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:	Glencorry
Name of provider:	St Michael's House
Address of centre:	Dublin 9
Type of inspection:	Unannounced
Date of inspection:	11 March 2025
Centre ID:	OSV-0002383
Fieldwork ID:	MON-0046475

About the designated centre

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

Glencorry is a designated centre operated by St. Michael's House. It is located in a campus based service for persons with intellectual disabilities located in North Dublin. The centre comprises of one large building and provides full-time residential services to six persons with intellectual disabilities. The building consists of six resident bedrooms, a large living room, a large dining room, a kitchen and separate pantry space, a staff office, a staff room, a bathroom, a separate shower room, a utility room, and a large entrance hallway. There is an outdoor patio space to the front of the centre with an area for outdoor dining, a seating area, raised planting beds and a water feature. Residents are supported by a person in charge, a clinical nurse manager, staff nurses, social care workers, care workers, a cook, and a household worker.

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
Tuesday 11 March 2025	10:45hrs to 17:30hrs	Karen McLaughlin	Lead

What residents told us and what inspectors observed

This unannounced inspection was carried out as part of the ongoing regulatory monitoring of the centre. The inspection focused on how residents were being safeguarded in the centre. Safeguarding is one of the most important responsibilities for a provider. Previous inspections of the centre had found that improvements were required to the safeguarding arrangements. Solicited information, by way of notifications throughout 2024 demonstrated that there were consistent and recurring safeguarding concerns relating to the incompatibility of residents.

The purpose of this inspection was to assess the actions being taken by the provider to address the ongoing incompatibility concerns in the centre and to assess if the provider had implemented their compliance plan response from a previous inspection of this centre that had identified non compliance in the areas of safeguarding, residents' assessed needs and residents' rights.

The centre consisted of one residential bungalow situated on a congregated campus setting in North Dublin. The designated centre has a registered capacity for six residents, at the time of the inspection there was no vacancies.

The person in charge was present to facilitate the inspection and an in person staff meeting was in progress when the inspector arrived.

The inspector used observations, in addition to a review of documentation, and conversations with staff and residents to form judgements on the residents' quality of life.

Many aspects of the service provided to residents were to a high standard, and while the provider and person in charge had made extensive efforts to ensure that residents were safe from potential abuse in the centre, their efforts were not effective. The incompatibility of residents and associated safeguarding concerns which presented in 2022, 2023 and 2024 had not been resolved, and this meant that residents were living in a centre that did not protect them from potential and actual abuse.

The inspector spoke with the person in charge, social care worker and a health care assistant on duty on the day of inspection. They all spoke about the residents warmly and respectfully, and demonstrated a rich understanding of the residents' assessed needs and personalities and demonstrated a commitment to ensuring residents needs were met to a high standard at all times.

Furthermore, all staff spoken with expressed concerns about the ongoing compatibility issues which were impacting on all residents' safety and wellbeing. Staff were aware of the safeguarding policies and associated plans and were implementing them to the best of their ability. Despite this, it was apparent that systemic and operational issues, such as the lack of a suitable placement for a

resident, was preventing the provider from fully meeting residents' needs in a safe and timely manner.

Residents were observed throughout the course of the inspection receiving a good quality, person-centred service. Observations carried out by the inspector, feedback from residents and documentation reviewed provided suitable evidence to support this. On the day of the inspection, some residents attended day services, while others relaxed in the centre which was in line with their will and preferences.

However, the incompatibility of some residents posed an ongoing risk to their safety and wellbeing, and the provider had not yet ensured that all residents were in receipt of services that was appropriate to their needs.

The provider and the person in charge were responding to the compatibility issues by increasing staffing levels and supporting residents through their personal and behaviour support plans. The person in charge was satisfied with the staff skill-mix and arrangements, and said that residents' needs and rights were being mostly met in the centre. They also outlined that the current safeguarding concerns posed a risk to the residents' overall well-being. The person in charge told the inspector that the provider was engaging with their funder and external providers to source a more appropriate residential placement for one resident to address the incompatibility issues however, they had not been successful yet.

The inspector met with the resident in question when they came to the office, when the inspector tried to engage in conversation, the resident left the room on two occasions and did not verbalise or respond to the inspector, except to say they were out for the day. The inspector did not get an opportunity to meet with any of the other residents, who were busy coming and going from the designated centre throughout the day.

This inspection found there were still improvements required in relation to Regulation 5: Individualised assessment and personal plan, Regulation 8: Protection and Regulation 9: Residents' rights. This is further discussed in the main body of the report.

The next two sections of the report presents 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

The management structure in the centre was clearly defined with associated responsibilities and lines of authority. The person in charge was full-time and supported in the management of the centre by a service manager. The person in charge reported to a service manager and Director, and there were effective

systems for the management team to communicate and escalate any issues.

The registered provider had implemented management systems to monitor the quality and safety of service provided to residents including annual reviews and six-monthly reports, plus a suite of audits had been carried out in the centre.

There was a planned and actual roster maintained for the designated centre. Rotas were clear and showed the full name of each staff member, their role and their shift allocation. From a review of the rosters there were sufficient staff with the required skills and experience to meet the assessed needs of residents available.

The inspector spoke with staff members on duty throughout the course of the inspection. The staff members were knowledgeable on the needs of each resident, and supported their communication styles in a respectful manner. However, not all staff had 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 provided quality support and formal supervision to staff working in the centre. Staff also attended regular team meetings which provided an opportunity for them to any raise concerns regarding the quality and safety of care provided to residents.

This inspection found that systems and arrangements were in place to ensure that residents received care and support that was person-centred and of good quality. However, in assessing the provider's capacity and capability, the inspection identified that systems designed to monitor the quality and safety of care and support were not fully effective.

While the provider had responded to the centre's safety challenges by increasing staff ratios, enhancing the skill mix, and implementing to additional supports to residents, such as a more structured routine and activity planning, there are still fundamental gaps in service delivery. These deficiencies posed significant risks to the centre's effective operation, impacting the provider's efforts to create a safe and supportive environment, particularly in relation to regulations 5: Individualised assessment and personal plan, 8: Protection and 9: Residents rights. These regulations will be discussed further in the report under Quality and safety.

Regulation 15: Staffing

Residents were in receipt of support from a stable and consistent staff team. Staffing levels were in line with the centre's statement of purpose and the needs of the residents.

The provider had provided additional staffing resources as a measure to reduce the safeguarding concerns in the centre. The person in charge told the inspector that the complement and skill-mix was sufficient and that the additional support

measures have had a positive impact on safeguarding residents.

The inspector observed staff engaging with residents in a respectful and warm manner, and it was clear that they had a good rapport and understanding of the residents' needs.

The inspector reviewed actual and planned rosters at the centre for January 2025 and the current February 2025 roster. The person in charge maintained a planned and actual staff rota which was clearly documented and contained all the required information.

Judgment: Compliant

Regulation 16: Training and staff development

Staff working in the centre had access to appropriate training as part of their continuous professional development, and to support the delivery of care to residents.

The inspector reviewed the training records for staff working in the centre.The staff training audit, reviewed by the inspector, required updating as it did not accurately reflect or capture training needs for staff working in the centre. A revised version was requested by the inspector. However, it still found that some staff required refresher training in a number of areas such as positive behaviour support and fire safety.

The person in charge provided effective support and formal supervision to staff. Informal support was provided on an ongoing basis and formal supervision was carried out in line with the provider's policy. In the absence of the person in charge, staff could contact the service manager or on-call system for support and guidance.

Judgment: Substantially compliant

Regulation 23: Governance and management

There was a clearly defined governance structure which identified the lines of authority and accountability within the centre and ensured the delivery of good quality care and support that was routinely monitored and evaluated.

There was suitable local oversight and the centre was sufficiently resourced. For example, there was sufficient staff available to meet the needs of residents, adequate premises, facilities and supplies and residents had access to a transport vehicle which was assigned for the centre's use only.

Safeguarding concerns were well documented and due to the complex nature of the compatibility issues, the introduction of ongoing multi-disciplinary meetings and increased staffing demonstrates a concerted effort to mitigate against safeguarding risks and improve residents quality of life.

There were effective arrangements for staff to raise concerns. In addition to the staff supervision and support arrangements, staff also attended regular team meetings which provided an opportunity for them to raise any concerns about the quality and safety of care and support provided to residents.

The provider was in the process of carrying out an annual review of the quality and safety of the centre for 2024, and there were arrangements for unannounced visits to be carried out on the provider's behalf on a six-monthly basis.

Additional audits carried out included fire safety, infection prevention and control (IPC), health and safety, safeguarding and medication.

The National Safeguarding Office's self audit tool was completed by the person in charge in September 2024 and recommendations set out show the need for an alternative placement for one resident, recruitment of staff and a review of the compatibility of all residents as a follow up to the ongoing safeguarding concerns present in the designated centre.

The provider had identified that the service was not meeting the assessed needs of all residents living in the centre. Nonetheless, the provider had not ensured that the service provided in the centre was safe and appropriate to residents' needs. The ongoing incompatibility issues and safeguarding concerns that date back to 2022 evidenced there was a persistent challenge in meeting residents' needs safely and appropriately. While the provider had made extensive efforts to address these matters including plans to transition one resident, the efforts had not been fully effective.

Despite initiatives and efforts on the part of the provider and person in charge to respond to and manage the ongoing incompatibility issues in the centre, arrangements remained overall ineffective in, resolving the safeguarding concerns presenting. As a result, the provider is not adequately meeting all residents' needs or ensuring robust safeguarding arrangements.

Judgment: Substantially compliant

Quality and safety

This section of the report details the quality of the service and how safe it was for the residents who lived there. Regulations which relate to safeguarding were specifically assessed as part of this thematic inspection.

This inspection found that the provider and person in charge were operating the centre in a manner that supported residents to receive a service that was person-centred. However, as previously stated improvements were required in relation to residents assessed needs, rights and safeguarding.

The design and layout of the premises ensured that each resident could enjoy living in an accessible, comfortable and homely environment. The provider ensured that the premises, both internally and externally, was of sound construction and kept in good repair. There were some minor maintenance issues were identified by the person in charge and they had already been reported to the provider's maintenance department.

The inspector spoke with staff members on duty throughout the course of the inspection. The staff members were knowledgeable on the needs of each resident, and supported their communication styles in a respectful manner.

There was a comprehensive assessment of need in place for each resident, which identified their health care, personal and social care needs. These assessments were used to inform detailed plans of care, and there were arrangements in place to carry out reviews of effectiveness.

However, not all residents' assessed needs were being met in the centre and and this was having an adverse impact on the quality and safety of service provided to them and their peers and resulting in ongoing and protracted incompatibility issues that were contributing to safeguarding concerns.

A suitable alternative living arrangement had not yet been sourced and this was impacting all residents living in the centre. While the provider was endeavouring to source suitable accommodation for them, these unmet needs presented incompatibility and safeguarding risks between residents.

Positive behaviour support plans were in place for residents, where required. The plans were up-to-date and readily available for staff to follow.

The inspector found that the quality and safety of the service provided in the centre to residents was significantly compromised due to deficits and risks in relation to the assessment and meeting of residents' full needs, safeguarding and resident's rights.

While the provider had good arrangements for managing safeguarding concerns, the risk to residents' safety had not been mitigated, and residents remained at risk of harm from other residents in the centre.

Regulation 10: Communication

The inspector saw that residents in this designated centre were supported to communicate in line with their assessed needs and wishes.

Residents' files contained communication care plans where required, and a communication profile which detailed how best to support the resident.

The inspector saw that staff had received training in communication and were informed of residents' communication needs and described how they supported residents' communication.

Staff knew residents' communication requirements and the inspector observed throughout the inspection that staff were flexible and adaptable with all communication strategies used.

Communication aids, including visual supports, had been implemented in line with residents' needs and were readily available in the centre.

Residents had access to telephone and media such as radio and television.

Judgment: Compliant

Regulation 17: Premises

The registered provider had ensured that the premises was designed and laid out to meet the aims and objectives of the service and the number and needs of residents. Communal rooms and corridors were large enough to accommodate residents' required mobility aids.

The centre was maintained in a good state of repair and was clean and suitably decorated.

The centre had also been adapted to meet the individual needs of residents ensuring that they had appropriate space that upheld their dignity and improved their quality of life within the designated centre.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The person in charge had ensured assessments of residents' needs were completed and informed the development of personal plans. There was a comprehensive assessment of need in place for each resident, which identified their healthcare, personal and social care needs. These assessments were used to inform detailed plans of care, and there were arrangements in place to carry out reviews of effectiveness.

The inspector reviewed two residents' assessments and plans. The plans, included

those on personal, health, and social care needs, were up to date, sufficiently detailed, and readily available to staff in order to guide their practice.

However, not all residents' assessed needs were being met in the centre and and this was having an adverse impact on the quality and safety of service provided to them and their peers. The provider had not ensured that the appropriate arrangements were in place to meet the needs of one resident. They had identified that the centre was not fully suitable to meet all residents' assessed needs, particularly in relation to the required living arrangements for one resident and their incompatibility with other residents, which was resulting in ongoing safeguarding concerns.

The provider was engaging with their funder and reviewing their own internal resources to source more suitable accommodation, however they had not yet been successful. They remained committed to sourcing appropriate accommodation, and until then were utilising additional resources such as increased staffing and multidisciplinary team services.

Judgment: Not compliant

Regulation 7: Positive behavioural support

The provider had ensured that where residents required behavioural support, suitable arrangements were in place to provide them with this. Clear behaviour support plans were in place to guide staff on how best to support these residents, and regular multi-disciplinary input was sought in the review of residents' behavioural support interventions.

The inspector reviewed behaviour support plans in place for residents. The plans detailed proactive and reactive strategies to support residents in managing their behaviour. They were devised in consultation with the clinical team and reviewed regularly as per the providers policy.

The inspector found that the person in charge was promoting a restraint-free environment within the centre. The inspector completed a review of restrictive practices in place in the centre and found that all restrictive practices were logged, regularly reviewed and risk assessed in line with the provider's policy. In addition the person in charge and staff team were monitoring the use of restrictive practices and attempting to reduce the frequency of use within the designated centre.

Judgment: Compliant

Regulation 8: Protection

The registered provider had implemented systems, underpinned by written policies and procedures, to safeguard residents from abuse. Staff working in the centre completed safeguarding training to support them in the prevention, detection, and response to safeguarding concerns.

It was evident to the inspector that staff took all safeguarding concerns seriously. Staff spoken with were knowledgeable about abuse detection and prevention and promoted a culture of openness and accountability around safeguarding. In addition, staff knew the reporting processes for when they suspected, or were told of, suspected abuse.

The person in charge had ensured that written personal care plans had been prepared to guide staff in supporting residents in this area in a manner that respected their dignity and bodily integrity.

Safeguarding incidents were notified to the safeguarding team and to the Chief Inspector of Social Services in line with regulations. However, over the past 12 months, a high number of safeguarding notifications had been submitted to the Chief Inspector of Social Services. For example, a total of 23 had been submitted to the Chief Inspector between May and September 2024.

The inspector found that although the provider was endeavouring to manage and implement strategies to reduce the compatibility issues in the house, the overall impact of the incidents was affecting residents' lives in a negative manner. Recently there had been a reduction in safeguarding incidents, with trending showing six safeguarding incidents were submitted to the Chief Inspector in December 2024 and a further three in January 2025, however both staff and residents expressed that this was due to the residents changing their routine and increased activity planning outside the centre to avoid conflict.

Without further intervention, the inspector could not be assured that residents were protected from all forms of abuse at all times. Residents are were still at risk and their quality of life is was being impacted upon in their own home.

Judgment: Not compliant

Regulation 9: Residents' rights

The provider had ensured that the centre was operated in a manner that ensured residents had participated and consented to decisions about their care and support.

The inspector saw that staff interactions with residents were in a manner which upheld residents' dignity and provided residents with choice and control. Staff were seen offering residents choices, responding to their needs and providing direct assistance in a manner which respected residents' right to dignity and privacy.

Residents' rights were discussed regularly at residents meetings. However, residents'

rights were being impacted by the ongoing incompatibility issues.

The inspector found evidence that the person in charge and staff team were ensuring that residents knew how to make a complaint and could freely make complaints in an accessible manner.

Complaints reviewed by the inspector demonstrated a consistent theme relating to residents' rights regarding their privacy and living space and ultimately the right to peace in their own home.

Complaints from residents regarding safeguarding, albeit managed appropriately and in line with the provider's complaints policy and procedures, remained unresolved on the day of inspection.

Residents no longer wanted to live with each other and due to the nature of the incidents and their frequency demonstrating the implementation of a rights-based approach to care was proving challenging in the centre and improvements were required. As a result, the incompatibility issues and ongoing safeguarding concerns were adversely impacting on the quality and safety of the service, reinforcing the need for urgent intervention.

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	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 17: Premises	Compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Glencorry OSV-0002383

Inspection ID: MON-0046475

Date of inspection: 11/03/2025

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 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: PIC will ensure all staff get time and opportunity to access and complete all mandatory training and refresher training as part of continuous professional development programme. PIC will review training audit on a monthly basis. PIC will book all staff that require face to face training. PIC will discuss with Training Department difficulties staff are having accessing certain training and escalate this with the Organisation if not resolved.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The Registered Provider will continue to review and explore all existing residential vacancies in line with the resident's assessed needs and ongoing support requirements. St Michaels House Residential approvals committee meet monthly, and the resident remains on the active list, should a suitable place become available. The Registered Provider in consultation with the Director of Estates will continue to explore external properties within the resident's community and support network, with the intentions of submitting an application to register the property as a designated centre, should a suitable location be identified. The resident's MDT will continue to engage with safeguarding team in the HSE to assess the effectiveness of Compatibility Assessment Tool and agreed supports. Additional staff will continue to be included in the roster to help ensure safe and appropriate staffing to meet the resident's needs, and any	

vacancies will be actively monitored and filled as soon as possible. Following an assessment by a CHO7 review officer on 14.11.2024, it was advised that there was no case manager available and that we should look at external, private placements. The PIC has identified 3 private, external organisations and is in the process of submitting applications on the resident's behalf. A Compatibility Team meeting took place on 20.03.2025 and it was agreed that the necessary MDT reports, to support the application, be available by 30.4.2025. It was also agreed that the PIC would contact all 3 by 30.04.2025 to ensure that the necessary psychiatry supports would be available to the resident. The PIC will then submit the external applications.

Regulation 5: Individual assessment and personal plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
The Registered Provider will continue to provide additional supports to the residents within the centre and maintain the identified residents supports that are currently in place. Advocacy services are aware of the situation and will be updated. Open complaints will be reviewed regularly and new complaints will be reported using the SMH policy for Complaints and Compliments. DSMAT hours will continue to be provided to promote good quality care. Safeguarding MDT's will continue to be scheduled for all residents.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
The Person In Charge will continue to work closely with St Michaels House Designated Officer and the SMH Safeguarding team and schedule regular reviews to ensure all residents within the centre have up to date safeguarding plans in place.
PIC met with Principle Social Worker on 4/4/2025 and identified external placements that may be suitable. A Safeguarding and Compatibility meeting took place on 20/4/2025, where agreement was reached to provide the necessary clinical reports to support the applications.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights: The Person in Charge will review all the resident's assessment of needs and support plans within the centre and in particular in relation to residents' rights. Person In Charge will ensure that residents rights within the centre are discussed at resident forums and residents will be supported to make complaints as required. The Registered Provider will continue to explore all internal and external residential options for the identified resident and in meeting all resident's needs. The PIC will continue to liaise with advocacy services and update them of the situation.	

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 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	30/04/2025
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	19/09/2025
Regulation 05(2)	The registered provider shall ensure, insofar as is reasonably practicable, that arrangements are	Not Compliant	Orange	19/09/2025

	in place to meet the needs of each resident, as assessed in accordance with paragraph (1).			
Regulation 05(3)	The person in charge shall ensure that the designated centre is suitable for the purposes of meeting the needs of each resident, as assessed in accordance with paragraph (1).	Not Compliant	Orange	19/09/2025
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	19/09/2025
Regulation 09(2)(a)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability participates in and consents, with supports where necessary, to decisions about his or her care and support.	Not Compliant	Orange	19/09/2025
Regulation 09(2)(b)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability has the freedom to exercise choice	Not Compliant	Orange	19/09/2025

	and control in his or her daily life.			
Regulation 09(3)	The registered provider shall ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.	Not Compliant	Orange	19/09/2025