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:	Baile Geal Residential Service
Name of provider:	Barróg Healthcare Limited
Address of centre:	Cork
Type of inspection:	Unannounced
Date of inspection:	16 April 2025
Centre ID:	OSV-0008798
Fieldwork ID:	MON-0046843

About the designated centre

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

Baile Gael is a detected bungalow residence in the outskirts of a large town. The centre can provide full-time residential support to three adults over the age of 18, of both genders, with an intellectual disability and/or autism. Residents are supported by social care workers, support workers, the person in charge and a team leader. Each resident has their own bedroom and other rooms in the centre include bathrooms, a multipurpose room and a kitchen.

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
Wednesday 16 April 2025	08:30hrs to 17:15hrs	Conor Dennehy	Lead
Wednesday 16 April 2025	08:30hrs to 17:15hrs	Kerrie O'Halloran	Support

What residents told us and what inspectors observed

One resident spoken with indicated that they liked living in the centre. While one resident spent the inspection day in the centre, the other two residents left the centre in the company of staff members. Such staff were pleasant in their general interactions with the residents.

Three residents were living in this centre with the premises divided up so that each resident had their own individual living areas. When inspectors arrived to commence the inspection all three residents were in bed. Soon after the inspection started, two residents had gotten up. One of these residents was briefly met by an inspector in the company of two staff. This resident left the centre shortly after in the company of their assigned staff to go swimming. This was something that was important to the resident. The resident did not return to the centre until near the end of the inspection and was not met again by either inspector.

An inspector did meet the other resident who had initially gotten up. This resident greeted the inspector and pointed to 'Nice to meet you' documents which both inspectors had provided to help explain who the inspectors were and why they were in the resident's house. The resident told the inspector that they had been living in the centre for a while and liked living in the centre. When asked what they liked about living in the centre, the resident responded by saying "the place". The resident then indicated that they would be going shopping later in the day. Inspectors were informed though that they resident could often decline to leave the centre with this resident seen to spend the remainder of the day in the centre' kitchen. The resident seemed content as they did so.

Nearly three hours after the inspection commenced, the third resident got up. The resident initially spent some time in a multipurpose room that served as the resident's social, recreational and dining space. The designated staff toilet was also accessed via the same space. An inspector went to meet this resident in the company of two staff members. While the resident did communicate verbally, the inspector did have some difficulty to clearly understand what the resident was saying at times. As a result, the inspector could not understand the answers given by the resident to some questions asked. Therefore, the inspector did sometimes have to rely on staff present to get a better sense of what the resident was saying.

At one point while the inspector was meeting this resident, a staff member started talking to the resident about movies. At this point the resident got a DVD of a movie that was present in the multipurpose room and got the staff member to read some of the information on the DVD case. The resident then took the DVD out of the case and said that it was chipped. The staff member told the resident that they would look to see if they could a new copy of this DVD and then left the multipurpose room. The resident then proceeded to talk to the remaining staff member about other movies. The inspector asked the resident what they were doing later with the resident responding "I dunno". The staff member present told the inspector that the

resident would be going for a walk later.

Shortly after this, the inspector left the multipurpose room and went to staff office where a staff member was overheard making a telephone call about the chipped DVD that the resident had mentioned earlier. This resident left the centre during the afternoon of the inspection but had returned by the end of the inspection. The same inspector met this resident again in the company of two staff members with the resident showing the inspector a new DVD of the movie they had highlighted earlier in the day to replace the chipped DVD. One of the staff members present told the inspector that the resident had bought this DVD while away from the centre and had also go for a walk in a park.

The residents met during inspection appeared comfortable in the presence of staff on duty with such staff overheard and observed to be pleasant when engaging with residents. The premises where resident lived was also observed during the course of this inspection. This premises was seen to be well-presented in some aspects. For example, resident bedrooms were seen to be brightly decorated and personalised. However, a number of concerns were identified with the premises relating to its layout, drainage, ventilation and fire safety systems provided amongst others. Such matters prompted urgent actions to be issued to the provider and are discussed in greater detail elsewhere in this report.

In summary, all three residents living in this centre were met during this inspection with two of these residents leaving the centre for part of the day. The residents met appeared comfortable with the staff members present. Such staff helped one resident to replace a DVD that had been chipped.

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

Capacity and capability

Despite being already identified during the December 2024 inspection, the centre continued to be operating outside of a condition of registration. Significant concerns were identified during this inspections relating to the governance, resourcing, premises quality and fire safety precautions of this centre. These concerns lead to urgent actions being issued to the provider.

This designated centre was first registered as a designated centre in May 2024 with three permissive registration conditions with its registered provider being Barróg Healthcare Limited. As registered provider, Barróg Healthcare Limited), bears ultimate responsibility for compliance with the Health Act 2007, relevant regulations, standards and the centre's conditions of registration. The centre received its first inspection in December 2024. While evidence of some good supports to residents

were found during that inspection, regulatory actions were identified regarding the premises provided and aspects of fire safety. It was also apparent during that inspection that the actual layout of the premises was different to the floor plans that the centre had first been registered against as part of one of its permissive registration conditions. As a result the registered provider had not complied with relevant regulations nor a condition of registration at the time of that inspection.

Since then the provider submitted a compliance plan response outlining the actions it would take to come back into compliance. This included a commitment to submit an application to vary its conditions of registration by 25 March 2025 in order to address the difference in premises layout noted. This application had not been submitted meaning that this centre continued to be operating outside of a condition of registration. In addition, some information of concern was submitted to the Chief Inspector of Social Services which raised significant concerns around the governance, resourcing, premises quality and fire safety precautions of this centre. The current inspection was conducted to assess these matters and, overall, it was found that the concerns raised were founded. This contributed to urgent actions being issued to the provider for Regulation 17 Premises, Regulation 23 Governance and management, Regulation 26 Risk management procedures and Regulation 28 Fire precautions. The responses submitted by Barróg Healthcare Limited to these urgent actions will be discussed further below under the relevant regulations.

Aside from such concerns, during this inspection inspectors were informed that this centre was provided with a weekly amount of €345 from Barróg Healthcare Limited every Wednesday This weekly amount was intended to cover food for residents and staff, cleaning supplies, administration costs, art and craft materials and activities for residents. Given that the centre was home to three residents who could be supported by up to 10 members of staff each day, it was indicated to inspectors that making the €345 last seven days could be tight. For example, an inspector was informed that the day before this inspection (which took place on a Wednesday), the balance of money available for the centre was down to €0.23. As a result, when the €345 was provided on a Wednesday, its use was prioritised for food shopping. Inspectors was informed though that requests for additional money could be made to Barróg Healthcare Limited and no staff member provided any example of when a request for such additional money had been refused. It was highlighted though that multiple requests had to be made before additional money for residents to attend a St Patrick's Day event was provided.

Registration Regulation 8 (1)

During the previous inspection of this centre in December 2024 it was identified that this centre was not being operated in accordance with one condition of its registration as the premises layout of the centre at that time did not match the floor plans that the centre was registered against. While the provider had previously indicated that it would submit an application to vary its conditions of registration by 25 March 2025 to address this issue, this had not happened. As such, at the time of

this inspection, Barróg Healthcare Limited continued to be operating this centre outside a condition of its registration.

Judgment: Not compliant

Regulation 15: Staffing

Based on discussions with staff members and management during this inspection, along with staff rotas reviewed for 2025 and observations during this inspection, high levels of staff were present in this centre. It was highlighted that such staff levels were maintained to support the needs of residents living in the centre. Inspectors were also informed that in recent months, a reliance on agency staff (staff sourced from a body external to the provider), had decreased. This was directly contributed to by more staff working in the centre who were directly employed by Barróg Healthcare Limited. This was positive as it promoted a greater continuity of staff support for residents.

Judgment: Compliant

Regulation 23: Governance and management

Under this regulation the provider was required to submit an urgent compliance plan to address an urgent risk. The provider's response did not provide assurance that the risk was adequately addressed.

The registered is explicitly required to ensure that management systems are in operation to ensure that the services provided in a designated centre are safe. The registered provider must also ensure that that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the centre's statement of purpose. The statement of purpose, alongside the floor plans, forms the basis for a condition of registration. As discussed further elsewhere in this report, Barróg Healthcare Limited was previously found to operating this centre outside of this condition of registration in the context of its floor plans. This remained the case on this inspection. Additionally, on the current inspection, there was clear evidence that the registered provider was not providing the services in manner which was consistent with the statement of purpose that the centre was registered against. These concerns related primarily to the premises provided and the fire safety systems contained within which are discussed further under relevant regulations. The nature of these findings raised significant concerns around the management systems and resourcing of the centre by Barróg Healthcare Limited.

The statement of purpose which the centre was registered against made a number of clear commitments regarding the services to be provided to residents in the

centre. These included:

- The layout of the premises promoting residents' safety, dignity, independence and wellbeing.
- The accommodation provided being safe.
- Facilities being serviced and maintained.
- The environment of the centre affording residents an opportunity to be alone.

While this inspection did find evidence that residents were being well-supported in some areas, the inspection's findings relating to the premises and the fire safety systems, as discussed elsewhere in this report, demonstrated that Barróg Healthcare Limited's stated commitments as outlined above were not being met.

Based on documentation reviewed and discussions with management of the centre, the findings of the current inspection, were known to the provider including those in senior management positions. Despite this, timely and satisfactory actions had not been taken to address such concerns by the time this inspection took place. This was evidenced by the following:

- A fire risk assessment was conducted for the centre in July 2024 by an external suitably qualified competent person while premises works were ongoing in the centre. This assessment raised high concerns around the provision of fire safety in the centre with a number of recommended actions made. These recommendations covered areas such as ensuring fire doors of a sufficient standard were in place, installing additional external emergency lighting and arranging specific testing of certain facilities in the premises provided. It was notable that the July 2024 fire risk assessment found that there was limited evidence of contractors employed by Barróg Healthcare Limited being assessed for competence. During the current inspection, it was indicated that a number of recommended actions had not been completed.
- The previous inspection of this centre in December 2024 on behalf of the Chief Inspector highlighted some regulatory actions related to the premises provided and the fire safety provisions in place. This included an action related to the standard of a fire door leading to a laundry area in a resident's living space. While the provider had replaced this door since then, it was apparent on the current inspection that the replacement door and its installation was not of a sufficient standard.
- A further fire risk assessment conducted for the centre in February 2025 (by the same external suitably qualified competent person) raised significant concerns around the provision of fire safety in the centre with a higher number of recommended actions made. It was particular concerning that this fire risk assessment determined that the risk to life from fire was "Intolerable" with some of the recommended actions being similar to those raised by the July 2024 fire risk assessment. These included concerns around fire doors, the installation of external emergency lighting and arranging specific testing of certain facilities. This February 2025 fire risk assessment, which was carried out after previous premises works had been completed, again highlighted that there was limited evidence of contractors employed by Barróg Healthcare Limited being assessed for competence. Accordingly the

fire risk assessment stated that "The premises was in poor condition following alterations that have been carried out to a poor standards [sic], using inappropriate materials".

On the current inspection, it was highlighted to inspectors that the premises works and fire safety works completed in the centre had been arranged by Barróg Healthcare Limited. It was also highlighted that the vast majority of recommended actions from the February 2025 fire risk assessment had not been followed up. This was despite a number of these actions being classed as a high priority actions. One action that had been followed up related to addressing electrical defects and while some works had been completed in this regard, local management of the centre raised concerns around the quality of this work. Inspectors were informed that the electrical works that had been carried out had been arranged by Barróg Healthcare Limited.

The concerns relating to the premises provided and the fire safety systems were discussed with management of the centre and management of Barróg Healthcare Limited on the day of this inspection. It was notable that some varying information was provided during the course of these discussions. For example, one of those spoken with indicated that there was no plan to address the premises and fire safety issues raised while another stated that there was a plan. However, such management were consistent in being unable to indicate when remedial works to address the issues raised would take place while no documentary evidence of a plan to address these issues was provided during this inspection. This lack of clarity and the nature of the concerns raised on this inspection contributed to the issuing of an urgent under this regulation and three other regulations. The urgent actions issued under this regulation related to the management systems and resourcing of the centre.

In response to the urgent actions issued the provider acknowledged the serious concerns and recognised "a delay in decision-making and inadequate escalation procedures". A commitment was also given to that "Full fire safety upgrade works" were scheduled for completion within 21 days. The response to the urgent actions, which was submitted on 18 April 2025, also indicated that a new maintenance officer was being introduced into the provider (during the inspection it was indicated that Barróg Healthcare Limited did not have a maintenance department). It further stated that future contractors engaged by Barróg Healthcare Limited would require evidence of "relevant qualifications, registration, and insurance" and "sign-off by both local and central management". The provider also indicated that a new "Compliance Task Group" had been established to oversee "all remedial works and governance failures". However, it was notable that the response to urgent action did not sufficiently address resourcing of the centre. As such, adequate assurances had not been provided in this area so the the Chief Inspector took the step in setting the time frame by which Barróg Healthcare Limited was to address such issues. This time frame was set at 9 May 2025 which is 21 days after the response to the urgent actions was submitted. This time frame corresponded with the time frame given by the provider for completing fire safety works with the provider having also given a commitment to provide timely updates during this period in the response to the

urgent actions.

Membership of the "Compliance Task Group" would not include some of the existing senior management of Barróg Healthcare Limited. During this inspection it was highlighted that the person in charge, a regional manager (who was also a designated person participating in management for this centre), a quality assurance manager and an assistant director would all be leaving their posts with Barróg Healthcare Limited in the weeks and months following this inspection. An interim plan for the governance of Barróg Healthcare Limited and its designated centres was provided during this inspection. This involved an organisational restructuring which would result in new Heads of Operations, Operations Manager and Quality and Audit Officer roles being created. This plan also indicated that a candidate had been offered the role of person in charge for the centre. In the days following this inspection, a notifications was submitted confirming that the person in charge would be leaving their role at the end of May 2025 but it did not appoint a new person in charge.

Notifying the Chief Inspector of changes in the management of a designated centre is required under relevant regulations. Under Regulation 23 governance and management, the registered provider is required to ensure that an unannounced visit to the centre is conducted every six months. This centre was first registered in May 2024. As such it would have been required that an announced visit had taken place months before the current inspection. Inspectors were informed that the centre had received its first provider unannounced visit, the day before the current inspection. Given the proximity of this visit, a report of this visit was not available on the day of inspection. However, it was subsequently identified that some staff had been informed in advance of this provider visit. This compromised the required unannounced nature of such a visit. As such, the provider had not ensured that an unannounced visit had been carried out in this centre since this centre was first registered.

Judgment: Not compliant

Regulation 3: Statement of purpose

A statement of purpose was provided for this centre. This contained much of the required information such as details of the specific care and supports the centre was intended to meet and the admission criteria. However, it was noted that a copy of a centre's registration certificate contained within the statement of purpose was outdated. It also identified that the stated staffing compliment for the centre in whole-time equivalent was not accurately stated.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

The provider had a system for recording any complaints that had been made. This system was reviewed during this inspection and it was noted that only one complaint had been logged on this since the previous inspection. This complaint had only been made shortly before this inspection took place so the outcome of the complaint was not known on the day of this inspection. Information about the complaints process was seen to be on display in the centre but it was only located in the living area of one of the three residents living in this centre. As such, information about the complaints procedure was not on display in the living areas of the other two residents.

Judgment: Substantially compliant

Quality and safety

A number of issues were identified during this inspection related to the premises provided and fire safety. The nature of such matters raised concerns from a risk management perspective and contributed to urgent actions being issued to the provider in these areas.

The December 2024 had identified issues with the premises layout of the centre such as not all residents having access to a separate kitchen area. The premises layout remained unchanged at the time of this inspection so the same issues remained. However, further premises issues were highlighted during the current inspection relating to the space available for one resident, drainage issues, ventilation issues and the maintenance/testing of some of the facilities and equipment in the centre. Additional concerns were also evident relating to fire safety in the premises and the quality of some previous premises works that had been completed in the centre. Accordingly, urgent actions were issued to the provider related to the premises and fire safety while an urgent action was also issued relating to risk management. Similar issues which prompted the issuing or urgent actions were also identified by the centre's designated officer (person who reviews safeguarding concerns) as being alleged neglect.

Regulation 12: Personal possessions

While facilities were provided for residents to store their personal belongings, such as wardrobes, residents did not have inventory lists of their personal possessions in place on the day of the inspection. This was not consistent with the provider's policy in this area. This policy also identified that if a resident wished for their money to be

managed on their behalf then a written agreement was to be drafted to clearly set out the services and safeguards that would be put in place.

In terms of residents' finances, it was identified that one resident had a bank card in place, however a parent was overseeing the account in terms of bank statement and ensuring money was on the card. No issues were raised with inspectors regarding this resident's access to money. A second resident had their own bank card while the third resident was in the process of setting up their own bank account. This was due to be completed by the end of April 2025.

When reviewing one resident's financial records, it was noted that the resident was recently supported to go to an indoor theme park with the support of staff. The management of the centre informed the inspectors that the resident had paid for entry for staff. The resident's contract for the provision of services was reviewed and this contract did not include such staff costs as part of the fees the resident was to pay.

Judgment: Substantially compliant

Regulation 13: General welfare and development

The residents living in this centre had been supported and encouraged to avail of social, recreational and education opportunities in accordance with their assessed needs and wishes. Two residents had the choice to avail of day services which were provided by external providers. Staff spoken with highlighted that these residents could refuse to attend but that the choice each week was given to both residents. Such staff members also discussed the activities that residents participated in. For example, staff supported residents on day trips (to aquariums and indoor theme parks), to go shopping in the local community, to go swimming and to eat out or get a take away.

Residents were also supported by staff to have goals in place. Resident goals included attending the hairdressers, going bowling, going shopping and developing independent living skills. Some of these goals had been documented as completed with pictures of residents completing their goals. The person in charge informed the inspectors that residents' person-centred planning meetings were scheduled for the week after the inspection. It was indicated that during such meetings, residents' goals would be reviewed with new goals developed if required.

Judgment: Compliant

Regulation 17: Premises

Under this regulation the provider was required to submit an urgent compliance plan to address an urgent risk. The provider's response did provide assurance that the risk was adequately addressed.

During the December 2024 inspection, it was seen that the premises provided for the centre was divided into three individual living areas, one for each of the three residents that lived there. Some regulatory actions were identified with regard to the premises layout of the centre in place at that time. These were:

- Two residents not having access to a separate kitchen area that included suitable and sufficient cooking facilities and kitchen equipment.
- One resident's social, recreational and dining space being located in a converted garage next to the building where the resident's bedroom and bathroom was. This space, while registered as part of the centre, could only be accessed by exiting the building where the resident's bedroom and bathroom were. It was not that if this arrangement was adequate, or if consideration had been given to the risks posed in accessing this space in the event of adverse weather

In response to the December 2024 inspection, the provider indicated that a kitchenette for one resident would be installed by 1 May 2025 and that a risk assessment for the resident accessing the external space was created.

On the current inspection, it was seen that the premises layout present during the December 2024 inspection remained unchanged. As a result, two residents continued not to have access to a separate kitchen area that included suitable and sufficient cooking facilities and kitchen equipment with all food stored and prepared in the centre's one kitchen that was located in the third resident's living area. Inspectors were informed that there was "no possible way" that the 1 May 2025 time frame for installing a new kitchenette would be met. It was also indicated that a risk assessment for the resident accessing the social, recreational and dining space had been completed. This was requested but not provided during this inspection. However, it was highlighted that the resident involved did benefit from having this space available to them given their needs.

Aside from following up on the specific issues raised during the December 2024 inspection, the current inspection identified other issues related to the premises provided for this centre. These included:

- Documentation reviewed, discussions with the person in charge and observations during the inspection highlighted drainage and ventilation issues with some areas of the centre.
- A wooden fence in the rear garden was in a poor state of repair and held upright by pieces of wood.
- One resident required the use of a shower chair due to a diagnosis of epilepsy. However, the shower in their living area in the centre had not been working January 2025. It was highlighted that the resident could use other residents' showers and that their shower chair could be moved there but one staff member indicated that these other showers were not suitable for the

resident. Inspectors were also informed that because their shower was not working, the resident was having their hair washed in their day service.
- Given the layout of the centre, one resident did not have access to a private area to spend their time in aside from their bedroom. Throughout the inspection, it was observed that this resident spent much of their time in the centre's kitchen but staff were constantly seen to be in this area with some of them conducting work tasks during such observations. As such, the living environment provided to the resident was not affording the resident an opportunity to be alone. This was something that was expressly provided for in the centre's statement of purpose.
- The hot tank for the centre being located in a resident's bedroom. When viewing the press where the hot tank was located, it was observed that there was some peeling wallpaper present.

The February 2025 fire risk assessments raised concerns around the quality of previous premises and fire safety works conducted in the centre. This was also was observed during this inspection and is discussed further under Regulation 28 Fire Precautions.

In addition to the above points, a review of electrical installations conducted on 30 January 2025 highlighted that the quality of workmanship for electrics in the centre was poor with notice of potential hazard issued to the provider. As part of this a full rewire was strongly recommended and a high number of electrical issues and defects were highlighted. While it was indicated that electrical work had since taken place in the centre during April 2025, it is unclear if the full rewire strongly recommended had taken place or if all electrical issues highlighted have been adequately addressed. Due to these concerns an urgent action was issued seeking assurances that all electrics in the centre were in proper working order and did not pose a risk to residents and staff. In response the provider indicated that a recommissioning of electrical works was completed on 11 April 2025 and that "All previous deficiencies…were addressed." Such works were not highlighted during the course of the inspection day on 16 April 2025 nor was any documentation about this provided either. In the urgent action the provider also indicated that they would provide the Chief Inspector with a "full report…including certification and verification of all electrical safety standards".

Addressing the electrical issues and defects arising from the review conducted in January 2025 was highlighted as an action in the February 2025 fire risk assessment. The same fire risk assessments also highlighted the following areas related to the premises and its equipment and facilities:

- Testing of portable electrical appliances was to be arranged.
- The centre's oil boiler needed to be inspected.

Similar actions had also been highlighted by the July 2024 fire risk assessment. The July 2024 fire risk assessment also contained an action to arrange an "asbestos containing materials survey" for the centre. During the inspection documentation provided indicated that this action had not been completed with the potential for asbestos to be present in some of the centre's structures referenced in the February

2025 fire risk assessment also. The February 2025 fire risk assessment also recommended that an architect should be engaged before proceeding with any building works in the centre. During the inspection, it was unclear if such an architect had been engaged by Barróg Healthcare Limited although their urgent compliance plan response did indicate that "A qualified and independent engineer has been contracted to conduct a full audit of the premises".

Judgment: Not compliant

Regulation 18: Food and nutrition

Staff completed meal planners with residents each week on a Tuesday. These planners informed the food shopping for the seven days ahead which was carried on Wednesdays (as was observed during this inspection). Residents' meals and food intake was recorded on residents' daily notes with an inspector reviewing a sample of the meal planners and daily notes for two residents. Such records were found to be clear and well recorded. The centre followed a planned list of shopping weekly which included food identified in residents' weekly meal planners. Two residents were being encouraged to eat healthier options due to identified health needs with such options purchased for these residents based on records reviewed.

Judgment: Compliant

Regulation 26: Risk management procedures

Under this regulation the provider was required to submit an urgent compliance plan to address an urgent risk. The provider's response did provide assurance that the risk was adequately addressed.

As referenced earlier in this report, a fire risk assessment was conducted for the centre in July 2024 by an external suitably qualified competent person. This fire risk assessment assessed the risk to life from fire in centre as being "Substantial". A number of recommended actions arising from this assessment were made. A subsequent fire risk assessment conducted in February 2025 assessed the risk to life from fire in the centre as being "Intolerable" and made a higher number of recommendations with some of these actions being recurrent actions from the July 2024 fire risk assessment. Despite some of these action being identified as high priority action, the vast majority of these actions had not been addressed by the time that this inspection took place.

It was also notable that a risk assessment related to fire safety as outlined in the centre's internal risk register had last been reviewed in November 2024. This indicated that the risk from fire was low. This was not consistent with the two fire

risk assessments conducted by the external suitably qualified competent person nor the findings of this inspection. The internal risk assessment related to fire safety referenced control measures to mitigate the risks from fire as including fire signage, fire doors and a fire alarm amongst other. However, as will be discussed further under Regulation 28 Fire precautions, issues had been identified regarding such fire safety measures. Ultimately, based on the contents of the external fire risk assessments and the evidence gathered during the inspection on 16 April 2024, the risk related to fire safety in the centre had increased since July 2024 and the provider had not taken appropriate measures to mitigate the risks identified. This prompted an urgent action to be issued under this regulation.

In response to this it was accepted by the provider that "risk management procedures at Baile Geal Residential Service were insufficient to respond to the increasing fire safety risks identified in both the July 2024 and February 2025 fire risk assessments". However, the same response also appeared to suggest that issues raised by the July 2024 fire risk assessment had been addressed but this was not consistent with neither the February 2025 fire risk assessment nor the findings of this inspection. The provider in their response also highlighted that a new risk escalation protocol had been implemented that provided for risks of certain ratings to be reported directly to the provider within one hour. The response further indicated that a centralised risk register for the centre had been updated to reflect all premises and fire safety risks. While such measures were noted, it remained of a significant concern to the Chief Inspector that the Barróg Healthcare Limited had not adequately responded to the fire safety risks identified in this centre in a timely manner until such issues were highlighted during the inspection process.

Judgment: Not compliant

Regulation 28: Fire precautions

Under this regulation the provider was required to submit an urgent compliance plan to address an urgent risk. The provider's response did provide assurance that the risk was adequately addressed.

A fire risk assessment conducted by an external suitably qualified competent person in February 2025 identified a number of concerns related to the fire safety with a number of actions recommended as a result. The fire safety issues identified during the February 2025 fire risk assessment included:

- Inappropriate material had been used along escape routes and enclosures in the centre. Such materials used did not provide for suitable fire containment as some of these materials when conducting premises works for the centre were "combustible".
- Gaps in ceiling joints and around ducts, cables and pipes were identified which also did not promote fire containment.
- Given the layout of the centre, for one resident to evacuate the centre from

their bedroom, they would have to pass through the centre's kitchen. As the kitchen was regarded as a higher risk room from a fire safety perspective, this was described as "not an acceptable practice".
- Some doors present in the centre were not identifiable as fire door that offered sufficient fire containment. Such doors were highlighted being "not acceptable fire doors". Other issues were also identified with the doors in the centre such as doors not self-closing appropriately into their door frame, excessive gaps between doors and doorframes and intumescent strips and smoke seals having been incorrectly fitted or missing from some doors.
- A sliding door was located between the kitchen and a lobby for a bedroom and a bathroom. This door was highlighted as not being a fire door and "being difficult to open in the event of fire and evacuation".
- An identified fire escape route had been comprised by the addition of an unnecessary door.
- The provision of emergency lighting in the centre was highlighted as "not adequate" with additional external lighting identified as being needed at all emergency exits.
- Additional fire safety signage was needed certain in areas.
- The installation of the fire alarm was identified as requiring confirmation that it met required standards.
- Some evacuation routes and doors were smaller than was required for wheelchair users.

The issues listed above was not an exhaustive list and recommended actions in responses to these issues had been made as part of the February 2025 fire risk assessment. Despite this, inspectors were informed that such recommendations had not been addressed at the time of this inspection. This was also apparent from observations during the inspection. For example, inappropriate fire containment measures was seen in the centre while the layout of the centre was unchanged meaning that if one resident was in their bedroom they would have to evacuate through the kitchen if required. This latter matter had also been explicitly highlighted during the December 2024 inspection. Given the fire safety issues identified, an urgent action was issued to the provider under this regulation. The provider's response, as submitted on 18 April 2025, acknowledged a delay in addressing fire safety concerns and stated that "Full fire safety upgrade works are scheduled for completion within 21 days". A commitment was also given to provide timely updates during this period.

The provider response to the urgent action also outlined some measures to ensure the safety of residents pending completion of fire safety works. These included the presence of three waking night in the centre which was in place based on staff rotas reviewed and discussions with staff during this inspection. An inspector also saw records of daily and weekly fire safety checks that had been completed in the month leading up to this inspection. Each resident had a personal emergency evacuation plan (PEEP) provided also that outlined the supports residents needed to evacuate if required (for example, one resident was identified as needing a wheelchair to evacuate the centre). Such PEEPs had been reviewed in April 2025. Records of three frills conducted since the December 2025 were seen also with these drills done at

varying times with different staff levels.

The fire risk assessments from February 2025 indicated that evacuation from the centre should be achieved during the daytime within 2:30 minutes. The last two fire drills conducted in the centre were in excess of this time frame. One of these was conducted at 5:58pm in February 2025 with an evacuation time recorded of 3:35minutes. The other took place at 9:16pm in March 2025 and had an recorded evacuation time of over 6 minutes. During the December 2024 inspection, a fire drill evacuation of a similar time was also identified. The length of these fire evacuation times were also a concern given the identified fire containment issues in the centre and the size of some evacuation routes and doors.

As such, while the provider's commitment to complete fire safety works and mitigated measures outlined did provide some assurances, taking into account the seriousness of the fire safety issues raised and some stated actions from the December 2024 inspection compliance plan response not being met, the Chief Inspector took the step in setting the time frames by which Barróg Healthcare Limited were to address failings under this regulation. This time frame was set at 9 May 2025 which is 21 days after the response to the urgent actions was submitted. However, as referenced under Regulation 17 Premises, the February 2025 fire risk assessment also recommended that an architect should be engaged before proceeding with any building works in the centre. This included fire safety works but during the inspection, it was unclear if such an architect had been engaged by Barróg Healthcare Limited. This was not directly addressed in the urgent response submitted so it was unclear if an architect would be involved in the fire safety works to be carried out.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

The personal plans of all three residents living in this centre were reviewed by an inspector and it was noted that these plans were informed by assessments of needs. It was seen that the personal plans contained information relevant to supporting residents. This included full personal information, details of residents' likes and dislikes and clear communication profiles. Such communication profiles provided for the use of visual activity planners with such planners seen on display. The healthcare needs of residents had been reflected in residents' personal plans with corresponding support plans in place for such needs. These support plans clearly identified the supports that residents required to manage their healthcare needs.

For example, one resident had cerebral palsy and it had been identified how left sided hemiplegia or weakness that the resident could experience could be supported. Residents also had protocols in place which informed staff on specific supports residents required in areas such as community engagement. Overall, the personal plans reviewed provided assurances that guidance was provided for staff to

support the needs of residents while staff members spoken with demonstrated a good awareness of the supports residents required.

Judgment: Compliant

Regulation 7: Positive behavioural support

Some restrictive practices were in use in the centre with some of these relating to the layout of the centre. Such restrictive practices were reflected in a restrictive practice log for centre and were also identified in residents' individual personal plans. Consent sheets were in place for these restrictive practices which residents had signed with an easy-to-read for each restrictive practice also provided. Documentation reviewed indicated that all restrictive practices had been reviewed in January 2025 and were due for review again in July 2025.

Two residents had positive behaviour support plans in place which are important in providing guidance for staff in supporting residents. At the time of this inspection, the third resident was in the process of being supported to develop a full positive behaviour support plan with an external body. A draft positive behaviour support plan was in place for the staff to follow while the full plan was being developed. Ongoing meetings were taking place with a positive behaviour support specialist to support the development of the full positive behaviour support plan.

The positive behaviour support plans that were in place used a traffic light system with clear guidance on how to support residents. They identified triggers and specific responses to support staff during periods of escalation for residents. Staff spoken with during the inspection were knowledgeable on the residents' positive behaviour support plans. For example, staff spoke about different triggers or signs for residents and how they supported the residents.

The centre's statement of purpose indicated that named training in de-escalation and intervention was mandatory for all staff. Records provided indicated that most staff had completed this training but two staff had not. Inspectors were informed that the staff who had not completed this training were newer members of the staff. The centre's statement of purpose also indicated that additional training in positive behaviour support was offered. Ten staff were not listed as having completed this training. It was indicated to the inspectors that this training was to be delivered by an external body but that a date of such training had not been identified.

Judgment: Substantially compliant

Regulation 8: Protection

Records provided indicated that staff working in this centre had completed relevant safeguarding training. Between 16 December 2024 and 14 April 2025 two matters of a safeguarding nature were notified to the Chief Inspector from this centre. For one of these, a copy of a relevant safeguarding plan related to this matter was provided during the inspection. Discussions with management and notes of a staff meeting provided also indicated that identified actions following this safeguarding matter had been followed up on. However, for the other safeguarding matter, inspectors were informed that there was no copy of a safeguarding plan related to this matter present in the centre.

On 15 April 2025 a further notification of a safeguarding matter was notified to the Chief Inspector by the centre's designated officer. A copy of this notification was subsequently provided during the course of this inspection which indicated that the safeguarding concern related to Barróg Healthcare Limited not addressing matters raised in the February 2025 fire risk assessment which had been completed by an external suitably qualified competent person. The safeguarding notification submitted on 15 April 2025 classed these concerns as alleged neglect which is a type of abuse. The outstanding fire safety issues referenced in the safeguarding notification submitted were clearly evident on this inspection as discussed in further detail elsewhere in this report. As such, inspectors were not assured that the three residents living in this centre had been sufficiently protected from all forms of abuse by Barróg Healthcare Limited.

In addition, following inspectors leaving the centre on 16 April 2025, an incident of a safeguarding nature occurred between two residents. The nature of this incident resulted in one resident sustaining injuries and engaging with an external body. While this type of incident had not occurred previously in the centre, the nature of this incident and the impact on the resident impacted caused concern from a safeguarding perspective.

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 8 (1)	Not compliant
Regulation 15: Staffing	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 12: Personal possessions	Substantially compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Not compliant
Regulation 18: Food and nutrition	Compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Not compliant

Compliance Plan for Baile Geal Residential Service OSV-0008798

Inspection ID: MON-0046843

Date of inspection: 16/04/2025

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**
Registration Regulation 8 (1)	Not Compliant
Outline how you are going to come into compliance with Registration Regulation 8 (1): An application to vary relating to this condition has been submitted to HIQ, including a revised floor plan.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: An urgent compliance plan has been submitted to HIQA outlining all the works that are taking place at the property. All of the fire issues raised in the report will be addressed and works are due to be completed by the end of May 2025. A replacement PIC has been recruited and their information will be uploaded through the HIQA portal on their commencement. A temporary maintenance officer is now in place which has resulted in works being checked to ensure that they are completed to a high standard. Once the works have been completed an unannounced visit will take place by the PPIM. Please see the attached spreadsheet with the position of all works detailed by HIQA in the report. This itemises all of the fire issues and has been completed by the maintenance officer. Whislt we recognise that the deadline imposed by HIQA to complete the works has been missed, additional issues arose during the works which caused delays. In particular the sewage and drainage issues were more significant than anticipated and have taken longer to resolve. By completing everything, including these extra items it means that further disruption to the residents will not be required and the	

property will need the needs of the residnets going forward.

The management of the centre is being overseen by the PIC from another service, who is regularly on site. The Deputy Manager remains in post and is working full time based in the centre. Additional support is also provided by the PPIM and the Registered Provider, who are both on site at least every other week (registered provider one week, PPIM the next). The new PPIM for the centre is due to start on 3rd June, who will be an additional support. The outgoing deputy director has remained in post until 29th May and a new Quality Assurance Manager started on 19th May.

The compliance plan response from the registered provider does not adequately assure the Chief Inspector that the action will result in compliance with the regulations.

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:

A revised statement of purpose has been submitted to HIQA.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:

Complaints information is now displayed in all client areas, this will be rechecked once the works have been completed.

Regulation 12: Personal possessions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 12: Personal possessions:

Inventory lists have been put in place for the residents and these will continue to be reviewed regulary. Staff costs are now being covered by Barrog Healthcare in line with the contract of care and a policy to that effect is being developed by the Policy Group.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:

Significant works have begun at the property, including, heat and light, drainage, ventiliation, fencing, showers, hot water and fire related work. It is expected that these will be complete by the end of May 2025.

All electrical work has been completed with electrical certification in place. A new contractors form has been put in place, ensuring that we have full details of those working in the building.

Please see the attached spreadsheet with the position of all works detailed by HIQA in the report. This itemises all of the fire issues and has been completed by the maintenance officer, providing an up to date record of all works. Whilst we recognise that the deadline imposed by HIQA to complete the works has been missed, additional issues arose during the works which caused delays. By completing everything, including these extra items it means that further disruption to the residents will not be required.

Also attached is an updated floor plan showing the two kitchen areas. One area is shared by two residents and the other is for one resident. The work to the kitchen areas is fully complete, meaning all residents have access to kitchen facilities should they wish to use them.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:

A new process is in place for raising serious risks directly with the registered provider.

A new Quality and Audit Officer has joined the company, they will be completing health and safety reviews of all registered services as part of their work.

Risk management will be discussed with the new PIC as part of their induction.

There was significant learning for the organisation in dealing with this issue, the registered provider is now fully aware of their obligations and the whole organisation is committed to ensuring that this does not happen again. The seriousness of the situation has been understood and the registered provider has met with all relevant parties to reiterate the need for issues to be raised with him as well as to reassure staff and clients of his willingness to undertake required works to ensure the safety of all.

The compliance plan response from the registered provider does not adequately assure the Chief Inspector that the action will result in compliance with the regulations.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:

All fire related works are currently being undertaken and are due to complete by the end of May 2025, this also includes the emergency lighting and the changes to the layout and an architect has been engaged.

Personal evacuation plans will be updated in line with the changes to the building and will be reviewed once works are completed.

A test fire alarm evacuation will take place once works are complete.

A fire alarm evacuation took place on 28th April 2025, this was with 3 residents in situ and the centre was evacuated in 59 seconds. As mentioned above, fire drills will continue to be scheduled on a regular basis to ensure the evacuation time remains under 2 mins 30 seconds.

The compliance plan response from the registered provider does not adequately assure the Chief Inspector that the action will result in compliance with the regulations.

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:

Training in de-escalation has now taken place for all staff bar two, these are both booked on the next available session on 7th July 2025.

Positive behaviour support training has been arranged for staff, to be provided by An Cuan during July, exact date to be confirmed.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:

Safeguarding plans continue to be updated within the centre, contact has been made with the HSE safeguarding team to request copies of forms submitted by staff who have since left. Copies of all safeguarding submissions are already held within the centre, this was simply an extra precaution as the new HSE Safeguarding Portal does not allow for mutlple people from an organisation to view submitted records. We already had a copy of the submitted documents held within the centre but were confirming with the safeguarding team that they do not have any documentation that we were not aware of. The safeguarding team have been informed about the leavers and their portal access has been removed.

All fire related works are currently being completed, removing the safeguarding risk in relation to these.

Once all works are completed with the new layout of the building, the compatibility assessment for the residents will be reviewed.

Please see the attached spreadsheet with the position of all works detailed by HIQA in

the report. This itemises all of the fire issues and has been completed by the maintenance officer. Whilst we recognise that the deadline imposed by HIQA to complete the works has been missed, additional issues arose during the works which caused delays. By completing everything, including these extra items it means that further disruption to the residents will not be required.

Whilst the works have been carried out, the compatablity of the two residents in question has not been an issue as one of these residents has been on holiday for the period of the works. A compatability review meeting for all three residents has been scheduled for 16th June which means that the new PPIM can be in attendance.

The compliance plan response from the registered provider does not adequately assure the Chief Inspector that the action will result in compliance with the regulations.

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 8(1)	A registered provider who wishes to apply under section 52 of the Act for the variation or removal of any condition of registration attached by the chief inspector under section 50 of the Act must make an application in the form determined by the chief inspector.	Not Compliant	Orange	30/05/2025
Regulation 12(1)	The person in charge shall ensure that, as far as reasonably practicable, each resident has access to and retains control of personal property and possessions and, where necessary, support is provided to manage their financial affairs.	Substantially Compliant	Yellow	30/05/2025

Regulation 17(1)(a)	The registered provider shall ensure the premises of the designated centre are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.	Not Compliant	Orange	30/05/2025
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Not Compliant	Orange	20/06/2025
Regulation 17(4)	The registered provider shall ensure that such equipment and facilities as may be required for use by residents and staff shall be provided and maintained in good working order. Equipment and facilities shall be serviced and maintained regularly, and any repairs or replacements shall be carried out as quickly as possible so as to minimise disruption and inconvenience to residents.	Not Compliant	Orange	20/06/2025
Regulation 17(7)	The registered provider shall make provision for	Not Compliant	Orange	20/06/2025

	the matters set out in Schedule 6.			
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.	Not Compliant	Red	09/05/2025
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	31/07/2025
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 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	Not Compliant	Orange	31/07/2025

	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	31/07/2025
Regulation 28(1)	The registered provider shall ensure that effective fire safety management systems are in place.	Not Compliant	Orange	09/05/2025
Regulation 28(2)(a)	The registered provider shall take adequate precautions against the risk of fire in the designated centre, and, in that regard, provide suitable fire fighting equipment, building services, bedding and furnishings.	Not Compliant	Orange	09/05/2025
Regulation 28(2)(b)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Not Compliant	Orange	09/05/2025

Regulation 28(2)(c)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Orange	09/05/2025
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	09/05/2025
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.	Not Compliant	Orange	09/05/2025
Regulation 28(5)	The person in charge shall ensure that the procedures to be followed in the event of fire are displayed in a prominent place and/or are readily available as appropriate in the designated centre.	Substantially Compliant	Yellow	09/05/2025
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose containing the information set out in Schedule 1.	Substantially Compliant	Yellow	30/05/2025
Regulation 34(1)(d)	The registered provider shall provide an effective complaints	Substantially Compliant	Yellow	20/06/2025

	procedure for residents which is in an accessible and age-appropriate format and includes an appeals procedure, and shall display a copy of the complaints procedure in a prominent position in the designated centre.			
Regulation 07(2)	The person in charge shall ensure that staff receive training in the management of behaviour that is challenging including de-escalation and intervention techniques.	Substantially Compliant	Yellow	31/07/2025
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	20/06/2025