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:	SVC - AT
Name of provider:	Avista CLG
Address of centre:	Dublin 7
Type of inspection:	Announced
Date of inspection:	01 October 2025
Centre ID:	OSV-0004022
Fieldwork ID:	MON-0039371

About the designated centre

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

SVC - AT is designated centre which is made up of two individual units both of which are located on a large campus in the North-West of Dublin City. Both units are located within close distance of each other and provide services to a group of 12 residents with intellectual disabilities and complex medical conditions. The age range of residents living in the centre was 50 to 80 years. The centre provides 24 hour residential supports through a nurse led team to meet the needs of residents availing of its services. There is a person in charge, clinical nurse manager and a staff team of staff nurses, carers and household staff employed in the centre. The core values of the centre which are outlined in the statement of purpose communicate a commitment to service, respect, excellence, collaboration, justice and creativity.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	12

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 1 October 2025	09:00hrs to 17:00hrs	Maureen Burns Rees	Lead

What residents told us and what inspectors observed

From what the inspector observed, there was evidence that the residents living in the centre received good quality care and support. However, some improvements were required regarding maintenance of premises, residents individual support plans and opportunities for residents to purchase and prepare their own meals within the centre.

The provider had been granted an application to change the foot print of the centre and to reduce the capacity of the centre from 14 to 12 in June 2025. At the time of this inspection there were 12 residents living in the centre and no vacancies.

The centre comprises of two separate units which were located adjacent to each other within a campus-based setting operated by the provider. The layout of each of the units was similar and each contained six bedrooms, three accessible bathrooms, a large kitchen come sitting come dining area, laundry room, sluice room, a visitor room, and storage room. Each house had a large, private and accessible back garden. The centre was located in close proximity to local amenities, including, shops restaurants, cinema, swimming pool, public parks and public transport links.

Each of the 12 residents had been living together for an extended period and were reported to get along well together. The residents ranged in age from 50 to 80 years with the majority of the residents progressing in years. Each of the residents had significant medical and care needs. Over the course of the inspection, the inspector met briefly with each of the residents. Although the majority of the residents met with were unable to tell the inspector their views on the quality of the service, they appeared in good spirits. Two of the residents spoke with the inspector and indicated that they were happy living in the centre. A number of residents were observed to go out for walks on campus with staff while other residents went out for periods to a day service located within the campus. One of the residents was supported by staff to attend a well known college following an invitation to meet students studying in the social care field. A number of residents went out for shopping and lunch within the community on the day of inspection.

Residents with limited speech were observed to be supported by staff to communicate their feelings and wishes. Lunch period was observed in one of the houses where a number of the residents required staff assistance with their meal. This was observed to be undertaken in a kind and dignified manner. All six residents in that house sat together for their meal which was unhurried and noted to be a social occasion. However, as discussed under Regulation 18, lunch and evening meals were not prepared in the centre but delivered from a central kitchen within the campus.

There was evidence that residents and their representatives were consulted and communicated with about decisions regarding their care and the running of the centre. One of the residents, as documented in their personal support plan, decided

each morning which of the staff team they wanted to support them on any given day. Each of the residents had regular one-to-one meetings with their assigned key workers. Residents were supported to communicate their needs, preferences and choices at these meeting in relation to activities and meal choices. The inspector did not have an opportunity to meet with the relatives or representatives of any of the residents but it was reported that they were happy with the care and support that the residents were receiving. The provider had consulted with residents' families as part of its annual review of the quality and safety of the service and the feedback from families was positive. Seven of the residents had been supported by staff to complete an office of the chief inspector questionnaire which indicated that they were happy with the care that they were receiving. Records were also maintained of positive feedback and comments received from family members.

Residents were supported and encouraged to maintain connections with their friends and families. A number of the residents were supported to visit their family home on a regular basis and visits by friends and family to the centre were facilitated. There were no restrictions on visiting in the centre. There had been a recent 70th birthday celebration in the centre for one of the residents which was attended and reportedly enjoyed by family members and the other residents.

There were bi-weekly resident meetings in the centre and residents rights were discussed as part of these meetings. Residents were observed to be treated with dignity and respect and staff were noted to interact with the residents in a caring and respectful manner. There was a human rights officer in place within the organisation who was available as a resource for staff and residents. There was evidence that residents choice was promoted in the centre. For example, their choice of clothing and of the staff that they wanted to support them was respected. There had been one complaint recorded in the previous 12 month period which had been resolved at a local level. One of the residents was involved in producing a newsletter with the assistance of staff for circulation to designated centres across the campus. Two of the residents were members of the providers advocacy committee.

Overall, residents were supported to engage in meaningful activities in the centre and in the community. A number of residents were engaged in a book club and were also reported to enjoy attending a community coffee morning group which had been established by a former member of staff. In the preceding period a small number of the residents had enjoyed a spa day together in a local hotel. It was noted that some of the residents had minimal opportunities for community integration. This was attributed to the high support needs and medical fragility of a number residents and the required staffing levels to meet those needs. This is discussed further under Regulation 5. The majority of residents were engaged in the day service programme located on the campus which had a sessional activity schedule. As part of this programme some residents were taken off campus for walks and activities in the community. There was a small church on the campus and a number of residents enjoyed attending weekly mass in the church. Examples of other activities that residents engaged in within the centre and in the community included, walks within the campus and to local scenic areas, church visits, beauty treatments and spa days, baking, arts and crafts and shopping. An activity log was

maintained of activities engaged in.

The centre had access to a vehicle and usage was coordinated by the providers transport manager. This could be used to facilitate residents to access community activities and visits to families. Each house had a good sized private back garden and it was noted that residents had engaged in planting flowers and some vegetables, such as tomatoes in their gardens. Residents also had access to a number of communal areas on the campus and a sensory garden. There was a horticulturist working on the campus who supported some of the residents with gardening tasks.

The next two sections of this report present the inspection findings in relation to governance and management in the centre, and how governance and management affects the quality and safety of the service being delivered.

Capacity and capability

There were suitable governance and management arrangements in place to promote the service provided to be safe, consistent and appropriate to residents' needs..

The person in charge had a background as a registered nurse in intellectual disabilities and held a degree in nursing studies and a certificate in management. They had been working within the service for an extended period and had more than 25 years of management experience. They was in a full-time position and was not responsible for any other service. They were found to have a good knowledge of the requirements of the regulations and of the assessed needs for each of the residents. The person in charge reported that they felt supported in their role and had regular formal and informal contact with their manager.

There was a clearly-defined management structure in place that identified lines of accountability and responsibility. This meant that all staff were aware of their responsibilities and who they were accountable to. The person in charge was supported by a clinical nurse manager (CNM 1). The person in charge reported to a clinical nurse manager grade 3 (CNM 3) who in turn reported to the service manager. The person in charge and CNM 3 held formal meetings on a regular basis.

The provider had completed an annual review of the quality and safety of the service and unannounced visits, to review the safety of care, on a six-monthly basis as required by the regulations. A number of other audits and checks had been completed. Examples of these included, infection prevention and control, finance, incident reports, hygiene, care plans and medication. There was evidence that actions were taken to address issues identified in these audits and checks. There were regular staff meetings and separately management meetings with evidence of communication of shared learning at these meetings.

A record of all incidents occurring in the centre was maintained and where required, these were notified to the Chief Inspector of Social Service, within the time frames required in the regulations.

Regulation 14: Persons in charge

The person in charge was found to be suitably qualified and experienced. The inspector reviewed the Schedule 2 information, as required by the Regulations, which the provider had submitted for the person in charge. These documents demonstrated that the person in charge had the required experience and qualifications for their role. The person in charge was in a full time position and was not responsible for any other centre. The person in charge reported in to this CNM3 who in turn reported to the service manager. In interview with the inspector, the person in charge demonstrated a strong knowledge of the residents' care and support needs and oversight of the centre.

Judgment: Compliant

Regulation 15: Staffing

The staff team were found to be appropriately qualified and experienced to meet residents' needs. This was a staff nurse-led service with a registered staff nurse rostered on each shift. There were two whole-time equivalent staff vacancies at the time of inspection. However, it was reported that recruitment for each of the positions was in the final stages. These vacancies were being covered by regular relief staff and on infrequent occasions agency staff were being used. This promoted consistency of care for the residents. The actual and planned duty rosters were found to be maintained to a satisfactory level. The inspector reviewed a sample of staff files and found that all of the documentation required by the regulation was in place.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Staff were provided with appropriate training to support them in their role. All training was coordinated centrally and a training tracker maintained. Records showed that all staff had completed all mandatory training. A training needs analysis had been completed. Suitable staff supervision arrangements were in place.

Judgment: Compliant

Regulation 23: Governance and management

Suitable governance and management arrangements were in place. The provider had completed an annual review of the quality and safety and unannounced visits, to review the safety of care, on a six monthly basis as required by the regulations. There were clear lines of accountability and responsibility.

Judgment: Compliant

Regulation 3: Statement of purpose

There was a statement of purpose in place, dated July 2025. This was found to contain all of the information outlined in schedule 1 of the regulations.

Judgment: Compliant

Regulation 31: Notification of incidents

Notifications of incidents were reported to the Chief Inspector in line with the requirements of the regulations. Overall, there were relatively low numbers of incidents in this centre.

Judgment: Compliant

Regulation 34: Complaints procedure

There were appropriate complaint procedures in place. Information about the complaint procedure was on display in the centre. There was a nominated complaint officer. There had been one complaints in the preceding 12 month period which had been appropriately responded to in line with the provider's policy. Staff spoken with were aware of the complaint process and the process was discussed with residents as part of house meetings. Contact details for the confidential complaint recipient were on display in both of the houses.

Judgment: Compliant

Regulation 4: Written policies and procedures

The provider had a suite of policies and procedures in place on the matters set out in schedule 5 of the Regulations. However, a small number of these policies had not been reviewed at intervals not exceeding three years as required by the Regulations. These included the communication with residents policy, dated July 2022 and the recruitment, selection and Garda vetting of staff policy dated April 2022.

Judgment: Substantially compliant

Quality and safety

The residents living in the centre appeared to receive person- centred care and support which was of a good quality. However, some improvements were required regarding maintenance of the premises, residents' individual support plans and opportunities for residents to purchase and prepare their own meals within the centre.

The majority of residents living in the centre had complex medical needs, were wheelchair users and were progressing in years. Overall, residents' medical needs and welfare was maintained by a good standard of evidence-based care and support. However, it was noted that goals identified for some residents were limited and in some cases not specific, For example, a goal for one resident was to access the community. Activity records did not always indicate if certain activities were on site or within the community. Consequently, there was limited written records for a small number of residents to show if they had left the campus for an extended period. A review of each residents care and personal plan was undertaken by the multi-disciplinary team on an annual basis. However, in a sample reviewed it was noted that these reviews had not been conducted in a manner that ensured the maximum participation of each resident and where appropriate, their representative, in accordance with their wishes and in line with the requirements of the regulations.

A staff nurse was rostered on each shift to ensure that residents' medical needs were being met. There was a health action plan for each of the residents which included an assessment and planning for individual resident's physical and mental health needs. Personal care plans and support plans reflected the assessed needs of individual residents and outlined the support required in accordance with their individual health, communication and personal care needs and choices. A new template for the personal support plans had recently been introduced. A 'think ahead' document had been put in place for a number of the residents. This documented individual residents will and preference in relation to end of life care. Detailed communication passports were in place to guide staff in supporting the resident to effectively communicate. The inspector reviewed the transition plan

which had been used for the successful transition of a resident from one unit to a larger bedroom in the other unit.

There were suitable infection control procedures in place. All areas appeared clean. However, small amount of chipped paint were noted on some doors and the sink surround in one of the bedrooms had broken areas. Colour-coded cleaning equipment was available. Sufficient facilities for hand hygiene were observed and hand hygiene posters were on display. There were adequate arrangements in place for the disposal of waste. Specific training in relation to infection control had been provided for staff.

There were measures in place to protect residents from being harmed or suffering from abuse. There had been a small number of allegations or suspicions of abuse in the preceding period. These had been appropriately responded to in line with the providers policies and had not been upheld. There were no safeguarding plans in place at the time of inspection. Staff spoken with were knowledgeable about safeguarding procedures and of their role and responsibility in the event of disclosure or observing an abuse. Appropriate arrangements were in place to report and respond to any safeguarding concerns. The provider had a policy for the protection of vulnerable adults and the management of allegations of abuse.

Residents were provided with appropriate emotional and behavioural support. Residents presented with minimal behaviours of concern. There had been no peer-to-peer incidents in the preceding period. Support guidance for managing behaviours were in place for small number of residents identified to require same. There were a small number of restrictive practices in place which were subject to regular review. Individual rights assessments had been completed for all restrictions.

Regulation 17: Premises

The centre was comfortable, homely and in a reasonable state of repair. However, small amount of chipped paint were noted on some doors and the sink surround in one of the bedrooms had broken areas.

The provider had been granted an application to change the foot print of the centre and to reduce the capacity of the centre from 14 to 12 in June 2025. This enabled the provider to establish a dedicated area for the storage of medical equipment and consequently more space within communal areas and residents bedrooms.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

Residents were provided with adequate food and nutrition. However, it was noted

that the arrangement of preparing meals in a centralised kitchen off site was an institutionalised practice and limited residents' involvement or inclusion in this process. There was a supply of snacks available in the centre and a supply of food for breakfast. However, the residents' lunch and evening meal were prepared in a centralised kitchen on the campus and transported to the centre. This meant that residents were not being supported to buy, prepare and cook meals in their own home if they so wished.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

The health and safety of the residents, visitors and staff were promoted and protected. Individual and environmental risk assessments had been completed and were subject to review. Further to the last inspection when it was identified that there was limited storage facilities for medical equipment, a risk assessment and management plan had been put in place for same. Since that inspection, the layout of the centre had been changed to establish an area dedicated to the storage of medical equipment. Health and safety audits were undertaken on a regular basis with appropriate actions taken to address issues identified. Health and safety audits were undertaken on a regular basis with appropriate actions taken to address issues identified. There were arrangements in place for investigating and learning from incidents and adverse events involving the residents. This promoted opportunities for learning to improve services and prevent incidents.

Judgment: Compliant

Regulation 28: Fire precautions

Suitable precautions had been put in place against the risk of fire. Fire fighting equipment, emergency lighting and the fire alarm system were serviced at regular intervals by an external company. There were adequate means of escape and a procedure for the safe evacuation of residents was prominently displayed. Fire drills involving residents had been completed at regular intervals and the centre was evacuated in a timely manner. Staff had attended fire safety training and the provider had a fire safety policy in place.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

Residents' medical needs and welfare was maintained by a good standard of evidence-based care and support. However, it was noted that goals identified for some residents were limited and in some cases not specific. For example, a goal for one resident was to access the community. Activity records did not always indicate if certain activities were on site or within the community. Consequently, there was limited written records for a small number of residents to show if they had left the campus for an extended period. A review of each residents care and personal plan was undertaken by the multi-disciplinary team on an annual basis. However, in a sample reviewed it was noted that these reviews had not been conducted in a manner that ensured the maximum participation of each resident and where appropriate, their representative, in accordance with their wishes and in line with the requirements of the regulations.

Judgment: Substantially compliant

Regulation 6: Health care

The residents' health needs were being met by the care and support provided in the centre. There was a registered staff nurse rostored on duty at all times. Detailed health action plans were in place. Records were maintained of all contacts with health and social care professionals.

Judgment: Compliant

Regulation 7: Positive behavioural support

Residents appeared to be provided with appropriate emotional support. Overall the residents presented with minimal behaviours of concern. Guidance was in place for residents who were identified as needing that support.

Judgment: Compliant

Regulation 8: Protection

There were measures in place to protect residents from being harmed or suffering from abuse. There had been two allegations or suspicions of abuse in the preceding period which had been appropriately responded to in line with the providers policies and found not to be up held. Safeguarding information was on display and included

information on the nominated safeguarding officer.

Judgment: Compliant

Regulation 9: Residents' rights

The residents rights were promoted by the care and support provided in the centre. There were bi-weekly resident meetings in the centre and residents rights were discussed as part of these meetings. Residents were observed to be treated with dignity and respect and staff were noted to interact with the residents in a caring and respectful manner. There was a human rights officer in place within the organisation who was available as a resource for staff and residents. There was evidence that residents choice was promoted in the centre. For example, their choice of clothing and of the staff that they wanted to support them was respected. There had been one complaint recorded in the previous 12 month period which had been resolved at a local level. One of the residents was involved in producing a newsletter with the assistance of staff for circulation to designated centres across the campus. Two of the residents were members of the providers advocacy committee.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Substantially compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for SVC - AT OSV-0004022

Inspection ID: MON-0039371

Date of inspection: 01/10/2025

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: Two new staff nurses have been recruited and will be in position in the first week of November 2025	
Regulation 4: Written policies and procedures	Substantially Compliant
Outline how you are going to come into compliance with Regulation 4: Written policies and procedures: The Communication with residents policy, dated July 2022 will be reviewed and updated. The Recruitment and Selection policy dated April 2022 has now been reviewed and updated (28/10/2025) Timeframe; 31st December 2025	
Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: Chipped paint on doors and the sink surround in one of the bedrooms will be repaired Timeframe; December 31st, 2025	

Regulation 18: Food and nutrition	Substantially Compliant
Outline how you are going to come into compliance with Regulation 18: Food and nutrition: Residents will be supported to buy, prepare and cook meals in their own home Timeframe; 31st December 2025	
Regulation 5: Individual assessment and personal plan	Substantially Compliant
Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan: Each resident and where appropriate, their representative will be invited to participate in multi-disciplinary team meetings and Person centered planning meetings Records of Residents activity levels will be reviewed, and future records will be reflective of Residents engagement in social activities in their local communities Timeframe; 31st December 2025	

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Substantially Compliant	Yellow	31.11.2025
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.	Substantially Compliant	Yellow	31.12.2025
Regulation 18(1)(a)	The person in charge shall, so far as reasonable and practicable, ensure that residents are supported to buy,	Substantially Compliant	Yellow	31.12.2025

	prepare and cook their own meals if they so wish.			
Regulation 04(3)	The registered provider shall review the policies and procedures referred to in paragraph (1) as often as the chief inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.	Substantially Compliant	Yellow	31.12.2025
Regulation 05(6)(b)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall be conducted in a manner that ensures the maximum participation of each resident, and where appropriate his or her representative, in accordance with the resident's wishes, age and the nature of his or her disability.	Substantially Compliant	Yellow	31.12.2025