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:	Meadowview
Name of provider:	Health Service Executive
Address of centre:	Sligo
Type of inspection:	Unannounced
Date of inspection:	30 April 2025
Centre ID:	OSV-0005508
Fieldwork ID:	MON-0046706

About the designated centre

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

Meadowview is a bungalow located in Co. Sligo. The service is provided by the Health Service Executive for four female residents with an intellectual disability. The care and support needs for each person is tailored to specifically meet their individual needs. Meadowview aims to support each person to meet their maximum potential in all areas of their lives. The service advocates a person-centred approach to care, and to provide people with the opportunities to participate in social activities, hobbies and community engagement. Services provided in the centre are suitable, meaningful and age appropriate and in line with residents' wishes and desires. Support is provided by a team of nurses and social care staff, and there are three staff on duty during the day and there are two waking staff on duty at night.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	4

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 30 April 2025	12:10hrs to 18:30hrs	Angela McCormack	Lead

What residents told us and what inspectors observed

This inspection was an unannounced inspection which focused on safeguarding. The Chief Inspector of Social Services issued a regulatory notice to providers in June 2024 outlining a plan to launch a regulatory adult safeguarding programme for inspections of designated centres. This inspection was completed as part of this programme.

Overall, this inspection found that residents living in Meadowview designated centre were receiving a safe and person-centred service. Improvements were required however, in ensuring that all staff received appropriate supervision and the training required to support and promote residents' protection and safety.

There were four residents living in the centre at the time of inspection. One resident attended an external day service, while the other three residents took part in activities from their home. The inspector provided a document at the start of the inspection called 'Nice to Meet You' that inspectors use to support residents to understand about why they are visiting their home. Staff members supported residents with this information.

On arrival to the centre by the inspector, there was nobody home. Shortly after, staff and three residents arrived back to the centre on the service vehicle after being out for the morning. The inspector was informed that two residents had been to the 'alpaca farm', while one resident went out for breakfast in their local coffee shop. These activities occurred regularly as part of residents' weekly schedule for activities.

The inspector initially met with one resident, who greeted the inspector in a friendly and welcoming manner. They agreed to show the inspector around their home, including their bedroom. They showed the inspector the framed photographs on display in their bedroom. With staff support, they talked about their photographs and family.

Residents had individual person-centred plans (PCPs) which were found to be up to date and kept under review to assess progress. One resident agreed to show the inspector their PCP. With support from staff they pointed out, and spoke about, various photographs of activities that they took part in, and day trips that they recently enjoyed. They were supported by staff in communicating with the inspector. It was clear that they were comfortable with staff and that staff knew them well.

Other residents were met with at a time that suited their daily routines. Throughout the day, residents were observed relaxing in their home, watching television and listening to music on their computer. Residents were observed freely moving around their home and they appeared comfortable with the staff supporting them and with

each other.

From a walk around of the centre, the inspector observed a clean, spacious home that appeared to meet the needs and numbers of residents. Residents had their own bedrooms that were nicely decorated and reflected their individual personalities. There were ample communal spaces for residents to relax in, where they had the autonomy to choose to spend time together or alone. The centre promoted accessibility with ramps, hand rails and easy access to the garden areas observed.

The inspector observed easy-to-read notices and pictures around the home, to support residents in making choices in their day-to-day lives. For example; there were pictures available for meal choices and activities. In addition, the staff arrangements for the day and night were explained through a pictorial rota that was in an accessible location.

Residents were consulted about the running of the centre and their views sought through regular meetings. Residents were supported to meet with staff individually each week where their choices and preferences for the week ahead were discussed. This had a positive impact on residents as it meant that staff were regularly checking with them if they had any issues or if anything made them sad or upset in the centre. Two residents that the inspector spoke with said that they liked living in the centre, and expressed that they felt safe. These meetings also provided a forum for the easy-to- read documents to be discussed.

The inspector spoke with three staff members. Staff members were found to be knowledgeable about the needs of residents, their individual communication preferences and the supports required. Observations were that staff were supporting residents in line with their support plans and in a caring and respectful manner.

The inspector observed residents coming and going to the house during the day. Observations by the inspector were that residents had a wide range of interests. Furthermore the inspector observed that residents were supported to take part in their preferred activities when they chose to. For example; one resident was observed asking staff if they could go out to the beach in the afternoon, and this was facilitated. Other activities enjoyed by residents and noted in residents' PCPs and meeting notes included: attending music therapy, visiting religious amenities, going to Mass every Sunday, horse-riding, swimming and visiting family. The staffing levels in the centre supported residents to do individual activities if they wished.

Overall, the inspector found that Meadowview provided person-centred and safe care where residents' individuality and choices about how they lived their lives were found to be respected.

Capacity and capability

The inspector found that in general, there were good arrangements for the management and monitoring of the service provided. However, there were gaps in documentation which meant that the inspector could not be assured that all staff had undertaken training in safeguarding and behaviour management, or that all staff had been supported through the provider's annual performance management meetings and team meetings.

The person in charge was on leave at the time of inspection; therefore a person in charge from another centre who was providing cover, facilitated the inspection. There was a clear governance and management structure in place.

The provider had policies and procedures in place to guide staff and which promoted residents' safety and protection. An annual audit schedule was in place and covered topics such as safeguarding, complaints, restrictive practices, finances and medication. This also covered a monthly review and analysis of incidents. This promoted good oversight of the centre.

Residents received support from a staff team of nurses and care assistants. The centre used a number of regular agency staff, which helped to ensure continuity of care; however recruitment for these posts to make sure the centre was fully resourced in line with the statement of purpose, required completion. In general, staff were found to have completed mandatory training in safeguarding and behaviour management. Improvements were required however, in the oversight of training for all staff supporting residents.

Regulation 16: Training and staff development

The inspector reviewed the current staff training matrix in place, and found that there were gaps in the training records which meant that the inspector could not check if all staff working in the centre had received mandatory training in positive behaviour support and safeguarding.

The inspector reviewed the centre's roster for the week and saw that it was resourced with 15 staff. These were a mix of permanent staff and agency staff. A sample of six staff training records were reviewed. All of these staff members were on the rota to work in the centre the week of inspection. However, one staff member's records were not available for review and there was no evidence of an induction programme completed with them. One staff member was overdue refresher training in management of behaviours; however a date was set for June for this to be completed.

In addition, the inspector found that the centre's current training matrix had only seven of the 15 staff members recorded on it. The records showed that six of the seven staff members were overdue their 'performance management' meetings. The minutes of previous meetings were not available for review on the day; therefore the inspector could not confirm if staff had received supervision through the

provider's policy of annual meetings.

Judgment: Not compliant

Regulation 23: Governance and management

The person in charge was on leave at the time of inspection. While there was a 'buddy system' in place whereby a person in charge from another centre covered in their absence, this person did not have access to some records. This impacted on some of the findings noted below.

The inspector reviewed various documentation, including safeguarding plans, staff meetings, residents' meetings and staff safeguarding awareness audits, and found that were gaps in the documentation. In addition, the recruitment for permanent staff positions in the centre required completion to ensure that the centre was suitably resourced. The following areas for improvement were found:

- The inspector reviewed two residents' meetings records from 12/01/2025 to 28/04/2025. Individual resident meetings were held weekly, which demonstrated a person-centred approach. However, the minutes of these meetings asked if any 'easy-to-read' documents were reviewed with residents at their meetings. Where entries said 'yes', they generally did not indicate what topics were reviewed, meaning that it was not noted what topics were reviewed with residents. Improvements in recording of the notes would ensure more effective monitoring about how residents are supported to understand how to keep safe from abuse.
- The inspector reviewed the records of the monthly staff safeguarding awareness audits for 2025 and found that there were only two records, one for January and one of which did not include the date or name of person completing the audit. Therefore, it was not clear that the audits were completed every month, in line with the audit schedule.
- The inspector reviewed the safeguarding plans for the past year, and found that it wasn't clear if the actions from the most recent safeguarding plan, dated and agreed in November 2024, had been reviewed in line with the date for review. While safeguarding was reviewed at team meetings and staff members were knowledgeable about safeguarding arrangements, the inspector could not be assured that each safeguarding action was reviewed as to it's effectiveness and completion.
- The inspector requested the team meetings minutes for 2024 and 2025 and found that there were gaps in staff meeting minutes that were held in the centre, as only two records were available for review (December 2024 and March 2025). The inspector was informed that the other records were possibly archived.
- The inspector reviewed the staff rota for the week commencing 28/04/2025 and observed that there were 10 agency staff and five permanent staff supporting residents that week. The inspector was informed that there were

five staff vacancies which were in progress for completion. In the interim, the vacant gaps were covered by a cohort of agency staff who were regular and consistent, which helped to reduce the impact on residents' continuity of care. However, the completion of this recruitment would ensure that residents had a consistent and steady staff team supporting them at all times.

While these gaps noted above did not appear to cause a moderate to high risk to residents' protection, it did create a risk that there could be a gap in knowledge about safeguarding arrangements for both residents and staff members.

An annual audit schedule was in place and covered topics such as safeguarding, complaints, restrictive practices, finances and medication. This also covered a monthly review and analysis of incidents. Provider unannounced audits were completed every six months as required in the regulations. The inspector reviewed the last report dated in November 2024, and found that there was good monitoring of safeguarding and practices in the centre by the provider. The inspector reviewed the centre's most recent quality improvement plan (QIP) and found that actions arising from various audits were recorded and kept under ongoing review. This helped to promote good monitoring and oversight by the management team.

Judgment: Substantially compliant

Quality and safety

The inspector found that residents living in Meadowview designated centre received person-centred care and support.

Residents' wellbeing and protection were found to be effectively monitored through the ongoing reviews of care and support plans. Residents were also consulted regularly about how they were feeling through individual meetings with staff members. This meant that any concern that a resident had could be identified and responded to within in a reasonable time frame.

A culture of openness about safeguarding was evident during this inspection. Residents' safety and protection were promoted through monthly review of incidents, and through discussions about safeguarding at various meetings. A collaborative approach to safeguarding could be seen through the meetings held. For example; the provider held safeguarding meetings every quarter, where senior managers, a Garda Liaison office and members of the safeguarding and protection team met.

Residents' review meetings also demonstrated a partnership approach to protection and safety where residents, their representatives and MDT were consulted at the three meetings reviewed by the inspector. Residents were empowered to make choices in their lives and were provided with information in a manner that supported

their communication and understanding.

In summary, the inspector found that the service promoted a holistic approach to care that strived to protect residents and promote their safety and wellbeing.

Regulation 10: Communication

The inspector reviewed the provider's communication policy which was available in the centre. This was found to be up to date. The inspector reviewed three residents' 'Communication Passports' and found that residents were supported to communicate through a variety of preferred methods which were individual to them. These included; verbal means, Lámh, picture schedules, choice boards, social stories, objects of reference and through the use of a smart phone application for symbols. These care plans clearly outlined each residents' individual communications, their likes and dislikes and described about how to support them in making their choices and needs known. Staff spoken with by the inspector were knowledgeable about residents' individual communication preferences. This was also observed in practice by the inspector throughout the inspection.

In addition, the inspector observed that residents had access to easy-to-read documents on topics such as advocacy, protection, and making complaints. These documents were located in a communal area meaning residents had easy access to them. The inspector was shown a sample of social stories that was used for one resident to support them with various information. This included information to help them become more self-aware about a specific behaviour that could unintentionally impact on others. This demonstrated that the service used a holistic approach in supporting residents with communication needs and behaviours in order to help them learn about how their actions could unintentionally impact others. This approach also promoted their own protection.

The inspector observed that residents had access to televisions, music players, computers and technological devices on which they could access the internet and preferred musical and television programme clips.

Judgment: Compliant

Regulation 17: Premises

The centre was found to be suitable to meet the numbers and the needs of residents. The house was clean, spacious and well maintained. The house was decorated in warm colours which created a cosy and calming atmosphere. There was a system in place for requesting maintenance and refurbishment of the premises.

Residents had individual bedrooms which were nicely decorated and personalised with framed photographs, soft furnishings and residents' belongings. Residents had suitable storage facilities for their belongings.

The house had ample communal space for residents to spend time together or alone. The house was designed and decorated to support residents' individual interests and hobbies. For example; one resident had their own computer in their bedroom on which they could spend time watching their favourite music videos and television programmes. Other residents were seen to have preferred chairs to sit on where they could watch television easily, or be near the windows at the back garden area.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The inspector reviewed three residents' personal plans, including care plans, assessment of needs and meeting notes from annual review meetings. In addition, the inspector reviewed all four residents' person-centred plans (PCP), where it could be seen that residents enjoyed a wide variety of activities that were meaningful to them. These included; going to concerts and festivals, going on outings to the beach, swimming, reflexology, horse-riding, music sessions, bowling and baking. One resident agreed to show the inspector their easy-to-read PCP folder, which contained photographs of the resident's personal goals and various outings that they enjoyed.

Through a review of the care plans and discussions with staff and residents, it was clear that residents' needs were kept under review and that their protection, health and wellbeing were promoted. The inspector saw that a collaborative approach to residents' care and support was taken, where residents and their representatives (as relevant) were involved in the reviews of care plans. In addition, the meetings of the annual reviews showed that safeguarding was a topic that was discussed also. This demonstrated a culture where safeguarding was openly discussed and where a partnership approach was taken to ensure residents' safety and welfare were promoted.

Judgment: Compliant

Regulation 7: Positive behavioural support

The inspector reviewed the provider's policies and procedures for behaviour support and restrictive practices. These were found to be up-to-date and available to staff.

The inspector reviewed three residents' positive behaviour support plans. These were found to be comprehensive and provided clear guidance to staff on the supports each resident required with possible distress and anxiety. The inspector was informed, and also observed in the documented support plans, that residents had MDT supports where this was required, and who were involved in the development and review of support plans. The plans also included a section on human rights' principles which highlighted the need to ensure the rights of residents were considered when providing supports.

Staff spoken with were knowledgeable about the supports each resident required to promote their wellbeing and to protect other residents from any potential impact of behaviours. The inspector observed staff supporting residents in line with their support plans.

There were no restrictive practices in use in the centre. The inspector reviewed the annual audit schedule for 2025 for the local management team and saw that there was a template for auditing restrictive practices, should there be any used in the centre.

Judgment: Compliant

Regulation 8: Protection

The inspector reviewed the policies and procedures that the provider had in place for safeguarding and for the provision of personal and intimate care. These policies and procedures were available to staff in the centre.

The inspector observed notices on display throughout the centre outlining the process for reporting incidents of a safeguarding nature and about who the designated officers are for the centre. The inspector spoke with three staff members about safeguarding arrangements and the supports that residents required to keep safe. Staff were found to be knowledgeable about measures to promote residents' protection and about the procedures to be followed in the event of a concern.

The Chief Inspector was notified of four concerns between 21/07/2024 and 27/01/2025, through monitoring notifications as required in the regulations. The inspector reviewed the safeguarding documentation associated with these concerns and found that the safeguarding procedures were followed. In addition, it was clear that every effort was made to establish the cause of the negative interactions between residents. For example; it was noted that the impact of a storm had caused upset to residents which led them to react in a negative way that impacted others.

Where required safeguarding plans were developed to ensure residents' protection. Staff spoken with were knowledgeable about the incidents that occurred, the possible reason for same, and the actions taken to reduce the risk of similar incidents from occurring. The inspector observed that the two staff team meeting records (December 2024 and March 2025) included a review of safeguarding and

incidents.

The inspector reviewed the easy-to-read documents that were available for residents about how to self-protect, how to make a complaint and about human rights and advocacy. The inspector reviewed two residents' meetings records from 12/01/2025 to 28/04/2025. These meetings covered an agenda item asking if there were any concerns about residents' safety that week. The agenda also covered if any easy-to-read documents were discussed. The inspector found that while most entries indicated that an easy-to-read document was reviewed with residents, it did not always record what topic was discussed. Improvements in this documentation were required in order to effectively monitor and ensure that residents' were supported to develop the knowledge, self-awareness, understanding and skills required for self-care and protection. This gap in documentation is covered under Regulation 23: governance and management.

Judgment: Compliant

Regulation 9: Residents' rights

A human rights based approach was observed by the inspector, through the interactions between staff and residents on the day, and through the language used in the care and support plans. For example, the inspector observed in the three behaviour support plans reviewed that each plan outlined the importance of human rights and included the FREDA (fairness, respect, equality, dignity and autonomy) principles. In addition, the four PCPs reviewed by the inspector reflected the individuality of each resident in their choices about personal goals. This meant that residents were treated fairly and respectfully as individuals who have unique personalities and preferences about how they lived their lives.

The inspector reviewed the residents' meeting notes, and found that consultation occurred with residents about the centre. These meetings also demonstrated that residents were empowered to make choices in their day-to-day lives and that staff regularly checked with them if there was anything in the centre that upset them. Residents' meetings were held weekly with each resident on an individual basis, which the staff spoke about and said that this way was more effective than a group meeting. This demonstrated how the service strived to ensure that each resident's voice, will and preference were promoted and that they were supported with this in a person-centred manner.

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 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Substantially compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 17: Premises	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Meadowview OSV-0005508

Inspection ID: MON-0046706

Date of inspection: 30/04/2025

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 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • The Person in Charge ensures that staff are appropriately supervised. Completed 03/06/2025. • The Person in Charge has now a schedule in place for Performance Achievement meetings for all staff, including consistent agency staff. Completed 03/06/2025. • The Person in Charge has now a protocol around induction and training of all new staff commencing work within the designated centre. Completed 03/06/2025. • The Person in Charge has ensured that evidence of mandatory training records for all agency staff is now included in the induction process. Completed 03/06/2025. • The person in charge has ensured that all staff have access to appropriate training, including refresher training, as part of a continuous professional development programme. Completed 03/06/2025. • The Person in Charge has all consistent agency staff on the training matrix within the designated centre. Completed 03/06/2025. • The Person in Charge has a training schedule in place for mandatory training, including refresher training in Positive Behaviour Support and Safeguarding. Completed 03/06/2025. • The Person in Charge has ensured that when they are off and records are locked away that an arrangement is in place on site for the key to be accessed by whoever is facilitating the inspection. Completed 03/06/2025.	
Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management: • The Registered Provider has ensured that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored. Completed 03/06/2025. • Management have developed a checklist system to incorporate inductions, training and certs during governance visits to support the Person in Charge. Completed 03/06/2025. • The Person in Charge has ensured that these records are locked away and an arrangement is in place in line with GDPR for the key to be accessed by whoever is facilitating the inspection. Completed 03/06/2025. • The Person in Charge has ensured that the audits in relation to safeguarding have been completed. Completed 03/06/2025. • The Person in Charge has ensured that all safeguarding incidents are reviewed in line with the Safeguarding policy and all actions are evaluated or completed as required. Completed 03/06/2025. • The Person in Charge has now ensured that team meetings are clearly documented, are completed on a bi-monthly basis and are available to be viewed. Completed 03/06/2025. • The Person in Charge has ensured that discussions from all residents meetings are captured in a detailed format. Completed 03/06/2025. • The Registered Provider has ensured that the Human Resources have re-escalated staff vacancies for approval within the designated centre. Completed 03/06/2025. • The Person in Charge ensures that regular and consistent agency staff is rostered within the designated centre. Completed 03/06/2025.	

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 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.	Substantially Compliant	Yellow	03/06/2025
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	03/06/2025
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.	Substantially Compliant	Yellow	03/06/2025
Regulation 23(1)(c)	The registered provider shall ensure that	Substantially Compliant	Yellow	03/06/2025

	management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.			