



# Report of an inspection of a Designated Centre for Disabilities (Adults).

## Issued by the Chief Inspector

Name of designated centre:	Avondale
Name of provider:	St John of God Community Services CLG
Address of centre:	Co. Dublin
Type of inspection:	Unannounced
Date of inspection:	25 February 2026
Centre ID:	OSV-0008930
Fieldwork ID:	MON-0049743

## About the designated centre

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

Avondale is a designated centre operated by St. John of God Community Services CLG. This designated centre consists of two houses which is registered to accommodate nine residents with an intellectual disability. The houses are situated in an area in Dublin that is near to local shops, public transport, the church and chemist and local amenities such as walks, pubs, restaurants, cinema and swimming. The centre provides a service to residents 24 hours a day and seven days a week. Residents in this centre require low to medium supports which is determined and supported by their personal plans. On the ground floor in one house there is a dining areas, sitting room, kitchen, laundry area, an accessible shower facility and toilet. Upstairs there is a resident's bedroom, a sitting room, dining room and shower facilities. There is a staff sleepover room upstairs and staff office downstairs. In the other house, the ground floor there is resident's bedroom, office, kitchen, living room, storage room, a conservatory sitting room and assessible toilet and shower facility. On the first floor there are four bedrooms, a toilet and shower facility and a separate shower facility. The person in charge of the designated centre is also responsible for two other centres. The person in charge is currently supported by a team of social care workers.

**The following information outlines some additional data on this centre.**

Number of residents on the date of inspection:	6
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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 25 February 2026	09:20hrs to 19:00hrs	Jacqueline Joynt	Lead

## What residents told us and what inspectors observed

This unannounced inspection was carried out as part of the regulatory monitoring of the centre. It particularly focused on how the provider safeguarded residents from abuse, promoted their human rights, and empowered them to exercise choice and have control in their lives.

The inspector used observations, conversations with the person in charge, the person participating in management and staff members as well as engagements and conversations with residents, and a review of documentation, to form judgments on compliance with the regulations inspected.

Overall, the inspector found that person in charge and staff team were striving to provide good care and support to residents. However, poor oversight of the centre had resulted in a number of deficits being identified on the day and overall, was impacting negatively on the lived experience of residents.

The inspector observed poor infection prevention and control practices and measures (in one house), unsatisfactory record keeping regarding residents care and support needs, poor follow up and review of two safeguarding incidents, untimely response to residents' complaints and restrictive practices that were not processed in line with best practice or the provider's own policy. These deficits are discussed in detail in the next two sections of the report.

The centre was made up of two houses that were approximately five minutes' drive away from each other. The designated centre is currently registered for seven residents. In January 2026 the provider submitted an application to vary, which was almost at completion, to change the layout of rooms in one house and increase the numbers of beds by two.

On the day of the inspection there were six residents living in the designated centre. The inspector was provided the opportunity to meet all six residents during the inspection.

On arriving at the first house of the designated centre, a resident opened the door to the inspector. They advised the inspector that there were no staff in the house and that they were on their own. The inspector, introduced themselves to the resident and showed their ID to them, however did not enter the house. The resident appeared a little nervous. They said that the staff member was dropping other residents to day service and would be back shortly. The inspector informed the resident that they would call the manager and wait for their arrival before entering the house.

As the inspection was unannounced, the inspector provided the person in charge with a 'nice to meet you' document to give to the residents in advance of meeting

the inspector. The document included easy-to-read information about the inspector, why they were visiting the residents' home and overall, what the inspection entailed. This document was in place to support residents understand the inspection process but also to ease any anxieties residents may have about unexpected visitors in their home.

Residents were supported to engage in their community in a way that was meaningful to them and supported their interests. In one house four of the five residents were attending day service. On the day, one resident stayed at home, as it was their preference to not attend day service on Wednesdays. The resident had made plans to meet a family friend for coffee and later in the afternoon to go the hairdressers. In the other house, the resident also attended day service and on the evening of the inspection, went out with their staff to a local fast food restaurant.

The inspector carried out an observational walk around of both houses in the designated centre. One of the houses consisted of a kitchen and dining area that led out on to a decking. As the decking was unsafe to walk on, there was no access from the kitchen double doors to this area. The kitchen was observed to be clean and tidy and to the back of the kitchen there was an accessible toilet and shower facility. The rest of the ground floor consisted of a staff office, sitting room and an additional dining space. The rooms contain a number of pieces of old furniture and equipment that belonged to a resident who had moved out of the house in October 2025. The inspector was informed that the maintenance team was due to pick it up. In the upstairs section of the house, there was a resident's bedroom. There was also a bathroom and toilet facility and a room used as a living and dining space, a sitting room and a staff sleep over room.

The other house had underwent a major renovation during 2025. The works were to support the aging and accessibility needs of residents living in the house. The residents had temporary relocated to other designated centre's run by the provider in July 2025. The residents had been consulted about transitioning to alternative accommodation and rehabilitation facilities and were all provided with accessible formats of individualised transition plans. In addition, residents were supported to visit the alternative accommodations in advance of moving into them. The works had taken longer than expected and residents had just returned to their home mid-December 2025.

The house consisted of a sitting room and conservatory, kitchen and two shower and toilet facilities. There were five residents' bedrooms, four of which were located upstairs. The two shower facilities, one upstairs and one downstairs included a number of mobility aids to support residents with their assessed physical and personal care needs. There was also a small office and storage room for records in the downstairs section of the house. Out the back of the house there was a small garden. Due to recent storm damage a large tree had fallen and was laying across most of the garden area. The person in charge said that they were waiting for the maintenance team to remove it.

The front porch and hallway which led into the house and had been part of the refurbishments, provided an accessible, bright and welcome space on entering the

residents home. There were a number of green plants in pots and a new console table, which residents had picked out for the area.

The refurbishment works supported a resident enjoy an accessible bedroom as well as the use of a downstairs toilet and shower facility. Overall, this had resulted in positive outcomes for the resident and improved their lived experience in their home as well as promoting their independence, dignity and privacy.

Despite the recent refurbishment, the inspector observed that a number of rooms in the house were unclean and in poor upkeep and repair, including some of the facilities. This situation posed a potential infection and control (IPC) risk to residents and staff. This is discussed further under Regulation 17.

On walking around both houses the inspector saw that residents bedrooms were in line with their likes and preferences and contained items and memorabilia that were important to them. All bedrooms were observed to be clean and tidy and provided a suitable space for residents to relax and sleep in. Some residents advised the inspector that they had chosen the colour for their newly painted bedrooms. Residents had been supported to buy new beds and bedding for their room. One resident told the inspector that they were waiting for the maintenance team to hang a number of their pictures and posters back up on their walls. Overall, residents spoke positively about their bedrooms and appeared happy and relaxed when in them.

Since returning to their home in December 2025, there had been an emergency evacuation due to an electrical fault resulting in no electricity for three days. Residents either went home for a few days or to another residential service. In the morning, one resident expressed their unhappiness at having to move to another centre during this period, they said they would of preferred to go to a hotel. They said they and their peers raised a complaint but had heard nothing since. They also said they had complained about the staff printer in the residents' sitting room.

Later in evening when the inspector returned to the house to meet the four other residents, one other resident mentioned the complaint and said they were very glad to be back in their own house again. Two residents expressed their unhappiness that no works had been completed on the conservatory (that was attached to the sitting room) and said it would have been nice to have a room where all five residents could eat together. They also expressed their concerns about the fallen tree in the back garden.

One of the residents who came into the sitting room after enjoying a video-call with their family, gave the inspector a thumbs up when asked about the refurbishment of their home. In particular, the resident seemed happy to have an accessibly toilet and shower facility.

The inspector also met with two other residents who were spending some time relaxing in their own bedrooms. Both residents were working on knitting projects, one resident was knitting a scarf for themselves and the other resident told the inspector they were knitting the scarf for their favourite musician. One residents said

they liked who they lived with. Residents said they were happy with their freshly painted rooms and comfortable new beds.

In the other house, the inspector met the resident when they returned from their day service. They seemed happy to meet the inspector and also appeared upbeat and happy to see the person in charge and person participating in management in their home. The staff member supporting the resident was familiar with the residents' needs, likes and preferences and the resident appeared comfortable in their company. The resident was heading out to a fast food restaurant for the evening with their staff. The resident seemed happy about this choice of activity and informed the inspector what they were planning on eating.

As of the day of the inspection, there were initial plans in place for a new resident to be admitted to this house. A compatibility assessment had yet to be completed however, the familiarisation stage of the admission process, was almost complete. The potential new resident had visited the house on a few occasions. They had met with the resident living in the house. The person in charge had arranged for the residents to meet in the community in an informal way. There was a plan in place for the resident to visit the house for a meal. The person in charge was ensuring that this process was going at the pace that best met both residents assessed needs and likes and overall ensured their safety.

Residents were provided with weekly house meetings where the agenda included topics such as menu alternatives, opportunities in the community, weekend activities and service news and developments. Residents were also supported to learn about the complaints procedure, as part of the meetings. On review of the minutes of residents household meeting on 03 February 2026, the inspector saw that residents had voiced a complaint about having to move to other designated centres when there was no electricity for three days. There was no further meeting minutes to demonstrate how the complaint had been addressed or followed up with residents.

Overall, the inspector observed that the residents seemed relaxed and happy in the company of staff and that staff engaged with residents through positive and caring interactions. On observing residents interacting and engaging with staff using different styles of communication, it was obvious that staff interpreted what was being communicated.

Families played an important part in the residents' lives and the person in charge and staff acknowledged and supported these relationships and in particular, made strong efforts to facilitate and enable residents to keep regular contact with their families.

In summary, the inspector found that the person in charge was striving to ensure each resident's wellbeing and welfare was maintained to a good standard however, due to poor oversight systems in the centre, which had resulted in a number of deficits found on the inspection, the provider could not be assured that, at all times, safeguarding system in place were adequate, residents rights were promoted and residents were empowered to exercise choice and have control in their lives.

These are discussed further in the next two sections of the report which 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 to each resident living in the centre.

## Capacity and capability

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

The provider had failed to implement adequate management systems that were effective in providing oversight of risks in the service and as such had not ensured that residents were safeguarded and in receipt of a good quality and person-centered service at all times.

The current management structure in place was not ensuring that staff were aware of their roles and responsibilities in relation to the day-to-day running of the centre. The person in charge was responsible for three designated centres. The inspector found that the provider had not ensured adequate resources were in place to support the person in charge in their role. There was one social care leader vacancy in the centre which overall, was impacting on the monitoring and oversight systems in place in the centre.

Staff were provided training in safeguarding to enable them provide a safe service and support to residents. However, where there had been a safeguarding incident there was no record of shared learning at team meetings to support staff to better understand their roles and responsibilities in reducing the risk of harm while promoting the rights, health, wellbeing and quality of life of residents. Systems in place to ensure that staff were provided supervision to support them in their practice was not in line with the frequency of the centre's supervision schedule in place.

The governance and management systems in place had not ensured good safeguarding practice in the centre. Not all safeguarding incidents had been followed up appropriately or in line with best practice. The documentation to guide and support staff implement interim safeguarding measures was found to be inadequate.

The provider had ensured that there was a complaints policy and procedure in place in the organisation however, the effectiveness of the procedures was not assured. Where residents had made a complaint there was no record of a response or follow-up.

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

## Regulation 15: Staffing

The provider was endeavouring to ensure that staffing arrangements in the centre included enough staff to meet the needs of residents and were in line with the statement of purpose. In one house, to support residents enjoy activities in the community and attend appointments, the provider had ensured a number of 'double cover' shifts were in place. This meant that one staff member could support residents in their home while another staff could support residents in the community.

Each of the houses provided a photograph format of the weekly staff roster. This was in place so residents could see who was working with them each day and evening. For one resident in one of the houses, this system was important to them and reduced any potential anxieties they had about staff working with them and in particular, sleepover staff.

On the day of the inspection, there was one social care leader vacancy since the end of January 2026. The provider was currently recruiting for this role. The social care leader role was an integral part of the governance and management structure of the centre and the vacancy was having significant impact on the provision of oversight in the centre. This is addressed in full under Regulation 23.

A social care worker was leaving at the end of the week however, another social care worker had been recruited and was due to commence their induction the following week. Where relief staff were needed to cover various staff leave, the person in charge was striving to ensure residents were provided continuity of care. For example, the inspector saw from a sample of rosters that the same 2 -3 relief staff were employed on a regular basis.

On review of the sample of rosters from January to February 2026. For the most part, the inspector found that they were maintained appropriately. However, some areas for improvement were identified. For example; two relief staff members' names were not included in full on the February 2026 roster.

The person in charge was responsible for three designated centre and their whole time equivalent (WTE) hours were spread 0.33 per designated centre. However, their 0.33 WTE hours had not been reflected accurately on the designated centre's January and February roster. As such, the provider could not be assured of the level of on-site oversight in the centre during this period.

A review of the oversight systems in place for staff rosters was also needed. The person in charge advised the inspector that a staff member was supporting them with one of the house's rosters. On the day of the inspection, the roster showed that

one of the staff members working in one house had also been allocated to work in the other house the next day. This error was identified when the roster was being shown to the inspector and meant that another staff needed to be allocated at short notice.

Judgment: Substantially compliant

### Regulation 16: Training and staff development

There was a training matrix in place for all staff working in the centre. On review of the matrix, the inspector found that staff had been provided with the organisation's mandatory training and that overall, staff training was up-to-date. There was a colour coded system in place that notified the person in charge and staff when their training was due to be refreshed.

Staff were provided training related to safeguarding vulnerable adults, Triple C communication systems, fire safety, safe administration of medication, positive behaviour supports, crisis management intervention and infection prevention and control.

In line with the provider's policy, staff were provided a professional development review once a year which was followed by a one to one supervision meeting. On review of one staff member's meeting minutes, the inspector saw that topics such as safeguarding, health and safety, key working updates, documentation, policy and procedures and training were discussed. Overall, these meetings were in place to support staff perform their duties to the best of their ability.

However, the inspector saw that the schedule for 2025 had not been adhered to and a number of these meetings were outstanding for staff. In one house, two staff were due performance development reviews in January and February 2026.

In addition, while the person in charge was able to show the inspector a sample of minutes from one to one supervision meetings for staff in one house, they were unable to find copies of minutes of these meetings for staff working in the other house. As such, the provider could not be assured that staff in that house were provided with appropriate supervision to support them to perform their duties to the best of their ability.

Judgment: Substantially compliant

### Regulation 23: Governance and management

The governance and management systems in place did not ensure that the services approach to safeguarding was appropriate, consistent or effectively monitored. The

current management structure in the centre was not adequate and was impacting on the effectiveness of driving quality improvement for residents living in the centre. This situation was resulting in poor outcomes for residents living in the centre and not ensuring their safety at all times.

The management structure was not in line with the statement of purpose and this was due to the current vacancy for a social care leader. The person in charge was responsible for three centres which included six houses. For two of the centres, the person in charge was supported by a full-time social care leader, however, there was no social care leader support in place for this centre. This staffing deficit impacted on a number of the local governance and management oversight systems in place and overall, resulted in a number of non-compliant Regulations.

In addition, due to the levels of responsibility required for three designated centres, the inspector was not assured that the person in charge had the capacity to manage all three centres to ensure the effective governance, operational management and administration of this centre.

The inspector found that there were no adequate records in place to demonstrate management on-site presence in the designated centre. The times the person in charge was present in the centre was not accurately reflected on the centre's roster. The person in charge informed the inspector that they visited the centre once a week for a few hours however, would not always get the opportunity to observe the house in full or review documentation during that visit.

In one of the houses within the centre, there was little evidence to demonstrate oversight over a number of the local monitoring systems in place. For example; there had been poor oversight of residents' personal plans which had resulted in a number of gaps throughout the plans. There was no audit or review completed of residents' personal plan during the latter half of 2025. On review of three residents' plans, the inspector found that the section at the back of residents, 'All about me', assessment of needs document, which required review by management, was blank, with no other evidence of review or oversight.

The inspector observed two annual reviews of the quality and care and support provided to residents during 2024 when the houses were previously attached to another centre. Deficits relating to the record keeping and documentation within residents' personal plans had been raised on both. On review of the centre's current quality enhancement plan, actions for these deficits were due to be completed in July 2025. However, as of the day of the inspection this action remained outstanding.

There was poor oversight of the effectiveness of the day to day infection prevention and control measures. One of the houses was observed to be unclean in a number of areas. In an upstairs bathroom, stains on the sanitary bin and mirror demonstrated they had not been cleaned for a period of time.

In the same house, the inspector observed a number of gaps in the staff daily and evening duty checklist. For example; during the month of February 2026, there were eight dates where the checklist had not been completed. This checklist was in place

to ensure the safety of residents and well as the smooth day to day running of the centre. For example, some of the items on the daily duty checklist included, handing over information to on-coming staff related to the care and support of residents. It also included reading the diary for updates, checking cash and petty cash, means and routes of escape, fire alarm panel, telephone messages, medication administered and cleaning lists for residents' bedrooms. In addition to the gaps, there was no sign-off or evidence of oversight by management, on any of the daily or evening duty checklists reviewed.

The centre's emergency plan had been put into action on 28th of January 2026 when residents in one house had be evacuated for three days due to an electrical fault resulting in no electricity in the house. Part of the emergency plan procedures included a post-incident review to assess the effectiveness of the plan and to share learning. However, as of the day of the inspection, there was no planned date in place for a critical review of the incident to take place.

Three residents had logged a compliant on the 3rd of February regarding the emergency plan and in particular, their upset at the locations they were transitioned to over the three day period. However, the compliant had not yet been logged and there no record of management follow-up on the complaint.

The provider had not been effective in ensuring all restrictive practices were followed up in line with the organisation's policy and procedures. One six monthly unannounced review had identified a rights' restriction however, this had not been followed up in timely manner or reported to the Office of the Chief Inspector of Social Services (Chief Inspector) as required. In addition, on the day, the inspector identified another restrictive practice, relating to residents' money management, which had not been identified or processed as a restrictive practice.

On review of two safeguarding incidents during 2025, the inspector found that the provider had poor oversight of the actions to mitigate the risk of recurrence. There had been no review of an interim safeguarding plan and there was inadequate documentation contained within the residents' personal plan to demonstrate the effectiveness of the plan and if risks associated with the incident had been mitigated.

The inspector found that overall, the above deficits in the local governance and management systems meant that the provider could not be assured of the effectiveness or consistency of systems in place to keep residents' safe at all times.

Judgment: Not compliant

## Quality and safety

This section of the report details the quality and safety of the service for residents who lived in the designated centre. The inspector found that the provider had failed to ensure that a safe and quality service was delivered to residents at all times.

Overall, the inspector found that many of the principles outlined in the National Standards for Adult Safeguarding were not promoted in the service to ensure resident were receiving a service that promoted and upheld their rights and kept them safeguarded. Improvements were needed to the areas of premises, individual assessment and personal plan, risk management, protection and rights.

There had been a lot of improvement to one of the houses in the designated centre in terms of upkeep and accessibility. However, systems in place to ensure the cleanliness and upkeep and repair of all areas of the house were not effective at all times and overall, were impacting on the safety of residents in terms of IPC.

Documentation associated with the care and support of residents was found to be poor and overall, not effective in providing up-to-date guidance or information to staff when supporting residents.

There was poor record keeping and evidence of follow up after a safeguarding incident which meant that measures in place to reduce the risk of recurrence could not be effective at all times.

Risk assessments and associated measures required review. This was to insure that they were up-to-date, related to the centre the residents were living in and measures were still relevant.

While there were systems in place to promote resident's rights, as well as empowering residents to be knowledgeable and aware of their rights, the systems were not effective at all times and were resulting in negative outcomes for residents.

## Regulation 10: Communication

Overall, the inspector found that residents received information in a way that they understood. Information was provided to residents verbally as well as easy-to-read format, pictures, photographs and social stories.

In each house there were notice boards that included information that was relevant and important to residents. For example, there was easy-to-read weekly meal plans that included meal choice from residents. There was photographic weekly staff rosters for day and night time, to ensure residents knew what staff were supporting them during the day, evening and overnight. For some residents, this information helped with reducing their anxieties by letting them know and see what staff would be working with them during the week.

Residents were supported to participate in household meetings about matters that were important to them. In line with some residents assessed communication needs, visuals were used to support them make choices and also as a guide for staff to engage with residents in a way the resident understood.

In one house, the inspector saw that there was a poster of the designated officer as well as an easy-to-read complaints procedure's poster. This ensured, in so far as practical, that the resident knew who to speak to if they wanted to make a complaint or had a concern. Where residents communicated a complaint at their most recent household meeting, which was awaiting a response, this has been addressed in detail under Regulation 9.

A communication assessment using the Triple C format had taken place for each resident in the designated centre. The outcome of the assessments informed the support plan required for residents. The plan guided staff on how to best understand and communicate with residents in line with the outcome of the assessments' symbolic established level.

The inspector saw an example of one resident's accessible format of a personal communication passport.. The document, which was all about the resident, was in place to support staff get to know the resident, there likes and dislikes and in particular, how they like to communicate.

Overall, the inspector found that there were good systems in place to support residents communicate and be communicated with in a format that was in line with their assessed needs.

Judgment: Compliant

## Regulation 17: Premises

The provider had arranged for major refurbishment works to be completed to one of the houses in the designated centre. This was to meet the changing needs of residents in terms of age and accessibility. The residents had temporarily relocated to other designated centre's run by the provider. The residents had been consulted about transitioning to alternative accommodation and were all provided with accessible formats of individualised transition plans. In addition, residents were supported to visit the alternative accommodations in advance of moving into them. On review of some of the documented discussions with residents, the inspector saw that residents were happy to move to their new locations and were happy with who they were going to temporarily live with.

Through observations and from speaking with the person in charge, the inspector saw that part of the refurbishments included flooring installed in the hall, kitchen, sitting room and residents' bedrooms. The house ensured that a resident with assessed mobility needs was provided their own bedroom downstairs with an accessible shower and toilet facility across the hall from their bedroom. The whole

house was painted included each resident's bedroom. Residents were provided with a new bed which they were supported to choose themselves. Residents were also supported to pick out the colour of the walls as well as soft furnishing for their room. The changes to the house provided a bright, clean and spacious new environment to many of the areas in the house.

However, there were a number of areas and facilities in the house that remained in poor upkeep and repair that had not been part of the refurbishment works. Overall, the state of repair was impacting on the effectiveness of infection prevention and control measures in place and meant there was a potential risk of spread of healthcare-associated infection to residents and staff.

For example, a conservatory room that extended out from the residents' sitting room was observed to have a lot of mould on the floor, wall and ceiling, the room was observed to be cold and found to have with a damp odour. The inspector observed old phones, wiring and internet boxes lying on the floor in the corner of the room waiting to be cleared. Some of the blinds in the room were hanging down on one side and there was a disused old seat, observed to have stains and marks on it, that also required moving.

In addition, the same house was observed to be unclean in some areas and in particular, the upstairs toilet and shower facility, the stairs and sitting room floor. The bathroom was observed to have mould and in-grained grime on the tiles on the floor, the shower base and door. The inspector observed the sink mirror to be unclean with white scuff marks on it and the sanitary bin under the sink was observed as unclean with stains. Furthermore, the paper towel and toilet roll holders were empty. While there was a system in place, in line with a residents' needs, to rotate hand towels, there was no towel in place at the time. There was one toilet roll out loose in the bathroom however, this was observed to be soiled and presented a serious health-associated infection risk to residents and staff. On the day, when staff went to replace the toilet roll, it was identified that there was no stock of toilet roll in the centre.

The new accessible shower and toilet facility was available to all residents and staff however, the inspector observed that while there was a removable accessible toilet chair over the bowel, there was no toilet seat in place once the chair was removed. In addition, there was no toilet lid in place.

Some other items required upkeep such as the sitting room coffee table that was chipped and stained. The ceramic on the kitchen kettle was badly peeling and there were gaps in the grout between the cooker top and tiles leaving it difficult to keep clean.

The front of the house was observed to be unkempt with papers and plastic lying outside the front door. To the back of the house, a large tree had been cut down due to storm damage and was awaiting removal.

Judgment: Not compliant

## Regulation 26: Risk management procedures

For the most part, where there were identified risks in the centre, the person in charge ensured appropriate control measures were in place to reduce or mitigate any potential risks.

For example, there were a range of risk assessments with appropriate control measures, that were specific to residents' individual health, safety and personal support needs. There were also centre-related risk assessments completed with appropriate control measures in place.

However, some improvements were needed. Two examples are listed below;

Since the last inspection of the centre in August 2025, the inspector had identified that the provider's risk management system was unable to update the the correct designated centre's name on risk assessments associated with centre and residents. However, as of the day of this inspection, this issue had not yet been rectified and remained outstanding. This meant that risks associated with both houses were inaccurately referred to under the previous designated centres each house had been associated with. This posed a risk to residents as some risks may be missed as they were not assigned to the correct centre.

On review of a resident's risk assessment regarding them being alone in their home without staff, the inspector saw that it had been first developed and implemented in 2021. Many of the measures to mitigate the risks had been put in place in 2021. For example, 'stranger danger' training, staff to call the resident every hour when they were alone, and for the resident not to answer the door or to be left alone if they have had an absent seizure that day. The most recent review of the risk assessment had been completed in 2022. Overall, the timeliness to review the risk assessment was not satisfactory and meant that the provider could not be assured of the effectiveness of the measures in keeping the resident safe from any potential harm.

Judgment: Substantially compliant

## Regulation 5: Individual assessment and personal plan

Overall, residents' personal plans were found to be in poor order and very difficult to navigate. There was poor oversight of personal plans at management level. There was information found within residents plans that was duplicated and out of date. This situation meant that the systems in place to support staff access the plans and guidance related to the care and support needs of residents was not effective and posed a risk of residents current assessed needs not being met.

Below are a list of deficits found on the day that required addressing;

- two residents plans had not included an up-to-date 'all about me' assessment. One resident's personal plan contained a 2023 assessment of their needs. The two assessments were later printed out and put into the residents' plans
- the inspector found a number of gaps in the plans and where plans required oversight and sign off by a manager, this had not always taken place. For example, three residents 'all about me' assessment had no record of management review
- residents' personal plans contained a 'contents sheet' at the front detailing what was in each section however, many of the sections had no contents within them. This made it difficult to locate information within the plan and to find guidance and support plans regarding residents' care and support needs
- on observing one resident's plan under 'my safety and protection', (section 7), not all documents listed under the contents of this section were in place. For example this section included, an 'I am safe' assessment, risk assessment, fire evacuation, falls assessment, mental health and well being plan, behaviour support plan and review, risk assessment and supports, manual handling supports and restrictive practices. However, on review of this section the inspector found that only the fire evacuation plan and falls assessment were included
- in another resident's plan, there was a section relating to 'safety', however, the section was empty with no documentation or records relating to the residents safety contained within it.

There was a lot of 2023 and 2024 information contained within the four plans reviewed. This was confusing and likely to impact the effectiveness of the guidance to help staff support residents. For example, there was a 2024 picture format activity plan in one resident's current personal plan, however, at the back of the plan there was another 2026 activity plan. This had the potential that the resident may not receive the most current applicable supports.

In addition, there was no record of management oversight of residents' financial passports. The passports reviewed residents' finances including income and savings and weekly outgoings. One resident's financial passport had no date which made it was difficult to ascertain if it was current and relevant to the resident.

Overall, there was poor order to the plans and the were very hard to navigate. This impacted on staff being able to effectively and efficiently access residents' support plans and guidance in supporting them provide good quality care and support to residents. While the provider had recognised this, and included an action in the centre's quality enhancement plan, the timeliness to address the deficits was not satisfactory.

Judgment: Not compliant

## Regulation 7: Positive behavioural support

Overall, the provider and the person in charge promoted a positive approach to behaviours of concern. At the time of the inspection, no resident was assessed as requiring a positive behaviour support plan. Where a resident was previously provided with a positive behaviour support plan, this was closed by the organisation's psychologist as the implementation of measures had successfully reduced behaviours that were presenting.

On the day of the inspection, the inspector observed two behaviour support incident report forms relating to behaviours of concern for one resident in June and November in 2025. The person in charge advised the inspector that a referral had been made to the organisation's psychologist and they were currently awaiting a response.

The provider and person in charge were endeavouring to support a restraint free environment as much as possible. There had been no restrictions notified on a quarterly basis to the Chief Inspector and on the day, the person in charge advised the inspector that there were no restrictive practices used in the centre.

However, on the day, the inspector identified two restriction that were in place. On review of the money management system in place for residents in both houses, the inspector found that it constituted a restrictive practice. For example, to keep residents' money safe, their money wallets were kept locked in an office cupboard and made available to residents when they requested.

In addition, in one of the houses, due to poor upkeep and repair of the premises outside decking area, as well as the associated health and safety risks, residents were restricted from using this facility. The inspector observed a sign on the double doors leading out to the area instructing staff and residents not to exit through the door or use the decking. On review of the provider's most recent six monthly unannounced review, the inspector saw that they had acknowledged this situation as a restriction however, there had been no adequate action or follow up in place.

Overall, the inspector found that while these restrictions were put in place as a safety measure to protect residents, there had been no risk assessment or restrictive practice process completed. As such there was no review or reduction plan in place for the restrictions which overall meant that the provider could not be assured that they were in line with best practice or if they were the least restrictive for the shortest amount of time.

Judgment: Substantially compliant

## Regulation 8: Protection

Overall, the inspector found that the provider had not ensured that where there were safeguarding incidents, that these were always followed up appropriately and in particular, regarding the review of the incidents. This meant that there was a risk of similar safeguarding incidents occurring and overall, resulting in negative outcomes for residents.

On review of a peer to peer safeguarding incident in the centre in May 2025, the inspector found that there was limited information within a resident's personal plan to provide assurances of appropriate follow up and review of the incident.

The inspector observed an interim safeguarding plan completed in May 2025 which was due for review in June 2025. However, there was no evidence of review of the plan in June.

The plan included a number of measures to mitigate the risk of similar incidents occurring and to ensure the safety of residents. One of the measures referred to an educational piece to be provided to both residents involved. However, on the day, there was no evidence to demonstrate this measure had been implemented or what the educational piece actually entailed.

On review of the response from the national safeguarding team, the incident was closed off on the basis that the plan was kept as a live working document in the centre and that it was known and utilised by the resident's staff team.

Overall, the detail within the resident's personal plan was not sufficient to ensure the protection of the resident or to guide and support staff in implementing measures to reduce the risk of similar incidents occurring. In addition, there was no evidence to demonstrate shared learning about the incident among the staff team.

Furthermore, on the day of the inspection, a concern regarding a resident's safety arose. On arriving at one of the houses, a resident, who was alone in the house, opened the door to the inspector. It was clear that the resident was not aware of who was at the door and appeared nervous upon opening it. The inspector showed their ID however, did not enter the house until management arrived. An associated risk assessment, that was in place to ensure sufficient measures were in place to keep the resident safe was not effective and had not been provide sufficient oversight or review. Overall, the lack of review and oversight over this situation, had put the resident at potential risk of harm during times they were alone in their home.

Judgment: Not compliant

## Regulation 9: Residents' rights

Overall, the inspector found that the provider had failed to promote residents' rights at all times. Residents were not always supported to engage in shared decision-making about matters related to the care and support provided to them, as well as

matters related to their home. In addition, the provider had failed to ensure that the systems in place, to empower residents raise their voice and be heard, were effective. Overall, these failures were resulting in negative outcomes for residents living in the centre.

For example: three residents spoke up during a residents' meeting and logged a complaint about having to move to another designated centre for three days, when the electricity went in their home. However, their complaint was not followed up. Residents had voiced that they would of preferred to stay in a hotel. As of the day of the inspection, the response remained outstanding.

The centre's emergency plan had been reviewed and updated in January 2025. Changes were made to a section that referred the alternative locations residents could stay during an emergency. For example, previously the plan included hotels, holiday homes and vacant designated centres. However, the new plan also included 'a designated centres with a vacancy'. This change in information was not relayed to the residents and they had not been consulted or part of the decision-making regarding the change.

The designated centre had a number of works completed to the house to make it more accessible and to meet the changing needs of residents. For example, a new accessible bathroom had been installed downstairs in the house. There was also work completed to the front hallways to allow for better access. While this led to positive outcomes for residents, the provider had not considered all areas of the house that impacted on residents' accessibility. The inspector observed that the back kitchen fire exit door included a step rather than a ramp. The inspector was informed that one resident, (who used mobility equipment), would require assistance from staff to exit this door. Overall, this meant that the provider was not fully promoting the resident's right to independently access all areas of their home.

The inspector observed a large office printer in the residents' sitting room. This took away from the homeliness of the environment. In addition, as it was the staff office printer, it posed a potential risk of private information pertaining to residents being printed out in a room where others were sitting. On the evening of the inspection, two of the residents relayed their unhappiness of the printer's location in their sitting room and said they had not been consulted about its location.

Overall, the inspector found that residents' rights were not considered or promoted at all times, and in particularly in terms of making a complaint, promoting independence, having their voice heard or being consulted or updated on matters regarding their lives as well as their home.

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
<b>Capacity and capability</b>	
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Not compliant
<b>Quality and safety</b>	
Regulation 10: Communication	Compliant
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Not compliant

# Compliance Plan for Avondale OSV-0008930

Inspection ID: MON-0049743

Date of inspection: 25/02/2026

## Introduction and instruction

This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant** - A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.
- **Not compliant** - A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

## Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

### Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 15: Staffing	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 15: Staffing:</p> <p>A SCL has been appointed to the 1st house. The PIC will continue to manage the 2nd house directly. Complete.</p> <p>Recruitment continues for a Social Care Leader for Avondale DC. Timeframe: 20th July 2026.</p> <p>Rota's have been reviewed and all staff members names are included on the rota including relief staff members. Complete.</p> <p>The Person in Charge is documenting their hours accurately on the rota to reflect their time in the Designated Centre. Complete.</p> <p>A SCL has been appointed to the first house. The SCL is managing the rota. The PIC is managing the rota for the second house. Complete.</p>	
Regulation 16: Training and staff development	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 16: Training and staff development:</p> <p>A Supervision and PDR schedule for 2026 has been completed and will be adhered to for the Designated Centre. Complete</p> <p>The PDRs for two staff due in January and February 2026 are complete. Timeframe: 30th of April 2026.</p> <p>A newly developed SCL shared folder is now in place &amp; will contain records of PDRs and Supervisions. Complete</p>	

Regulation 23: Governance and management	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 23: Governance and management:</p> <p>The Person in Charge is documenting their hours accurately on the rota to reflect their time in the Designated Centre. Complete.</p> <p>Programme Quality and Safety have completed audits of the residents personal plans and a timebound action plan is now in place. Timeframe: 30th of June 2026.</p> <p>A SCL has been appointed to one location. This will ensure oversight of the residents personal plans. PIC will oversee the personal plans at the second location. Complete.</p> <p>The cleaning schedules have been reviewed with the staff team to ensure responsibilities are clearly understood. Bathroom cleaning frequency has been increased. Complete</p> <p>Daily duty checklists are reviewed and monitored by the SCL/PIC. Complete</p> <p>Post-incident review to assess the effectiveness of the emergency plan and to share learning was completed by the PPIM. Complete</p> <p>Residents complaints regarding the locations they were moved to have been documented and managed in line with the SJOG Complaints Policy. Complete</p> <p>The Emergency plan was reviewed and updated in line with the post incident review and outcome of residents complaints. Timeframe: Complete</p> <p>The restriction relating to the decking has been referred to the Equality and Human Rights Committee, and a protocol has been put in place. This restriction will be placed on the Q&amp;S log and reported via the quarterly notifications. Timeframe: 30th April 2026</p> <p>The restrictive practice relating to money management will be reviewed with each resident and their circle of support, and follow up actions completed as required. This will also be reflected in the residents financial passport. Timeframe: 31st July 2026</p> <p>Safeguarding governance tool has been completed, which includes the review. This will be monitored by the SCL/PIC on an ongoing basis. Complete</p> <p>Safeguarding plan is stored in residents file and available to all staff. Additional documentation pertaining to the safeguarding incident is also stored in the residents file (e.g. educational based key working sessions). Complete</p>	
Regulation 17: Premises	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 17: Premises:</p>	

Conservatory room has been deep cleaned. This area is cleaned in line with the revised cleaning schedule and a risk assessment has been completed regarding the mould. Complete.

Old phones, wiring, internet boxes and disused old seat have been removed. Complete

A quote is being sought for new thermal blinds/curtains for use in the conservatory for cold weather. Once this is received they will be fitted in the conservatory. Timeframe: 30th May 2026

The person in charge is currently exploring alternative heating option with the maintenance department. Once the most effective is identified this will be installed to ensure the conservatory can be used by residents at all times in the year. Timeframe: 30th June 2026

Deep clean was completed of the mould, in-grain grime on the tiles on the floor, shower base and door. Complete

The cleaning schedules have been reviewed with the staff team to ensure responsibilities are clearly understood. Bathroom cleaning, stairs, conservatory and sitting room frequency has been revised alongside monitoring front of house for plastics/papers. Complete

Replacement of hand towels schedule now in place and all staff are aware. Complete

Toilet rolls are consistently in the toilet roll dispensers to support protection against infection. Complete

Occupational Therapy referral has been submitted to support resident with identified needs. Risk assessment has been completed as an interim measure. Complete

Toilet roll stock is being monitored on a weekly basis by an identified staff member. Complete

A toilet seat is currently being sourced to fit under the accessible toilet chair. Complete

Sitting room coffee table will be replaced. Timeframe: 30th of May 2026

Kitchen kettle has been replaced. Complete

Grout between cooker top and tiles will be completed. Complete

Papers/plastic blowing into front of house will be monitored to ensure this area is clean. Complete

The large tree has been removed from the back garden. Complete

Regulation 26: Risk management procedures	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 26: Risk management procedures:</p> <p>All risk will be reviewed to ensure they accurately reflect the name of the Designated Centre. Where the RMS system cannot be updated, an interim arrangement will be put in place to clearly document the Centre name on the risk. Timeframe: 30th of April 2026</p> <p>Resident risk assessment regarding staying home alone has been reviewed and all follow up actions are being implemented. Staff team are aware of all control measures in place. Timeframe: 30th of April 2026</p>	
Regulation 5: Individual assessment and personal plan	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:</p> <p>Programme Quality and Safety have completed audits of the residents personal plans and a timebound action plan is now in place. Timeframe: 30th June 2026</p> <p>To support staff in the area of personal plans and related documentation, a Quality and Safety Advisor from Programme Quality and Safety will be available weekly for 4-6 weeks, and longer if required in this Designated Centre. This support will take the form of 1:1 practice development sessions and keyworker support with staff members. Timeframe: 30th of June 2026</p> <p>All About Me Assessments have been audited &amp; are in the process of being updated for all residents, and a copy will be placed in the residents file. The All About Me will be reviewed by SCL/PIC and signature included to prove same. Timeframe: 30th of April 2026</p> <p>The contents of the Personal Plans has been reviewed with the staff team, and included within all plans. The contents will be adhered to throughout the plan. Complete</p> <p>Archiving will be completed to ensure all out date documentation is removed from circulation. Timeframe: Complete</p> <p>Financial passports will be updated by the keyworkers to ensure all current information is included. The financial passports will then be reviewed and signed by SCL/PIC. Timeframe: 30th of April 2026.</p>	
Regulation 7: Positive behavioural support	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:</p> <p>The restriction relating to the decking has been referred to the Equality and Human Rights Committee, and a protocol has been put in place. This restriction will be placed on</p>	

the Q&S log and reported via the quarterly notifications. Timeframe 30th April 2026

The restrictive practice relating to money management will be reviewed with each resident and their circle of support, and follow up actions completed as required. This will also be reflected in the residents financial passport. Timeframe: 31st of July 2026

Regulation 8: Protection	Not Compliant
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Outline how you are going to come into compliance with Regulation 8: Protection:

Safeguarding governance tool has been completed, which includes the review of the incidents. This will be monitored by the SCL/PIC on an ongoing basis. Complete

Safeguarding plan is stored in residents file and available to all staff. Additional documentation pertaining to the safeguarding incident is also stored in the residents file (e.g. educational based key working sessions). Complete

Learning from safeguarding incidents is included as part of staff meetings. Complete

Resident risk assessment regarding staying home alone has been reviewed and all follow up actions are being implemented. Staff team are aware of all control measures in place. Timeframe: 30th of April 2026

Regulation 9: Residents' rights	Not Compliant
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Outline how you are going to come into compliance with Regulation 9: Residents' rights:

Residents complaints regarding the locations they were moved to have been documented and have been managed in line with the SJOG Complaints Policy. Complete.

Quality & Safety Advisor from the Programme Quality & Safety team has completed a practice development session regarding the Complaints process alongside rights at the staff meeting on 23rd March 2026. Complete

Resident meetings schedule will now include education-based discussion points to support residents. Complete

Emergency plans have been reviewed and updated in line with the post incident review and outcome of residents' complaints. Complete

The back kitchen door for means of fire escape requires reviewing by OT and physiotherapy as currently one resident needs support by staff to lift her rollator down the step so that she can exit safely. Referral will be made to both clinicians for a review of the emergency exit for this resident to ensure we are promoting their rights. Timeframe: 30th of April 2026.

Printer location will be discussed at residents meeting, and an alternative location will be reviewed with ICT. Timeframe: 30th of June 2026.

## Section 2:

### Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Substantially Compliant	Yellow	20/07/2026
Regulation 15(4)	The person in charge shall ensure that there is a planned and actual staff rota, showing staff on duty during the day and night and that it is properly maintained.	Substantially Compliant	Yellow	30/03/2026
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	30/04/2026
Regulation 17(1)(a)	The registered provider shall	Not Compliant	Orange	30/06/2026

	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.			
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	30/06/2026
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Not Compliant	Orange	30/06/2026
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 provision.	Not Compliant	Orange	31/07/2026
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the	Not Compliant	Orange	31/07/2026

	designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.			
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.	Substantially Compliant	Yellow	30/04/2026
Regulation 05(6)(c)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall assess the effectiveness of the plan.	Not Compliant	Orange	30/06/2026
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with	Substantially Compliant	Yellow	31/07/2026

	national policy and evidence based practice.			
Regulation 07(5)(c)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation the least restrictive procedure, for the shortest duration necessary, is used.	Substantially Compliant	Yellow	31/07/2026
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	30/04/2026
Regulation 09(1)	The registered provider shall ensure that the designated centre is operated in a manner that respects the age, gender, sexual orientation, disability, family status, civil status, race, religious beliefs and ethnic and cultural background of each resident.	Substantially Compliant	Yellow	30/06/2026
Regulation 09(2)(a)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability participates in and consents, with supports where necessary, to	Not Compliant	Orange	30/06/2026

	decisions about his or her care and support.			
Regulation 09(2)(e)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability is consulted and participates in the organisation of the designated centre.	Not Compliant	Orange	30/06/2026