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:	Teach Lorcán
Name of provider:	The National Association for the Deaf T/A Chime - The National Charity for Deafness and Hearing Loss
Address of centre:	Dublin 9
Type of inspection:	Unannounced
Date of inspection:	01 August 2025
Centre ID:	OSV-0008368
Fieldwork ID:	MON-0047767

About the designated centre

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

Teach Lorcán aims to provide individualised, person-centred, community-based residential supports through Irish Sign Language to maximise the quality of life of each individual living with deafness and hearing loss while fostering autonomy, personal growth, and development. Teach Lorcán consists of two two-story properties in north Dublin. The centre can accommodate a maximum of 5 residents. Residents present as having an intellectual disability, or complex needs which may include mental health support or physical and sensory needs. Residents are supported by residential community facilitators and a person in charge.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	5

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
Friday 1 August 2025	10:50hrs to 16:20hrs	Erin Clarke	Lead
Friday 1 August 2025	10:50hrs to 16:20hrs	Brendan Kelly	Support

What residents told us and what inspectors observed

This risk-based unannounced inspection was undertaken to evaluate the effectiveness of governance arrangements in the designated centre and to assess the impact of leadership absences on service delivery. Inspectors found that some residents were unhappy with their living arrangements, and this was having a negative impact on their lived experiences in the centre.

Overall, inspectors identified significant failures in the governance and management arrangements in the this centre that directly led to poor adherence by the provider to safeguarding and complaints procedures. The failure to follow established processes meant that concerns were not adequately addressed, and effective measures to mitigate risks and resolve issues were not in place. Systems in place to govern and manage aspects of care and support were not in line with best practice and were having a negative impact on aspects the residents' quality of life.

Teach Lorcan comprises two two-storey buildings registered for five residents situated in an urban area of Co. Dublin, located a short drive apart. The centre was first registered in February 2023. In April 2024, the provider was granted an application to vary the conditions of registration by expanding the centre to include a second house. Following this change, three residents who had previously lived together in the original house moved into the second house, as it was assessed to better meet their physical needs.

Inspectors found significant discrepancy in the lives of residents between the two houses, as outlined throughout the report. Overarching findings in relation to a lack of governance and oversight remain. However, different experiences for residents directly relate to resident compatibility and a lack of a comprehensive response to concerns by the provider.

On arrival at the first house, which is now home to two residents, inspectors were welcomed by two support staff on duty. During the visit, inspectors were joined by the acting interim team leader, who is based in the second house, and were also contacted by the interim director of services to address governance-related queries and self-identified system issues.

Staff spoken with in the first house reported that despite recent governance changes, the presence of acting team leaders had been a source of some house specific guidance and oversight. Both residents, who had moved into the house in September 2024, were described as settled in their home. Inspectors were introduced to the residents, who were observed sitting together on the couch watching television before leaving to attend a swimming activity.

It was further reported that one resident was preparing to begin a supported employment scheme, which staff described as a significant personal achievement. Both residents, having only recently transitioned into residential services within the

past year, were said to have adapted well to their new home and were developing positive routines.

The second house in the centre was home to three residents who had been living together since 2023. Inspectors found that, unlike in the first house, there were significant difficulties in relationships between the residents. The lack of compatibility resulted in frequent arguments and tensions within the home, which caused ongoing distress for those living there.

During the inspection, all three residents were engaged in individual activities outside the home. One resident returned from their place of work, greeted inspectors, and then requested to speak with staff in private.

Staff informed inspectors of the approaches they used to manage negative interactions between residents and demonstrated awareness of the common triggers. They highlighted that the limited communal space in the house was a contributing factor to tensions among residents.

Inspectors observed a complaints/suggestion box in the sitting room of the house. Staff confirmed that residents are free to make suggestions or complaints by using the box; however, on the day of inspection, the box was locked with a padlock and visibly full. When questioned about the process for reviewing the contents, staff stated that the person in charge would normally review the box's contents. Given the absence of the person in charge, staff indicated that a senior member of the management team would review the box; however, they were unsure of the timeframes for this review.

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

Capacity and capability

Overall, this inspection identified significant deficits in the provider's capacity and capability to ensure the effective governance, oversight, and leadership of the designated centre. Key statutory posts remained vacant for extended periods, including the person in charge (absent since April 2025) and the person participating in management (absent since January 2025), both of which carry essential responsibilities for the safe and compliant operation of the service.

These gaps demonstrated a significant area for improvement in the centre's approach to managing complaints and feedback, which directly impacts the quality of care and the satisfaction of residents.

Two days prior to the inspection, the provider had been invited to a formal warning meeting regarding missed payment of registration fees, constituting a breach of the

registration regulations for designated centres.

Outside of the formal deficits in the governance structures, the presence of a consistent staff team provided stability within the centre. Staff were well known to residents and their individual needs, and relationships were supported through the limited use of unfamiliar or relief staff. This familiarity led to staff having to cover management tasks and make decisions that were outside of their remit due to their being an absent layer of management.

Registration Regulation 7: Changes to information supplied for registration purposes

The person in charge had been absent since April 2025. While a notification was submitted in May 2025 naming the person appointed to replace the person in charge, the prescribed information required under the regulations was not submitted in full within 10 days of the appointment, despite multiple requests from the Chief Inspector of social services. This was a repeat finding under this regulation. At the time of inspection, evidence of a management qualification for the appointed person remained outstanding.

Judgment: Not compliant

Registration Regulation 9: Annual fee to be paid by the registered provider of a designated centre for persons with disabilities

Due to the provider's generic email account being set as the email address for an absent stakeholder, direct communication was limited. Following one missed payment and communication from the Chief Inspector the provider failed to rectify the system identified as failing. As a result, a second missed payment of regulatory fees occurred, leading to a formal warning meeting with the provider on 30 July 2025.

Judgment: Not compliant

Regulation 15: Staffing

Inspectors reviewed rosters for June, July, and August 2025, and it was noted that the centre was fully staffed, with no vacancies present. There was no reliance on agency staff during the months reviewed, indicating a stable staffing arrangement within the centre.

A key requirement for staff in the centre is the possession of a minimum Level 3 Irish Sign Language (ISL) qualification, in addition to their care qualifications. This ensures effective communication with residents, who rely on ISL for interaction. The rosters reviewed reflected this requirement, with staff members meeting the necessary qualifications.

The rosters also included scheduled dates for team meetings, training sessions, supervision, and designated hours for local team managers' responsibilities related to cleaning and administration. Shift patterns were well-organised, being a mix of both sleepovers and day duties, ensuring appropriate staffing levels at all times. All frontline staff are designated as keyworkers for residents.

During the inspection, in both locations where residents were present, inspectors observed staff interacting with residents using ISL. The residents appeared entirely comfortable and at ease in the presence of staff.

Judgment: Compliant

Regulation 23: Governance and management

The provider did not have effective governance and management systems in this centre. The inspectors found system failures, particularly relating to safeguarding, assessment of resident need and risk. In addition the management of complaints and restrictions.

The centre had experienced substantive governance changes across several key leadership levels. The post of person participating in management (PPIM), held by the director of specialist services, had been vacant since January 2025. This role carried significant responsibilities within the centre, including acting as the designated complaints officer and safeguarding officer. In addition, the post of person in charge, a legally mandated role under the regulations, had been vacant since April 2025. Governance capacity was further impacted by both team leaders being on extended statutory leave, with acting team leaders assigned to these positions.

The provider is required to complete an annual review of the quality and safety of care and support in the centre, measuring service performance against the National Standards, identifying areas for ongoing improvement, and making the review available to residents, their family members, and the Chief Inspector. This review was not available for inspectors to examine during the inspection.

Legislation also places a responsibility on registered providers, or a nominated person, to carry out unannounced visits to the designated centre at least every six months. The purpose of these visits is to monitor the safety and quality of care and support provided and, where necessary, to put an action plan in place to address any concerns identified. The last unannounced visit in the centre was carried out on 11 November 2024; therefore, the next visit was due in May 2025 but had not

occurred.

While the absence of an annual review was identified in the November 2024 unannounced audit, this action had not been progressed by the provider. It was also unclear how the provider was made aware of the audit findings, as the report had not been co-signed.

In reviewing the centre's safeguarding arrangements, it was reported through the six-month unannounced audit that no actions were required as only one allegation of peer-to-peer abuse had been recorded in the preceding six months. However, inspectors found written records indicating ongoing safeguarding incidents that warranted safeguarding plans. Similarly, under complaints management, the provider reported no visible trends in the complaints log; however, inspectors identified multiple complaints from other sources that had not been managed in line with the provider's complaints process.

Judgment: Not compliant

Regulation 34: Complaints procedure

The provider's complaints policy clearly outlined the role of the complaints officer; however, the individual appointed to this role had been absent for a prolonged period, and no replacement had been assigned. Furthermore, the policy, dated March 2022, had not been updated or reviewed within the three-year timeframe stipulated by the regulations.

The policy specified that all complaints will have a designated complaints officer and that an initial response should be made within five days. However, none of the complaints reviewed by inspectors had an assigned complaints officer, nor were they responded to within the defined timeline. Furthermore, the provider's policy stated that the local manager was responsible for maintaining a monthly record of complaints, which should include residents' views on their satisfaction with the outcome. This record was not maintained in the centre, and no evidence of a system in place to capture resident satisfaction with complaint resolutions was found.

The complaints log for 2025 was not available for inspectors to review. Staff confirmed that maintaining the log was typically the responsibility of the person in charge, but they were unsure of how to locate the log for the year 2025. Inspectors also reviewed residents' meetings for May, June, and July 2025. The minutes of these meetings included residents' views, some of which could be interpreted as complaints regarding both staff and peers.

Judgment: Not compliant

Quality and safety

The purpose of the inspection was to assess the impact of absent leadership figures on the governance systems within the centre, with a particular focus on safeguarding and the management of risk. Significant concerns were identified in relation to the oversight of safeguarding matters, awareness of safeguarding responsibilities, and the recognition and management of risk. The provider was failing to keep residents safe within their homes.

Inspectors found that risk management systems were not effective, as significant incidents did not result in a critical incident review or reassessment of risks. This failure directly impacted the provider's ability to ensure residents' safety and effectively mitigate ongoing risks.

Inspectors reviewed a substantial number of Antecedent, Behaviour, and Consequence (ABC) recording sheets maintained in the centre. These were used to track behaviours of concern for review by an external behavioural specialist who visited the centre every two months to meet with residents and support their emotional wellbeing. While this process provided a resource for understanding and managing behaviours, the volume and nature of incidents recorded indicated a compatibility issue among residents.

Inspectors found that information within residents' records indicated ongoing interpersonal conflicts, leading to emotional distress, withdrawal from communal areas, and complaints about both peers and staff. These matters were not being addressed through the centre's safeguarding procedures or its complaints management processes, representing a significant gap in oversight and protection for residents.

Regulation 26: Risk management procedures

The provider's system for identification, oversight and monitoring of risks was ineffective at the time of inspection.

Inspectors reviewed the systems in place for monitoring serious risks within the centre and found significant gaps. For example, a risk assessment relating to injury by sharp objects was rated as low risk but had not been reviewed following a related incident in July 2025. A corresponding restrictive practice assessment, which was updated after the same incident, concluded that no changes were required, as existing measures were considered effective. This was despite a significant incident resulting in self-harm occurring only three weeks prior.

In addition, a behavioural support plan dated October 2021 included specific protocols to be followed after an incident, such as completing a full debrief and

carrying out a comprehensive review of the resident's assessment of need. Inspectors found that these steps had not been implemented, demonstrating a failure to adhere to the agreed support plan and to ensure learning from incidents further placing residents at risk.

Judgment: Not compliant

Regulation 28: Fire precautions

Inspectors reviewed the centre's fire folder and completed a walkabout of the premises. The fire folder was person-centred in its approach, providing clear, tailored instructions for both deaf and hearing impaired residents and staff and those who could hear.

All required fire safety equipment, including fire blankets, fire extinguishers, alarm panels, emergency lighting, and fire doors, was in place and serviced in line with regulatory requirements. During the inspection, two fire doors were tested, and both were found to be operating correctly.

Residents' personal emergency evacuation plans (PEEPs) were also reviewed and found to be person-centred, completed by keyworkers, and signed off by local managers. Records confirmed that fire drills had taken place in the centre; however, there was no evidence that a night-time drill had been carried out in one location. This was of particular importance given the proximity of a resident's bedroom to the kitchen and the reliance on a narrow walkway as the primary means of escape.

Judgment: Substantially compliant

Regulation 8: Protection

Inspectors found that a number of allegations between residents, as well as negative peer interactions, some of which were linked to incidents of suicidal ideation, had not been screened or reviewed in accordance with the provider's or national safeguarding policy. Written records demonstrated that residents expressed ongoing unhappiness living together, with one resident reporting feeling frightened and others engaging in frequent arguments, resulting in emotional distress. These issues were documented over a prolonged period, from October 2023 to the present day. These well documented concerns had not been dealt with in an effective or timely manner.

Despite the seriousness and persistence of these concerns, incidents had not been screened under established safeguarding procedures, nor were they notified to the relevant statutory agencies as required. In addition, safeguarding plans had not

been developed to address or mitigate the ongoing risk of psychological harm arising from these negative interactions.

Judgment: Not compliant

Regulation 9: Residents' rights

The absence of key personnel and failure to follow agreed procedures compromised the provider's ability to address and resolve complaints and safeguarding incidents effectively, impacting residents' rights and satisfaction.

Inspectors found evidence of a long-standing and consistent pattern of conflict between residents living in one house. Staff spoken with described the challenges of working in a difficult environment and the measures they implemented to support the group dynamics as best as possible. For example, meal times were staggered to reduce tensions in the kitchen, which was often a trigger point for incidents. Staff said this also negatively impacted one resident who valued spending time cooking and preparing food. Similarly, another resident reportedly expressed frustration at having to share the communal living room with peers, which further limited their comfort and use of shared spaces.

Despite staff efforts, inspectors found that the provider had not addressed this issue at a strategic or management level. The level of incompatibility between residents was having a significant impact on the overall atmosphere of the home, creating stress, conflict and emotional distress. It had not been recognised as an infringement of residents' rights to live in an environment that promotes their wellbeing and reflects their choices. There were no documented strategies or timebound plans in place to resolve the incompatibility or to consider alternative living arrangements. As a result, residents continued to live in an environment that did not fully respect or promote their dignity, rights or quality of life.

Judgment: Not 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 7: Changes to information supplied for registration purposes	Not compliant
Registration Regulation 9: Annual fee to be paid by the registered provider of a designated centre for persons with disabilities	Not compliant
Regulation 15: Staffing	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 34: Complaints procedure	Not compliant
Quality and safety	
Regulation 26: Risk management procedures	Not compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Teach Lorcán OSV-0008368

Inspection ID: MON-0047767

Date of inspection: 01/08/2025

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
Registration Regulation 7: Changes to information supplied for registration purposes	Not Compliant
Outline how you are going to come into compliance with Registration Regulation 7: Changes to information supplied for registration purposes: We have submitted an application form to register our Acting Director of Specialist Services as a designated Person In Charge. In order to bring the individuals qualifications in line, they will attend a DCM Level 6 Management Course in September 2025.	
Registration Regulation 9: Annual fee to be paid by the registered provider of a designated centre for persons with disabilities	Not Compliant
Outline how you are going to come into compliance with Registration Regulation 9: Annual fee to be paid by the registered provider of a designated centre for persons with disabilities: Since August 1, a new email address with multiple users has been set up to ensure invoices and reminder letters are actioned regardless of whether an individual staff member is on leave.	

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
• We will complete a new application to register a new PPIM by October 15.
• We will commence recruitment for an experienced Residential Services Manager.
• We will implement an annual review of Quality & Safety.
• We had previously maintained a robust internal process of unannounced inspections every six months. Given the absence of staff, we felt a more thorough and comprehensive approach was to carry this out with the use of an external consultant. In June 2025 we retained HCI who carried out an audit of the centre on August 21, 2025.
• We will complete a review of our Safeguarding policy and processes to ensure there is a clearly defined process to support staff in the proper recording and reporting of behaviours and incidents, both internally and to HIQA, that are fully captured in each of the Resident's support plans.

Regulation 34: Complaints procedure	Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
We will ensure the timely processing of client complaints and undertake a review of the complaints process and policy.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
We have retained the services of a psychologist to carry out an up-to-date Assessment for the three residents living in Hazelwood Court. On completion of this, a Compatibility Assessment will also be carried out. These will inform behaviour support plans going forward.

Regulation 28: Fire precautions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: The fire drill procedure will be reviewed to include adequate nighttime drills.	
Regulation 8: Protection	Not Compliant
Outline how you are going to come into compliance with Regulation 8: Protection: This judgement will be addressed by actions taken to comply with Regulations 23 and 26.	
Regulation 9: Residents' rights	Not Compliant
Outline how you are going to come into compliance with Regulation 9: Residents' rights: In addition to the action plans noted under Safeguarding and Quality & Safety, we will implement a more formal, better documented system of obtaining the Resident's feedback.	

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
Registration Regulation 7(2)(b)	Notwithstanding paragraph (1) of this regulation, the registered provider shall in any event supply full and satisfactory information, within 10 days of the appointment of a new person in charge of the designated centre, in regard to the matters set out in Schedule 3.	Not Compliant	Orange	15/10/2025
Registration Regulation 7(3)	The registered provider shall notify the chief inspector in writing of any change in the identity of any person participating in the management of a designated centre (other than the person in charge of the designated centre) within 28 days of the change and supply full and	Not Compliant	Orange	15/10/2025

	satisfactory information in regard to the matters set out in Schedule 3 in respect of any new person participating in the management of the designated centre.			
Registration Regulation 9(2)	Subject to paragraphs (3) and (4) of this regulation, the annual fee is payable by a registered provider in three equal instalments on 1 January, 1 May and 1 September each year in respect of each four month period immediately following those dates and each instalment is payable not later than the last day of the calendar month in which the instalment falls due.	Not Compliant	Orange	15/10/2025
Regulation 23(1)(b)	The registered provider shall ensure that there is a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service	Not Compliant	Orange	15/10/2025

	provision.			
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	15/10/2025
Regulation 23(1)(d)	The registered provider shall ensure that there is an annual review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards.	Not Compliant	Orange	15/10/2025
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.	Not Compliant	Orange	15/10/2025
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	Not Compliant	Orange	15/10/2025

	determined by the chief inspector and shall prepare a 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 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Not Compliant	Orange	15/10/2025
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.	Substantially Compliant	Yellow	15/10/2025
Regulation 34(2)(b)	The registered provider shall ensure that all complaints are investigated promptly.	Not Compliant	Orange	15/10/2025
Regulation 34(2)(d)	The registered provider shall ensure that the complainant is informed promptly	Not Compliant	Orange	15/10/2025

	of the outcome of his or her complaint and details of the appeals process.			
Regulation 34(2)(e)	The registered provider shall ensure that any measures required for improvement in response to a complaint are put in place.	Not Compliant	Orange	15/10/2025
Regulation 34(2)(f)	The registered provider shall ensure that the nominated person maintains a record of all complaints including details of any investigation into a complaint, outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.	Not Compliant	Orange	15/10/2025
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	15/10/2025
Regulation 08(3)	The person in charge shall initiate and put in place an Investigation in relation to any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.	Not Compliant	Orange	15/10/2025
Regulation 09(2)(b)	The registered provider shall	Not Compliant	Orange	15/10/2025

	ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability has the freedom to exercise choice and control in his or her daily life.			