



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

Issued by the Chief Inspector

Name of designated centre:	Bealach Beag
Name of provider:	Avista CLG
Address of centre:	Dublin 15
Type of inspection:	Unannounced
Date of inspection:	05 February 2026
Centre ID:	OSV-0007889
Fieldwork ID:	MON-0046544

About the designated centre

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

Bealach Beag provides full time residential care for up to four adults with an intellectual disability. It is a two-storey house with five bedrooms situated in a suburb of Co. Dublin. It is close to a number of local amenities such as shops, hairdressers, coffee shops and restaurants. Residents have access to a bus to and the house is close to good public transport links including a railway station and bus routes. Residents are supported by social care workers and care staff 24 hours a day, seven days a week.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	3
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This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Thursday 5 February 2026	09:00hrs to 17:00hrs	Maureen Burns Rees	Lead

What residents told us and what inspectors observed

From what the inspector observed and the individuals spoken with said, there was evidence that two residents currently living in this centre received quality care, in which their independence was promoted. Appropriate governance and management systems were in place which ensured appropriate monitoring of the services provided. Areas for improvement were identified in relation to fire precautions, maintenance of the premises and the arrangements to review policies and procedures within the required time-lines as set out in the Regulations.

The centre is registered for four adult residents but there were only three residents identified to reside in the centre at the time of inspection with one vacancy. The three residents had been living together for an extended period, were of a similar age and considered to get along well together. Two residents only, however, were in the centre and present on the day of inspection. The third resident had been convalescing post a medical procedure, in another designated centre operated by the provider, as the layout of this centre had been assessed as not suitable to support their convalescence. There had been recent discussions regarding the suitability of the centre to meet residents' needs should their physical health change but no decisions had as yet been reached.

This centre comprises a five-bedroom two-storey house. It is located in a residential area, in a suburb of Dublin close to a range of local amenities and local transport links. The house was observed to be homely and well maintained. However, worn and chipped paint was observed on walls and wood work in some areas. The ceiling in the kitchen had an area of blistered and peeling paint from a possible leak. There was evidence that this had been reported to the provider's maintenance department. The centre comprised of one resident bedroom on the ground floor which had accessible en-suite facilities. There were three resident bedrooms upstairs and an accessible shower room and separate bathroom. There was a further toilet on the ground floor. A good sized kitchen was on the ground floor and a dining room come sitting area which looked out on the back garden and led to a sitting room to the front of the house. There was a good sized enclosed and paved accessible garden to the rear of the centre. It included planted flower beds and a table and chair for outdoor dining.

The inspector met with the two residents living in the centre on the day of inspection. There was a storm and weather warning on the day and with the inclement weather, the residents had chosen to spend the day in the centre relaxing, colouring, listening to music and watching television. One of the residents was reluctant to engage with the inspector but the other resident told the inspector that they were 'happy' and felt 'safe' living in the centre. It was evident that both residents were proud of their home and in particular new flooring which had recently been fitted in the sitting room. The inspector observed a meal time which was noted to be a social and unhurried occasion. Both residents were noted to enjoy

homemade apple crumble on the afternoon of this inspection. Staff were observed to treat residents with kindness and respect. This included observations of a staff member supporting a resident to enjoy their meal and seeking residents permission to show the inspector around their home.

There was an atmosphere of friendliness in the centre. Residents were observed to appear happy and content in each others company and to interact with staff and each other. The staff members on duty were observed to spend time chatting and laughing with both residents. The centre was located in an established residential area and it was noted that the residents had good relations with a number of their neighbours who had also been living in the area for an extended period.

There was evidence in daily notes reviewed by the inspector of active consultations with residents and their families or representatives regarding residents' care and decisions related to the the running of the centre. The inspector did not have an opportunity to meet with the relatives of any of the residents. However, staff and the person in charge told the inspector that the residents' families were happy with the care and support being provided for their loved ones. The residents were supported to maintain relations with their respective families with visits in the centre by family and resident visits to their respective family homes. The provider had completed a survey with the residents and their relatives as part of their annual review of the quality and safety of care. This indicated that families were happy with the care and support being provided for their loved ones.

There had been no recorded complaints in the centre in the preceding 12 month period. Suitable complaints policies, procedures and processes were in place. Information in relation to complaint process, the confidential recipient, decision-making capacity and the national advocacy service were available in the centre. Records reviewed by the inspector showed that all staff had completed training in a human-rights based approach to health and social care, in addition to training on the Assisted Decision Making (Capacity) Act, 2015.

The residents were advancing in years and enjoyed a consistent routine and engaged in a number of meaningful activities in their local communities. None of the residents were engaged in a formal day service program but enjoyed an individualised service from the centre. One of the residents was supported by staff to engage in unpaid employment in a local shop for a period of one day per week. One staff member was allocated to each resident during the day. It was noted that all of the residents enjoyed partaking in a number of activities together, including overnight hotel breaks. Activities that one or more of the residents engaged in included, visits to family, church visits, shopping trips, beauty treatments in the centre and local beauticians or hairdressers, walks in local area and cinema trips. One of the residents had been engaged in a local weight management community group. The centre had its own dedicated vehicle for the use of staff supporting the residents to attend various activities and outings within the community. With staff support, one of the residents accessed local transport links. It was noted that one of the residents used mobility aids, a rollator when in the centre and a wheel chair while out in the community. The person in charge reported that a request had been

submitted for the purchase of a wheel chair accessible vehicle to ease transport for this resident and their wheel chair.

In summary, this was a well run service which provided quality care for the residents living in the centre. 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 management systems and processes in place to promote the service provided to be safe, consistent and appropriate to the residents' needs. However, as identified under regulation 28, the provider had failed to identify a number of deficits in relation to fire safety precautions. The provider had ensured that the centre was resourced with sufficient facilities and available supports to meet the needs of the residents. However, there were three whole time equivalent staff vacancy at the time of inspection. Recruitment for this position was underway and the vacancies were generally being covered by a small number of regular agency staff.

The provider had completed an annual review of the quality and safety of the service and unannounced visits on a six-monthly basis as required by the Regulations. A number of audits and checks were completed in the centre in line with an audit schedule in place. These included health and safety, finance, infection prevention and control audits, medicines management, finance audit and fire safety checks. There was evidence that actions were taken to address issues identified in these audits and checks. Management were actively involved in overseeing the service and were visible within the centre, ensuring they were known to residents. Feedback mechanisms were in place. This allowed residents, staff, and family members to share their views, which informed ongoing improvements in the service.

The centre was managed by a suitably qualified and experienced manager. The person in charge was in a full time position but was also responsible for two other centres located within the same geographical area. They had a background as a registered general nurse and midwife, and held a masters in health management planning and a degree in art and science. The person in charge had more than 10 years management experience.

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 reported to the clinical nurse manager 3 (CNM 3) who in turn reported to the service manager.

The inspector reviewed meeting records which showed that the person in charge and CNM 3 held formal meetings on a regular basis.

Regulation 14: Persons in charge

The person in charge was found to be competent, with appropriate qualifications and management experience to manage the centre and to ensure it met its stated purpose, aims and objectives. 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 but was responsible for two other centres located within the same geographical area. They were found to be effectively involved in the governance and management of this centre. In interview with the inspector, the person in charge demonstrated a good knowledge of the residents' care and support needs and oversight of the centre.

Judgment: Compliant

Regulation 15: Staffing

The staff team were found to have the right skills and experience to meet the assessed needs of the residents. However, at the time of inspection, there were three whole time equivalent staff vacancies. These vacancies were being covered by a regular small number of agency staff. Recruitment for the positions was reportedly underway. A significant number of the staff team had been working in the centre for an extended period. The inspector reviewed the actual and planned duty rosters which demonstrated that there were an adequate number of staff with the required skills to meet residents' assessed needs rostered on shifts. The inspector noted that the individual residents' needs and preferences were well known to the person in charge and the staff met with on the day of this inspection. The staff team comprised of social care workers, a healthcare assistant and the person in charge.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Training had been provided to staff to support them in their role and to improve outcomes for residents. Training records reviewed by the inspector showed that staff had attended all mandatory and refresher training. There was a staff training

and development policy. A training programme was in place and coordinated centrally. A training needs analysis had been completed. There were no volunteers working in the centre at the time of inspection. Staff supervision arrangements were in place. Team meetings were undertaken on a regular basis. The inspector reviewed the minutes of staff meetings. These were chaired by the person in charge and noted to provide an opportunity for staff to discuss residents' needs and any emerging issues. The meetings were considered to be supportive of staff member roles and promoted consistency in the operation of the centre.

Judgment: Compliant

Regulation 31: Notification of incidents

Notifications of incidents were reported to the Chief Inspector of social services in line with the requirements of the regulations. The inspector noted that there were overall a low number of incidents in the centre. A staff member spoken with was clear about the reporting requirements.

Judgment: Compliant

Regulation 4: Written policies and procedures

The provider had a suite of policies and procedures in place pertaining to the matters set out in schedule 5 of the Regulations. These were readily available for use by staff in the centre. However, a small number of the policies had not been reviewed in line with the frequency required in the Regulations. These included, the communication with residents and provision of information for residents policy, dated July 2022 and the risk management policy, dated October 2022.

Judgment: Substantially compliant

Quality and safety

The residents appeared to receive care and support which was of a good quality, person centred and promoted their rights. Some areas for improvement were identified in relation to fire precautions, the maintenance of the premises and arrangements for annual review of residents' personal plans.

The residents' wellbeing, protection and welfare was maintained by a good standard of evidence-based care and support. A personal support plan document reflected the assessed health, personal and social care needs of each resident and outlined the support required to maximise their personal development in accordance with their individual needs and choices. However, improvements were required to ensure that a comprehensive annual review of the personal plan in line with all of the requirements of the regulations was undertaken. The residents individually and collectively presented with minimal behaviours of concern. There were minimal restrictive practices in use in the centre.

Overall, the health and safety of residents, visitors and staff were promoted and protected. However, as outlined under Regulation 28, the systems to ensure the health and safety risk for fire precautions had not been effective. Adverse events were reported and actions were put in place where required, which were then shared with the staff team to ensure that they were implemented. A cleaning schedule was in place which was overseen by the person in charge. Sufficient facilities for hand hygiene were observed. There were adequate arrangements in place for the disposal of waste. Specific training in relation to infection control arrangements had been provided for staff.

Regulation 17: Premises

The inspector observed that all of the matters set out in schedule 6 of the Regulations had been put in place. However, worn and chipped paint was observed on walls and wood work in some areas. The ceiling in the kitchen had an area of blistered and peeling paint from a possible leak. There was evidence that this had been reported to the provider's maintenance department. The kicker board of units in the kitchen had some broken areas and the arms of the sofa in the sitting room appeared stained and lightly worn in areas. The door of a resident's wardrobe in their bedroom on the ground floor was broken. These issues had been identified through the providers own audits and referred to the providers maintenance team for repair or replacement.

The residents had personalised their own bedrooms according to their individual taste and preference. Pictures of loved ones and other memorabilia were on display in each of the residents bedrooms and some communal areas.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

The health and safety of the residents, visitors and staff were promoted and protected. The inspector reviewed environmental and individual risk assessments

and safety assessments, which had recently been reviewed. These indicated that where risk was identified, the provider had put appropriate measures in place to mitigate against the risks, including staff training. The inspector reviewed a schedule of checklists relating to health and safety, fire safety and risk, which were completed at regular intervals. 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 incidences. The inspector reviewed records of incidents. Overall, there was a low number of incidents and evidence that all incidents were reviewed by the person in charge, and where required, learning was shared with the staff team and risk assessments were updated to mitigate their re-occurrence.

Judgment: Compliant

Regulation 28: Fire precautions

Precautions were in place against the risk of fire. However, it was identified on the day of this inspection that a self closing hinge was not in place on a door in the centre, the door leading from the sitting room to the front hall. Fire drills with residents were undertaken at regular intervals. However, it was noted that two of the staff team had not engaged in a fire drill in an extended period or in line with the time line proposed in the provider's policy.

A personal emergency evacuation plan was in place for each resident and accounted for the mobility and cognitive understanding of the respective resident. Risk assessments for fire had been completed and were subject to regular review. The inspector observed that there were adequate means of escape. A fire assembly point was identified in an area to the front of the house. The inspector reviewed documentary evidence that the fire fighting equipment and the fire alarm system were serviced at regular intervals by an external company. Records reviewed by the inspector showed that the fire fighting arrangements in place were checked regularly as part of internal checks in the centre. The inspector tested the release mechanism on a sample of doors which had a self closing device in place and found that they were successfully released and observed to close fully. There was a fire safety policy in place.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

The inspector reviewed the personal support plan for each of the residents. The plans were found to reflect the assessed needs of the residents and outlined the support required to maximise their personal development in accordance with their

individual health, personal and social care needs and choices. There was evidence of multidisciplinary team input where required. for example dietitian for one of the residents who required a modified diet. There was evidence that each resident's personal plan was reviewed by the resident's key worker on a regular basis. However, improvements were required to ensure that a comprehensive annual review of the personal plan, with participation of the resident and their representatives and to include an assessment of the effectiveness of the plan in place was completed, in line with regulatory requirements.

Judgment: Substantially compliant

Regulation 6: Health care

The inspector found that the residents' healthcare needs appeared to be met by the care provided in the centre. However, an emergency transfer sheet with pertinent information should they require transfer to hospital was not available in the centre for each of the residents. It was noted that a template hospital transfer sheet was on file for one of the residents but had not been completed.

The residents had their own General Practitioner (GP) who they visited as required. A healthy diet and lifestyle was being promoted for each resident with weekly menu planning. An emergency transfer sheet was available with pertinent information for each resident should they require emergency transfer to hospital.

Judgment: Compliant

Regulation 8: Protection

There were measures in place to protect the residents from being harmed or suffering from abuse. There had been no safeguarding or behavioural concerns reported in the centre in the preceding 12 month period. The residents individually and collectively presented with minimal behaviours of concern. One of the residents had previously been engaged with the provider's behavioural support team but had recently been discharged from the teams care and a behaviour support plan that had been in place was removed as considered to no longer be required. There were no safeguarding plans in place at the time of inspection. Suitable safeguarding procedures and reporting arrangements were in place. The provider had a safeguarding policy in place. The person in charge and staff members met with on the day of inspection had a good knowledge of safeguarding procedures.

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 31: Notification of incidents	Compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Bealach Beag OSV-0007889

Inspection ID: MON-0046544

Date of inspection: 05/02/2026

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 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: <ul style="list-style-type: none"> • • The provider continues to recruit and advertise for all current vacancies to ensure the number of qualifications and skill mix is appropriate to the assessment of needs of individuals and as per Statement of purpose • Social Care Interviews held on February 23rd, 2026. Further Interviews scheduled for 30th March 2026 • Care staff Interviews held 11 March 2026. Further recruitment in progress • Advertisements on Social media platform sites utilize re-current vacancies • The center continues to engage with Regular agency to provide continuity of care during recruitment phase • New Induction Form implemented for all staff/Agency • Standard operating procedures are being implemented locally in relation to local induction procedures • All new agency staff will have induction form completed by person in charge or shift leader at the commencement of designated shift. 	
Regulation 4: Written policies and procedures	Substantially Compliant
Outline how you are going to come into compliance with Regulation 4: Written policies and procedures: <ul style="list-style-type: none"> • All schedule 5 policies are reviewed according to schedule. Outstanding policy review was completed 5 February 2026 as evident in the organisational policy folder on site 	
Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises:	

- All Maintenance works have been reviewed and schedule of works to be completed has been identified
- Kitchen area has been assessed and awaiting quotations re refurbishment
- Replacement wardrobe has been ordered for one resident. Sofa in Sitting room is under refurbishment

Regulation 28: Fire precautions	Not Compliant
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Outline how you are going to come into compliance with Regulation 28: Fire precautions:
 Door 03 Living room to hallway; Door, doorframe and door closer have been replaced
 And are now compliant with Fire Regulations
 Schedule has been completed and All staff members will participate in a fire drill in accordance with Policy

Director of Property Estates and Technical Services reviewed premises on 11th March and has confirmed;

The house was upgraded in 2018 by HSE to meet the requirements set out in Code of Practice for Fire Safety in New and Existing Community Dwelling Houses 2017. This standard requires fire containment of the stairway & protected corridors only to be fitted with Fire Doors. Given the layout of this house the door (06) from the kitchen to the front hall, door (02) Bedroom to Hallway & door (03) Living Room to Hallway are required to be a fire door.

The inspection carried out has confirmed that all identified fire doors have been fitted with intumescent strips & automated self-closer device linked to the fire alarm.
 Door 07 store to hallway is required to be a fire door and is fitted with intumescent seal but not self-closer (as permitted by the regulations). Doors 05 & 09 do not require fire rating.

Under the requirements of the same standard Exit Signage is only required where it is deemed that the escape route is not apparent, and, through risk assessment, it is deemed that exit signposting is required, the signposts should be provided in accordance with S.I. 299 of 2007 Safety Health & Welfare at Work (Signs) Regulations 2007.

As this is a small house with straight forward exit routes it is deemed that exit signage is not required.

Emergency lighting is installed and maintained to the requirements of the section 3.3.13 Emergency lighting of Code of Practice for Fire Safety in New and Existing Community Dwelling Houses 2017.

Regulation 5: Individual assessment and personal plan	Substantially Compliant
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Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:

- Personal plan reviews will comply with the requirements of the regulation
- Personal plans under review to ensure compliance with the regulation

- Staff implementing revised PCP policy which came to effect February 2026
- Training to support staff with the implementation of PCP policy schedule on 7 May 2026 & 24 June 2026

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	30/07/2026
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	30/07/2026
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting,	Not Compliant	Orange	11/03/2026

	containing and extinguishing fires.			
Regulation 28(4)(b)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Substantially Compliant	Yellow	30/04/2026
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	31/03/2026
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	Substantially Compliant	Yellow	30/04/2026

	<p>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.</p>			
<p>Regulation 05(6)(c)</p>	<p>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 assess the effectiveness of the plan.</p>	<p>Substantially Compliant</p>	<p>Yellow</p>	<p>30/04/2026</p>