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:	Brook House
Name of provider:	Stepping Stones Residential Care Limited
Address of centre:	Dublin 4
Type of inspection:	Announced
Date of inspection:	27 March 2025
Centre ID:	OSV-0005419
Fieldwork ID:	MON-0038006

About the designated centre

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

The designated centre is based in a suburban area of South Dublin and is comprised of one detached three storey building. On the ground floor of the centre there is an entrance hallway, a living room, a utility room and toilet, a small medication room, and a large kitchen and dining room. On the first floor there are two resident bedrooms, a staff sleep-over room, a main bathroom, and a hot press. On the second floor there is a large resident bedroom. All resident bedrooms contain en-suite facilities. Externally, the centre provides a small enclosed garden space to the rear with an outdoor dining area and a staff office in an external building. The centre provides a residential support service to individuals with intellectual disabilities and the staff team is made up of a person in charge, a social care leader and a team of social care workers and carers.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	3

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
Thursday 27 March 2025	10:00hrs to 17:35hrs	Erin Clarke	Lead

What residents told us and what inspectors observed

The inspector had the opportunity to meet with all residents throughout the inspection and observed positive interactions between residents and staff. Residents were supported to express their preferences, engage in daily routines, and participate in activities aligned with their interests. There were examples of good practice, including residents being encouraged to maintain community connections, contribute to household tasks, and pursue personal goals. However, the inspection also identified areas for improvement, including the need for clearer communication around external service fees and ensuring that all healthcare-related training was up to date for staff supporting residents with specific clinical needs. Additionally, one resident shared a desire to explore alternative living options, indicating the importance of continued support around self-advocacy and informed decision-making.

This inspection was announced and undertaken as part of the process to determine the renewal of registration for the designated centre. The inspection date was communicated to the provider four weeks in advance, to allow residents and their families to be informed and supported to participate.

One resident engaged in a detailed conversation with the inspector, discussing topics of personal interest such as politics and international affairs. During this conversation, the resident expressed a clear desire to live elsewhere, stating that they were unsure of how to progress this goal and were finding the process difficult. While the resident's care plan had not acknowledged this preference and ongoing difficulties with the placement, staff confirmed that they were continuing to provide support and encouragement in line with the resident's wishes.

A second resident was briefly observed during their preparations to leave the centre for a preferred community activity, as well as while preparing lunch. They appeared comfortable in the company of staff and actively sought out their support to organise the outing. The resident also engaged with management, speaking about places of personal interest. Staff responded in a respectful and familiar way, and the interactions observed were warm and supportive.

The third resident returned from their day service in the afternoon and was met by the inspector while settling back into their personal routine. They appeared relaxed and content, stating they were happy living in the centre, and were seen sitting at their desk using a laptop, engaging independently in an activity of interest.

Two residents had also completed Health Information and Quality Authority (HIQA) questionnaires in advance of the inspection. Both respondents noted that there were aspects of the centre that could be improved upon, including the need for greater choice and decision-making in certain areas. These comments were reviewed by the inspector and followed up with staff and care records. Additionally, one resident referenced previous compatibility issues within the centre. While this was a known

risk in the centre, the frequency of related incidents had significantly decreased over the previous year with improved relationships between residents.

Residents provided consent for matters including healthcare decisions, photography, finances, medicines support, and behaviour plans. Where a restrictive procedure was required, consent was also obtained and documented. Information about advocacy services and the confidential recipient was displayed in the centre. Throughout the centre, photographs were displayed showing residents engaging in outings and community activities, including recent events attended by two of the residents.

Overall, residents were seen to have positive relationships with staff and were supported to engage in daily routines, express their preferences, and take part in social and community-based activities.

The inspector found that two residents had experienced positive outcomes in their lives since moving into the centre. Despite some initial challenges during their transition, there was clear evidence of progress in several areas, including greater participation in the community, increased family involvement, and the development of independent living skills. These improvements reflected the efforts of the staff team in supporting residents through personalised planning and consistent engagement.

The inspector reviewed healthcare plans and found that some residents required support with specific healthcare needs, including the administration of subcutaneous medication. While staff were familiar with residents' clinical support requirements, it was identified that not all staff had received the necessary training to safely carry out these tasks. This had not been previously flagged, as the training was not recorded on the centre's training matrix. Management acknowledged the gap and took immediate steps to ensure that only appropriately trained staff would support residents in this area going forward.

In addition, a concern had been raised by a family member regarding fees associated with private assessments. The inspector found that while written contracts were in place, there was a lack of clarity around charges when external services were recommended as part of assessed support needs.

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

Capacity and capability

The inspection found that the centre was guided by a governance structure with clearly defined roles and responsibilities. There was evidence of strong communication and collaboration across all levels of management. While some areas

for improvement were noted in the clarity of fees and within areas outlined under the quality and safety section, the centre was actively working towards strengthening systems and ensuring residents received person-centred care.

Audit systems were embedded in day-to-day operations, with findings used to drive continuous improvement. Quality improvement actions were well documented, with clear ownership and timelines in place. Management showed an ability to identify and address issues proactively, ensuring accountability and follow-through.

Staffing arrangements were appropriate and responsive to residents' needs. The team remained stable, with no vacancies, and additional support had been introduced where required. Staff demonstrated a good understanding of residents' support needs, and relationships observed were warm, respectful, and person-centred. There was a strong focus on continuity, which residents clearly benefited from.

Staff were supported through regular supervision, guidance, and access to learning opportunities. Team meetings were well attended and used effectively to share updates and promote consistent approaches to care.

Residents had access to information about their services, and written agreements were in place outlining the terms of their residency. Some improvements were identified regarding clarity on specific external fees, and more transparent communication to support residents and families in understanding all aspects of service provision.

Registration Regulation 5: Application for registration or renewal of registration

All the required documentation was submitted with the application to renew the registration of the designated centre.

Judgment: Compliant

Regulation 14: Persons in charge

The registered provider had appointed a full-time person in charge. They were found to be suitably skilled and experienced for the role, and possessed qualifications in social care and management.

Judgment: Compliant

Regulation 15: Staffing

The centre had adequate staffing arrangements in place to meet residents' needs. Three staff were rostered daily from 09:00 to 21:00, with a staff member added from 16:00 to 21:00 following a serious incident. Overnight staffing consisted of one waking night staff and one sleepover staff, with the sleepover role available to support in emergencies.

There were no staff vacancies at the time of inspection. Relief staff were well known to residents, and agency staff were not used, which supported continuity of care. Staff had worked in the centre for several years and had established strong, trusting relationships with residents.

Judgment: Compliant

Regulation 16: Training and staff development

Staff in the centre had access to a range of mandatory and resident-specific training relevant to their roles and responsibilities. Training records showed that staff had completed core modules such as safeguarding, fire safety, manual handling, infection prevention and control, and behaviour support.

In addition to formal training, staff received ongoing guidance and informal coaching from the person in charge, particularly in areas such as financial rights, risk management, and behaviour support. Supervision was scheduled regularly, and the inspector found that team meetings were well attended and structured to promote reflective practice and information sharing.

Team meetings were held monthly, with every second month dedicated to keyworker-specific topics. Minutes showed that staff were updated on operational procedures, online documentation systems, individual support needs, behavioural plans, and risk assessments.

A specific concern in relation to resident-specific medication training was identified during the inspection; this matter is addressed in detail under Regulation 29: Medicines and pharmaceutical services.

Judgment: Compliant

Regulation 21: Records

A new online documentation system had been recently implemented across the provider's services, including Brook House. This system was designed to streamline processes, ensure uniformity, and improve access to resident records, training logs, and incident reports. Staff were being supported to access and utilise the system effectively, and records reviewed by the inspector were well maintained and accessible.

Judgment: Compliant

Regulation 23: Governance and management

The governance structure had recently undergone significant change. A new person in charge was appointed in February 2025, along with a new service manager. The inspector met with both during the inspection. At a wider organisational level, the provider had also appointed a director of services to enhance oversight and provide ongoing support to managers and service leads.

The provider acknowledged a high turnover of persons in charge across its services and identified the need for improved consistency and structured support. While the governance team at Brook House was still embedding, there was clear evidence of improved lines of accountability and a renewed focus on stability and leadership. The person in charge was supported by a long-serving team leader who had in-depth knowledge of the residents and the centre.

The governance structure included a monthly audit schedule, with themes such as health and safety, medicine management, and infection control. Findings from audits were used to update the quality improvement plan, with assigned leads and deadlines for actions.

Residents were encouraged to attend and contribute to family forum meetings, which took place every six months. These meetings were well attended, though improvements were required to ensure feedback from both residents and families was actively used to inform the annual review. Given that the annual review is a publicly available document within the centre, it was also recommended that personal information be reviewed in future versions to safeguard residents' privacy.

Judgment: Substantially compliant

Regulation 24: Admissions and contract for the provision of services

The provider had prepared written contracts of care for each resident, outlining the terms and conditions of their residency in the centre, including the fees to be paid.

These contracts were made available to residents and/or their representatives and were signed accordingly.

However, the inspector found that improvements were needed in the clarity and transparency of charges related to private assessments and health and social care services, particularly where such services were recommended as part of an identified support need. In one case, a resident had paid for private assessments, and their family raised concerns about the clarity of associated costs. This had previously been actioned on a previous inspection within another centre under the provider, so there remained a need for greater consistency in how such fees were communicated to residents and families.

Judgment: Substantially compliant

Quality and safety

The centre was found to provide a supportive and caring environment, with a committed staff team and positive resident relationships. However, the inspection found that improvements were required in medicine management and in ensuring the centre was able to meet the assessed needs of all residents.

Safeguarding systems were well established. The provider had established clear oversight mechanisms, including behavioural specialist involvement, incident reviews, and routine governance monitoring to ensure that any potential safeguarding concerns were identified and addressed promptly.

Behaviour support strategies were in place and regularly reviewed, with guidance and oversight provided by a behavioural specialist. Staff were trained in low-arousal approaches and de-escalation techniques. A clear structure was in place for reviewing and managing restrictive practices, with all instances recorded, reviewed, and consented to, by residents where appropriate. Each restriction was guided by an associated risk assessment, and the centre maintained a rights restoration plan for each resident to track progress in reducing restrictions over time.

Risk management was an active part of the service. Risks were clearly documented, assessed, and reviewed regularly. Each resident had an individualised assessment and personal support plan developed with the support of keyworkers. Residents received support through psychology, psychiatry, and key working in areas like emotional regulation, community access, self-care, and decision-making. Notable progress was seen in residents who had previously presented with high levels of need, including improvements in self-regulation, confidence, and community participation.

As previously mentioned, the support provided to residents with specific medicine administration requirements was actioned during the inspection.

Regulation 13: General welfare and development

Residents were supported to participate in meaningful activities suited to their interests and abilities. Some individuals had engaged successfully with day services, community activities, and outings. Staff worked to promote confidence, social skills, and independence.

Some residents were observed to have made significant progress since moving into the centre, particularly in areas like family contact, social participation, and engagement with structured day services. Residents accessed a range of activities including sports, community outings, and shopping, with support from staff as needed.

Judgment: Compliant

Regulation 17: Premises

The centre was clean, comfortably furnished, and maintained to a good standard. Environmental adaptations had been undertaken to reduce incidents and manage identified risks. In particular, the layout of the kitchen area was altered to remove flash-points where incidents had previously occurred.

Physical modifications, such as changing a bedroom door to allow emergency access, had been completed and were under review by the provider's restrictive practice committee.

Judgment: Compliant

Regulation 26: Risk management procedures

A centre-wide risk register was maintained, with risks including behaviours of concern, resident compatibility, and property damage. The inspector reviewed a sample of individual and environmental risk assessments and found that they were up to date, clearly written, and relevant to the presenting risks. Each assessment outlined the nature of the risk, current controls, and an appropriate risk rating. In addition to identifying hazards, the assessments also included sections detailing resident choice and decision-making, reflecting a person-centred approach to risk that balanced safety with autonomy.

Incident data review meetings were held monthly to monitor trends and agree on actions. Each resident had an individual risk assessment that covered personal

safety, health, social participation, and home/community-based activities. Key working sessions were carried out after incidents to promote understanding, regulation, and planning.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

This regulation was not reviewed in full as part of this inspection. However, a specific issue was identified in relation to resident-specific training requirements for the safe administration of medication.

A risk assessment for one resident with diabetes outlined that staff were required to be trained in blood sugar monitoring, weekly subcutaneous injections, and the administration of rescue medication, if necessary. The inspector found that one staff member had not completed this training despite having responsibilities that included administering medication and supporting the resident's health needs.

On further review, it was noted that this training had not been included in the centre's training matrix and, therefore, had not been tracked or flagged for completion. Management acknowledged that this was an oversight and gave assurances that immediate action was taken. The staff member was removed from all medication-related duties, and training would be scheduled and the training matrix would be updated to include this resident-specific training to prevent future gaps.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

The inspector found that while there had been an overall reduction in incidents and safeguarding concerns, the centre was not meeting the full needs of all residents. One resident had withdrawn from routine daily activities, with signs of reduced motivation and activities of daily living. A routine had been agreed whereby staff would check in with the resident each afternoon if they had not gotten up. The resident expressed a clear wish to live elsewhere, highlighting the importance of reviewing their current placement and supports. In addition, improvements were required to ensure care plans and assessment of needs fully reflected the current needs of the resident.

These findings indicate a need for a multidisciplinary review of the resident's needs and preferences, and for the provider to reassess the appropriateness of the placement in terms of supporting individual wellbeing and quality of life.

Judgment: Not compliant

Regulation 7: Positive behavioural support

There was a strong emphasis on supporting residents with behaviours of concern using positive behavioural support strategies. The inspector reviewed one resident's behavioural support plan, which included proactive approaches, rapport-building, and emergency protocols. The plan had been recently updated and included input from the behavioural specialist.

A number of environmental restrictions were in place, including locked sharps, perspex screens, window locks, and physical blocking techniques. One bedroom door had been altered to allow emergency access; this change had been appropriately referred to the restrictive practice committee for oversight. The restrictive practice committee met quarterly and included the person in charge, team leader, and behaviour specialist.

In response to a serious incident in October 2024, de-escalation training was extended to all staff who might be required to visit the house, including non-frontline staff, to improve preparedness in the event of a crisis.

Judgment: Compliant

Regulation 8: Protection

Compatibility between residents had been identified as a known risk in the centre. However, the frequency and severity of incidents linked to compatibility had significantly decreased over the previous 12 months. The inspector found that ongoing review and discussion of compatibility risks took place through team meetings, supervision, and incident data review meetings, ensuring the risk remained under active monitoring and management.

Where incidents had occurred, prompt safeguarding responses had been implemented, and all concerns were reported in line with national policy. A number of environmental adjustments had been made in response to incidents, including a redesign of the kitchen space, which staff reported had helped reduce potential triggers.

Residents were supported in managing their personal finances in a way that respected their abilities and preferences. Where direct support was required, records were accurate and up to date. Staff had also received informal guidance from the person in charge to promote a rights-based approach to financial management,

ensuring that residents remained in control of their money and possessions wherever possible.
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	
Registration Regulation 5: Application for registration or renewal of registration	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 21: Records	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 24: Admissions and contract for the provision of services	Substantially compliant
Quality and safety	
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Brook House OSV-0005419

Inspection ID: MON-0038006

Date of inspection: 27/03/2025

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
Outline how you are going to come into compliance with Regulation 23: Governance and management: In response to the inspection findings regarding the evolving governance structure at Brook House, a robust compliance action plan has been developed to ensure full alignment with Regulation 23: Governance and Management and Feedback. To stabilise leadership, a structured induction and mentorship programme for the newly appointed Person in Charge (PIC) and Service Manager will be completed by 31 May 2025, alongside monthly peer support meetings and quarterly monitoring of PIC turnover across all centres. To embed effective governance systems, the centre will maintain its monthly audit schedule using standardised templates, and update the Quality Improvement Plan (QIP) monthly with clearly assigned actions, deadlines, and progress tracking, reviewed weekly by the Senior Manager. To improve responsiveness to residents and families, the family forum template will be updated to include a feedback-to-action section by July 2025, with outcomes reflected in the Annual Review. Additionally, to safeguard privacy, the Annual Review will be revised to exclude personal or sensitive details in its publicly accessible version. Ongoing oversight will be provided through fortnightly visits by the Senior Manager, monthly governance reports, and a bi-annual review of the governance structure's effectiveness to ensure sustained compliance and leadership stability at Brook House.	
Regulation 24: Admissions and contract for the provision of services	Substantially Compliant
Outline how you are going to come into compliance with Regulation 24: Admissions and contract for the provision of services:	

In response to the HIQA inspection finding regarding the lack of clarity and transparency in contracts of care related to private assessments and health and social care services, the provider has developed a robust compliance action plan. The contract of care template will be updated to include a dedicated section outlining potential charges for private assessments and services recommended as part of identified support needs. All current contracts will be reviewed and updated accordingly, with clear documentation of any past or future fees. The PIC will meet with residents' representatives to explain any associated costs, ensuring informed consent is documented. Staff training will be delivered to support clear communication and proper documentation of charges. A revised admissions and fees policy will be implemented, and satisfaction with fee transparency will be measured through resident and family surveys. Monthly audits will include a review of contract clarity and associated fees, and the Senior Manager will provide ongoing oversight to ensure timely completion and sustained compliance.

Regulation 29: Medicines and pharmaceutical services	Not Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
Following the HIQA finding regarding a staff member's lack of resident-specific training for the safe administration of medication, immediate corrective action was taken by removing the staff member from all medication-related duties. The required training in blood sugar monitoring, weekly subcutaneous injections, and administration of rescue medication has been scheduled, and a competency assessment will follow upon completion. The centre's training matrix is being updated to include all resident-specific training to prevent such oversights in future. Additionally, individualised training profiles for each resident will be developed to clearly outline the training required for supporting staff. Monthly audits of the training matrix will be implemented to ensure compliance, and a staff allocation procedure is now in place to verify that only appropriately trained staff are assigned to residents with complex care needs. These actions will be documented in the May Quality Improvement Plan (QIP) and reviewed regularly under Regulation 23 governance oversight to ensure sustained compliance.

Regulation 5: Individual assessment and personal plan	Not Compliant

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

In response to the finding that the centre was not fully meeting the needs of a resident who had withdrawn from daily activities and expressed a wish to live elsewhere, a comprehensive action plan has been developed. A multidisciplinary team (MDT) review will be conducted to assess the resident's current needs, quality of life, and appropriate support options. A formal meeting will take place with the resident to explore their preferences regarding future living arrangements, including the possibility of supported living. In parallel, a structured independent living skills programme will be designed and implemented in collaboration with Occupational Therapy to build the resident's capacity for increased autonomy. The resident's assessment of need and care plan will be updated to reflect current presentation, including reduced motivation and engagement, and a documented daily wellbeing and engagement check will be put in place. Oversight will be maintained through weekly reviews by the PIC, monthly audits, and inclusion of the case in governance meetings. The resident's representative or advocate will also be engaged to support decision-making, and all staff will receive refresher training on identifying early signs of withdrawal and the importance of responsive planning. While some improvement has been noted, these actions are aimed at ensuring the resident's needs are fully supported and that compliance is restored and sustained.

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 23(1)(e)	The registered provider shall ensure that the review referred to in subparagraph (d) shall provide for consultation with residents and their representatives.	Substantially Compliant	Yellow	30/06/2025
Regulation 24(4)(a)	The agreement referred to in paragraph (3) shall include the support, care and welfare of the resident in the designated centre and details of the services to be provided for that resident and, where appropriate, the fees to be charged.	Substantially Compliant	Yellow	30/06/2025
Regulation 29(4)(b)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating	Not Compliant	Orange	30/05/2025

	to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine which is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.			
Regulation 05(2)	The registered provider shall ensure, insofar as is reasonably practicable, that arrangements are in place to meet the needs of each resident, as assessed in accordance with paragraph (1).	Not Compliant	Orange	30/06/2025