



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

## Issued by the Chief Inspector

Name of designated centre:	Hampton Gardens
Name of provider:	Talbot Care Unlimited Company
Address of centre:	Co. Dublin
Type of inspection:	Unannounced
Date of inspection:	18 November 2025
Centre ID:	OSV-0008510
Fieldwork ID:	MON-0048492

## About the designated centre

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

Hampton Gardens provides a full-time residential service for people under the age of 18 years with intellectual disabilities who may also have autism spectrum or mental health diagnoses or present with behaviours of concern. Hampton Gardens is a social care led service with the objective of promoting independence and maximised potential of young people in fulfilling their aspirations. The designated centre consists of a two-storey house in a suburban residential area of County Dublin which is registered to accommodate up to two young people.

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

Number of residents on the date of inspection:	2
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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
Tuesday 18 November 2025	10:30hrs to 18:00hrs	Gearoid Harrahill	Lead

## What residents told us and what inspectors observed

The inspector had the opportunity to meet both of the young people living in this designated centre, and observe some of their routines and review documentary evidence related to their support. The inspector's observations of interactions and care delivery, documentary evidence and commentary from or on behalf of the young people, families and staff members was used to indicate the lived experience of young people using this service.

Both young people were in full-time education and went to school five days a week. However, on the day of this inspection, one young person was off school for a dentist appointment. The inspector observed how the staff explained the appointment through social stories before leaving, and the young person arrived home later in the afternoon following a successful visit. This young person was in overall good form during the day, watching cartoons on their electronic tablet. While the communication support needs of this young person did not allow for verbal conversation with the inspector, when asked if they liked the house they placed their hand on the inspector's head and smiled. The inspector observed the young person to be very comfortable with their staff members, reaching for their hand and smiling and laughing with them.

The second young person arrived home after school, greeted the inspector and showed them their room before changing to their pyjamas and relaxing for a while before dinner. They told the inspector that they liked this house and liked that they had two homes, confirming with the staff when they were next planned to stay with their family. The young person was excited and smiling as they wound down after their school day. The inspector was advised by staff that the two young people preferred to do their own separate things but were comfortable sharing the house together.

The house was designed and decorated suitable for the gender and age profiles of the young people, and was overall clean and well-maintained. Each bedroom had a double bed, art by the young people, and posters, figurines and soft toys of their favourite characters. The back yard was featured with a swing set, trampoline and padded ground surface, and there was a plan to paint the back wall based on what the young people wanted and to get them involved in the project. The premises had some environmental restrictions for health and safety reasons, however the inspector found that these were revised or removed as appropriate for the young people as they got older and the associated risk was rated low, allowing them more unrestricted access around the house.

The inspector was advised by staff of challenges in encouraging engagement by a young person in varied and meaningful recreational and social activities in the community. Staff advised the inspector of attempts to support engagement with outings to castles, shopping centres, nature walks and beaches and how they tried

to incentivise engagement, however in a review of four months of activity logs, the vast majority of outings consisted of long drives around in the car without getting out anywhere including to places the young person had previously enjoyed.

The provider had been in receipt of positive commentary and feedback from the young people's representatives. Representatives praised the support by the staff team and that they were kept updated with an appropriate level of communication from the provider. A formal complaint had been submitted regarding the quality of care in the centre, and the inspector observed evidence that the complainant was satisfied that appropriate action had been taken to address the matter and prevent further issues going forward.

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.

## Capacity and capability

The purpose of this inspection was to monitor and review the arrangements the provider had in place to ensure compliance with the Care and Support regulations (2013), follow up on solicited and unsolicited information received by the Chief Inspector of Social Services, and to inform a decision to grant an application to renew this centre's registration. In the main, the inspector found this service to be appropriately resourced, with suitable management arrangements to ensure oversight and accountability of the performance and quality of the staff team.

Staff demonstrated a good knowledge of their roles and of the interests, personalities and histories of the young people. Local and provider-level audits indicated areas in which the service was doing well and where it required action to improve adherence to regulation, standard of care, best practice and provider policy. Some improvement was required in how the provider was overseeing the timely implementation of clinician recommendations, and the ongoing data being collected to evidence progress or effectiveness of care and support interventions. The team was resourced with a person in charge who had a strong understanding of the regulations and standards and a front-line staff team which was fully resourced and facilitated to maintain continuity of familiar care and support of the young people.

The inspector met with a young person who had been admitted since the last inspection, who had settled in well and had been facilitated to engage in a phased pre-admission process to provide assurance to the young person, their representatives and the registered provider that the admission was appropriate to their needs and wellbeing.

## Regulation 14: Persons in charge

The inspector reviewed information on the person in charge submitted to the Chief Inspector, and met with them throughout this inspection. The person in charge started in their role in August 2025 and worked full-time in a supernumerary capacity as person in charge. They split their time between this centre and one other in the same role, and were appropriately deputised to ensure supervisory oversight when not on-site. The person in charge has suitable experience in management of health and social care services, and demonstrated a good knowledge and understanding of their duties and responsibilities under the regulations.

Judgment: Compliant

## Regulation 15: Staffing

There were no staff vacancies at the time of this inspection and the centre was staffed in accordance with the assessed needs of the young people and in line with centre's statement of purpose. The inspector reviewed a sample of worked rosters and observed these to be clear in recording who worked in the centre and when. The provider maintained a low use of regular contingency personnel to cover annual leave and other absence, who were deployed from a relief panel and did not require the use of external agency personnel. This resulted in protection of continuity of support, and ensured that the young people were supported by staff members they knew and trusted.

Judgment: Compliant

## Regulation 23: Governance and management

The centre was sufficiently resourced with a full front-line team of direct support workers. The person in charge was deputised by two full-time team leaders who worked opposite each other to ensure managerial oversight and a clear reporting structure which was in line with the statement of purpose. Staff who spoke with the inspector commented that they felt supported in their role and duties by their respective line managers. The centre had exclusive use of a vehicle to support community access for the young people.

The inspector reviewed an annual report for this centre composed in September 2025 by the assistant director of service at provider level. This report reflected on some of the achievements and events enjoyed by the young people in the preceding year as well as commentary attained from the young people's families and

representatives. The report also outlined priorities for the year ahead, including supporting young people's personal development in areas such as communication and managing personal income as part of preparation for adulthood. The provider had also conducted an inspection of the service's quality and safety in August 2025, scoring the service 94% compliant with regulatory and policy requirements, with actions primarily relating to management of documentation in the centre. Neither of these provider level audits reflected the commentary of staff and the records in social logs which indicated that one of the young people required additional support through 2025 to engage in meaningful social, recreational and community activities. As referenced elsewhere in this report, the inspector observed evidence which indicated gaps in timely implementations of support strategies recommended by clinicians as well as specific and measurable data to evaluate the level of progress with support objectives.

Judgment: Substantially compliant

### Regulation 24: Admissions and contract for the provision of services

One young person had been admitted to this centre since the previous regulatory inspection. The inspector observed that the provider had ensured that the new admission was facilitated to visit the house or go on outings with the staff to ensure they were comfortable with their support structures prior to admission. This also allowed time to carry out work in the premises based on their wishes, such as installing a swing. An assessment of compatibility was carried out to identify any potential concerns regarding sharing the living space with the other young person. While potential concerns were identified, a post-admission review indicated that said concerns had not presented since admission. The inspector observed that the contract agreeing terms between the provider and the young person's representative had been drawn up and signed on admission.

Judgment: Compliant

### Regulation 3: Statement of purpose

The provider submitted the current version of the statement of purpose for this designated centre as part of their application to renew registration. This included information required under Schedule 1 of the regulations.

Judgment: Compliant

### Regulation 31: Notification of incidents

The registered provider had notified the Chief Inspector of events and practices occurring in the centre within the required timeframes set out by the regulations.

Judgment: Compliant

### Regulation 34: Complaints procedure

The inspector reviewed the complaints log for this centre for 2024 and 2025. The details of these records included information on the concern raised, evidence of engagement with the complainant and the conclusion and actions taken on foot of the complaint. The inspector observed evidence that the outcomes of complaints were being relayed to the complainant, and how the provider was assured the complainant was satisfied with the action taken to prevent the issue from happening again, and that they were provided details on the appeals process if they wished to move their complaint to the next stage of the process.

Judgment: Compliant

### Quality and safety

In the main, the young people were kept safe in this designated centre and their personal and health care needs were subject to assessment by the provider's multidisciplinary team and related clinicians. Some recommendations from clinicians had not been implemented in a timely fashion, including guidance and training for the front-line staff. In other areas, where support strategies had commenced, there were gaps in how the staff team were collating information to report back to the relevant clinician to evidence attempts made and progress in delivering on the assessed support needs. The inspector observed inconsistent information and a lack of progress in implementing practices to optimise and develop the non-verbal communication methods of a young person who required them.

All the young people attended full-time education, and were afforded suitable and age-appropriate opportunities to be alone, to stay in contact with friends and family, and to go out to their community. In spite of commentary and records which indicated that one young person had continuously declined to engage in meaningful recreational activity over recent months, the inspector observed evidence to indicate that staff were continuing to ensure this was offered, and where alternatives were recorded as tried to see if they would be more successful. Young people's assessed risks were kept under review, and the inspector observed where risk controls

measures were being phased out when deemed no longer necessary to mitigate lower risks based on evidence collected.

## Regulation 10: Communication

The inspector observed assessments and recommendations by the speech and language therapist (SLT) to support the young people's ability to communicate their choices and wishes and to optimise staff understanding of their communication needs. However, their recommendations had not been implemented in a timely fashion. For one young person, the SLT identified in January 2025 that they learn and develop verbal skills in gestalt language processing and that staff were to receive training in this, as well as training in Lámh (a manual sign system used by children and adults with intellectual disability and communication needs in Ireland), and literacy education in coordination with the child's school. At the time of this inspection almost a year later, Lámh training was being provided to team leads, but the inspector was advised that there had been no progress in implementing the other recommendations. Actions set out in the centre annual report indicated that by December 2025 the residents would be supported in developing their skills in Lámh and the use of electronic communication supports, however, these were also not in progress.

The provider had implemented some non-verbal communication recommendations in the form of choice boards with which staff and young people used pictures to plan out activities and routines, and identify which staff were working and what was for lunch and dinner. One young person was observed referring to one of these charts to note what day they would be going to visit family. However, the inspector observed examples of conflicting information between the boards available to the young people. Boards contradicted each other in what was being made for that day's meals or what activities were taking place for the young people. Some examples were discussed with staff of activities on boards which were not actually taking place that day or had not happened for a long time. One young person who could not read words, and was to use pictures instead, had a word-based weekly planner chart in their bedroom. Some of this information was removed from the walls when queried by the inspector.

Judgment: Not compliant

## Regulation 13: General welfare and development

The inspector spoke with staff on the social and recreational outlets enjoyed by the young people in the centre. One young person was supported by the team to engage in sensory events and activities, and was active in their local community. The staff indicated that for the second young person there had been a decline in

engagement in activities beyond using their computer tablet for extended time. As referenced elsewhere in this report, it was not evident how the data collected by staff on the lack of activation had been escalated for support plan review. However, the inspector observed evidence that the team were striving to offer these activities, going on drives to different locations to see and note if the young person would get out of the car, and reinforcing to them that their tablet stays at home when they go to do things outside of the house.

Both young people were supported to attend full-time education in school, with which they engaged well. Young people were supported to stay in contact with their families through home visits, receiving them as visitors and structuring times for video calls into their weekly schedule.

Judgment: Compliant

### Regulation 17: Premises

The inspector walked the premises and observed it to be clean, bright, and in a good state of repair. Each young person had a large double bedroom which they were supported to personalise with their decorations and belongings. The young people had suitable play equipment in the garden and unrestricted access to the bathroom and kitchen areas.

Judgment: Compliant

### Regulation 26: Risk management procedures

The inspector reviewed a sample of risk assessments related to the centre and young people and how these tied to needs assessments, behaviour support and restrictive practices. The inspector found that the provider had risk-assessed hazards using trends in adverse incidents, and where the risk controls set out were not proportional to the level of assessed risk, these were revised. This review process had resulted in environmental restraints such as locked doors and cabinets being reviewed to determine their continued necessity and where this was not evident based on the findings of a trial period, they were discontinued. For example, a successful trial period had resulted in deactivation of electronic locks preventing independent use of the young people's own house doors. The provider had conducted appropriate risk assessments related to the admission of new resident to identify potential hazards to be assured that the admission was successful and appropriate for those affected.

Judgment: Compliant

## Regulation 5: Individual assessment and personal plan

The inspector reviewed the assessment of care needs for the young people and the support plans and staff guidance which had been composed based on these assessments to deliver on identified personal, health and social care needs. In the main, assessments were written in a person-centred and respectful manner. Assessments had been conducted by the relevant members of the multidisciplinary team and staff were advised on how to collect data for use in future assessments and reviews.

Some care plan reviews were observed to be kept up to date to reflect current or changing young peoples' needs, for example in how to identify and respond to incidents in which young people may become anxious or express their distress in a manner which presented a risk to themselves or others. Care plans were also in effect with the view to phase out medicines and restrictive practices based on the trend and analysis of certain risks.

Through review of care plans and discussion of these with staff members, the inspector observed some gaps in the creation and implementation of care and support strategies for young people based on the findings of their assessments of need. For example, one of the young people required support to have more healthy and varied meals in their diet, with the dietitian recommending strategies for the front-line team to gradually introduce fruits and vegetables. However, there was no evidence on how this was being tracked to record whether the strategy was successful or being attempted by the team. In another example, goals were set out for young people to develop their life skills to prepare for adulthood, such as doing household chores, using appliances and doing the weekly shop with staff support, again there was no evidence on how staff were keeping a record of the young person successfully engaging in these to indicate progress or success of the objective.

There were also gaps in the support for front-line staff to deliver on some care needs, for example reference was made to behaviour support guidelines to assist staff in supporting a young person with emotional regulation, and supporting a young person to engage in sensory workbooks, neither of which had been provided to the team. Where staff commentary and a sample of four months of daily notes indicated that there had been a significant decline in meaningful social and recreational activity, and incentives not being successful, there was limited evidence that this trend had been referred for reassessment of support plans and strategies.

Judgment: Substantially compliant

## Regulation 6: Health care

In reviewing the comprehensive assessment of needs and notes on referrals, appointments and care plans, the inspector observed that the young people had had timely access to clinicians relevant to their support needs including occupational therapy, dentistry, speech and language therapy, mental health and behaviour support services, and their general practitioner (GP). In the main, where relevant in care and risk assessments, these clinicians had made recommendations for how the front-line team can support the young people's assessed needs.

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
<b>Capacity and capability</b>	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 24: Admissions and contract for the provision of services	Compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
<b>Quality and safety</b>	
Regulation 10: Communication	Not compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant

# Compliance Plan for Hampton Gardens OSV-0008510

Inspection ID: MON-0048492

Date of inspection: 18/11/2025

## 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 23: Governance and management	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 23: Governance and management:</p> <p>The registered provider has reviewed and strengthened the annual review process to ensure that feedback and experiences from residents, families/representatives and staff are consistently captured and documented. The provider will ensure that ongoing efforts to seek feedback are evidenced, and where feedback is not received, this is clearly recorded. A variety of sources of information will be used to triangulate the feedback and enhance the quality of the report.</p> <p>The Person in Charge will ensure that accurate and transparent information regarding residents' engagement, or non-engagement, in meaningful social, recreational and community activities is available to inspectors and auditors at all times.</p> <p>To ensure governance oversight and data integrity, the Assistant Director of Services will review the Annual Review for accuracy, completeness and regulatory compliance prior to finalisation and publication. This action will support ongoing compliance with Regulation 23 (Governance and Management). Actions arising from the Annual Review will be tracked to completion.</p>	
Regulation 10: Communication	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 10: Communication:</p> <p>The registered provider has ensured that Team Leads in the designated centre have completed LÁMH training, this training programme is in the process of being delivered to the wider staff team. All staff members working in the centre will have completed LÁMH training by 28 February 2026. The provider has arranged online Gestalt Language Processing Training which will be completed by all staff in the centre with the SLT before the end of February 2026.</p> <p>A comprehensive review of communication systems for both residents has been completed. All notices within the centre have been reviewed and updated to ensure they are accessible, individualised, and aligned with each resident's communication plans and</p>	

assessed needs.

Following liaison with the residents' schools, it has been confirmed that while communication devices are used within the classroom setting, they are not utilised as individualised learning tools for each child. In line with advice from Speech and Language Therapy (SLT), the centre will continue to consistently implement LÁMH, First-Then boards, visual supports and PECS within the designated centre. The Person in Charge will ensure staff adherence to these communication strategies and these will be monitored by the ADOS at monthly governance meetings.

All recommendations arising from SLT and multidisciplinary team (MDT) reviews will be actioned in a timely manner. A follow-up review will be completed within two weeks of each MDT meeting to ensure actions have been progressed and outcomes monitored, with oversight maintained through governance structures.

Regulation 5: Individual assessment and personal plan

Substantially Compliant

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

A review of residents' personal plans has been completed to ensure that information is accurate, comprehensive and reflective of each resident's Assessment of Need. The updated plans have been shared with the full staff team to ensure consistency in understanding and implementation.

Personal plans will be reviewed prior to every MDT review and updated following, completion of any assessment, receipt of professional recommendations, updates to risk assessments or identification of new risks, and where there is any change in a resident's circumstances. Reviews are completed using a person-centred approach, with residents supported to participate to the maximum extent possible. Representatives are invited and encouraged to contribute to the development and review of care and support plans.

The Assistant Director of Services (ADOS) will continue to monitor progress on a monthly basis, and more frequently if required. The resident was reviewed at MDT on January 5th 2026, with actions identified. Progress will be monitored and reviewed again at the MDT follow-up meeting scheduled for January 19th 2026 with regard to meaningful social and recreational activity, All MDT recommendations and feedback will also be reviewed by the ADOS and Person in Charge during monthly governance meetings. Residents may be referred back to MDT for review at any time as required.

All residents' assessed care and support needs are reviewed at their Assessment of Need (AON) and multidisciplinary team (MDT) meetings. Any gaps in service provision or support identified through this process are addressed by the MDT, and relevant documentation, including behaviour support plans and sensory guidelines, is developed and communicated to the staff team for implementation in practice.

Where MDT recommendations are not effective or require further review, the Person in Charge (PIC) and Assistant Director of Services (ADOS) will re-refer the resident for discussion at the children's MDT meeting, which takes place on a bi-weekly basis, to ensure that supports remain appropriate, responsive and effective.

## 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 10(1)	The registered provider shall ensure that each resident is assisted and supported at all times to communicate in accordance with the residents' needs and wishes.	Substantially Compliant	Yellow	28/02/2026
Regulation 10(3)(b)	The registered provider shall ensure that where required, residents are facilitated to access assistive technology and aids and appliances to promote their full capabilities.	Not Compliant	Orange	05/01/2026
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents'	Substantially Compliant	Yellow	05/01/2026

	needs, consistent and effectively monitored.			
Regulation 05(4)(b)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which outlines the supports required to maximise the resident's personal development in accordance with his or her wishes.	Substantially Compliant	Yellow	05/01/2026
Regulation 05(6)(c)	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.	Substantially Compliant	Yellow	19/01/2026