



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

Issued by the Chief Inspector

Name of designated centre:	Villa Maria
Name of provider:	Sunbeam House Services CLG
Address of centre:	Wicklow
Type of inspection:	Unannounced
Date of inspection:	17 June 2026
Centre ID:	OSV-0001686
Fieldwork ID:	MON-0050700

About the designated centre

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

Villa Maria is a designated centre operated by Sunbeam House Services CLG. Villa Maria is located in a town in Co. Wicklow. The designated centre can provide residential care for up to six male or female residents over the age of 18 years with disabilities. The centre provides services for residents who are dependent in many areas of their daily life and require staff support to maintain and increase independence as much as possible. Staff also support residents to manage personal risks and provide healthcare supports. The centre is managed by a full-time person in charge. An operations manager is also assigned to the centre and provides supervisory support to the person in charge. The staff skill-mix includes social care workers and healthcare assistants.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	6
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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 June 2026	09:55hrs to 16:20hrs	Michael Muldowney	Lead
Wednesday 17 June 2026	09:55hrs to 16:20hrs	Sarah Barry	Lead

What residents told us and what inspectors observed

This unannounced inspection was carried out as part of the regulatory monitoring of the centre. It focused on how the provider safeguarded residents from abuse, promoted their human rights, and empowered them to exercise choice and have control in their lives. The inspection was scheduled following the previous inspection of the centre in February 2026, which found high levels of not compliance with regulations. Following the inspection, the provider attended a warning meeting with the Office of the Chief Inspector of Social Services (Chief Inspector) and submitted a detailed compliance plan that outlined actions on how the provider would meet compliance with the regulations.

During this inspection, inspectors used observations, conversations with staff, engagements with residents, and a review of documentation to form judgments on compliance with the regulations inspected, and to verify if the compliance plan actions had been implemented. Overall, inspectors found that the provider had implemented the actions to a high standard. This was contributing to much improved compliance with the regulations, enhanced governance and management of the centre, and an overall, better quality and safety of care and support for residents. However, the centre remained unsuitable to fully meet the assessed needs of one resident.

The centre accommodated six residents, and inspectors met them throughout the inspection. Residents were observed doing different activities, such as going to a community-based art class, going for walks and coffee with staff, watching television, and listening to music. Most residents used non-verbal means to communicate, such as manual signs, visual aids, gestures and body language. Some residents did not wish to engage with inspectors, and this was respected. Other residents engaged with inspectors by smiling, using some words and manual signs, and holding inspectors' hands. One resident took an inspector by the hand to show them their bedroom, which was very personalised and decorated in line with their interests. The residents did not express their views on what it was like to live in the centre.

Inspectors observed that staff had a good understanding of how residents communicated; for example, they used manual signs when engaging with certain residents and promptly responded to their requests. Inspectors also observed visual aids, such as a picture staff rota in the hallway for residents to refer to. Overall, it was found that residents received very good support to communicate, and this was underpinned by the recent training for staff from the provider's speech and language therapist and the development of written communication plans for staff to follow that clearly outlined how each resident communicated.

Inspectors observed that staff engaged respectfully with residents. Staff spoken with told inspectors that since the previous inspection there has been many positive

changes in the centre, such as increased opportunities for residents to go on social outings and better consistency of staff, which meant that residents were more settled. Staff were found to have a good understanding of the topics discussed with inspectors, such as residents' behaviour support plans and how restrictive practices were used in the centre. These topics are discussed further in the next sections of the report.

The centre comprises a two-storey detached house in a busy seaside town. Inspectors walked around the house with the deputy manager of the centre. Residents had their own bedrooms, and there were personalised to their individual tastes. The communal spaces included a front sitting room, an open plan living area with a kitchen and dining space, and an upstairs sensory room. There was also a utility room, two offices, and nice front and rear gardens for residents to use. Since the previous inspection, the provider had renovated parts of the premises. The front driveway had been resurfaced to address trip hazards, and the sensory room had been refurbished with input from the provider's occupational therapist. Staff told inspectors that one resident in particular loved the new sensory room, and that it was contributing to a reduction in behavioural incidents. The provider was also planning on renovating the main bathroom.

Inspectors observed that there was a reduction in the number of environmental restrictions used in the centre, and this was enabling residents to have more access around their home. For example, the back door was no longer locked, and staff told inspectors that residents were now spending more time in the garden. Restrictive practices are discussed further in the quality and safety section of the report.

The inspection was facilitated by the person in charge with support from a deputy manager and an operations manager. It was clear to inspectors that the management team were bringing positive changes to the centre and driving quality improvements. For example, they had supported residents to access independent advocate services to help them with decisions affecting their lives and had enhanced the oversight and monitoring systems in the centre. These initiatives and changes were contributing to improved compliance. The previous inspection found all eight regulations inspected to be not compliant. This inspection found five regulations to be compliant, one substantially compliant, and one not compliant.

The not compliant finding related to Regulation 5: Individual assessment and personal plan, as the centre remained unsuitable to meet one resident's assessed needs. This had been determined by a multidisciplinary team assessment. While the provider was endeavouring to meet the resident's needs and engaging with other stakeholders on the matter, at the time of the inspection, there was no confirmed plan or time frame for the resident to move to a more appropriate home that was in line with their needs.

The next two sections of the report present the findings of this inspection in relation to the governance and management arrangements in place in the centre and how these arrangements impacted on the quality and safety of the service being delivered to each resident living in the centre.

Capacity and capability

This inspection found much improved governance and management systems that were contributing to a safer, more consistent and better quality service for residents. The provider had implemented the previous inspection's compliance plan actions to good effect. The centre was also found to be better resourced; for example, the staffing arrangements had been enhanced, parts of the premises had been renovated, and a second vehicle had been sourced to improve residents' opportunities for social outings. However, the centre was not meeting one resident's assessed needs.

The management structure in the centre was clearly defined with associated responsibilities and lines of authority. The person in charge was full-time and supported in the management of the centre by a newly appointed deputy manager. The person in charge reported to an operations manager, and there were systems for them to communicate and escalate information, including scheduled meetings. The management team were driving improvement initiatives and programmes, such as the establishment of a local restrictive practice group to review and reduce the use of restrictions in the centre. The operations manager reported to an operations director, who in turn reported to a Chief Executive Officer (CEO).

The provider and local management team had implemented management systems to ensure that the centre was safe and effectively monitored through audits and ongoing reviews. Improvement actions were monitored by the management team via a service improvement plan.

The staff skill-mix and complement had been enhanced and was deemed to be appropriate to the number and assessed needs of residents. There was one vacancy, however it was well-managed to reduce the risk of any adverse impact on residents.

Staff attended team meetings which provided an opportunity for them to raise any concerns regarding the quality and safety of care provided to residents. Inspectors viewed a sample of the recent staff team meetings from March to May 2026 which noted discussions on inspections, audit findings, restrictive practices, residents' goals and care plans, supporting residents to communicate, and fire safety. Some of the meetings were also attended by the operations manager and members of the provider's multidisciplinary team, such as behaviour support specialists.

Regulation 15: Staffing

The registered provider had ensured that the staff complement and skill-mix, comprising the person in charge, a deputy manager, social care workers and healthcare assistants, was appropriate to the number and assessed needs of the residents in the centre.

Since the previous inspection, the provider had reviewed the staffing arrangements and enhanced it with the addition of deputy manager and additional social care workers. Inspectors were told that this was having a positive impact on resident's quality of service; for example, residents had more opportunities for social activities and there was less reliance on agency staff.

There was one whole-time equivalent vacancy in the staff complement which the provider was recruiting to fill. However, the vacancy was well-managed to reduce any potential adverse impact on residents. The person in charge endeavoured to use regular relief and agency staff who residents were familiar with, and there was an induction folder for agency and relief staff to read with key information such as how to access policies and procedures, and report concerns. Agency staff working in the centre signed the folder to indicate that they read and understood its contents.

Inspectors viewed a sample of the May, June and July 2026 planned and actual staff rotas, and found that they clearly showed the names of staff working in the centre during the day and night including agency staff.

Staff Schedule 2 files were not reviewed as part of this inspection.

Judgment: Compliant

Regulation 23: Governance and management

Inspectors found that the governance and management systems had much improved since the last inspection and were contributing to a better quality service that was consistent and effectively monitored.

Inspector found that the centre was also better resourced to deliver effective care and support; for example, the staffing arrangements had been enhanced. However, as discussed and actioned under Regulation 5: Individualised assessment and personal plan, the centre remained unsuitable to meet all residents' full needs.

Following the previous inspection, the provider submitted a comprehensive compliance plan that outlined the actions it intended to take to come into compliance. Inspectors found that the actions had been implemented and sustained to a high standard; for example:

- the staff complement and skill-mix had been enhanced, including with the addition of a deputy manager
- a root cause analysis of the issues found during the previous inspection was completed to identify learning

- the centre's improvement plan was regularly reviewed and updated to monitor quality improvement actions
- parts of the premises had been upgraded and renovated, including the front driveway
- a working group was formed and met on a regular basis to plan for one resident's move to a more suitable centre
- staff had completed Lámh (manual signs) communication training
- a new wheelchair accessible vehicle had been secured and was due to be delivered shortly after this inspection
- residents' behaviour support and communication care plans had been reviewed and updated by the provider's multidisciplinary team
- the person in charge had established a local restrictive practice oversight group to review the use of restrictions in the centre.

There was a clearly defined management structure with associated lines of authority and responsibilities. The person in charge had responsibility was supported in their role by a deputy manager, and reported to an operation manager. There were arrangements for them to communicate and escalate information, such as scheduled governance meetings. The operations manager also visited the centre as part of their oversight.

There were effective arrangements for staff to raise concerns. In addition to the support and supervision arrangements, staff attended team meetings, which provided a forum to raise concerns. Staff told inspectors that they felt supported in their roles and could easily raise concerns with the person in charge.

Judgment: Compliant

Quality and safety

Overall, inspectors found that the quality and safety of the care and support provided to residents in the centre had improved since the last inspection, particularly in relation to the management of restrictive practices, safeguarding arrangements, and supports residents received to communicate. However, the centre remained unsuitable to meet the needs of one resident, and this was having an adverse impact on them and other residents.

The person in charge had ensured that residents' care needs were assessed which informed the development of personal plans. Inspectors viewed a sample of two residents' health, social and personal care plans including intimate care, medication, communication, eating and drinking, behaviour, personal goals, finances, health, and safety plans. They provided information to inform staff on the supports and interventions required to meet residents' needs. There was also information on residents' likes and dislikes to support staff in facilitating residents' interests and

preferences. The plans reflected input from a wide range of multidisciplinary team services, including speech and language therapists and behaviour therapists. However, one resident was assessed as requiring a specific type of home environment, which the centre could not provide. Although the provider was endeavouring to source a suitable environment, at the time of the inspection, one had not been identified.

Residents communicated using multi-modal and mostly non-verbal means. They did not express their views to inspectors. However, inspectors observed that staff knew how to communicate with residents and responded to their needs.

Staff spoken with told inspectors that the residents' quality of life had improved since the last inspection. For example, they said that residents had more opportunities for social outings, and that the reduction in the use of restrictions had contributed to more relaxed environment. However, they were concerned that the centre was not meeting one resident's needs, and although upgrades to the premises had been beneficial, the resident still displayed behaviours that indicated distress and which could also impact on other residents.

The person in charge told inspectors about the activities residents enjoyed, such as swimming, eating out, having holistic treatments, live music, spending time with their family, shopping, and using the recently refurbished sensory room. One resident had recently returned from a hotel break with staff, and another resident was planning a holiday.

Inspectors found that safeguarding concerns were better managed. Incidents had been appropriately reported and actions were implemented to protect residents from potential harm. Staff had completed safeguarding, and they told inspectors that they knew how to report any potential concerns.

Inspectors observed that there was a reduction in the number of environmental restrictions, and that those in place were under regular review to ensure that they were in line with the provider's policy. These improvements were having a positive impact on residents' lives as they could more freely use their home and the garden. However, at times, residents were restricted from parts of the centre due to the behaviours of other residents.

Regulation 10: Communication

The previous inspection found this regulation to be not compliant; however, this inspection found that the registered provider and management team had implemented significant improvements to ensure that residents were assisted and supported to communicate in their own individual means.

Residents mostly communicated using non-verbal means, and used manual signs, gestures and visual aids. The provider's speech and language therapist had assessed each residents' communication needs, and prepared written care plans for staff to

follow on how to communicate with residents and ensure that they were understood. The plans were comprehensive, written in a person-centred way, and readily available to staff.

Staff had completed communication training to inform their practices. Some had also completed specific training in manual signs (Lámh). Within in the centre, there was a 'Lámh Champion' who had responsibility for promoting the use of Lámh and helping staff and residents to understand it. Other initiatives included staff and residents learning a new sign each month. Inspectors observed the sign of the month on a notice board in the hallway as well as other visual aids, such as planners with pictures. Inspectors also read that staff were reminded during team meetings to use residents' communication aids, such as visual aids. These initiatives demonstrated a commitment to support residents' right to communicate their needs and wishes, and to be heard.

The provider had ensured that residents could access different media forms in the centre, including televisions and the Internet.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The centre was not meeting the full assessed needs of one resident. This had been determined in an assessment by the provider's multidisciplinary team. The resident requires a low-stimulus and autism-specific environment, which the centre could not provide. This was resulting in the resident displaying behaviors of concern, such as exhibiting distress, which were also having an adverse impact on other residents.

Inspectors read and were told about the provider's efforts to source an appropriate environment for the resident. For example, the provider was engaging with stakeholders, including the local county council and the provider's funder on the matter, and had considered other potential properties available to the provider. However, an appropriate home had not been identified at the time of the inspection. Living in the current environment presented an ongoing risk to the residents' wellbeing.

Inspectors also found that the resident's assessments and plans contained conflicting information regarding the specific staff support they required. This required review as it posed a risk to the quality and safety of support they received.

Judgment: Not compliant

Regulation 7: Positive behavioural support

Residents received good support to manage their behaviours of concern. Inspectors reviewed a sample of the residents' positive behaviour support plans. They had been completed by the provider's behaviour support team, and were found to be up-to-date, comprehensive, written using person-centred language, and prepared in an easy-to-read format to be more accessible to residents. The plans were readily available in the centre for staff to follow, and staff told inspectors that they were effective. The provider's behaviour support specialists had also attended recent staff team meetings to help staff understand the strategies in the plan.

The systems for the oversight and management of restrictive practices had vastly improved since the previous inspection, and were driven by the person in charge, for example:

- a local restrictive practice group was established in the centre to review all restrictions
- the restrictions were submitted to and approved for use by the provider's oversight group to ensure review at a provider level
- updated restrictive practice registers had been prepared for each resident and were monitored by the person in charge
- easy-to-read information was used to help residents understand the rationale for restrictions
- the person in charge had completed a restrictive practice self-assessment tool to ensure that restrictions were implemented in line with evidence-based practice

The improved systems and practices were resulting in positive outcomes for residents. For example, some restrictions had been removed, such as nightly checks and the locking of the back door. This ensured that residents' right to privacy was protected, and that they had free access to their back garden. Inspectors also observed that less restrictive interventions were in place, such as wind chimes at an exit door to alert staff if residents left unattended instead of locking the door.

Judgment: Compliant

Regulation 8: Protection

The registered provider and person in charge had implemented systems to safeguard residents from abuse. The provider had prepared a written safeguarding policy, which underpinned the systems and outlined the associated arrangements.

Staff were required to complete safeguarding training to support them in the prevention, detection, and response to safeguarding concerns, and there was guidance in the centre for them to refer to.

The inspector found that safeguarding incidents in the centre had been appropriately reported, responded to, investigated, and managed. For example, the

inspectors reviewed three safeguarding incidents reported since the last inspection and found that they had been reported in line with the provider's policy. Safeguarding support plans had also been prepared for each resident and outlined the necessary actions to keep residents protected from abuse. The plans were monitored by the person in charge to ensure that they were kept up to date.

Information on residents' personal and intimate care needs was noted in their care plans for staff to follow to help ensure that they supported residents in a manner that respected their privacy and dignity.

Judgment: Compliant

Regulation 9: Residents' rights

The registered provider and management team of the centre had made improvements to better support residents to exercise choice in their lives and promote their rights in the centre. For example,

- an independent advocate had been sourced for a resident to help inform the decision-making around their care and support
- information written about residents was person-centred and outlined their individual needs, personalities, interests and preferences to guide the support they received from staff
- residents were supported by allocated key workers to plan and achieve personal goals, such as going on holidays
- the provider had resourced the centre to ensure that residents had more opportunities for social activities. For example, staffing levels had increased and a second vehicle had been sourced
- as described under Regulation 7: Positive behaviour support, there was a reduction in the use of restrictive practices, and those that were in place were kept under scrutiny to ensure that they were in line with evidence-based practice and with input from the residents concerned
- as described under Regulation 10: Communication, staff had completed communication training and communication care plans were in place to ensure that residents' right to communicate was upheld

However, due to the needs of one resident not been fully met in the centre, residents were not able to freely access all parts of their home at all times, such as when the resident displayed behaviours of concern.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 23: Governance and management	Compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Villa Maria OSV-0001686

Inspection ID: MON-0050700

Date of inspection: 17/06/2026

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 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: 1. As an interim measure, the provider is preparing a dedicated day service space to provide the resident with access to a low-stimulus environment pending relocation to a more suitable home. Completion date: 08/08/2026 2. A wheelchair accessible vehicle was delivered to the centre and is now available for use as a second vehicle. Completion date: 15/07/2026 3. The provider will continue to progress their Housing Pathway through fortnightly meetings, with actions documented and reviewed until a suitable low-stimulus, autism-specific home is secured for the resident. Completion date: 31/12/2026 4. The provider will continue engagement with the funder to secure approval of the submitted business case and the funding required to progress the resident's relocation. Completion date: 31/12/2026 5. The risk of incompatibility will be raised to the Quality and Risk Management Committee (QRMC) for quarterly review, with any high risks escalated to the Board through regular governance reporting. Ongoing. 6. The person in charge will develop a comprehensive transition plan once a suitable service has been identified, incorporating the resident's communication preferences and required supports. Completion date: 31/12/2026 7. A multidisciplinary case review will take place to assess the resident's ongoing current support needs and housing plan. Completion date: 30/09/26 8. The resident's support plans have been updated to reflect the assessed requirement for 1:1 staffing. A second staff member may be required during periods of increased	

stress however their presence is not required at all times and can be a trigger for the resident. This has been clearly reflected in the resident's support plans and communicated to the staff team. Completion date: 22/07/2026

9. The PPIM and PIC will hold monthly meeting to review progress against this Compliance Plan, monitor completion of agreed actions and assess ongoing risks within the designated centre. Ongoing.

Regulation 9: Residents' rights	Substantially Compliant
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Outline how you are going to come into compliance with Regulation 9: Residents' rights:

1. As an interim measure, the provider is preparing a dedicated day service space to provide the resident with access to a low-stimulus environment, pending relocation to a more suitable home. Completion date: 08/08/2026

2. The risk of incompatibility will be raised to the Quality and Risk Management Committee (QRM) for quarterly review, with any high risks escalated to the Board through regular governance reporting. Ongoing.

3. The provider will continue to progress their Housing Pathway through fortnightly meetings, with actions documented and reviewed until a suitable low-stimulus, autism-specific home is secured for the resident. Completion date: 31/12/2026

4. The person in charge will continue to record, monitor and review all restrictive practices through the Human Rights Committee and local restrictive practice review group with view to reducing eliminate restrictions wherever possible. Completion date: 01/12/2026

5. The PPIM and PIC will hold monthly meeting to review progress against this Compliance Plan, monitor completion of agreed actions and assess ongoing risks within the designated centre. Ongoing.

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 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	31/12/2026
Regulation 05(3)	The person in charge shall ensure that the designated centre is suitable for the purposes of meeting the needs of each resident, as assessed in accordance with paragraph (1).	Not Compliant	Orange	31/12/2026
Regulation 09(2)(b)	The registered provider shall	Substantially Compliant	Yellow	31/12/2026

	ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability has the freedom to exercise choice and control in his or her daily life.			
Regulation 09(3)	The registered provider shall ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.	Substantially Compliant	Yellow	31/12/2026