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:	Blossomville
Name of provider:	St Joseph's Foundation
Address of centre:	Limerick
Type of inspection:	Unannounced
Date of inspection:	24 November 2025
Centre ID:	OSV-0001822
Fieldwork ID:	MON-0048004

About the designated centre

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

Blossomville is a purpose built single storey bungalow located in a town. The centre comprises of six bedrooms, two sitting rooms, a kitchen-dining room, a utility room, a staff office and bathroom facilities. The centre has a maximum capacity of six residents and can provide full-time residential care to residents with intellectual disabilities and /or autism who present with behaviour that challenges and additional needs. Both male and female residents over the age of eighteen years can reside in the centre. The staff team comprises of a person in charge, social care workers, nurses and care assistants.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	6

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
Monday 24 November 2025	08:05hrs to 18:10hrs	Conor Dennehy	Lead

What residents told us and what inspectors observed

All residents living in this centre were met during this inspection. Direct feedback from these residents was limited but the atmosphere in the centre on the day of the inspection was quiet and calm. Aside from residents, the inspector did speak with a former person in charge for the centre, a member of the centre's current management, three members of the staff and two relatives of one resident.

On arrival at the centre two residents were present in the centre's communal areas with other residents in their bedrooms. The inspector greeted one of these residents but they did not respond despite some encouragement from staff present. After this the inspector did a quick walkthrough of communal areas of the centre when he noticed that the bedroom door of one resident, who was in bed at the time, was left open. During previous inspections of this centre, it was indicated that this was want the resident wanted. On the current inspection though, it was also observed that in the hall outside this resident's bedroom was two clothes horses, an armchair and a poof. While these items were seen to be removed shortly after the inspection commenced, the hall where they were seen led to an identified fire exit for the centre. The inspector later highlighted such observations to management of the centre from a fire safety perspective. In doing so, the inspector was informed that the armchair was located outside the resident's bedroom door at night to enable staff to be present to support the resident given a recent change in circumstances for the resident.

Shortly after the inspection commenced, the inspector was requested by a member of staff to remain in the smaller sitting room so that they could let all residents know that the inspector was present. The inspector followed this request and a short time later the inspector was informed that this had been done. After this the inspector spent much of the morning of the inspection observing happenings in the centre including residents being provided with breakfast. From this, the provision of choice for residents in having their meals was found to have noticeably improved since the previous inspection of this centre in June 2025. This will be covered in more detail later in this report. During such observations, the inspector met all other residents of the centre. Three of these residents did not interact the inspector. A fourth resident did approach the inspector at times and, while they did not communicate verbally, they were seen to smile and appeared excited at times. A fifth resident did indicate to the inspector in response to questions asked that things were good and that they had had a good weekend at home. Aside from this there was limited verbal interaction with residents during this inspection.

As such, the inspector relied on documentation, discussions with others present and observations to get a sense of what residents' life in the centre was like. Throughout the inspection, staff members on duty were observed and overheard to interact with residents in a pleasant and respectful manner. For example, one staff was noted to offer one resident drinks. On another occasion, a different resident was being

supported to move into the larger sitting room for the centre when they put up their hand to indicate that they wanted to go somewhere else. In response to this, the staff member supporting the resident got photos of different rooms of the centre and showed them to the resident. The resident pointed at a photograph of a bathroom from these with the staff member then supporting the resident to go there. Based on observations throughout the day, staff members were mostly present with residents in communal areas of the centre. Some brief instances though were observed though where two residents were left alone in one of the centre's sitting rooms without staff being present. This is discussed further later in this report in the context of safeguarding given that some safeguarding matters between residents were present in this centre.

Given how staff interacted with residents throughout the day, the overall atmosphere in the centre on the day of inspection was quiet and calm. This was in keeping with the environment residents needed when having their mealtimes. Staff also supported residents to leave the centre at different points during the day. One resident though was observed to spend much of the day in the larger sitting room of the centre although it was acknowledged that the resident had particular needs. The centre had full-time access to one vehicle for outings and had access to another vehicle for most of the week. On day of inspection, these vehicles were used to take residents for drives while one resident was also supported to attend a gym. This was a new activity for this resident with the inspector also informed by staff that some residents had also recently commenced social farming.

During the course of the inspection, one resident received a visit from two of their relatives with the inspector meeting both of these relatives together. One of the relatives spoke at length about the background of the resident and indicated that the resident had no quality of life. In doing so it was referenced how the resident did not smile and just wanted to go for drives and eat. It was further indicated by one of the relatives, that management of the centre told them nothing and that they did not known most of the staff. Some concerns were raised by the relatives around aspects of the care provided to the resident and some photographs of the resident that were on display in their bedroom. Given the nature of these concerns, the inspector advised these relatives that they were entitled to raise complaints around such matters with the provider having specific responsibilities around complaints under the regulations.

In summary, one resident spoken with indicated that things were good in the centre while another was seen to smile at times. Feedback from two relatives of one resident was not positive. Staff supported residents to leave the centre with such staff also interacting with residents in a respectful manner on the day of inspection. A quiet and calm atmosphere was encountered on the day of this inspection taking place.

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

Capacity and capability

This inspection found that the provider had implemented stated actions in response to a warning letter previously issued. This resulted in improved compliance overall although compliance with Regulation 8 Protection remained a concern.

Four inspections of this centre between January 2024 and June 2025 raised concerns around the services being provided to residents in this centre. Such concerns were reflected in high levels of non-compliance with the regulations across such inspections. The nature of these concerns prompted the Chief Inspector of Social Services to issue provider with a warning letter in July 2025. This letter highlighted that if the provider did not improve compliance in specific regulations then the Chief Inspector could attach a restrictive condition to the centre or cancel the registration of the centre. The specific regulations highlighted in the warning letter included Regulation 8 Protection, Regulation 9 Residents' rights, Regulation 18 Food and Nutrition and Regulation 23 Governance and management.

The provider submitted a response to this warning letter in July 2025 outlining the measures that they were going to take to come back into compliance with these regulations. With the centre currently registered until December 2026, the decision was made to conduct the current inspection to assess progress with the stated actions as stated by the provider in the warning letter response. As a result, the four regulations outlined above were focused upon. Overall, the current inspection found that the provider had implemented their stated actions from the warning letter. This resulted in improved compliance's in some areas, particularly for Regulation 18 Food and Nutrition, and better services for residents. There was also evidence of a greater level of oversight for the centre. While such findings were a positive development, as will be discussed further elsewhere in this report, the provider had yet to achieve compliance with Regulation 8 Protection.

Regulation 23: Governance and management

Under this regulation, the provider is required to ensure that management systems are in place in the designated centre to ensure that the services provided are safe, appropriate to residents' needs, consistent and effectively monitored. Previous inspections identified that the provider was not meeting such requirements which contributed to the provider being issued with a warning letter in July 2025 around key regulations. The provider's response to the warning letter (as submitted in the same month), outlined the measures that the provider was going to take to come back into this compliance with these regulations. As outlined elsewhere in this report, the provider implemented these measures which resulted in improved compliance in Regulation 9 Residents' rights and Regulation 18 Food and nutrition.

While issues remained regarding Regulation 8 Protection, the measures taken by the provider offered assurances that the provider had responded to specific concerns raised by the warning letter.

In addition, there was also evidence of active and ongoing monitoring of services provided in the centre. For example:

- The provider had arranged for an external body to conduct an unannounced visit to the centre on 19 June 2025 to review the quality and safety of care and support provided to residents. A report of this unannounced visit was provided to the inspector which included an action plan to address any areas for improvement identified during that unannounced visit.
- A follow up audit by the same external body was completed in November 2025. This audit was announced but took place over the course of two days. A report of this audit was provided to the inspector which indicated improvement overall and that most actions arising from the June 2025 unannounced visit had been addressed.
- Based on documentation reviewed for the centre since August 2025, audits had been completed in the centre in areas such as cleaning, finances and medicines.
- Management of the centre and provider (including the provider's Chief Executive Officer) had conducted separate unannounced visits to the centre at varied times. This was evident from discussions with a member of the centre's management and a visitors' log reviewed. For example, one member of the centre's management was indicated as visiting the centre at 5:50am on 24 September 2025 while a member of the provider's management visited the centre at 8:47pm on 10 October 2025.
- Staff team meetings were taking place at least monthly in the centre based on meeting notes reviewed from July 2025 on. In reviewing these meeting notes it was read that various topics were discussed including safeguarding, incidents and restrictive practices. These meetings notes indicated that the person in charge in place at the time these meetings took place attended them while another member of centre management had attended three of these meetings.

This regulation also requires that the provider ensures that the designated centre is resourced to ensure the effective delivery of care and support. In this regard, based on information provided verbally to the inspector by a member of management, the number of staff vacancies in the centre had decreased which resulted in less agency staff being used in the centre. The announced audit conducted in November 2025 also indicated that staffing levels had improved in the centre in recent months. In addition, due to a change in circumstances for one resident, additional staff support had been provided temporarily to support this resident. This additional staff support remained in place at the time of this inspection.

Judgment: Compliant

Quality and safety

Residents were being offered choice around their meals while the provision of food and nutrition in the centre had improved since the previous inspection. Matters of a safeguarding nature between residents had continued to occur which raised concerns around resident compatibility in the centre.

On the inspection day it was seen that different types of food and drink were present in the centre with residents offered choice around their meals. Certain recommended types of food for one resident were also found to be present in the centre while the environment offered by the centre was in keeping with guidance on how residents were to be supported at meal times. Outside of food, residents were consulted and given information through residents' meetings. These were mostly done via one-to-one meetings but some communal meetings also based on records reviewed. Other documentation reviewed during this inspection confirmed that matters of a safeguarding nature between residents had continued to occur since the June 2025 inspection. This raised ongoing compatibility concerns but the provider did not have a plan on how to address this at the time of inspection.

Regulation 18: Food and nutrition

During the June 2025 inspection, a number of concerns were identified relating to the provision of food and nutrition in this centre. These included recommended foods for one resident not being present, food records not containing sufficient information and recommended mealtime settings not being provided. On the current inspection the following was found:

- Facilities were seen to be present in the centre for food to be stored in. These included presses and a large fridge-freezer in the kitchen-dining room.
- Food and drink observed to be stored in the centre on the day of inspection included breakfast cereals, bread, milk, orange juice, butter, fruit, vegetables, meat, cheese, waffles, pizzas, beans and sauces.
- Recommended food for resident that were not present at the time of the previous inspection were seen to be present on the current inspection. This included protein yogurts.
- All residents had placemats, which had been reviewed in July 2025, which gave information on residents' nutritional diets and how residents were to be supported during mealtimes.
- Such information in residents' placemats indicated that residents should not have meals in a loud environment or be around loud noise while eating. The breakfast meal time experience for residents was observed by the inspector and it was noted that the environment was kept quiet and calm for residents during this time.

- New logs had been introduced for recording food eaten by residents. The inspector reviewed these logs for two residents from 15 September 2025 on and noted that these logs were appropriately maintained for the majority of dates in this period.

In addition to the above, during the June 2025 inspection it was found that one resident required fluid monitoring in line with their assessed needs and associated support plans but not all fluids drank by the resident were being recorded. In the warning letter response, the provider had indicated that the requirement for fluid monitoring for this resident had been discontinued following consultation with a general practitioner. The inspector was informed that this remained the case at the time of the current inspection.

The June 2025 inspection also highlighted how staff members were preparing potatoes and vegetables for dinner as residents were having their breakfast. In its response to the warning letter, the provider acknowledged that this was inappropriate and that this had been raised with staff at staff team meetings during July 2025. The inspector reviewed notes of such meetings and saw that they referenced that the practice of dinner meal preparation early in the morning was to stop. Despite this, when the inspector arrived at the centre for the current inspection he saw large saucepan filled with water and peeled potatoes.

Judgment: Compliant

Regulation 8: Protection

Under this regulation, the provider is required to ensure that residents are protected from all forms of abuse. Findings of inspections from April 2024, October 2024 and June 2025 along with a high volume of safeguarding incidents occurring in the centre involving residents during that time period raised concerns about the compatibility of these residents to live together. The June 2025 inspection also raised concerns around the high volume of safeguarding plans that were active at that time as well as the effectiveness of these plans. During a meeting with the provider in July 2025 to issue the warning letter, compatibility concerns within the centre were acknowledged by a representative of the provider. Despite this, the warning letter response did not directly address this matter. In response to follow up queries for this response, the provider subsequently undertook to review a previous compatibility assessment that been completed for the centre in November 2024.

Since the June 2025 inspection, the volume of safeguarding incidents occurring in the centre remained high based on notifications submitted to the Chief Inspector. In total since that inspection, 28 notifications of a safeguarding nature which involved incidents or allegations between residents had been submitted from this centre. While some residents were involved in such matters more than others, each of the six residents living in this centre was involved in at least one of these safeguarding

notifications. Some of these incidents involved residents hitting or shouting at each other. The nature of these notifications continued to raise safeguarding and compatibility concerns for this centre.

On the current inspection, it was found that the November 2024 compatibility assessment had been reviewed by the provider's multidisciplinary team. A report of this review was read by the inspector but it was noted that this did not result in a definite finding. Despite this, the external announced audit of the centre in November 2025 highlighted "significant computability issues" and that "there is no clear plan or timeframe as to how these issues were going to be resolved". On the current inspection, the inspector was informed by management of the centre that the compatibility assessment for the centre was to be reviewed again. While this information was noted, given the volume of safeguarding notifications received from the centre, compatibility concerns remained with such matters contributing to safeguarding incidents in the centre. As such, the provider had not yet demonstrated that they could keep all residents safe from abuse in Blossomville.

It was acknowledged that a contributory factor to a number of the notifications received form the centre since the June 2025 inspection was the needs and presentation of one resident related to their mental health. Access for to psychiatry services for this resident had been previously highlighted as being beneficial for this resident. The November 2025 external announced audit of the centre highlighted how access to psychiatry services was not available on an ongoing basis. During the current inspection, the inspector was informed that the resident in question did have access to community mental health services at the time of this inspection and had been reviewed recently by a psychiatrist. The other five residents of the centre were indicated as last being reviewed by a psychiatrist in March 2025.

For the safeguarding allegations or incidents that had occurred in the centre since June 2025 inspection, documentation reviewed indicated that such matters were being appropriately screened with safeguarding plans put in place also. Since the June 2025 inspection, the frequency of reviews of such safeguarding plans had been increased while the amount of safeguarding plans had been consolidated. Such measures was in keeping with the warning letter response. Staff members spoken with during this inspection demonstrated a general good awareness of safeguarding plans in the centre. In addition, incident records reviewed for October and November 2025 highlighted how the presence of staff had prevented particular interactions between two residents from occurring. Had these interaction occurred, they would have amounted to further safeguarding incidents.

The inspector also observed instances during this inspection where safeguarding plans were followed such as one resident being assigned a staff member who accompanied the resident as they moved between rooms of the centre. Such a safeguarding measure was outlined in a specific safeguarding plan that had been put in place in July 2025. The inspector reviewed this plan which indicated that staff were to be beside the resident at all times when moving to another area of the centre. The inspector observed one instance when this did not happen on the inspection day but this did not result in any negative incident. This safeguarding plan also indicated that staff were to sign this safeguarding plan at the beginning of

each shift. A signature sheet for the plan indicated that it had not been signed by staff on 11 dates since 1 October 2025.

In addition, another active safeguarding plan which related to two residents (and had been reviewed in September 2025) expressly provided that staff were to remain in the sitting room at all times when these two residents were present there. While this safeguarding measures was seen to be followed at times during this inspection, the inspector also observed three brief instances where these two residents were left on their own in the larger room sitting without any staff present. No negative interaction between these residents was observed during such periods. However, such observations indicated that safeguarding plans were not consistently adhered to in the centre. The amount of safeguarding notifications since June 2025 also continued to raise concerns around the effectiveness of safeguarding plans.

Judgment: Not compliant

Regulation 9: Residents' rights

The provider must ensure that residents have the freedom to exercise choice and control in daily lives to comply with this regulation. During the June 2025 inspection, it was found that this requirement was not being met particularly with regard to resident choice at meals. Noticeable improvement was found in this area during the current inspection with stated actions from the warning letter response having being implemented. Examples of this included:

- On arrival at the centre, different breakfast options for residents were seen to have been laid out in the kitchen-dining room. These were intended to allow residents to pick what they had for breakfast. One resident was observed to be shown these different options by staff and was seen to point for bread which was prepared for the resident.
- The new logs that had been introduced for residents to record what food they ate also recorded what food they had been offered. When reviewing these logs for two residents from 15 September 2025 on it was seen that these logs indicated that residents were offered different choices of food for their meals.
- Visual choice boards for residents had been introduced to help residents in selecting their choice of food. Staff spoken with were aware of these and were seen using these after being overheard asking residents what they wanted.

It was also indicated to the inspector that these choice boards were to be used to allow residents to pick what activities they wanted to do for the day. The activities selected by residents were then to be indicated on an overall activity timetable that was on display in the centre. During the early stages of the inspection, the inspector observed a staff member making entries for two residents on this activity timetable even though both of these residents had yet to get up at this time. This staff member latter conceded that they had forgotten about asking residents what they

wanted to do when initially adding to the activity timetable but that they had asked both residents about this later in the day.

Aside from this, the inspector was also informed by a member of management that one-to-one meetings were held with residents to consult with them. Records reviewed for one resident for October and November 2025 indicating that such meetings were happening. Such notes indicated that topics such as activities and any wants for residents were discussed with this resident at these meetings. Further records reviewed showed that communal resident meetings took place during August 2025 and June 2025. These records indicated that the meetings were used to inform residents about the compliance plan response submitted by the provider for the June 2025 inspection and of restrictive practices used in the centre. Due to a change in circumstances for one resident, a restrictive practice that had affected other residents had been removed in the time leading up to this inspection.

It had also been identified by the provider that particular arrangements were in place related to residents' finances which amounted to restrictions. These restrictions meant that residents did not have direct access to and control over their personal financial accounts. Such arrangements impacted the residents' legal rights and were also not consistent with the provider's policy on residents' finances. This stated that the provider would "respect a resident's right to control their finances" and was "committed to supporting residents who use our services to use and manage their money". While this impacted residents' rights, a member of the centre's management outlined measures to ensure that residents were never short of finances. Furthermore, it was also found, based on records reviewed, that a new personal possessions log had been introduced for one resident since the June 2025 inspection. Previous inspections of this centre had found that this resident had particular needs around the self-ripping of clothes.

Judgment: Substantially 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 23: Governance and management	Compliant
Quality and safety	
Regulation 18: Food and nutrition	Compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Blossomville OSV-0001822

Inspection ID: MON-0048004

Date of inspection: 24/11/2025

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

This document is divided into two sections:

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

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

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 8: Protection	Not Compliant
Outline how you are going to come into compliance with Regulation 8: Protection: To come into compliance with Regulation 8: Protection: • The Provider raised this concern with the HSE at a meeting on the 20th of November. The Provider convened a meeting with HSE representatives on January 15th 2026 to discuss compatibility concerns within the designated centre. The meeting concluded the most appropriate course of action is for a Mental Health Assessment to be undertaken by a designated Mental Health Intellectual Disability (MHID) Consultant Psychiatrist. The Provider will inform the Chief Inspector of the date of such Assessment once it has been furnished with same. • In the interim, the Resident continues to be supported through the local Community Mental Health Service in conjunction with their General Practioner. The provider wishes to reassure the Chief Inspector that it is fully committed to achieving compliance with Regulation 8 at the earliest opportunity. • A Psychiatrist has been appointed to the CH03 area however is not open to accepting referrals at present. All residents have access to their GP and emergency services when/as required. • The Person in Charge discussed the importance of adhering to safeguarding plans and protocols especially where supervision and 1:1 supports are identified with senior staff members and discussed with all staff at a team meeting which was held on 29/12/2025. The Person in Charge also reviewed and updated associated protocols to increase compliance, particularly in the area of staff signatures. **The compliance plan response from the registered provider does not adequately assure the Chief Inspector that the action will result in compliance with the regulations.**	
Regulation 9: Residents' rights	Substantially Compliant
Outline how you are going to come into compliance with Regulation 9: Residents' rights: • The Person in Charge spoke with senior staff in relation to resident's choice boards for activities and the recording of same and was discussed with all staff members at a team	

meeting on 29/12/2025.
• The Provider wishes to confirm St. Joseph's Foundation is actively reviewing its practices in terms of supporting residents to manage and access their finances. This involves reviewing and updating the policies impacting our residents, particularly our Finance and Restrictive Practice Policies, mindful of our responsibilities of implementing the Assisted Decision-Making Act 2015 and the Health Act 2007. As previously indicated, the Provider has been liaising with its bank in regard to access to finances for its' service users. Following the most recent discussion with the bank the original implementation date of the 31st December 2025 unfortunately can no longer be met. The Provider wishes to assure the Chief Inspector that it is fully committed to resolving this and thus coming into compliance with Regulation 9. To that end, it is now envisaged that a solution will be implemented by 31st May 2026. The banks compliance unit and its local compliance manager are involved at both local and national level in determining a solution. The Provider wishes to assure the Chief Inspector that until this issue is resolved that monies are available to all residents at all times through the Finance department and in line with the Provider's Policy; To Support People Who Use Our Services to Manage their Money.

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 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	13/02/2026
Regulation 09(2)(c)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability can exercise his or her civil, political and legal rights.	Substantially Compliant	Yellow	31/05/2026