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:	Coolnevaun
Name of provider:	St John of God Community Services CLG
Address of centre:	Wicklow
Type of inspection:	Unannounced
Date of inspection:	21 April 2026
Centre ID:	OSV-0002879
Fieldwork ID:	MON-0046103

About the designated centre

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

This is a service providing residential and respite support to adults (both male and female) over the age of 18 years with an intellectual disability in Co. Wicklow. It is a specialized nurse led service, as many of the residents have other health related conditions such as middle to late stage Dementia, high medical needs and/or have palliative and end of life care needs. Coolnevaun is one part of a large residential building which also houses another separate designated centre and a separate day service. Coolnevaun provides residential care and also has one respite bed which is rotated between five respite service users. There is a kitchen area, a large dining room, a sitting room, a relaxation/therapeutic room and an activities room available to the residents. There are also very well maintained gardens for residents to avail of and a specialised herb garden that some residents use and look after with the support of staff. There are two service vehicles attached to Coolnevaun that residents can use to attend functions that are inaccessible by public transport and/or for residents who need support with transport.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	9

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (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 21 April 2026	10:00hrs to 17:00hrs	Karen McLaughlin	Lead
Tuesday 21 April 2026	10:00hrs to 17:00hrs	Mary Lillis	Support

What residents told us and what inspectors observed

This report outlines the findings of an unannounced inspection carried out to assess ongoing compliance with regulations and standards. The findings of the inspection were positive and showed the provider was responsive to the needs of residents and that residents were supported to enjoy an active and meaningful life.

To assess the quality of life for the residents inspectors relied on a combination of observations, discussions with residents, a review of relevant documentation, and conversations with key staff members.

The centre consisted of a large bungalow situated on a small congregated campus setting in Co. Wicklow. Coolnevaun is one part of a large building that contains one other designated centre and office areas on the first floor of the building.

Residents living in this designated centre required dementia related supports and ongoing nurse led care in relation to their high medical needs and/or have palliative and end of life care needs.

The provider has endeavoured to make the living arrangements for residents as homely and personalised as possible throughout.

There was adequate private and communal accommodation for the residents, including a sitting room, conservatory, sensory room and a kitchen/dining area.

The communal areas of the centre included a large sitting room and a dining room adjoined to a kitchen and were observed to be spacious and bright with adequate seating for residents, including a number of individualised 'comfy' chairs. There was a conservatory as you enter the premises and two residents were observed listening to music here throughout the course of the inspection.

There was a photo memory wall at the entrance to the premises beside the conservatory, that was updated weekly so that visitors would know what recent events/activities the residents had participated in and could therefore use as a conversation starter.

Each resident had their own bedroom which was decorated in line with their preferences and wishes, and the inspector observed the rooms to include family photographs, and memorabilia that was important to each resident.

Residents were observed to be supported by staff who knew them and their individual needs well. Inspectors observed residents coming and going from their home during the day. Staff were observed to interact warmly with residents. They

were observed to interact with residents in a manner which supported their assessed needs.

During the inspection, inspectors had the opportunity to meet with some residents and staff on duty.

Most residents living in the centre used a non-verbal form of communication. On observing residents interacting and engaging with staff using non-verbal communication, it was obvious that staff interpreted what was being communicated. Staff members supported the conversation by communicating some of the non-verbal cues presented by the resident. Staff supported residents to meet and engage with the inspectors and residents were observed smiling, making eye contact, using gestures and verbal interactions with staff during the course of the day to express their choices and personal preferences.

Inspectors met a resident's family member who came to visit. They spoke fondly of the service and about how happy they were with the quality of care their relative received. Furthermore, they told the inspectors that they were always made feel welcome when they visited, which was quite often.

There was evidence that the residents and their representatives were consulted and communicated with, about decisions regarding the running of the centre. A review of the provider's annual review of the quality and safety of care, evidenced that they were happy with the care and support that the residents received.

The inspection determined that, overall, residents received high-quality care provided by a familiar staff team who delivered care and support with kindness and respect. However, there were areas that required improvement relating to training and staff development and residents contracts of care. These are all discussed further in the main body of the report.

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

Capacity and capability

This section of the report sets out the findings of the inspection in relation to the leadership and management of the service, and how effective it was in ensuring that a good quality and safe service was being provided.

Overall, inspectors found that there were effective leadership systems in place which were ensuring that residents were in receipt of good quality and safe care. However, the provider had not ensured that all staff were up to date refresher training in positive behaviour support and safeguarding. Additionally, enhancements were

required to the supervision arrangements for all staff to ensure they received appropriate support and supervision from qualified and experienced personnel.

Furthermore, the registered provider had not agreed in writing with all residents and their representatives, the terms on which the residents would reside in the designated centre.

There was a clearly defined management structure in place and staff were aware of their roles and responsibilities in relation to the day-to-day running of the centre.

The registered provider had implemented management systems to monitor the quality and safety of service provided to residents including annual reviews and six-monthly reports, plus a suite of audits had been carried out in the centre.

The centre was managed by a suitably qualified and experienced person in charge who was employed on a full-time basis.

The staffing levels in place in the centre were suitable to meet the assessed needs and number of residents living in the centre. Warm, kind and caring interactions were observed between residents and staff and staff were observed to be available to residents should they require any support and to make choices.

A review of the roster demonstrated that staffing levels and skill mix were appropriate to meet the assessed needs of the residents. There was a planned and actual roster maintained for the designated centre. Rotas were clear and showed the full name of each staff member, their role and their shift allocation.

Notifiable incidents, as detailed under Schedule 4 of the regulations, were notified to the Office of the Chief Inspector of Social Services (Chief Inspector) within the required time frame.

An up-to-date statement of purpose was in place which met the requirements of the regulations and accurately described the services provided in the designated centre at this time.

The next section of the report will reflect how the management systems in place were contributing to the quality and safety of the service being provided in this designated centre.

Regulation 14: Persons in charge

The provider had appointed a person in charge for the centre that met the requirements of Regulation 14 in relation to management experience and qualifications.

There were adequate arrangements for the oversight and operational management of the designated centre at times when the person in charge was off-duty or absent.

The provider had the structures and pathways in place to support the person in charge in fulfilling their regulatory responsibilities.

Inspectors found that the person in charge was motivated to ensure that residents were happy and safe in their home.

Judgment: Compliant

Regulation 15: Staffing

Residents were in receipt of support from a stable and consistent staff team. A staff roster was maintained which demonstrated that there were sufficient staff to meet the residents' needs. Resources in the centre were planned and managed to deliver person-centred care. A high staff to resident ratio was maintained in the centre, which ensured resident's specific person-centred support needs were met in line with their assessed needs.

Inspectors examined the planned and actual staff rosters for March and April 2026. It was found that regular staff were employed, and the rosters accurately represented the staffing arrangements, including the full names of staff on duty during both day and night shifts.

The inspector spoke with staff members on duty throughout the course of the inspection. The staff members were knowledgeable on the needs of each resident, and supported their communication styles in a respectful manner.

Judgment: Compliant

Regulation 16: Training and staff development

Staff working in the centre had access to training as part of their continuous professional development and to support them in the delivery of effective care and support to residents living in the centre.

There was a training matrix in place that supported the person in charge to monitor, review and address the training needs of staff.

However, not all staff had completed relevant training as part of their professional development and to support them in their delivery of appropriate care and support to residents.

A review of the most recent training records made available to the inspectors evidenced gaps in relation to both mandatory and non-mandatory training for staff for example positive behaviour support and safeguarding vulnerable adults.

The deficits in staff training posed a risk to the quality and safety of the care and support provided to residents and their wellbeing. For example, while all staff had completed dementia specific training, all staff required refresher training in this area. Similarly all staff had completed communication training but 50 percent required refresher training. On the day of the inspection, inspectors were shown evidence that a refresher was scheduled for the end of April for all staff who required it.

Additionally, inspectors found that not all staff were receiving regular supervision as appropriate to their role.

The person in charge was responsible for the provision of supervision and support to all staff members within the designated centre. The inspectors reviewed the supervision schedule for 2025 and noted that there was significant gaps in in the provision of supervision. Without consistent staff supervisions, inspectors were not assured that staff were adequately supervised in respect of their work and their defined responsibilities.

This required considerable review and improvement by the provider and person in charge.

Judgment: Not compliant

Regulation 23: Governance and management

There was a clearly defined governance structure which identified the lines of authority and accountability within the centre and ensured the delivery of good quality care and support that was routinely monitored and evaluated.

However, enhancements were required to ensure that they effectively identified gaps in compliance with regulations and put in place plans to address these. The providers own internal audits in 2025 had identified gaps in both training and supervision and no traction had been made to rectify this. This is discussed further under Regulation16:Training and staff development.

Additionally, improvements were required to the oversight of residents contracts of care to ensure residents had agreed to the terms and conditions of the services being provided. This is discussed and actioned under Regulation 24: Admissions and contract for the provision of services.

There was suitable local oversight and the centre was sufficiently resourced to meet the needs of all residents. The provider had appointed an experienced and qualified person in charge. They reported to a programme manager who in turn reported to a director of care. Additionally, a supervisor was appointed at local level in the

designated centre to support the person in charge in fulfilling their regulatory responsibilities.

The provider was adequately resourced to deliver a residential service in line with the written statement of purpose. For example, there was sufficient staff available to meet the needs of residents, adequate premises, facilities and supplies and residents had access to a transport vehicle.

A series of audits were in place including monthly local audits (infection prevention control, safeguarding, fire safety, restrictive practices) and six-monthly unannounced visits. These audits identified any areas for service improvement and action plans were derived from these.

Judgment: Substantially compliant

Regulation 24: Admissions and contract for the provision of services

There was an absence of documentation to showed that residents and their representatives had agreed to the terms and conditions of the services being provided for in the form of a contract of care to inform their decision-making.

Following a review of four residents' contracts of care, the inspectors found that the provider had not agreed in writing, with all four residents and/or their representatives, the terms and conditions of their service, including the services provided for the support, care and welfare of the resident and the fees charged.

For example, one resident had remained without a written and signed contract of care, despite being admitted to the centre five months ago and therefore the provider was not in compliance with regulation 24(3).

Furthermore, two other contracts of care were not signed by the resident and their representatives and a third contact of care was in place naming another designated centre and was also not signed.

Improvements were required to ensure that enough assistance was made available when needed for all residents to meaningfully engage with the processes involved in understanding, agreeing to and signing their contract of care. This would ensure they were fully aware of the services to be provided and the fees they were responsible for.

Judgment: Not compliant

Regulation 3: Statement of purpose

The statement of purpose was reviewed on inspection and was found to meet the requirements of the Regulations and Schedule 1 and clearly set out the services provided in the centre and the governance and staffing arrangements.

A copy was readily available to the inspectors on the day of inspection.

It was also available to residents and their representatives.

Judgment: Compliant

Regulation 31: Notification of incidents

The person in charge had ensured that incidents occurring in the centre, such as allegations of abuse and use of restrictive practices, were notified to the Chief Inspector in the manner specified under this regulation.

Inspectors reviewed a sample of incident logs during the course of the inspection, and found that they corresponded to the notifications received by the Chief Inspector.

Furthermore, all required notifications were submitted within the expected time frame.

Judgment: Compliant

Quality and safety

This section of the report details the quality and safety of service for the residents living in the designated centre. This inspection found that the governance and management systems had ensured that care and support was delivered to residents in a safe manner and that the service was consistently and effectively monitored.

Inspectors found the atmosphere in the centre to be warm and relaxed, and residents appeared to be happy living in the centre and with the support they received.

The premises was designed and laid out in a manner which met residents' needs. Each resident had their own private bedroom which was decorated and furnished in line with individual preferences.

Residents were receiving appropriate care and support that was individualised and focused on their needs. The provider and person in charge were endeavouring to ensure that residents living in the centre were safe at all times.

Residents had access to a range of opportunities for recreation and leisure. Support plans and assessments undertaken supported further development in areas such as personal relationships, community and social development. Resident were supported to maintain and develop personal relationships and friendships.

Staff spoken with during the course of the inspection demonstrated comprehensive knowledge of residents' needs, personal preferences, communication needs and how they expressed choice and preference.

Residents that required support with their behaviour had positive behaviour support plans in place. There were some restrictive practices used in this centre. The restrictions were appropriately managed in line with evidence-based practice to ensure that it was monitored, consented to, and assessed as being the least restrictive option.

There were fire safety systems and procedures in place throughout the centre. There were fire doors to support the containment of smoke or fire. There was adequate arrangements made for the maintenance of all fire equipment and an adequate means of escape and emergency lighting provided.

Overall, the inspector found that the day-to-day practice within this centre ensured that residents were receiving a safe and quality service.

Regulation 10: Communication

The inspectors saw that residents in this designated centre were supported to communicate in line with their assessed needs and wishes. Some residents' had communication care plans in place which detailed that they required additional support to communicate.

All staff spoken with during the course of the inspection demonstrated comprehensive knowledge of residents' needs, personal preferences, communication needs and how they expressed choice and preference.

Throughout the duration of the inspection, inspectors observed residents receiving information and being communicated with in the best way that met their assessed needs.

Staff were observed to be respectful of the individual communication style and preferences of the residents.

Some residents required support to engage in conversations with the inspectors. Inspectors saw that staff members clearly understood residents' communications and were able to support conversations.

There was information available to the residents to support their communication including a visual activity board and social stories.

Residents had access to telephone and media such as radio and television.

Judgment: Compliant

Regulation 13: General welfare and development

Residents enjoyed a good quality of life and were facilitated to lead lifestyles of their choosing. The inspector saw staff using visual supports with some of the residents to ensure that they were informed and supported to make choices.

Residents were provided with a personal plan. The plan detailed their needs and outlined the supports they required to maximise their personal development. The plans reflected the residents' right to exercise choice in their lives.

As a result, residents were observed to engage in meaningful activities in line with their assessed needs, likes and personal preferences throughout the course of their day.

Activities residents had access to and enjoyed included music, lunch out, reflexology massage, spa days, hydro-pool, hotel breaks and attending events and concerts.

Judgment: Compliant

Regulation 17: Premises

The registered provider had made provision for the matters as set out in Schedule 6 of the regulations.

The registered provider had ensured that the premises was designed and laid out to meet the aims and objectives of the service and the number and needs of residents. The centre was maintained in a good state of repair and was clean and suitably decorated.

Minor wear and tear was observed by the inspectors on the walk around, mainly in the communal areas where there would be an increased footfall. This had been identified by the person in charge and reported to maintenance.

Judgment: Compliant

Regulation 28: Fire precautions

The registered provider had implemented good fire safety systems including fire detection, containment and fighting equipment.

There was adequate arrangements made for the maintenance of all fire equipment and an adequate means of escape and emergency lighting arrangements. The exit doors were easily opened to aid a prompt evacuation, and the fire doors closed properly when the fire alarm activated.

Following a review of servicing records maintained in the centre, inspectors found that these were all subject to regular checks and servicing with a fire specialist company.

The inspectors reviewed fire safety records, including fire drill details and the provider had demonstrated that they could safely evacuate residents under day and night time circumstances.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The registered provider had ensured that there were arrangements in place to meet the needs of each resident.

It was found that residents had an up-to-date and comprehensive assessment of need on file. They were personalised to reflect the needs of the resident including what activities they enjoy and their likes and dislikes.

Care plans were derived from these assessments of need. Care plans were comprehensive and were written in person-centred language. Residents' needs were assessed on an ongoing basis and there were measures in place to ensure that their needs were identified and adequately met. Support plans included communication needs, social and emotional well being, safety, health and rights.

Judgment: Compliant

Regulation 7: Positive behavioural support

The provider had ensured that where residents required behavioural support, suitable arrangements were in place to provide them with this. Clear behaviour support plans were in place to guide staff on how best to support these residents, and regular multi-disciplinary input was sought in the review of residents' behavioural support interventions.

Inspectors found that the person in charge was promoting a restraint-free environment within the centre. Inspectors completed a review of restrictive practices in place in the centre and found that all restrictive practices were logged, regularly reviewed and risk assessed in line with the provider's policy.

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	Compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 24: Admissions and contract for the provision of services	Not compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 7: Positive behavioural support	Compliant

Compliance Plan for Coolnevaun OSV-0002879

Inspection ID: MON-0046103

Date of inspection: 21/04/2026

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 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:

A full training matrix review has been complete to reflect all staff's status of training including relief, new staff and existing staff. This is reflective on the location's quality and governance. Any training out of date has been color coded and is being scheduled as per training expiry date. This has been added to the Quality enhancement plan for the location.

Positive Behavior support training has been scheduled with the aim of having all staff trained by November 2026. - 4 dates have been scheduled with Callan Insitute from June to November 2026 to accommodate staff shifts and availability. This is reflective on the staff's roster, so they are aware of importance of attending as part of their scheduled shift.

The Safeguarding Designated Officer of the service has been invited to attend a staff meeting to review how to report a safeguarding concern and the recognition of safeguarding concerns in the form of training- we aim to capture as many staff as possible in this session or if staff can't attend the CNM will discuss this with staff who can't attend. This will be facilitated by the end of June 2026.

A review of staff's hseland record for completion of Safeguarding Adults at Risk of Abuse eLearning Programme has been complete with the aim of those outstanding to have completed by End of June 2026.

Hseland Dementia course has been sourced "Support pathways for people with non-cognitive symptoms of dementia"
As part of the Dementia Assessment meetings that take place within this location the psychologist and chair of this committee has agreed to meet with the team on dementia

supports in the form of awareness training.

The Speech and Language Department completed one session already- 9 staff attended in April 2026. They will be returning on the 15th of June 2026 to facilitate a further training session for the staff remaining.

In relation to staff development:

Dates have been scheduled for all staff and are reflected in the Quality and Governance log. These dates will be completed by the end of September 2026. Following this, Supervision will be completed every 6 months in line with Organisational policy.

Dates have been scheduled for PDR for all staff outstanding and are reflected in the Quality and Governance log. These dates will be completed by the end of June 2026

The importance of training and development has been discussed with staff and is a standing agenda for their supervision meeting.

Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:

Induction and ongoing supports in place for new CNM1 and CNM3 to this location.

PDR schedule has commenced and will be completed by June 2026 for staff members who require same – this will form part of their annual review. Three staff will continue to follow their probationary schedule meeting dates.

Supervision Schedule has commenced and will be completed by September 2026. All dates will be reflected on the locations Quality and Governance log.

Contract of cares for the admissions and contract for provisions of services have been reviewed with the residents and their circle of support. This has been complete for all permanent residents, bar one outstanding with the family with the aim to be complete by the end of June 2026.

Local induction folder created for new staff, relief agency staff.

All assurances are in place by the organisational management structure.

Regulation 24: Admissions and contract for the provision of services	Not Compliant

Outline how you are going to come into compliance with Regulation 24: Admissions and contract for the provision of services:

Updates and reviews have been complete for permanent residents and returned on files- one outstanding with family with the aim to be complete by June 2026.

Going forward these reviews will align with the residents annual circle of support meetings for review.

All dates of contract of care are logged in the quality and safety governance log tab.

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 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Not Compliant	Orange	30/11/2026
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Yellow	30/09/2026
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a	Substantially Compliant	Yellow	10/10/2026

	written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.			
Regulation 23(3)(a)	The registered provider shall ensure that effective arrangements are in place to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.	Substantially Compliant	Yellow	30/09/2026
Regulation 24(3)	The registered provider shall, on admission, agree in writing with each resident, their representative where the resident is not capable of giving consent, the terms on which that resident shall reside in the designated centre.	Not Compliant	Orange	30/06/2026