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:	Baldoyle Residential Services
Name of provider:	St Michael's House
Address of centre:	Dublin 13
Type of inspection:	Unannounced
Date of inspection:	19 February 2026
Centre ID:	OSV-0002340
Fieldwork ID:	MON-0045577

About the designated centre

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

Baldoyle Residential Services is a designated centre operated by St. Michael's House. The designated centre is located in a seaside residential suburb of Co. Dublin and is located on the first floor of a large three storey building. The entire property is owned by St. Michael's House. The ground floor of this building comprises a primary school for children with disabilities, a day care facility for adults and a swimming pool. Administration offices are located on the second floor where outpatient clinics are also held. The designated centre is divided into two areas, each with their own living areas and kitchen facilities. Access to the designated centre is through a large reception area for the entire building and there is a lift and stairs available to residents. Six residents reside in the centre. Residents are supported by a team of nurses and care staff.

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
Thursday 19 February 2026	09:30hrs to 19:00hrs	Jacqueline Joynt	Lead

What residents told us and what inspectors observed

The purpose of this inspection was to monitor compliance with the regulations and in particular, to ensure residents living in the centre were provided with the services in accordance to the centre's statement of purpose.

The inspection was facilitated by the person in charge for the duration of the inspection. The inspector used observations and discussions with residents, in addition to a review of documentation and conversations with key staff and management, to inform judgments on the residents' quality of life.

On entering the centre, the inspector provided the person in charge with a 'nice to meet you' document to share with the residents. 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 support residents in relation to unexpected visitors in their home.

The provider, person in charge and staff team were striving to ensure that residents living in the designated centre, were provided with a good quality service. The person in charge promoted an inclusive environment where each of the resident's needs, wishes and intrinsic value were taken into account. However, improvements were needed in terms of residents' financial support arrangements and their living environment.

Residents were supported to manage their financial affairs. Since the last inspection, two residents had been supported to open their own personal accounts in financial institutions. While this was a positive move towards promoting residents' rights in terms of independence and access to their finance, further steps were needed to review the arrangements in place regarding residents' weekly payments.

The designated centre provided full-time residential care and support to six residents with intellectual disabilities. The centre was located on the first floor of a three-storey building. Access to the designated centre was through a large reception area for the entire building including a communal lift and stairs. However, the inspector found that this arrangement posed a potential risk to residents' safety as well as the safety of their personal property and possessions. On the day of the inspection, the inspector observed people from another service freely accessing the residents' home without permission.

Since the last inspection, there had been a change in plan for the centre. The plan to close the centre, in line with national de-congregation policy, was no longer in place. A planned new premise that was due to be completed in 2026, had not gone ahead. The inspector was informed that the planning permission had not been granted. On the day of the inspection, the inspector was advised by senior

management that there was no new plan in place regarding the transition of residents to alternative accommodation.

The inspector observed the layout and structure of the centre to present as institutional in nature, however, as an interim solution, the provider and person in charge had decorated and furnished the centre in a way that provided, as much as possible, a homely space for residents.

Overall, the communal spaces in the centre were observed to be in good upkeep and repair. There were three large sitting rooms in the centre which provided ample space for resident to move around freely. The rooms included large couches, soft furnishing, pictures and mirrors, all providing a homely and cosy atmosphere to the rooms. There was an array of large pictures and framed photograph collages of residents placed on the walls of the hallway.

The residents' bedrooms were observed to be individually decorated and took into account their likes, interests and preference. The inspector observed that residents' bedrooms were decorated to their individual style, taste and choice. Residents' bedrooms included soft furnishings, memorabilia, pictures and family photographs.Staff who spoke with the inspector, informed them that residents had been consulted regarding the décor and layout of their room as well as the communal spaces in the centre.

There were two large kitchens with cooking facilities which some of the residents liked to avail of. On speaking with staff on the day, they told the inspector that sometimes the residents liked to engage in cooking activities. Primarily, food was cooked in a central kitchen and delivered to the centre. Residents were consulted about, and were part of the decision-making about the food they ate. On a weekly basis during their household meetings, residents were supported to choose what meals they would like to eat during the week. Staff informed the inspector, that if residents chose to have a different meal on any day, that there was always another option available to them. Residents also enjoyed take-away food of their choice one night of the week. On the evening of the inspection, the inspector observed three residents being supported by staff to eat their meal in a caring and dignified manner.

Residents living in this designated centre required considerable supports in relation to their manual handling and healthcare needs. The provider had ensured the centre was supplied with a comprehensive scope of manual handling aids and devices to support residents' mobility and manual handling requirements.

Bathrooms were supplied and fitted with various assistive aids and overhead tracking hoists were also available. Residents were provided with aids and appliances that supported their personal hygiene and intimate care needs. However, the inspector observed bathrooms to be large and clinical in style and nature, including the flooring, screens and fixtures and fittings.

From speaking with staff and from a review of residents' healthcare support plans, the inspector found that the person in charge and staff team were proactive in referring residents to healthcare professionals and ensuring recommendations were

implemented. However, some improvements were needed to ensure that actions from the previous compliance plan regarding, GP annual visits and screening programmes, were facilitated in line with residents' needs, preferences and wishes, and clearly written in residents' plans.

During the day, most residents were attending a day service which was located on the ground floor of the building. During the morning the inspector met with one resident and their family member. The resident expressed their upset at the noise coming from the floor above. They said they could hear footsteps and loud cleaning equipment during the early evenings hours when they were in their bedroom.

The resident also relayed their unhappiness at the location of a seating clinic near the entrance of their home (next to the lift entrance). The resident said when the doors of the clinic opened there was a clicking sound that resulted in an uncomfortable buzzing and ringing sound in their ears. The resident informed the inspector that they had been supported to make a complaint about these matters.

The residents also relayed positive views about some of the activities they were supported to enjoy with staff. The resident had recently enjoyed attending a local Valentine's ball. They showed the inspector their outfit they wore to the ball while expressing their happiness and enjoyment about the night. The resident also talked enthusiastically about their enjoyment of fundraising for charities and completing a 10KM marathon with a staff member.

Later in the afternoon, the inspector met with five other residents. Two of the residents appeared tired and the inspector was informed that they had a busy day at their day service. Residents enjoyed activities such as swimming, cooking and arts and crafts as part of their day service. Staff informed the inspector that on most evenings the residents liked to relax at home watching movies, listening to music or spending some quiet time in their bedrooms. One of the residents who preferred to unwind in a more active way, was provided a room where they could listen to loud music and observe colourful flashing lights projected on to the walls and ceiling.

The inspector observed that overall, staff understood what residents were communicating to them. Throughout the day, during conversations between the inspector and a number of residents, staff members supported the conversation by communicating some of the non-verbal cues presented by residents.

The inspector reviewed the designated centre's 2025 and 2026 residents' photographic activity diary. The diary was divided up into sections with each month displaying a selection of photographs of various residents enjoying on-site and community activities. For example, there were photographs of residents dining out in local cafes, going to the cinema, going for walks, attending musicals in theatres, swimming and visits to the local church, to name but a few.

Residents were supported by a team of nurses and care assistants who were managed by the person in charge. On speaking with staff, the inspector found that they were familiar with the residents' different personalities and were mindful of each resident's uniqueness and different abilities.

The inspector found that there was an atmosphere of friendliness, and residents modesty and privacy was observed to be respected. In addition, residents' personal plans included clear detail on how to support each resident with their personal and intimate care needs in a way that respected their dignity. When walking around the centre the inspector observed that one of the communal bathrooms included an additional screen next to the shower bed. The inspector was informed by staff that the screen was used in line with a resident's privacy preference and wishes.

In summary, the inspector found that each resident's well-being and welfare was maintained to a good standard and that there was a strong and visible person-centred culture within the designated centre. For the most part, the inspector found that there were systems in place to ensure residents were in receipt of good quality care and support. Through speaking with residents and staff, through observations and a review of documentation, it was evident that staff and the local management team were striving to ensure that residents lived in a supportive and caring environment.

However, there were improvements needed to the areas of protection and premises to ensure the residents' safety at all times. These are discussed in detail 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 centre had a clearly defined management structure in place which was led by a capable person in charge. The person in charge was an experienced, qualified professional and demonstrated their knowledge of the residents' assessed needs and the supports required to meet those needs. The person in charge was supported in their role by a clinical nurse manager.

The registered provider had completed an annual review regarding the quality of safe care and support provided to residents during 2024 and was currently compiling an annual report for service provision during 2025. Six-monthly unannounced visit had also taken place in the centre and a suite of audits, including monthly data reports, had been carried by the person in charge.

There were clear lines of accountability at individual, team and organisational level so that all staff working in the centre were aware of their responsibilities and who they were accountable to. There was a staff roster in place and it was maintained

appropriately. There were no staff vacancies in the centre at the time of the inspection; The current staffing arrangements ensured continuity of care for residents living in the centre.

The inspector spoke with staff members throughout the course of the inspection. The staff members were knowledgeable on the support needs of residents. Whilst observing management and staff engage with residents, the inspector saw that interactions were positive, kind and caring.

Staff completed relevant training as part of their professional development and to support them in their delivery of appropriate care and support to residents. The person in charge regularly reviewed staff training needs and on the day of this inspection, staff training was found to be up-to-date.

For the most part, there was appropriate information governance arrangements in place to ensure that the designated centre complied with all notification requirements. However, some improvements were needed to ensure all quarterly notification were submitted as per the regulatory requirement.

The provider had suitable arrangements in place for the management of complaints and an accessible complaints procedure was available for residents in a prominent place in the centre. However, some improvements were needed to ensure the effectiveness of the procedures at all times.

Since the last inspection the provider had completed a number of actions in an effort to bring protection and premises back into full compliance and overall, ensure positive outcomes for residents. However, these actions had not been fully completed and were now impacting on the lived experience, safety and financial independence of residents.

Regulation 15: Staffing

The provider and person in charge had ensured there was enough staff with the right skills, qualifications and experience to meet the assessed needs of residents, at all times, and was in line with the statement of purpose and size and layout of the building.

The staff team consisted of nurses and care assistants as well as two household staff and a maintenance person. A review of staffing requirements had recently taken place and had found that currently due to the numbers of needs of residents that the centre was over resourced. Discussions were currently ongoing with the staff team about this matter.

The person in charge maintained a planned and actual staff roster. The roster accurately reflected the staffing arrangements in the centre, including the full names of staff on duty during both day and night.

The inspector reviewed a sample of the rosters for the months of January and February 2026. The roster demonstrated that regular staff worked in the centre during these months, which ensured continuity of care that promoted and maintained relationships between residents and the staff. A number of staff on the day, informed the inspector that they had worked in the centre for over twenty five years. Overall, the inspector found the person in charge and staff members to demonstrated good understanding of the residents' needs and of their individual likes and preferences.

On the afternoon of the inspection, the person in charge organised for a sample of eight staff records to be brought to the designated centre. On review of a sample of staff files (records), the inspector found that they contained all the required information as per Schedule 2.

Judgment: Compliant

Regulation 16: Training and staff development

Staff members were provided with a range of training as part of their professional development and to support them in the delivery of appropriate safe care and support to residents. Overall, staff training was up-to-date. Where training was due, this was noted in the training matrix with a plan in place for staff to complete the training.

The centre's training matrix records showed that staff had completed training in relevant areas, such as safeguarding and protection of vulnerable adults, fire safety, managing behaviours of concern, manual handling, epilepsy, food safety, feeding, eating and drinking (FED), infection prevention and control (IPC), open disclosure, dignity at the workplace and first aid.

Supervision and performance appraisal meetings were provided for staff to support them perform their duties to the best of their ability. The person in charge had developed a schedule of supervision for 2026 for all staff members. On review of the schedule, the inspector saw that all staff had been provided with a one to one supervision meeting in January this year with dates in place for the remaining three meetings throughout 2026.

Judgment: Compliant

Regulation 23: Governance and management

The inspector found that while the provider had systems in place to monitor the quality and safety of care provided in the centre these systems were not always effective.

Audits such as medication management, residents finances, restrictive practice and infection prevention and control (IPC) had been completed during 2025. However, while these audits had bee completed they had not been effective in identifying the issues that were found on the day of the inspection in relation to premises, protection, IPC and medication management.

Two six-monthly unannounced visits had taken place in the centre during June and December 2025 which included action plans and completion times lines. The inspector noted two items in the December 2025 unannounced visit documents relating to safeguarding and premises. The documents noted that financial safeguarding for one resident remained on-going and that the issue was unresolved. In relation to the premises, documents noted that the centre was an old hospital and that a suitable property in the community was needed. However, the review failed to identify a potential safeguarding issue in relation to access to the centre.

While the provider had identified the finance and need for a more suitable property in their review, there was no clear action plan in place to resolve them fully. In addition, both these issues had been raised during the last inspection of the centre in May 2024. Overall, the timeliness of the provider to resolve these issues was not satisfactory and posed a number of potential risks to the lived experiences and safety of residents. These issues are discussed in more detail under Regulation : 8 Protection and Regulation : 17 Premises.

The person in charge, had the appropriate qualifications and skills and sufficient practice and management experience to oversee the residential service to meet its stated purpose, aims and objectives. They were supported by a clinical nurse managers (CMNI) in assisting them with the operational oversight of the centre.

In addition, the person in charge completed monthly data reports, incident and accident trackers, and audits relating to health and safety, medication management, fire safety, and infection, prevention and control. Overall, where there were actions arising from audits these had been completed in a timely manner.

The provider had completed an annual report of the quality and safety of care and support provided in the designated centre during 2024 which included consultation with residents, families and staff. However, on the day a physical copy of the most up-to-date annual report was not available to residents or their family in the centre. The person in charge printed out a copy for the inspector on the day.

Judgment: Not compliant

Regulation 31: Notification of incidents

For the most part, there were effective information governance arrangements in place to ensure that the designated centre complied with notification requirements.

The inspector found that incidents were managed and reviewed as part of the continuous quality improvement to enable effective learning and reduce recurrence. It was evident that the provider and person in charge strived for excellence through shared learning and reflective practices. Where there had been incidents of concern, the learning from the incident was discussed with staff at team meetings.

However, an improvement was needed to ensure that there were adequate system in place when collating information regarding non-serious injuries. On speaking with the person in charge and on review on an incident tracker for 2025, a number of non-serious injuries had occurred. These had not been notified as required for the period October to December 2025.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

The provider had established and implemented a complaint handling processes. For example, there was a complaints policy in place. In addition, staff were provided with the appropriate skills and resources to deal with a complaint and staff spoken to on the day, had a full understanding of the complaints policy and procedures.

The inspector observed that the complaints procedure was accessible to residents and in a format that they could understand. It included access to a complaint's officer when making a complaint or raising a concern. On speaking with the person in charge and staff, the inspector was informed that the complaints process was discussed with residents during their household meetings. Resident are asked to relay any issues or complaints they want to raise at these meetings.

One resident informed the inspector about a complaint they had raised. On review of the complaint log, the inspector saw that the complaint had been logged and followed up with the resident. However, the complaint had been closed. The inspector saw that the resident's satisfaction level had not been recording on the complaint form. Overall, to ensure the effectiveness of the centre's complaints system, improvements were needed to the closing of complaints so that they clearly demonstrated a resolution as well as the satisfaction levels of the complainant.

Judgment: Substantially compliant

Quality and safety

This section of the report details the quality and safety of the service provided to residents who lived in the designated centre.

The provider and person in charge were striving to ensure that a safe and quality service was delivered to residents living in this centre. For the most part, the findings of this inspection demonstrated that overall, the provider had the capacity to operate the service in compliance with many of the regulations reviewed. However, improvements were needed to the residents living environment as well as some of their financial arrangements; This was to ensure that residents were appropriately protected at all times.

A review of the layout and location of the premises was needed to ensure that appropriate security measures were in place to keep residents and their property and possession safe at all times. The residents were living in premise that was institution in nature and style. Since the last inspection, the plan for a six-bedroom home in the community was no longer in place and there was no alternative plan or timeline in place.

There had been some improvements to two resident's financial independence during 2025. Arrangements were put in place to support the residents open personal accounts in a financial institution. However, further improvements were needed to ensure that residents were supported and empowered to access and manage their own finances as much as they were capable of.

The inspector reviewed a sample of residents' personal plans and saw that they included an assessment of each resident's health, personal and social care needs. There were corresponding support plans in place that guided staff on how to best support residents' assessed needs.

The person in charge and staff were endeavouring to ensure that residents could receive information in a way that they could understand. Residents were provided with communication support plans that had been developed from a comprehensive individual communication assessment.

Overall, appropriate healthcare was made available to residents having regard to their personal plan. Residents' plans were regularly reviewed in line with the residents' assessed needs and required supports. However, some improvement was needed to ensure that all residents were provided choice of access to national screening programmes.

Where required, positive behaviour support plans were provided to residents and were reviewed on a regular basis. All staff had completed training to support them in helping residents to manage their behaviours that challenged.

There were a number of restrictive practices used in this centre. They were clearly documented and subject to approval and review by the appropriate health professionals. The restrictive practices were supported by appropriate risk assessments which were also reviewed on an annual basis or sooner if required.

The inspector found that for the most part, the medicine arrangements and practices were appropriate and in accordance with the provider's associated policy. The person in charge was endeavouring to ensure that the designated centre had appropriate and suitable practices relating to the ordering, receipt, prescribing, storing and disposal and administration of medicines. However, on the day of the inspection, improvements were required with regards to the labelling arrangements for some resident's medication as well as the effectiveness of the associated audits.

Regulation 10: Communication

The person in charge was striving to ensure that residents were provided information in a way that they understood. The inspector observed examples of easy-to-read formats in residents' personal plan and an array of easy-to-read, picture and photographic formats of information displayed on the residents' notice board in the kitchen, sitting room and bedrooms.

Residents' assessment of need included a communication assessment and from this a communication support plan was developed. The support care plan included the method of communication the resident used to express themselves. The information in the support plan provided guidance for staff on how to best communicate with each resident in line with their needs, wishes and preference.

The person in charge showed the inspector an example of one resident's communication passport that was in the form of a small booklet. The passport included information that best described the resident's communication profile and preferences.

On observing the communication passport, the inspector saw that it relayed information on how the resident liked to be communicated with and how they communicated with others. It gave explanations of facial expressions, vocalisation and complexion as ways of explaining what the resident was communicating and how they made choices.

Overall, this provided a lot of information to guide and support staff to understand the resident's communication support needs. However, there was a large amount of typed information within the booklet, which was not in line with the resident's communication assessed needs and overall, took away from the person-centred nature of the booklet.

On the day of the inspection, the inspector was informed, that since the December 2025 six-monthly unannounced review, there was a plan in place to review residents' communication supports to ensure the effectiveness of what was in place and make quality improvements where required.

Judgment: Compliant

Regulation 17: Premises

The provider had failed to ensure that the residents were living in an environment that met the aims and objectives of a person-centre designated centre. In addition, the provider had failed to ensure that the layout and structure of the designated centre met the assessed needs of residents, in terms of their safety and security.

The last inspection of the centre in May 2024, found that there were plans to relocate residents to a more suitable environment in the community. At the time of the last inspection, planning permission was ready to be submitted, a site had been secured as well as funding to build the premises. It was estimated that the building would be ready by 2026. However, on the day of this inspection, the inspector was informed that the planning permission had been denied and there were currently no plans in place for alternative accommodation for the residents to move to.

The person in charge and staff team had made a lot of effort to make communal rooms, as well as each resident's bedroom, appear as homely as possible. This was an interim measure until the residents moved to their new home. However, the designated centre, which was previously an old hospital, was overall, institutional in nature and layout. The centre was very large in size and included long wide corridors, high ceilings, old large radiators, hard flooring throughout and clinical style shower, bathroom and laundry facilities. There were also a number of unused rooms that were formerly used as bedrooms, with some of the rooms containing previously owned equipment and furniture.

In addition, due to the location of the centre, there was no front door or private entrance available to the residents. The centre was accessed through a main front reception entrance (which was used by everyone accessing the building). The centre was located on the first floor and required entry though a lift or stairs. On the day of the inspection, the inspector observed that access to the centre, via the lift and stairs, posed a potential safety and security risk for residents. This is discussed further under Regulation 8: Protection.

Overall, the premises the residents were currently living in was not meeting the aims or objectives of a person centred service. The internal layout and external structure was presented as institutional. The type of entrance into the centre was not meeting residents assessed needs, in terms of their safety needs. While the interim décor and furnishings measures had provided a homely feel to the centre, this was only meant to be as an temporary measure. The timeliness of the provider to support the residents to move to an alternative accommodation in the community was not satisfactory and was impacting negatively on their lived experience in a home.

Judgment: Not compliant

Regulation 26: Risk management procedures

The inspector reviewed the centre's risk management policy and found that the provider had ensured that the policy met the requirements as set out in the regulations. The risk management policy had been reviewed in June 2023 and was due the next review in June 2026.

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.

The person in charge had completed a range of risk assessments with appropriate control measures, that were specific to residents' individual health, safety and personal support needs.

For example;

- where there was a risk of injury to a resident due to self-injurious behaviours, there were measures in place to reduce the risk. Some of the measures involved, eliminating triggers such as loud noise, one to one interaction in a quiet environment, ensuring the resident had their meals in a quiet environment, use of guidance in the resident's pain management support plan
- where there was a risk of injury due to seizure activity for a resident, there were a number of measures in place which included, epilepsy care plan in place, use of bed-rails, rescue medication prescribed, staff aware of triggers, and staff nurse on duty 24/7
- where there was a risk of injury relating to manual handling, there were a number of measures in place which included, all staff to follow occupational guidelines for sling and hoisting positions, two staff present at all time as well as taking guidance from residents if they said they were uncomfortable.

There were also centre-related risk assessments completed with appropriate control measures in place.

Judgment: Compliant

Regulation 27: Protection against infection

Overall, the inspector found that infection prevention and control (IPC) measures were effective and efficiently managed. There was an up-to-date comprehensive policy relating to IPC in the designated centre and it was made available to all staff.

On walking around the centre, the inspector observed the house to be clean and in good upkeep and repair. However, some improvements were needed to the IPC

guidance documents in place so that they provided adequate and up-to-date information to support the staff ensure the safety of residents at all times.

There was an IPC specific folder in place which provided information, guidance and updates to support staff in their role. However, the inspector observed that there was a lot of information related to 2023 and 2024 which primarily referenced COVID 19. For example, documents relating to signs and symptoms of COVID19, updates on COVID19 leave 2023 and COVID19 guidance July 2024. Overall, to support the effective implementation of IPC measures and to keep residents safe, improvements were needed so that information provided to staff was relevant, in date and considered all health associated infections.

Notwithstanding the above, staff were provided specific training in relation to the prevention and control of infection. To support staff with the cleaning of the centre, the provider had employed two household staff members. These staff members also supported residents with their laundry.

Cleaning records demonstrated a high level of adherence to cleaning schedules. The inspector observed that there were adequate cleaning equipment and cleaning products and that they were stored appropriately. There were cleaning checklist on the walls outside each bathroom, bedroom, hall area and communal area. On review of four of the checklists, which described the spaces and fixtures and fittings to be cleaned as well as scheduled bed linen change, the inspector saw that that all checklists had been completed.

The provider and person in charge had ensured that local monthly infection prevention and control audit were being completed as part of the monthly data report, which included an infection prevention and control checklist. The inspector observed that the most recent audit had been completed in January 2026.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The centre had appropriate fire management systems in place. The inspector found the registered provider had appropriate fire safety systems in place including fire detection, containment and fire fighting equipment.

There was adequate arrangements made for the maintenance of all fire equipment. All fire safety equipment was subject to regular checks and servicing with a fire specialist company. There was adequate means of escape and emergency lighting in place.

An inspection of the fire doors, to ensure their effectiveness and performance, was completed on an annual basis. The most recent inspection of the doors had been

completed and signed off by an external fire safety specialist company in September 2025.

On review of fire safety records, the inspector saw that there were systems in place for staff to carry out daily, weekly and quarterly fire safety checks. Regular fire drills were completed, and the person in charge had demonstrated that they could safely evacuate residents under day and night time circumstances.

All staff had completed fire safety training. On speaking with a staff member on the day, the inspector found that they were knowledgeable in how to support residents evacuation from the centre in case of fire, while keeping in mind residents' support needs.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

Overall, the inspector found that the provider had failed to ensure there were appropriate oversight systems in place to ensure safe medication practices and to ensure their effectiveness, at all times. As such, some of the medication systems and practices in place, posed a potential risk to the residents' safety.

Residents were supported with their medication by a team of nurses who were competent in the administration of medicines and medicine management. A member of the team showed the inspector the two medication cupboards and the systems, protocols and processes in place for the safe management of medicine. Overall, the staff member was knowledgeable on medicine management procedures and on the reasons medicines were prescribed. For the most part, the medication administration records indicated that medications were administered as prescribed.

The provider had ensured that, appropriate systems were in place for the ordering, receipt and prescribing of medicines. However, deficits were found in areas relating to the storing, disposal and administration of medications which posed a potential risk to the safety of residents.

For example: a review of the labelling and oversight systems in place, to monitor the expiry date of medications, was needed. The inspector observed that where medicines expired sooner than the actual expiry date, (once opened), that this was not recorded on the medicine's label.

In addition, the medication audit had recorded all medication expiry dates as per the date on the package and not the ‘once opened’ date. For example, the inspector saw one liquid medication opened label note 31/08/25. The audit noted expiry date June 2027. However, the medicine instruction leaflet stated that once opened, the medication expired within twelve months.

The inspector observed that where a resident's medical cream and liquid had been opened, it had not been provided a label to note the opening date. As such it was difficult to ascertain if the medication was still in date and safe to use.

Overall, these labelling issues meant that there was a potential risk to residents' health should the medication be administered.

There was a 'transfer of medication' log in place which demonstrated the safe procedures in place when medicines was transferred in and out of the centre during residents visit to their family home. However, the log did not take into account medications that were transferred between the designated centre and residents' day service, and this required review.

For example, where one resident brought medication (pain relief) to their day service, the inspector observed it to be recorded on the administration sheet as "day service", with no time of administration recorded. The nurse informed the inspector that they were aware the resident was administered the medication at the same time every day. However, there was no record handed over from the day service to confirm this. This meant there was a potential risk of the resident receiving a dosage of the same medication outside the recommended time frame.

There was a specific medical bin in place for disposal of out of date medication which was removed by an external company when full. However, a review of the disposal of soiled or refused medication was needed to ensure that it was disposed of appropriately and safely. For example, the inspector was informed that if a resident's medication was soiled and could not be administered, it would be wrapped in a tissue and put in the regular refuge bin. Overall, this practice posed a potential safety risk and was not in line with best practice.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

Each resident was provided with a personal plan that included an assessment of their needs.

The assessments were informed by each resident, their representatives and multidisciplinary professionals as appropriate. The main body of residents' assessment of need was made up of eight sections including, communication, social supports, emotional wellbeing, general health, physical and intimate care supports, safety , environment and rights.

The assessment informed comprehensive care plans which were written in a person-centred manner and detailed residents' preferences and needs with regard to their care and support. Residents were provided with an annual 'my life' review meeting

where their needs were reviewed and any update or change was recorded and relayed in their care support plans.

The care support plans were reviewed every three months or sooner if required. On review of a sample of support plans, the inspector saw that overall, they were in date and had been reviewed in line with the provider's policy. Where there were some gaps, these had been identified through a keyworker peer to peer review and labels placed within the sections of the plan to note the gaps that required addressing.

Residents were provided with different forms of an assessable format of their goal progress and achievement that were in line with their wishes and preferences and communication support needs. For example, plans were presented in photographic format within the personal plan, on residents' bedroom walls and through the centre's photographic annual activity book.

Judgment: Compliant

Regulation 6: Health care

The inspector found that, for the most part, appropriate healthcare was made available to residents having regard to their personal plan. Residents' personal plans took into account their physical wellbeing as well as their medical history, mental health, diet and nutritional needs but to mention a few.

Residents' healthcare plans demonstrated that each resident had access to allied health professionals. For example, residents were facilitated to have access to a dentist, chiropodist, psychologist, occupational therapist, physiotherapist, speech and language therapist, dietician and psychiatrist. Therapeutic supports were accessed as required through referral from the residents' nursing team and on the advice and recommendation from their general practitioner (GP).

Residents were supported to live healthily and were provided with choice around activities, meals and beverages that promoted healthy living. On review of the weekly menu planner, the inspector saw that there was a lot of healthy food options available to residents. Residents were supported to live an active life as much as possible. Many of the resident enjoyed swimming on a weekly basis as part of their day service. One resident told the inspector about their achievement of completing a10km mini-marathon during 2025.

Since the last inspection, the provider had employed a new GP for the organisation. In line with the centre's statement of purpose, residents' medical care and support needs were provided by a community and organisational GP.

The inspector found that improvements were needed to ensure, that where appropriate, and in line with residents preferences, all residents were provided the option to attend screening programmes. The provider had included in the last

inspection's compliance plan that national screening would be address by the organisation's GP during annual reviews. However, on the day of the inspection, there was no satisfactory evidence that this had occurred for two residents who came within that age range for one form of screening. This meant that the provider could not be assured that residents were in receipt of appropriate healthcare at all times of their life.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

The provider and person in charge promoted a positive approach in responding to behaviours of concern and ensured evidence-based specialist and therapeutic interventions were implemented.

The inspector found that there were arrangements in place to provide positive behaviour support to residents with an assessed need in this area. Two positive behaviour support plans reviewed by the inspector were detailed, comprehensive and developed by an appropriately qualified person. In addition, each plan included proactive and preventive strategies in order to reduce the risk of behaviours of concern.

The provider ensured that staff had received training in the management of behaviours of concern and they received regular refresher training in line with best practice. Staff spoken with were knowledgeable of support plans in place and the inspector observed positive communications and interactions throughout the inspection between residents and staff.

In line with the organisation's policy, the provider had a very clear restrictive practice assessment process in place. All restrictive practices were risk assessed. Where applied, the restrictive practices were clearly documented and were subject to approval and review by the organisation's positive approach monitoring group.

On speaking with the person in charge, the inspector was informed that they were always looking for ways to reduce restrictions in place. For example, from speaking with a staff member and on review of team meeting minutes, the inspector saw that there had been a discussion and review regarding the location of residents' money boxes in an effort reduce the current restrictions in place. While this had not yet been rolled out, it demonstrated the culture in place for reviewing and attempting to reduce restrictions in the centre.

Judgment: Compliant

Regulation 8: Protection

As mentioned earlier, the provider had failed to ensure that the layout and location of the designated centre protected the safety of residents, and their personal property and possessions at all times. The residents' home was located on the first floor of a very large old two story building that included a main reception entrance for all three floors, both the ground and third floor were occupied by other users. The second floor which is where the residents lived did not have a front door or a private entrance. The residents' home was accessed through either a lift or staircase at either end. This posed a significant potential risk to the safety, protection and privacy of the residents living in the centre, as well as the security of their belongings.

On the day of the inspection, when at the far end of the designated centre, the inspector observed a person wheeling another person in a wheelchair through the residents' kitchen and towards the sitting room. When asked, a staff member told the inspector that the people were from the service downstairs. The staff member said they were not aware of why the people were in the residents' home. Later in the day, the person in charge advised the inspector that the people, a staff member and service user from the day-service downstairs, had no permission to be in the residents' home or to access any of the areas within the centre. This demonstrated that unauthorised persons could access the residents home which posed a significant safety risk.

In addition, the provider had failed to ensure that all residents were provided adequate support to manage their own financial affairs including their own monies. Since the last inspection in May 2024, the provider had organised for two residents to open an account in a financial institution. However, as of the day of the inspection, residents' weekly payments were not paid directly into these accounts. There was no clear rationale for this situation. While there had been meetings between senior management and representatives of the residents concerned, the matter had not yet been resolved. This meant that the provider could not be assured that residents' finances were protected at all times. In addition, the situation was impacting on residents' rights, in terms of promoting their independence to access and manage their own finances.

Overall, these two issues were not ensuring the protection of residents at all times, in terms of their financial affairs and the environment they were living in. This posed a potential risk to the safety of residents as well as the safety of their personal property, possessions and finances.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Substantially compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Substantially compliant
Regulation 28: Fire precautions	Compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Substantially compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Not compliant

Compliance Plan for Baldoyle Residential Services OSV-0002340

Inspection ID: MON-0045577

Date of inspection: 19/02/2026

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 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:

• Families have been formally notified by registered post that residents must have access to their Disability Allowance and personal funds within two weeks. Failure to comply will result in referral to relevant statutory authorities. Date: 06/04/2026

• The process regarding residents' finances is currently being managed and regularly reviewed by the Director of Quality and the Designated Officer.

• The Director of Estates, Senior Assistant Technical Services Officer and the St. Michael's House Fire Officer conducted a site visit to the Designated Centre on 11/03/2026. Following an assessment of the premises, a plan has been implemented to enhance building security and prevent unauthorized access. Details of this plan have been submitted in conjunction with this compliance plan. Date: 17/07/2026

• In the interim, pending completion of the identified works, the following measures have been implemented to ensure the security and protection of residents:

- The main reception area is staffed from 9am-5pm Monday – Friday. During these hours, visitors are required to report to reception, where the receptionist will contact the Designated Centre to notify staff of their arrival.
- Outside of these hours, the front door remains locked. Individuals seeking access must ring the doorbell and will be admitted by staff on duty.
- Signage is in place at the top of the stairs leading to the Designated Centre, clearly indicating that the area is a Designated Centre. The signage advises individuals not to enter and to contact the Centre using the provided mobile phone number.
- A doorbell is installed at the exit point adjacent to the lift, allowing visitors to alert staff to their presence.
- A mobile screen has been placed at the exit point adjacent to the lift to clearly define the boundary to the Designated Centre.
- A memo has been issued to all users of the Baldoyle building reminding them to respect the boundaries of the Designated Centre and to follow the established procedure for requesting access.

Date: 17/04/2026

• An active plan is in place with the HSE to identify and progress suitable alternative accommodation for the Designated Centre. There is currently no defined timeline, but St Michael's House will keep HIQA updated on progress.
• All residents' profiles will be reviewed and updated for consideration by the Residential Approvals committee. Each resident will be considered and consulted in respect of any suitable vacancy as they arise. Date: 30/05/2026
• The person in Charge has implemented a transfer of medication recording sheet to ensure all medications are audited out and back in when residents transition between day and residential services. Date: 17/03/2026 Completed
• The date of opening of all prescribed cream and liquids will be recorded and documented in the audit process. Date: 17/03/2026 Completed
• A formal process is in place for the identification and management of spoiled medications. This process will be discussed at the next staff meeting. Date: 17/03/2026 Completed
• All discarded or spoiled medications are recorded in line with St Michale's House Safe Administration of Medication policy. A copy of the policy has been shared with all staff, and the policy will be discussed at the next staff meeting. Date: 17/03/2026 Completed
• The Person in Charge has completed a review of IPC folder ensuring that all obsolete documentation is removed. Date: 19/03/2026 Completed
• A new Outbreak Management plan has been developed in line with current guidance on the management of infectious diseases. Date: 19/03/2026 Completed
• The updated Outbreak Management plan and HSPC guidance will be added to the Centre's IPC folder to ensure staff have access to current and relevant information. Date: 19/03/26 Completed
• A memo section will be added to the IPC folder to ensure that all new information from IPC is accessible to staff. Date: 19/03/2026 Completed
• A hard copy of the most recent annual report has been printed and is on display in the entrance hallway of the Designated Centre. Date: 19/02/2026 Completed

Regulation 31: Notification of incidents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
• The Person in Charge submitted retrospective notifications to HIQA for the period October to December 2025. Date: 21/02/2026 Completed
• The Person in Charge will ensure all statutory notifications are submitted in line with regulatory requirements going forward. Date: 30/04/2026

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
• The complaint recording form (in the designated centre) has been reviewed and updated and staff have been instructed to document both the outcome of each complaint and the complainant's satisfaction level prior to closure.
Date: 25/03/2026 Completed

• The Person in Charge will ensure that all complaints will be formally closed once actions are completed. Date: 25/03/2026 • The Person in Charge will ensure complainant satisfaction is recorded before closing each complaint. Date: 25/03/2026 • Complaints management process will be discussed at the next staff meeting. Date: 30/03/2026 • Complaints will be included as a standing agenda item in management meetings to ensure continuous oversight. Date 30/04/2026

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises: An active plan is in place with the HSE to identify and progress suitable alternative accommodation for the Designated Centre. There is currently no defined timeline, but St Michael's House will keep HIQA updated on progress. • The Director of Estates, Senior Assistant Technical Services Officer and the St. Michael's House Fire Officer conducted a site visit to the Designated Centre on 11/03/2026. Following an assessment of the premises, a plan has been implemented to enhance building security and prevent unauthorized access. Details of this plan have been submitted in conjunction with this compliance plan. Date: 17/07/2026 • In the interim, pending completion of the identified works, the following measures have been implemented to ensure the security and protection of residents: - The main reception area is staffed from 9am-5pm Monday – Friday. During these hours, visitors are required to report to reception, where the receptionist will contact the Designated Centre to notify staff of their arrival. - Outside of these hours, the front door remains locked. Individuals seeking access must ring the doorbell and will be admitted by staff on duty. - Signage is in place at the top of the stairs leading to the Designated Centre, clearly indicating that the area is a Designated Centre. The signage advises individuals not to enter and to contact the Centre using the provided mobile phone number. - A doorbell is installed at the exit point adjacent to the lift, allowing visitors to alert staff to their presence. - A mobile screen has been placed at the exit point adjacent to the lift to clearly define the boundary to the Designated Centre. - A memo has been issued to all users of the Baldoyle building reminding them to respect the boundaries of the Designated Centre and to follow the established procedure for requesting access. Date: 17/04/2026 • All residents' profiles have been reviewed and updated for consideration by the Residential Approvals committee. Each resident will be considered and consulted in respect of any suitable vacancy as they arise. Date 30/05/2026

Regulation 27: Protection against infection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection: • The Person in Charge has completed a review of IPC folder ensuring that all obsolete documentation is removed. Date: 19/03/2026 Completed

• A new Outbreak Management plan has been developed in line with current guidance on the management of infectious diseases. Date: 19/03/2026 Completed • The updated Outbreak Management plan and HSPC guidance will be added to the Centre's IPC folder to ensure staff have access to current and relevant information. Date: 19/03/2026 Completed • A memo section will be added to the IPC folder to ensure that all new information from IPC is accessible to staff. Date: 19/03/2026 Completed

Regulation 29: Medicines and pharmaceutical services	Not Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services: • The person in Charge has implemented a transfer of medication recording sheet to ensure all medications are audited out and back in when residents transition between day and residential services. Date: 17/03/2026 Completed • The date of opening of all prescribed cream and liquids will be recorded and documented in the audit process. Date: 17/03/2026 Completed • A formal process is in place for the identification and management of spoiled medications. This process will be discussed at the next staff meeting. Date: 17/03/2026 Completed • All discarded or spoiled medications are recorded in line with St Michale's House Safe Administration of Medication policy. A copy of the policy has been shared with all staff, and the policy will be discussed at the next staff meeting. Date: 17/03/2026 Completed

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care: • As part of each resident's annual medical review, consideration will be given to participation in any relevant national screening programs, with all related documentation maintained in the resident's file. Date: 30/09/2026

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection: • • Families have been formally notified by registered post that residents must have access to their Disability Allowance and personal funds within two weeks. Failure to comply will result in referral to relevant statutory authorities. Date: 06/04/2026 • The process regarding residents' finances is currently being managed and regularly reviewed by the Director of Quality and the Designated Officer. • The Director of Estates, Senior Assistant Technical Services Officer and the St. Michael's House Fire Officer conducted a site visit to the Designated Centre on 11/03/2026. Following an assessment of the premises, a plan has been implemented to enhance building security and prevent unauthorized access. Details of this plan have been submitted in conjunction with this compliance plan. Date: 17/07/2026 • In the interim, pending completion of the identified works, the following measures have

been implemented to ensure the security and protection of residents:
- The main reception area is staffed from 9am-5pm Monday – Friday. During these hours, visitors are required to report to reception, where the receptionist will contact the Designated Centre to notify staff of their arrival.
- Outside of these hours, the front door remains locked. Individuals seeking access must ring the doorbell and will be admitted by staff on duty.
- Signage is in place at the top of the stairs leading to the Designated Centre, clearly indicating that the area is a Designated Centre. The signage advises individuals not to enter and to contact the Centre using the provided mobile phone number.
- A doorbell is installed at the exit point adjacent to the lift, allowing visitors to alert staff to their presence.
- A mobile screen has been placed at the exit point adjacent to the lift to clearly define the boundary to the Designated Centre.
- A memo has been issued to all users of the Baldoyle building reminding them to respect the boundaries of the Designated Centre and to follow the established procedure for requesting access.
Date: 17/04/2026
• All residents' profiles will be reviewed and updated for consideration by the Residential Approvals committee. Each resident will be considered and consulted in respect of any suitable vacancy as they arise. Date 30/05/2026

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 17(1)(a)	The registered provider shall ensure the premises of the designated centre are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.	Not Compliant	Orange	17/07/2026
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 to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	17/07/2026
Regulation 23(1)(f)	The registered provider shall ensure that a copy of the review referred to in subparagraph (d)	Substantially Compliant	Yellow	19/02/2026

	is made available to residents and, if requested, to the chief inspector.			
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.	Substantially Compliant	Yellow	19/03/2026
Regulation 29(4)(a)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that any medicine that is kept in the designated centre is stored securely.	Not Compliant	Orange	17/03/2026
Regulation 29(4)(c)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating	Not Compliant	Orange	17/03/2026

	to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that out of date or returned medicines are stored in a secure manner that is segregated from other medicinal products, and are disposed of and not further used as medicinal products in accordance with any relevant national legislation or guidance.			
Regulation 31(3)(d)	The person in charge shall ensure that a written report is provided to the chief inspector at the end of each quarter of each calendar year in relation to and of the following incidents occurring in the designated centre: any injury to a resident not required to be notified under paragraph (1)(d).	Substantially Compliant	Yellow	30/04/2026
Regulation 34(2)(f)	The registered provider shall ensure that the nominated person maintains a record of all complaints including details of any investigation into a complaint, outcome of a	Substantially Compliant	Yellow	30/04/2026

	complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.			
Regulation 06(1)	The registered provider shall provide appropriate health care for each resident, having regard to that resident's personal plan.	Substantially Compliant	Yellow	30/09/2026
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	17/07/2026