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:	Devon Lodge Services
Name of provider:	Ability West
Address of centre:	Galway
Type of inspection:	Unannounced
Date of inspection:	05 May 2026
Centre ID:	OSV-0001494
Fieldwork ID:	MON-0046866

About the designated centre

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

Devon Lodge Services provides a residential placement for four residents and a respite placement for two individuals on alternative weeks. Residents and respite users have varying degrees of learning disability, ranging from mild to moderate, from the age of 18 upwards. It can accommodate persons who have mental health issues, residents who have behavioural management strategies in place and with a range of medical and physical needs. The service can accommodate one person with limited mobility. The centre comprises of one house in a residential area by the sea on the outskirts of a city, and has good access to a wide range of facilities and amenities. Residents at Devon Lodge are supported by a staff team that includes; a person in charge, social care workers and care assistants. Staff are based in the centre when residents are present including at night.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	5

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Tuesday 5 May 2026	09:45hrs to 16:00hrs	Mary Costelloe	Lead

What residents told us and what inspectors observed

This was an unannounced inspection carried out to monitor compliance with the regulations. There was full compliance with the regulations reviewed on the last inspection which took place on 23 September 2024. While there was evidence of good practice noted on this inspection, improvements and further oversight was required to completion of an annual review of the quality and safety of care in the centre, staff training records for relief staff, assessment and personal planning documentation, and to ensuring appropriate personal storage space for respite users. The inspection was facilitated by the person in charge, the inspector also met with the area service manager and with two staff who were on duty.

There were four residents accommodated on a full-time residential basis and two residents were provided with a respite service on alternate weeks. The service supports a predominantly independent group though some required additional support due to age related factors including high falls risk. The inspector met and spoke with four residents. Residents spoken with had a good understanding of the role of HIQA and the role of the inspector. All residents attended day services on days of their choosing, some residents attended two or three days a week while others attended five days a week. One resident was supported to attend day services later on some mornings in line with their preference. On the morning of the inspection, three residents had already left the centre to attend their respective day services and another resident was still in their bedroom being supported with personal care. The inspector met with this resident later in the morning while they were having breakfast in the kitchen. The resident appeared well, was in good form and happy to chat with the inspector. They advised how they enjoyed going to day service on two days of the week and liked to relax at home or go out with support of staff on other days. They spoke about how they liked living in the house and how they got on well with everyone. They told the inspector how they enjoyed getting out for walks, going for drives in the bus, and going on day trips. They had recently been on day trips to Westport, Knock religious shrine and had visited a family grave. They mentioned how they liked to watch television in the evenings and how they particularly enjoyed watching the 'soaps' and the 'Late, Late show'. They spoke of how they continued to attend weekly mass and go out for dinner at weekends. They talked about the upcoming local elections and how they would probably go out to cast their vote. They spoke of the importance of family and how they regularly met up with family members and enjoyed watching GAA matches on television together.

The inspector met and spoke with three other residents during the afternoon on their return to the centre from day services. All residents were in good form. They engaged well with the inspector as they went about their own routines. They were observed to independently help themselves to snacks, fruit, cups of tea and participate in light household tasks including emptying bins and carrying out laundry. Residents and staff were observed engaging in friendly respectful banter contributing to a relaxed and homely atmosphere. Residents appeared comfortable

and familiar in their surroundings, moving freely and participating in their preferred routines. Interactions were warm and person centered, with staff demonstrating a good knowledge of residents personalities and preferences. Overall, the environment promoted a sense of well-being, dignity and social connection.

While there was consistent staffing arrangements in place from a core team of staff which had a positive impact on residents experiences, there had been a recent change to the person in charge and who was still getting to know residents. Further changes to staffing were also noted with two staff members going on planned extended leave and recruitment of new staff to fill those posts taking place. These planned changes had been discussed with residents at their weekly house meetings to provide reassurance, information and alleviate any concerns.

Residents' independence continued to be promoted. One of the residents spoke about how they enjoyed helping out with garden tasks and how they sometimes liked to cut the grass with the lawnmower. Some residents liked to help out with shopping, cooking, cleaning, laundry and recycling waste. Residents had their own key to the house and to their individual bedrooms. Some residents were supported to leave the house at their own discretion while having regard to letting staff know of their plans and also to spend time alone in the house. Most residents had their own mobile telephone which they used to keep in contact with staff, friends and family. One resident independently went to the local hotel for a few pints every weekend in line with an agreed protocol.

The house was designed and laid out over three floors. Accommodation for residents was provided on the ground and first floor, with storage rooms located on the second floor. There were five bedrooms, two with en suite shower facilities for residents use. One of the bedrooms with en suite facilities was located on the ground floor and four bedrooms were located on the first floor. One of the first floor bedrooms had an en suite shower room and an additional shower room was also available. There was a bedroom/office available for use by staff. There were two sitting rooms and a well equipped kitchen cum dining room. There was a separate utility room, storage rooms and an external store. Residents had easy access to well maintained mature garden areas. There was a lawn area and paved patio area to the rear. Residents spoken with told the inspector how they enjoyed spending time outside during the fine weather and were happy with the new outdoor table and chairs set. The building was accessible with suitable ramps provided to the front and rear entrance areas. The building and equipment were found to be visibly clean.

Some residents were happy to show the inspector their bedrooms which were found to be individually decorated and personalised. Residents reported that they liked their bedrooms and stated that they occasionally choose to relax there, including watching television or listening to music. Each resident had access to their own bedroom key and confirmed that they could choose to lock their room if they wished, supporting privacy and autonomy. Bedrooms were observed to provide adequate personal storage space and were personalised with photographs and items of personal significance, reflecting residents' individuality and preferences. Two respite service users shared one bedroom on alternative weeks, however, the arrangements for the storage of personal clothing and other personal items in this

bedroom required review to ensure that each service user had appropriate facilities provided for the duration of their respite stay and for the storage of personal items left in the centre between stays.

From conversations with residents and staff, observations made while in the centre, and information reviewed during the inspection, it was evident that residents were consulted with, were listened to, had choices in their lives and that their individual rights and independence was promoted.

The next two sections of the report outline 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 residents lives.

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Capacity and capability

The findings from this inspection indicated good compliance with many of the regulations reviewed and there was evidence of good practice in many areas. However, there was gaps in governance, oversight, and quality improvement processes. Improvements and further oversight was required to completion of an annual review of the quality and safety of care in the centre, staff training records for relief staff, assessment and personal planning documentation, and to ensuring appropriate personal storage space for respite users.

There was a clear organisational structure in place to manage the service. The management arrangements within the centre were in line with the statement of purpose. The person in charge worked full-time and also had other managerial responsibilities in the organisation. They had recently been appointed to the role and outlined how this was an interim arrangement pending the recruitment of a new person in charge. They were supported in their role by a team leader and area services manager. There were on-call management arrangements in place for out-of-hours.

On the day of inspection, there was one staff member on duty in the morning time, two staff on duty in the afternoon and evening with a staff member on sleepover duty at night-time. All residents were out attending their respective day programmes during the day-time. There was normally two staff on duty during the day-time at weekends to support residents get out and about in line with their preferences. The local management team advised that staffing arrangements were currently under review to ensure that the assessed and increasing needs of some residents were met, that recruitment was taking place to fill upcoming planned vacancies and to also fill the post of person in charge on a full-time basis.

Improvements were required to staff training records. The records showed that the core team of staff had completed all the required mandatory training as well as additional training to support them in their roles and meet the specific support needs of some residents. However, the person in charge could not demonstrate that all relief staff working in the centre had completed mandatory and role specific training. This issue had been identified in the most recent provider led audit but had not yet been addressed.

While the provider had some systems in place to monitor and review the quality and safety of care in the centre, the annual review for 2025 had not been completed in line with regulatory requirements. The provider had continued to complete six monthly reviews of the service. The most recent review had taken place in March 2026, however, many actions identified including the requirement to complete the annual review had not been addressed.

The local management team continued to complete a schedule of weekly and monthly audits of areas such as identified risk, infection, prevention and control, incidents, fire safety, medication management, restrictive practice and residents finances. The outcome of recent audits reviewed indicated satisfactory compliance. The area service manager continued to meet with the person in charge on a regular basis to discuss risk and other issues pertaining to this centre.

Regulation 15: Staffing

Staffing levels in the centre continued to be reviewed to ensure that they were adequate to meet the assessed support needs of residents. The staffing levels at the time of inspection met the support needs of residents. The rosters dated 27 April to 5 May 2026 were reviewed and were found to be reflective of staff on duty. The hours worked by the person in charge were clearly set out in the roster.

The local management team confirmed that recruitment was currently taking place to fill upcoming planned vacancies and to also fill the post of person in charge on a full-time basis.

Judgment: Compliant

Regulation 16: Training and staff development

Improvements were required to staff training. While the records showed that the core team of staff had completed all the required mandatory training as well as additional training to support them in their roles, the person in charge could not demonstrate that all relief staff working in the centre had completed mandatory

training. This posed a risk to residents as these staff worked alone in the centre at night-time.

Judgment: Substantially compliant

Regulation 23: Governance and management

Improvements were required to ensure that effective governance and management systems were in place.

The provider was not in compliance with the requirement to compete an annual review of the quality and safety of care and support in the centre. While six-monthly reviews of the service had been undertaken, actions identified through these reviews had not been completed, indicating gaps in governance, oversight, and quality improvement processes.

Further oversight was required to ensure that staff training records including those for relief staff were accurately maintained and monitored.

The inspection also identified gaps in oversight of assessment and personal planning documentation, to ensure consistency and guide care in line with residents specific needs. Improvements were also required to person-centered planning documentation and documentation of healthcare follow-up actions.

Judgment: Not compliant

Quality and safety

The inspector found that the local management team and staff were committed to promoting the rights and independence of service users and ensured that they received an individualised safe service. Residents spoken with confirmed that they were consulted with, had control over decisions regarding their care and support, their daily routines and could choose to partake in their preferred activities. However, as discussed earlier in this report, improvements in relation to assessment and personal planning documentation was fragmented which could result in a lack of readily accessible information to support effective care planning and the delivery of care. The provider also needed to ensure appropriate personal storage arrangements for the duration of respite users stay to further enhance the quality and safety of the service.

The centre was comfortable, visibly clean, furnished and decorated in a homely style. The person in charge outlined that plans were place to complete further

repainting, these works were logged on the Flex maintenance system. Residents that required assistive devices and equipment to enhance their mobility and quality of life had been assessed and appropriate equipment had been provided. On the day of inspection, the occupational therapist visited to review a residents chair which had recently been damaged. A new chair was delivered later in the day and a follow up review of the environment and the dining table was planned.

The local management team had systems in place for the regular review of risk in the centre. The management and staff team continued to promote a restraint free environment and while some restrictive practices were in use to ensure resident safety, these were managed in line with national policy. Risk assessments had been completed to support some residents spend time alone in the centre and to access the community independently. The inspector noted that there was a low level of reported incidents. All residents had been involved in completing fire drills and fire drill records reviewed indicated that there had been no issues in evacuating the building in a timely manner. There were no safeguarding concerns at the time of inspection.

Regulation 12: Personal possessions

The provider needed to review the current arrangements for personal storage in the bedroom used by for two respite service users who were accommodated in the same bedroom on alternative weeks. The provider needed to ensure that secure individual storage facilities were provided to ensure that each service users belongings were managed safely and securely between respite stays. This is to ensure dignity, privacy, enhance infection control and support person centered care.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

There were systems in place for the identification, assessment, management and on-going review of risk. The risk register had been recently reviewed and was reflective of risk in the centre. The centre had an emergency plan in place and all residents had a recently updated personal emergency evacuation plan in place. There were regular reviews of health and safety, incidents, medication management as well as infection prevention and control. The outcome of recent reviews indicated satisfactory compliance. The area service manager continued to meet with the person in charge on a regular basis to discuss risk and other issues pertaining to this centre.

Judgment: Compliant

Regulation 28: Fire precautions

There were fire safety management systems in place. Daily, weekly and monthly fire safety checks continued to take place. There was a schedule in place for servicing of the fire alarm system and fire fighting equipment. All staff had completed fire safety training. Regular fire drills were taking place involving all staff and residents. Fire drill records reviewed by the inspector indicated that residents could be evacuated safely in a timely manner. The provider had conducted an audit of all fire doors in May 2025 and all identified issues had been addressed.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

Improvements were required in relation to assessment and personal planning documentation. The inspector reviewed the files of three residents. Files reviewed included ' all about me' assessments , however, these did not include details of residents medical diagnosis. While some residents had specific care and support needs identified, the information available to guide care was fragmented throughout the files. In addition, there were no clear, individualised care plans in place to guide the management of specific care needs including falls management, incontinence care, diabetes management and epilepsy. As a result, information to support consistent and effective care delivery was not readily accessible within resident records. The person in charge outlined how the team leader had recently commenced a review of residents files and had identified a number of actions required. The local management team advised that they were committed to ensuring that these actions were addressed in the coming weeks.

Other improvements were noted to person centered planning (PCP) documentation as inconsistencies were noted in the files reviewed. Planning meetings involving each resident, key working staff and family members normally took place annually. The inspector noted that goals were clearly set out for some residents with evidence of progress updates. One residents file reviewed showed that goals outlined had already been completed. However, individual goals were not set out for all residents/ respite users.

Judgment: Substantially compliant

Regulation 6: Health care

Files reviewed indicated that residents generally had timely access to general practitioner (GP) services and other healthcare professionals as required. However, the arrangements in place for respite service users were not clearly defined. While some residents files evidenced referrals to allied health services, it was unclear if residents had been reviewed or not. The outcomes of a number of these reviews were not consistently documented, resulting in lack of clarity regarding follow-up actions and outcomes. For example, there was no outcome documented following a referral to psychology in October 2024, and there was lack of clarity and information regarding an upcoming planned orthopedic surgery for a resident.

Judgment: Substantially compliant

Regulation 8: Protection

The provider had systems in place to ensure that residents accommodated were protected from abuse. All staff had completed training in relation to safeguarding. Safeguarding and associated topics were regularly discussed with residents at weekly house meetings and with staff at team meetings. The designated officer had recently visited the centre to discuss the importance of safeguarding with staff. There were no safeguarding concerns at the time of inspection.

Judgment: Compliant

Regulation 9: Residents' rights

The local management and staff team supported residents to live person-centred lives where their rights and choices were respected and promoted. The privacy and dignity of residents was well respected by staff. Residents had keys to the front door and their bedrooms and could to lock their rooms if they wished. Residents who spoke with the inspector were knowledgeable regarding their rights. Staff were observed to interact with residents in a caring and respectful manner and residents spoke highly of staff supporting them.

The human rights charter was displayed and had been discussed with residents. There was evidence of ongoing consultation with residents, on a daily basis, at regular house meetings and individually at key working sessions. Residents spoken with confirmed that they were consulted with and had choices in their daily lives. The residents had access to information in a suitable accessible format, as well as access to the internet, televisions and their own mobile telephones. Residents advised that they could attend religious services if they wished and some regularly attended local church services. Residents also mentioned that they were registered

to vote and could choose to vote or not. Residents were supported to manage their own finances.
Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 12: Personal possessions	Substantially compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Devon Lodge Services OSV-0001494

Inspection ID: MON-0046866

Date of inspection: 05/05/2026

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 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: Training Matrix for all staff has been fully updated – including all relief staff working in the Centre. This is now visible in the office and in training folder. PIC has communicated with Ability West Training Manager re all in-person training that is required and same has been scheduled – all planned to be completed by the end of June 2026. Where there is online training required PIC has communicated same to all staff and will follow-up again in Team Meeting 28/5/26. All will be completed up to date by the end of June 2026. PIC will maintain training matrix with regular review.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: Annual Review for 2025 is now completed and on file in the service. New PIC and Team Leader reviewing all actions required in most recent Provider Led Audit, dated 12/3/26, to ensure all are completed. Actions required will be completed by the 26th June 2026. Staff Training records are now updated, visible in the office and added to training folder. These now include all relief staff. All residents personal working files have been thoroughly reviewed with Assessments and Personal planning documentation required identified. Where required MDT colleagues are being worked with to ensure that all clinical areas for all residents are up to date. This has involved meetings with all MDT departments represented and on-site work carried out with departments where this is required. All working files will be fully updated by 26th June 2026.	

Person-centred planning documentation is similarly being reviewed in full, to ensure that all residents have meaningful and active goals in place. This will be completed by 26th June 2026.
Clarified arrangements re GP services and healthcare practitioners for residential/respite users. In conjunction with allied health services all medical appointments will be co-ordinated by the residential/respite service to ensure the required medical information is available to both supporting agencies at all times. This will be in place by 26th June 2026.

Regulation 12: Personal possessions	Substantially Compliant

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

Large plastic boxes, clearly labelled for each individual, have been sourced that can accommodate all possessions of each respite service user. When not staying in the centre these will be packed and maintained in the storage space on the 2nd Floor under lock and key so that only the possessions of the resident in attendance are in the bedroom.

Regulation 5: Individual assessment and personal plan	Substantially Compliant

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

All residents 'All about Me' assessments have been fully reviewed. Health Information, including medical diagnosis, to be added to all within section 1.0 'About Me'. This will be completed by 2nd June 2026.
Residents specific care and support needs are being addressed with the support of relevant MDT colleagues. Clear, individualised care plans to be put in place for specific care needs i.e. falls management, incontinence care, diabetes management and epilepsy. This will be completed by 2nd June 2026.
Keyworker meetings have been planned for all residents, and annual reviews are being scheduled where required. Individual goals for all residents/respite users will be set that are meaningful to the person supported.

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:

Clarified arrangements re GP services and healthcare practitioners for residential/respite users. In conjunction with allied health services all medical appointments will be co-ordinated by the residential/respite service to ensure the required medical information is available to both supporting agencies at all times. This will be in place by 26th 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 12(3)(d)	The person in charge shall ensure that each resident has adequate space to store and maintain his or her clothes and personal property and possessions.	Substantially Compliant	Yellow	20/05/2026
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	19/06/2026
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	Not Compliant	Orange	26/06/2026

	to residents' needs, consistent and effectively monitored.			
Regulation 23(1)(d)	The registered provider shall ensure that there is an annual review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards.	Not Compliant	Yellow	20/05/2026
Regulation 05(4)(a)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which reflects the resident's needs, as assessed in accordance with paragraph (1).	Substantially Compliant	Yellow	02/06/2026
Regulation 05(4)(b)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which outlines the supports required to maximise the resident's personal development in accordance with his or her wishes.	Substantially Compliant	Yellow	02/06/2026
Regulation 06(1)	The registered provider shall provide	Substantially Compliant	Yellow	26/06/2026

	appropriate health care for each resident, having regard to that resident's personal plan.			
Regulation 06(2)(d)	The person in charge shall ensure that when a resident requires services provided by allied health professionals, access to such services is provided by the registered provider or by arrangement with the Executive.	Substantially Compliant	Yellow	26/06/2026