Substantially Compliant	Yellow	31/03/2020
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	30/06/2020
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery	Substantially Compliant	Yellow	27/01/2020

	of care and support in accordance with the statement of purpose.			
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	19/12/2020
Regulation 28(2)(b)(iii)	The registered provider shall make adequate arrangements for testing fire equipment.	Substantially Compliant	Yellow	31/01/2020
Regulation 34(1)(d)	The registered provider shall provide an effective complaints procedure for residents which is in an accessible and age-appropriate format and includes an appeals procedure, and shall display a	Substantially Compliant	Yellow	15/02/2020

	copy of the complaints procedure in a prominent position in the designated centre.			
Regulation 05(1)(b)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out subsequently as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.	Substantially Compliant	Yellow	31/03/2020