



# Report of an inspection of a Designated Centre for Disabilities (Adults).

**Issued by the Chief Inspector**

|                            |                     |
|----------------------------|---------------------|
| Name of designated centre: | Teach Gael          |
| Name of provider:          | St Hilda's Services |
| Address of centre:         | Westmeath           |
|                            |                     |
| Type of inspection:        | Announced           |
| Date of inspection:        | 07 October 2025     |
| Centre ID:                 | OSV-0003261         |
| Fieldwork ID:              | MON-0039890         |

## About the designated centre

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

Teach Gael offers residential services up to five adults who have an intellectual disability and may have a range of medical and physical care needs. There is one staff rostered during the day, two staff in the evening and a sleep over staff at night. The centre comprises two semi-detached houses which are interconnected via a bedroom and office on the first floor and accommodates two residents in one house and three residents in the other. The residents all have their own bedrooms with four double bedrooms and one single bedroom across the two houses with kitchen, living and suitable bathroom facilities in each. The centre is located in a housing estate in close proximity to the local community and all services and amenities. There is transport provided to travel to and from day services and activities.

**The following information outlines some additional data on this centre.**

|  |   |
|--|---|
| Number of residents on the date of inspection: | 5 |
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## 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 7 October 2025   | 11:00hrs to 18:30hrs | Julie Pryce | Lead |
| Wednesday 8 October 2025 | 09:45hrs to 12:30hrs | Julie Pryce | Lead |

## What residents told us and what inspectors observed

This announced inspection was carried out as part of a group inspection of six designated centres operated by this provider. Each centre was inspected independently and findings will be reported under each centre, however staff training, complaints, policies and procedures and staff recruitment were reviewed centrally in the providers main offices.

While in the main good practice was observed and residents enjoyed a good quality of life some improvements were required particularly in relation to governance and oversight, care planning and the quality of audits carried out by the provider. These matters will be further discussed later in this report.

The centre provided a full time service to five residents, and overall this inspection found that residents were in receipt of a quality-based service. The inspector had the opportunity to meet the residents over the course of this two-day inspection process. Some residents agreed to have a chat with the inspector, and others preferred to have only a brief meeting with the inspector.

One resident chose not to engage with the inspector, but joked with others and appeared to be happy and content, whereas another resident introduced themselves and spoke about some life events that were important to them. They also said that they liked the staff who were supporting them, and spoke about some recent activities, including their swimming that morning.

Another resident explained to the inspector that they had tea and a scone earlier on, and appeared to be content. They were able to tell the inspector who they would go to if they had any concerns, and named a staff member who they trusted. They also answered the inspector's question about fire safety, and indicated that they would know what to do in the event of an emergency.

One resident showed the inspector their person centred plan, and spoke at length about their interests. They showed the inspector their shed in the garden and a planter that they had made in their day service.

On the second day of the inspection the inspector found two residents enjoying breakfast. They greeted the inspector, and continued with their breakfast. They enjoyed a chat together, and at one point the inspector observed one resident clapping their hands and saying to the other 'Oh you do make me laugh'.

The resident who had recently moved into the centre had a chat with the inspector, and spoke at length about their hobbies and interests. It was evident that accommodations had been made to support these interests, for example the resident was involved in keeping the gardens and grounds of the house tidy, as this was a particular interest of theirs.

This was just some of the examples throughout the inspection that made it clear that residents enjoyed living together, and that the rights of residents to be compatible with each other had been taken into account by the provider as further discussed under Regulation 9: Residents' rights of this report.

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

## Capacity and capability

There was a clearly defined management structure in place, and lines of accountability were clear. There were various oversight strategies which were found to be effective for the most part, although improvements in auditing were required.

An annual review of the care and support of residents had been prepared as required by the regulations, and while it gave a good overview of the care and support offered to residents, it had not made provision for the inclusion of the views of residents and their families.

There was an appropriately qualified and experienced person in charge who was involved in the oversight of the centre and the supervision of staff.

There was a competent staff team who were in receipt of relevant training, and demonstrated good knowledge of the support needs of residents, and who facilitated the choices and preferences of residents.

All the required policies were in place and had been regularly reviewed. The provider had submitted all the required information with their application to renew the registration of the designated centre, including a statement of purpose and function.

## Registration Regulation 5: Application for registration or renewal of registration

The registered provider had submitted an application to the Chief Inspector to renew the registration of the designated centre which included all of the documents that are required to be submitted with this application.

Judgment: Compliant

## Regulation 15: Staffing

There were sufficient numbers of staff to meet the needs of residents both day and night. A planned and actual staffing roster was maintained as required by the regulations. There was a consistent staff team who were known to the residents, including any relief staff. If additional staff were required, they came from staff in the day services and were known to the residents, or as a last resort, from the organisation's relief panel. The use of staff from this relief panel had not been required this year.

A sample of three staff files was reviewed by the inspector, and all the information required by the regulations was in place, including garda vetting.

The inspector spoke to three staff members on duty and the person in during the course of the inspection, and found them to be knowledgeable about the support needs of residents. Staff responded to all questions posed to them by the inspector in a knowledgeable and confident manner. Staff were observed throughout the course of the inspection to be familiar with the care and support needs of each resident.

It was evident that the staffing arrangements were in accordance with the needs and preferences of each resident, and supported their independence whilst ensuring that support was always available to them

Judgment: Compliant

#### Regulation 16: Training and staff development

Records were maintained in relation to the training offered and undertaken by the staff team. The inspector found that staff were provided with training to ensure they had the necessary skills to respond to the needs of the residents. A training matrix was presented to the inspector, and a sample of certificates was reviewed by the inspector which provided assurances that staff had undertaken training in the following areas:

- Fire Safety
- Positive Behaviour Support
- Safeguarding
- Medicine Management ( including two competency assessments)
- Intimate Care
- Autism awareness
- Assisted decision making
- Infection prevention and control.

Staff were supervised on a daily basis through the daily presence of the person in charge (PIC), and formally through a system of six-monthly supervision

conversations with the PIC, and through monthly staff meetings.

The inspector reviewed a sample of two supervision conversations and found that the care and support of residents was reviewed at these meetings, and that staff had the opportunity to raise any concerns at these meetings. The inspector found that staff had not raised any concerns about the quality of care. The person in charge confirmed that this was the case for all staff.

Judgment: Compliant

## Regulation 22: Insurance

As part of the application to renew the registration of the centre, the registered provider had submitted a valid insurance certificate which included cover for the building and all contents and residents' property.

Judgment: Compliant

## Regulation 23: Governance and management

There was a clear management structure in place, and all staff were aware of this structure and of their reporting relationships.

The designated centre was well resourced. Any equipment required to ensure appropriate support to residents was in place, and there were vehicles available to meet the needs of residents.

There were various monitoring and oversight systems in place. An annual review of the care and support of residents had been prepared as required by the regulations, however there was insufficient evidence that this had incorporated the views of residents and their families as required by the regulations.

Six-monthly unannounced visits had been conducted on behalf of the provider, and there was a suite of audits which had taken place in the designated centre. Some of these audits required boxes to be ticked off, but did not include any evidence to support the findings of the audits. For example, the audit tools in place to monitor care plans, person-centred plans and risk assessments did not examine the quality of the documents, and only required the auditor to check that the documents were in place.

Where more detailed audits had taken place, for example the audit in relation to infection prevention and control, which included comments to support the findings, any identified actions had been implemented. There was also a monthly checklist undertaken by the PIC which looked at various areas of care and support and

identified actions required by staff members and this process was monitored by the PIC.

Regular team meetings were held and minutes were maintained from each meeting. Items for discussion included the care and support needs of each resident, rights, fire safety and risk management in the centre. The inspector reviewed the records of the previous two meetings indicated that they were useful and meaningful discussions, and saw that all staff were required to sign the minutes of the meetings to indicate that they had either attended the meeting or read the minutes.

Overall, while improvements were required in auditing and monitoring, it was evident that the PIC was ensuring that staff were appropriately supervised and that there was an emphasis on quality improvement.

Judgment: Substantially compliant

#### Regulation 31: Notification of incidents

All the required notifications had been submitted to the Office of the Chief Inspector, including notifications of any incidents of concern.

Judgment: Compliant

#### Regulation 4: Written policies and procedures

The registered provider had prepared written policies and procedures under Schedule 5 of the regulations and these Schedule 5 policies and procedures have been reviewed every three years as required under the regulations.

Judgment: Compliant

#### Regulation 3: Statement of purpose

The provider had developed a statement of purpose which included all the information required by Schedule 1 of the regulations.

The statement of purpose outlined a range of information about the centre, including the facilities and services in the centre, the organisational structure, and the arrangements for consultation with residents.

Judgment: Compliant

#### Regulation 14: Persons in charge

The person in charge was appropriately qualified and experienced, and had good oversight of the designated centre. He was knowledgeable about the support needs of residents, and about his role in relation to the regulations.

Judgment: Compliant

#### Quality and safety

There were systems in place to ensure that residents were supported to have a comfortable life, and to have their needs met. There was an effective personal planning system in place, and residents were supported to engage in multiple different activities.

The residents were observed to be offered care and support in accordance with their assessed needs, and staff communicated effectively with them.

Healthcare was effectively monitored and managed and changing needs were responded to in a timely manner.

Fire safety equipment and practices were in place to ensure the protection of residents from the risks associated with fire, and there was evidence that there were control measures in place to mitigate any identified risks associated with fire safety.

There were risk management strategies in place, and each identified risk had a detailed risk assessment and management plan.

Residents were supported in the safe management of their finances and possessions in accordance with their needs and preferences.

The rights of the residents were well supported, and residents indicated that they were happy in their home. Staff were knowledgeable about the support needs of residents and supported them in a caring and respectful manner.

#### Regulation 10: Communication

Each resident had detailed information about the ways in which they communicate

in their person-centred plans. For example, one resident used different finger movements to indicate pain or excitement, and this was described in their 'communication passport'. Staff were very familiar with the ways in which each resident communicated.

Information was made available and accessible to residents. There were various pieces of information throughout the designated centre, and social stories had been developed for some residents and were available in their person-centred plans to assist understanding. For example a social story had been developed for one resident which assisted them to understand a recurrent infection that they were prone to.

Another resident had anxiety around visits to the dentist, so there was a social story around this, and around a prescribed medication that would assist the resident with their anxiety when a dental visit was required.

All staff who spoke to the inspector could describe the various ways in which residents communicated, and the inspector observed effective communication with residents throughout the inspection.

Judgment: Compliant

#### Regulation 12: Personal possessions

Four residents each had their own bank account, and one resident was in the process of opening theirs. Residents received varying amounts of support from staff in managing these accounts. For example, one resident managed their finances independently without any support from staff.

There was a financial support plan in place for each resident which outlined the supports required, and an associated risk assessment. The support plans included information as to the knowledge and skills of each resident, for example one resident could identify notes and coins, but their support plan indicated that they did not have any awareness of the value of each of these.

The PIC undertook an audit of all transactions, receipts and statements for each resident. There was an inventory of each residents' possessions, and this was updated with each purchase which enabled detailed cross checking. An additional audit was undertaken annually by the organisation's financial officer.

The inspector was assured that residents received support in accordance with their needs and preferences, and that they were safeguarded against financial abuse.

Judgment: Compliant

## Regulation 13: General welfare and development

There was a clear emphasis in the designated centre on ensuring that residents had a meaningful life, and they were introduced to new opportunities, both in the community and in their home.

There was a system of person-centred planning, and within this process each resident was supported to set goals for achievement. The person-centred plans were made in an accessible format for the use of residents, and each had a tablet in which their person-centred plan was loaded, including their goals.

Residents each had a circle of support which included their friends and family, together with their supporting staff, as they each preferred. Their circle of friends also had access to the goals so as to support residents in achieving them. Goals included planning for events or holidays, developing new skills and increasing opportunities.

For example, one resident did not yet have their own bank account and they were working towards this. The goal had been broken down into steps towards achievement, and a record of progress was maintained. The resident had achieved the steps of getting a utility bill in their own name and applying for a passport.

Goals for other residents included holidays, and several residents had been supported by staff to go on holidays. They had photos of these holidays and other major events on their tablets, together with photos of their current goals.

Residents were all supported to engage in various activities both at home and in their local community. For example one resident was a member of a local band and another is a local at the nearby pub which they head down to on their own every week.

Overall it was clear that residents were supported to have work and leisure activities of their choice, and to be supported in personal development.

Judgment: Compliant

## Regulation 26: Risk management procedures

There was a current risk management policy in place which included all the requirements of the regulations. Risk registers were maintained which included both local and environmental risks, and individual risks to residents. There was a risk assessment and risk management plan for each of the identified risks.

Individual risk assessments included the risks relating to choking, wheelchair use on the local cycle track and manual handling. There were detailed management plans

in place for all the identified risks. In addition any changing circumstances which might pose a risk to residents were assessed, and risk management plans developed. For example, where a resident had recently had a fall, there was a detailed falls risk assessment and management plan which outlined control measures required to safeguard the resident. These control measures included increased supervision by staff, the introduction of a mobility aid and a referral to the physiotherapist.

General risks were identified, and each of these also had detailed management plans, including the risks associated with the lift in the house, overhanging trees and fire safety. Included in fire safety was a detailed risk assessment relating to the use of open fires in the winter months.

The inspector was assured that control measures were in place to mitigate any identified risks relating to residents in the designated centre.

Judgment: Compliant

### Regulation 28: Fire precautions

The provider had put in place structures and processes to ensure fire safety. There was well maintained fire safety equipment, and there were fire doors throughout.

All staff members had received fire safety training, and the inspector discussed fire safety with them, and they were confident about their role in ensuring the safety of residents and could describe the supports each individual resident would require in the event of an emergency.

Regular fire drills had been undertaken, including drills under night time circumstances where there were reduced staff numbers, and the records of these drills indicated that residents could be evacuated in the event of an emergency. The designated centre had regular contact with their local fire station, and the local deputy chief fire officer there had signed off the fire safety emergency plan for the centre.

There was a detailed personal emergency evacuation plan (PEEP) in place for each resident and the inspector reviewed all five of these plans. Each PEEP included information specific to the resident in relation to the supports they would require to evacuate in an emergency, and again the local fire officer had approved these plans for residents with reduced mobility.

During the inspection the inspector observed that the fire door to one of the kitchen areas did not close when activated as required. The door was retested, and did close on subsequent attempts, although not as quickly as the other doors in the house. The inspector reviewed the documentation relating to testing the effectiveness of fire doors, and found that they were tested every week. The record of test from the previous week indicated that the door had been effective on that

occasion.

It appeared from the test records that the fault must have developed in the days since the previous test. The PIC called the maintenance team who attended immediately, although they could not rectify the matter on the day. The PIC sent confirmation the day after the inspection that the fault had been rectified.

The PIC consistently monitored any risks associated with fire safety, and the inspector was assured that all required control measures were in place to ensure the safety of residents in the event of a fire.

Judgment: Compliant

### Regulation 5: Individual assessment and personal plan

There were personal plans in place for each resident which were reviewed at least annually and were based on a detailed assessment of need. Care plans in place included plans relating to healthcare, including mental health, communication and social care needs. Some of the plans gave detailed guidance to staff as to the support required by each resident, however others lacked sufficient detail to guide to support staff in the delivery of consistent and appropriate care and support.

For example the inspector reviewed care plans relating to anxiety, eating and drinking, and manual handling and found that each of these plans included detailed guidance for staff, and covered all aspects of care and support in relation to these issues.

However the care plans relating to intimate and personal care were vague and relied on the instruction for staff to 'support' the resident without identifying clearly what supports were required. Another care plan relating to the nutritional needs of a resident included the guidance that staff should support the resident to have a healthy diet, but did not include any information as to the type of diet the resident required.

Whilst the quality of the sections of care plans was inconsistent, all staff and the person in charge were knowledgeable about the care and support needs of residents, so that it was apparent that the failing was in the documentation.

Judgment: Substantially compliant

### Regulation 6: Health care

Healthcare was well managed, and both long term conditions and changing needs were responded to appropriately. For example, where a resident had an unexplained

seizure, medical assistance was sought immediately, and follow up referrals were made, initially to the general practitioner (GP), and then for follow up tests and a neurology consultation.

Where another resident had been observed to have changing needs relating to ageing, again appropriate referrals had been made, to the memory clinic, the psychologist and the occupational therapist. The advice and guidance of these healthcare professionals was being followed.

Regular healthcare assessments were conducted including an annual review by the GP, and residents had been offered, and supported to take up, age-appropriate healthcare screening.

Each resident had a 'health passport' which included information that might be needed in the event that they required transfer to acute medical services, and these documents were detailed and current.

Overall the inspector was assured that the healthcare needs of each resident were monitored and addressed.

Judgment: Compliant

## Regulation 9: Residents' rights

The rights of residents were given high priority in this designated centre. Consultation and communication was well managed. There were weekly 'house meetings' where residents were supported to make their views known. The inspector reviewed the notes kept on these meetings and found that each resident was supported to have their voice heard.

These meetings were also an occasion for staff to raise issues such as human rights, activities and infection prevention and control. Staff utilised the meetings to share learning and information with residents together with listening to their views. Residents signed the record of these meetings.

Compatibility of residents was also given priority. Where a resident had recently moved into the house there were clear records of the views of current residents being taken into account. The new resident had made several visits to the house, followed by overnight stays. Their admission to the designated centre had only taken place once all the current residents had agreed, so that it was evident that the rights of residents to be consulted and to participate in the organisation of the designated centre was upheld, as required by the regulations.

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                |
|--|-------------------------|
| <b>Capacity and capability</b>   |                         |
| Registration Regulation 5: Application for registration or renewal of registration | Compliant               |
| Regulation 15: Staffing  | Compliant               |
| Regulation 16: Training and staff development                                      | Compliant               |
| Regulation 22: Insurance   | Compliant               |
| Regulation 23: Governance and management   | Substantially compliant |
| Regulation 31: Notification of incidents   | Compliant               |
| Regulation 4: Written policies and procedures                                      | Compliant               |
| Regulation 3: Statement of purpose   | Compliant               |
| Regulation 14: Persons in charge   | Compliant               |
| <b>Quality and safety</b>  |                         |
| Regulation 10: Communication   | Compliant               |
| Regulation 12: Personal possessions  | Compliant               |
| Regulation 13: General welfare and development                                     | Compliant               |
| Regulation 26: Risk management procedures  | Compliant               |
| Regulation 28: Fire precautions  | Compliant               |
| Regulation 5: Individual assessment and personal plan                              | Substantially compliant |
| Regulation 6: Health care  | Compliant               |
| Regulation 9: Residents' rights  | Compliant               |

# Compliance Plan for Teach Gael OSV-0003261

Inspection ID: MON-0039890

Date of inspection: 08/10/2025

## 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:<br><br>A survey has been carried out for each centre (10/9/25) in order to establish the views of relatives regarding the services and supports provided. The survey results will be attached to the Annual Review as evidence of incorporation of views. Proof of consultation with residents going forward will be provided using Individual Unique Identifiers. |                         |
| The Audit Practice and Procedure has been revised and implemented on the 3rd November 2025. The service provider will implement a tracker to ensure oversight of all actions going forward. This tracker will be an Agenda Item on Senior Management Team Meetings and monitored by the Compliance Manager.   |                         |
| 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:<br><br>The Clinical Team has scheduled Individual Risk Assessments and Care Planning Training for all staff across the service which is practice based to improve the quality of care planning and understanding of same in the service to begin 7th Jan 2026.  |                         |
| The service provider will create an auditing document / tool for reviewing Risk and Care Planning in order to identify actions and monitor outcomes. This will commence after Q1 2026 to allow time for practice training to be implemented.  |                         |



## **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).

| <b>Regulation</b>   | <b>Regulatory requirement</b>  | <b>Judgment</b>         | <b>Risk rating</b> | <b>Date to be complied with</b> |
|---------------------|--|-------------------------|--------------------|---------------------------------|
| 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             | 03/11/2025                      |
| Regulation 23(1)(e) | The registered provider shall ensure that the review referred to in subparagraph (d) shall provide for consultation with residents and their representatives.  | Substantially Compliant | Yellow             | 03/11/2025                      |
| Regulation 05(4)(a) | The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the   | Substantially Compliant | Yellow             | 07/01/2026                      |

|  |   |  |  |  |
|--|---|--|--|--|
|  | resident which reflects the resident's needs, as assessed in accordance with paragraph (1). |  |  |  |
|--|---|--|--|--|