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:	Ardbeg
Name of provider:	St Michael's House
Address of centre:	Dublin 5
Type of inspection:	Unannounced
Date of inspection:	02 December 2025
Centre ID:	OSV-0002352
Fieldwork ID:	MON-0046239

About the designated centre

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

Ardbeg is a designated centre operated by St. Michael's House. The designated centre consists of a terraced house in a suburban area of North Dublin. It provides 24 hour residential care and support to six adult residents with intellectual disabilities. On the ground floor of the building there is an entrance hallway, a modest sized kitchen space, a large dining room, two living rooms, a side entrance with a small toilet, a utility room, a large shared bathroom, and two bedrooms. On the first floor there are four bedrooms, one staff office area which also acted as a sleep over room and contained en suite facilities, a main bathroom, and a small storage space. Exterior to the building there is a small driveway to the front with space for parking one vehicle while at the rear of the building there is a large enclosed garden with patio and outdoor dining space. The staff arrangement for the centre consists of a person in charge and a staff team of social care workers.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	5

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Tuesday 2 December 2025	10:00hrs to 16:00hrs	Jennifer Deasy	Lead

What residents told us and what inspectors observed

This inspection was an unannounced inspection to review the safeguarding arrangements in the centre. The inspection was completed over the course of one day and the inspector had the opportunity to meet with all of the residents who lived there.

Conversations with residents, observations of care and support and a review of documentation was used to inform judgments on the quality and safety of care. Overall, this inspection found that residents were in receipt of a good quality service. Some improvements were required to the oversight of documentation, and in particular to the review of daily progress notes and incident report forms to ensure that any adverse incidents were screened for safeguarding risks.

The designated centre is located in a busy suburb of Dublin and is registered to provide care and support to six residents. The centre is located close to many amenities and has good public transport links. The centre was seen to be clean and well presented on arrival. The inside of the house was warm, comfortable and homely. The inspector was told that the provider had recently completed works to the premises to enhance the fire safety arrangements for residents. Two ground floor bedrooms had been moved to the front of the house and a new evacuation corridor had been constructed. Downstairs, residents also had access to two sitting rooms, a large kitchen, a dining room, accessible bathroom and a utility. The garden for the centre had been recently landscaped and provided an accessible area for residents to enjoy.

Upstairs in the house there were four more resident bedrooms, a staff office and a communal bathroom. In general, most areas of the house were seen to be very clean and well-maintained; however, improvements were required to the upstairs communal bathroom. This will be discussed further in the quality and safety section of the report.

Two residents were at home when the inspector arrived. These residents were enjoying a relaxed start to their day and were observed preparing breakfast and cups of tea. Residents were supported by staff members with activities of daily living in a kind and respectful manner throughout the day. Both of the residents who were at home that morning had moved into new bedrooms. They both showed the inspector their bedrooms and were proud of them. The residents showed the inspector their important possessions, posters and photographs which were neatly displayed. One of the residents showed the inspector their wardrobes and described how happy they were with them.

Both residents told the inspector about their plans for the day which included shopping and getting their hair done. They also spoke of having busy and active lives and described the many activities that they availed of. These included

swimming, visiting friends and family, listening to music, art and knitting. One of the residents told the inspector they had worked previously but were now retired. This resident also told the inspector of an assessed healthcare need and of how they were being supported to manage it.

The residents expressed that sometimes there were arguments among the residents and that this made them feel uncomfortable. Both residents said that they would tell the staff team or person in charge if they felt unsafe. The inspector found, in assessing documentation, that a review was required of incidents and daily notes to ensure that any potential safeguarding concerns were identified as such and that national policy was implemented. This will be discussed further in the quality and safety section of the report.

The inspector met the remaining three residents when they returned from day services in the afternoon. Two of these residents spoke in detail with the inspector about their experiences of living in the centre. They told the inspector that they were very happy living here, that they liked the staff and, that the staff team helped them with cooking and with managing their health needs. One of the residents told the inspector of a restrictive practice which was implemented due to their assessed health needs. They told the inspector that they had agreed to the restrictive practice and that they were happy with how it was managed. Another resident told the inspector that they had recently moved in the centre and that they felt happy and safe living there.

Staff members, including a student who was on placement, spoke with the inspector over the course of the day. Staff members told the inspector of work that they had undertaken to promote the health, wellbeing and rights of residents. The social care student described how they were working with one resident to put together a life story book for them. The inspector was told that residents' rights were promoted through discussion at residents' meetings. The inspector was also told that residents were informed of the complaints process and were supported to make a complaint when they felt their rights had not been upheld.

The next two sections of the report will describe the oversight arrangements of the centre and how effective these were in ensuring the quality and safety of care for the residents

Capacity and capability

This section of the report describes the governance and management arrangements of the centre. This inspection found that there were clearly defined management arrangements which were effective in ensuring the quality and safety of care for the residents. Some minor improvements were required to the submission of notifications to the Chief Inspector.

The centre was sufficiently staffed by a consistent and stable staff team which was effective in ensuring continuity of care for the residents. Staff members were in receipt of regular support and supervision and also had access to regular training to ensure they had the competencies required to fulfil their professional duties. Staff members spoken with understood their roles and responsibilities and had clear accountability and reporting lines. They were aware of the policies and procedures to be followed to ensure the safety of the residents in the provision of care and support.

The centre had a competent person in charge who was suitably qualified and experienced. They were committed to driving service improvement and were well-informed of the residents' and the service's needs. The person in charge was supported in their role by a service manager and had access to their own ongoing support and supervision.

The provider had in place information governance arrangements and gained regular updates on the quality and safety of the service through audits which are required by the Regulations and other provider-led audits. These audits monitored and evaluated the quality of care and implemented action plans if required in order to bring about improvements and better outcomes for the residents living in the centre. This inspection identified that some minor improvements were required to the monitoring of adverse incidents to determine when these were required to be submitted to the Chief Inspector through a regulatory monitoring notification.

Regulation 15: Staffing

There were no vacancies in the staffing complement at the time of inspection. The centre was staffed by a consistent team who knew the residents and their assessed needs well. There was a very low number of agency staff used in the centre which was promoting continuity of care.

A planned and actual roster was maintained. The inspector reviewed the roster for November 2025 and found, across four dates examined, that there were sufficient staff to meet the needs of the residents in a person-centred manner.

The inspector reviewed the Garda vetting records for all staff in the Schedule 2 files. It was seen that there was an up-to-date Garda vetting disclosure maintained for each staff member.

Judgment: Compliant

Regulation 16: Training and staff development

Staff in this centre were in receipt of regular training to ensure they had the competencies required to fulfill their professional responsibilities. Staff training records demonstrated that all staff were up to date in mandatory training in positive behaviour support, safeguarding vulnerable adults, safe administration of medications and infection prevention and control.

A staff supervision schedule was maintained which showed that all staff were in receipt of supervision as frequently as required by the provider's policy.

Monthly staff meetings were also held. The inspector reviewed the records of the last two staff meetings and saw that these were used to inform staff of pertinent issues relevant to the residents' needs and goals and of provider level updates.

Judgment: Compliant

Regulation 23: Governance and management

There were clearly defined management systems in place in the centre. The staff team of social care workers reported to a person in charge. Staff members were performance managed and were given regular opportunities to raise any concerns regarding the quality and safety of care to the provider level through their individual supervisions and staff meetings. The person in charge had been in their role for many years. They demonstrated a comprehensive understanding of the residents' and the service needs and were committed to driving service improvement.

There were a suite of local and provider level audits designed to monitor the quality and safety of care. Local audits included monthly infection prevention and control (IPC) and health and safety checklists. The provider had also completed comprehensive six monthly unannounced audits of the service which identified deficits and implemented an action plan to address these.

A provider level IPC audit was completed in 2024 which identified a number of areas for improvement. Many of these were addressed by the time of this inspection. This showed that audits were effective in driving service improvements. The provider had completed an annual review of the service in consultation with the residents and their representatives. However, this review stated that only three residents were consulted with. It was not detailed why they remaining residents' views were not captured as part of the review.

The inspector noted, through a review of adverse incident documentation, that not all required monitoring notifications had been submitted to the Chief Inspector as required. For example, the inspector was told that there had been a recent outbreak of illness in the centre with three residents impacted; however a notification was not submitted to the Chief Inspector. In discussion with the person in charge it was not determined if the illness was notifiable and it was not evident that this outbreak had been reviewed by the provider's IPC lead to determine this. One resident required

treatment for an ongoing skin injury for which a quarterly notification had not been submitted.

Judgment: Substantially compliant

Quality and safety

This section of the report describes the quality of the service and how safe it was for the residents who lived there. Overall, this inspection found that residents were receiving a good quality service and that their rights were being promoted and upheld. Some improvements were required to one of the bathrooms of the centre to ensure it was clean and maintained to a suitable standard. Additionally, a review of adverse incidents and daily notes was required to ensure that any adverse incidents which could comprise a safeguarding incident were reviewed as such.

The designated centre was seen to be homely and accessible and promoted the privacy and dignity of each resident. All residents had their own individual bedrooms and they shared communal living areas. Residents had choices of two sitting rooms to relax in and some residents told the inspector that they also had televisions and music systems in their bedrooms and that they sometimes chose to relax there. Works had been completed to the downstairs of the centre to enhance the fire evacuation procedures. The inspector saw that improvements were required to the upstairs bathroom to ensure infection prevention and control (IPC) standards.

Staff members were guided by resident's individual assessments and care plans in meeting residents' assessed needs. Care plans detailed residents' preferences in respect of their care and were informed by multidisciplinary professionals as required; however, improvements were required to some aspects of two residents' care plans to ensure these reflected the most accurate and up-to-date information.

Residents were supported to express their feelings and received support to deal with issues that impacted on their emotional wellbeing. There was an approach to managing behaviour which was tailored to meet the needs of the individual and residents were consulted with regarding restrictive practices which may impact on their rights. While the inspector saw that individuals were supported to manage their own behaviour, it was not established that the potential impact of behavioural incidents on other residents had been fully assessed, or that all adverse incidents had been evaluated to identify learning and to improve service provision. This required review by the provider.

Residents' rights were promoted. Residents were consulted with in regards to the service and their opinion was elicited by the provider to determine areas for improvement. Residents had access to information in a format and medium that was appropriate to their communication abilities. Residents were supported to work out a structure in their daily life that best reflected their goals, activities and needs. The

inspector saw that the activities of daily living in the centre provided an opportunity for social interaction. Friendly and kind interactions between residents and between staff and residents were seen throughout the day.

Regulation 10: Communication

Most of the residents living in this centre did not have assessed communication needs. The inspector was told that some residents required support with their literacy and saw that those residents had associated care plans which detailed the supports that they required. The inspector saw that staff members communicated with residents in a manner which supported their literacy needs. Much of the information available in the house had been designed in an easy to read format.

The staff team were guided by the provider's Total Communication Policy which had been reviewed and updated within the past three years.

Judgment: Compliant

Regulation 17: Premises

The premises of the designated centre was seen to be very clean, warm and homely. Each resident had their own bedroom which was decorated in line with their individual preferences. Residents had sufficient storage in their bedrooms for their own personal belongings.

The provider had completed works to the premises in recent months to enhance the facilities and to ensure the safety of the residents. For example, the garden had been landscaped and a new evacuation corridor had been constructed. This had resulted in some changes to the footprint of the centre.

The inspector was told that the provider was in the process of acquiring new floor plans in order to submit an application to vary conditions of registration to the Chief Inspector.

The downstairs facilities of the centre were very clean and well-maintained. Residents had access to a large kitchen, dining room and two sitting rooms. Furniture and fittings were clean and comfortable. The accessible wetroom downstairs was also very clean.

The upstairs bathroom required upkeep. There was mildew around the base of the shower, the shower drain cover had come away and some of the fittings had rusted. The shower had evidently undergone previous repairs and was unsightly. There also was a malodour noticeable in this bathroom. Upgrade remedial works were required

to ensure this bathroom was not posing risks to infection prevention and control measures.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

The provider had implemented a comprehensive risk management policy which had been reviewed and updated within the past three years as required by the Regulations. A comprehensive risk register was maintained for the service. This detailed the risks at service and at individual level for each resident where required. The inspector reviewed a sample of risk assessments and saw that those risk assessments which impacted on residents included person-centred and proportionate control measures. There was a culture of positive risk-taking in the service and residents' were encouraged to be as independent as possible in their daily lives.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The inspector reviewed three residents' files in detail over the course of the day. Each resident had a comprehensive individual assessment of need which had been informed by multidisciplinary professionals. The assessment was used to inform care plans which detailed the residents' preferences in respect of their care and support. Care plans were reviewed and updated regularly by keyworkers in the centre. However, a review was required to ensure that there were care plans implemented for each assessed need, and to remove any care plans which were not required.

The inspector was told that one resident had been receiving regular treatment for an unknown skin condition since April 2025. The cause of this skin condition had not yet been determined; however, the resident was receiving regular care from their general practitioner and public health nurse in managing this. The inspector saw, on reviewing progress notes and multidisciplinary notes, that the care recommendations had changed on a regular basis over the preceding months. While the inspector was told that these recommendations were discussed at handover meetings, there was an absence of a care plan for this particular need. The impact of this was that there was no consistent, written guidance for staff to inform them of how best to support the resident and this need and to provide a benchmark and record for how the condition was being treated and the effectiveness of the treatment plan. The inspector also saw there were care plans on one resident's file

regarding transmissible infections; however, the inspector was told that this resident had not been diagnosed with any transmissible infections.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

There were two restrictive practices in the designated centre. These had been recorded as rights restrictions and were referred to the provider's rights committee for review. The inspector spoke with one of the residents regarding these restrictive practices. They told the inspector that they had been informed of them and were consenting to them. The resident described how one of the restrictive practices was assisting them with managing a health related need. The provider had an up-to-date restrictive practices policy to provide further guidance to staff. The inspector was told that this policy was being reviewed by the provider at present in line of recently enacted legislation.

Some residents in this centre presented with assessed needs in respect of behaviour support. The inspector saw that those residents who required such support had a comprehensive and up-to-date positive behaviour support plan on their file. These plans detailed proactive and reactive strategies to guide staff in assisting residents with managing behaviour. All staff had also received training in positive behaviour support.

Judgment: Compliant

Regulation 8: Protection

All staff members in this service were up to date with relevant safeguarding training including Safeguarding Vulnerable Adults and Children First. The inspector saw that residents' dignity was promoted during the course of the day; for example, staff members were seen knocking and asking permission before entering residents' bedrooms. Residents' files also contained up-to-date intimate care plans which detailed person-centred supports to assist residents with their personal care.

Two residents told the inspector that sometimes there were arguments among residents and that these made them feel uncomfortable. In reviewing the adverse incidents for the centre, alongside the progress notes, the inspector saw that the majority of adverse peer to peer incidents were identified as safeguarding concerns and were reported to the statutory authorities. Safeguarding plans were implemented which were agreed upon by the local Safeguarding and Protection Team.

However, there were a number of incidents identified in the daily progress notes which could have constituted a peer to peer safeguarding concern but were not reported as such. The incidents identified by the inspector took place in March, April and November 2025 and detailed arguments among residents. The notes were insufficiently detailed to determine if there had been an impact on residents and there was an absence of a documented follow up to assess any potential impact.

The inspector also saw in reviewing the adverse incidents for one resident that many behaviours of concern occurred late in the evening and had the potential to impact on other residents' evening and sleep routines. For example, on 04 April 2025, a resident was described as "shouting/screaming" at 11pm. Two other similar incidents occurred on 27 January 2025 and 16 February 2025. A review of adverse incidents and progress notes was required to determine if there were any trends or patterns in behaviours and how these may be impacting on the safeguarding arrangements of the centre.

Judgment: Substantially compliant

Regulation 9: Residents' rights

The designated centre was being operated in a manner which promoted residents' rights. Most of the staff team had received training in human rights. Staff members spoken with told the inspector that residents were informed of their rights through regular residents' meetings. They said that rights were explained to residents in a manner which met their literacy and communication needs.

The inspector was told that residents were informed of the complaints process and were supported to make a complaint when they felt that they rights had been impinged on. Residents were also informed of the day to day running of the centre and made choices in respect of their daily activities and their meals. The inspector saw that residents' choices were upheld throughout the inspection. Residents were enabled to have control over the structure of their day and to work out a routine which best met their needs.

Residents' rights to privacy and dignity were respected. The inspector saw staff members knocking on residents' doors and asking permission to enter. The inspector also saw and heard staff members communicating with residents in a respectful and kind manner. Staff members enabled residents to have autonomy in their daily activities and only provided support where required. Some residents told the inspector how they preferred to do their own laundry and other activities of daily living and that they are supported to do so.

The inspector reviewed a number of documents relating to rights over the course of the inspection. These included the complaints and compliments folder, the easy to read complaints procedure, records of three of the residents' meetings and care plans in respect of residents' finances. The inspector saw that these documents

promoted residents' freedom, choice and autonomy in respect of their daily lives and provided guidance to staff on how best to promote residents' rights.
Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Substantially compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Ardbeg OSV-0002352

Inspection ID: MON-0046239

Date of inspection: 02/12/2025

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 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: -The 2025 Annual Review Reflects the Residents Views through Questionnaires. It is Identified in the Annual Review how Many Residents chose to participate or not. To be Completed by 31/01/2026. -NF05: Unexplained absence incident occurred on 27/11/2025. NF05 submitted within 3 working day time-frame for unexplained absence. NF05 submitted by close of business on 02/12/2025. Completed on 02/12/2025. -IPC outbreak management and notification processes discussed and policies refreshed at staff meeting on 05/01/2026. The PIC has Reviewed with the staff team all Policies/ Procedure with possible outbreaks and Regulatory Notifications. Completed by 05/01/2026. -NF39D will be submitted as part of the 4th quarter 2025 notifications to reflect ongoing injury/skin integrity issues with respect to one service user. To be Completed by 31/01/2026.	
Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: -SMH maintenance department visited centre 05/01/2026 to measure downstairs large bathroom for new flooring, and upstairs bathroom to get costing for a complete re-fit i.e.	

new flooring, new shower, toilet suite and sink, including easy clean white rock wall coverings.
To be Completed by 30/09/2026.

Regulation 5: Individual assessment and personal plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
-Care plan drawn up 12/12/2025 outlining care response implemented for ongoing skin Integrity for one resident including ongoing treatments and contact personnel (doctors, public health nurse etc). Care plan will be reviewed monthly, or sooner if required, and will reflect changes in treatment as necessary.

-Care plans removed for one resident for transmissible infections that was not applicable.

Completed Date 12/12/2025

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
-Email sent to SMH Designated Officer and Training Department on 01/01/2026 requesting refresher training in safeguarding, with a focus on effective reporting, and on assessing impact on others following any potential incident. A review of adverse incidents to also take place of current systems in the centre with a view to determine if there are patterns of behavior which may be impacting on the safeguarding arrangements of the centre.
Due to be Completed date 31/01/2026.

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)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Substantially Compliant	Yellow	30/09/2026
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.	Substantially Compliant	Yellow	31/01/2026
Regulation 23(1)(e)	The registered provider shall ensure that the review referred to in subparagraph (d) shall provide for consultation	Substantially Compliant	Yellow	31/01/2026

	with residents and their representatives.			
Regulation 05(6)(c)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall assess the effectiveness of the plan.	Substantially Compliant	Yellow	12/12/2025
Regulation 05(6)(d)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall take into account changes in circumstances and new developments.	Substantially Compliant	Yellow	12/12/2025
Regulation 08(3)	The person in charge shall initiate and put in place an Investigation in relation to any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.	Substantially Compliant	Yellow	31/01/2026