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:	The Laurels
Name of provider:	St Michael's House
Address of centre:	Dublin 5
Type of inspection:	Unannounced
Date of inspection:	26 January 2026
Centre ID:	OSV-0003602
Fieldwork ID:	MON-0045268

About the designated centre

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

The Laurels is a designated centre operated by St Michael's House. It is located in a busy Dublin suburb. The centre provides a residential service to five adults. The service can accommodate both males and females who have a moderate to profound intellectual disability and who may also have complex health needs, mental health needs, autism, behaviours of concern, and mobility needs. Residents are supported by a team of nurses, social care workers and direct support workers. The centre is managed by a person in charge with support from a nurse manager. The centre aims to provide residential care in a homely environment where people feel happy, safe, valued and cared for.

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
Monday 26 January 2026	10:15hrs to 16:00hrs	Michael Muldowney	Lead

What residents told us and what inspectors observed

This unannounced inspection was carried out as part of the regulatory monitoring of the centre. The inspector used observations, conversations and engagements with residents and staff, and a review of documentation to form judgments on the quality and safety of the care and support provided to residents in the centre. Overall, the inspector found that residents received good quality and safe care in centre. Residents appeared relaxed and comfortable in their home and with the support they received from staff. However, improvements were required to meet full compliance under all of the regulations inspected.

The centre accommodates five adult residents. It comprises a large single-storey house that is very close to amenities and services, including shops, restaurants and parks. The centre shares a vehicle with another neighbouring centre. The house contains individual bedrooms, a dining room and kitchen, a utility room, bathrooms, two sitting rooms, storage areas, and a staff office. Overall, the house was seen to be clean, homely, comfortable, nicely decorated and well maintained.

Residents' bedrooms were personalised to their tastes and reflected their individual interests. Specialised equipment was available to residents, including patient handling and mobility aids, such as ceiling hoists and wheelchairs. However, one resident's specialised bed was no longer suitable to their needs, and posed a hazard to their safety. This issued was deemed by the management team as a high risk and had been escalated to the multidisciplinary and senior management team. The inspector also observed that a sitting room contained unused mobility equipment and boxes of documentation. These items prevented residents from using the room.

The inspector observed good fire safety systems, including fire detection, fighting and containment equipment. The premises and fire safety are discussed further in the quality and safety section of the report.

The inspector observed a warm and relaxed atmosphere in the centre. There was a pleasant aroma from home cooking at meal times, and staff were observed engaging with residents in a kind, responsive and familiar manner. The inspector met the residents in the afternoon. Four residents attended day services, and one resident was supported by staff in the centre with their social and leisure activities. The residents had individual communication means, and associated plans had been prepared for staff to follow. However, as discussed further in the quality and safety section of the report, some of the plans and assessments required review.

Three residents did not verbally communicate with the inspector, but engaged by smiling and making eye contact. One resident briefly spoke with the inspector about their favourite food and television programme, and the local café that they liked to visit. Another resident told the inspector that they liked living in the centre, their bedroom, and the staff team. They said that they liked to bake, spend time with

their family, and watch films, and was planning on attending an upcoming party organised by the provider.

The inspector did not have opportunity to meet any of the residents' representatives. However, the recent annual review had consulted with them, and noted that they felt that their loved ones were happy and well cared for. They also said that they felt welcome in the centre and had no concerns.

The inspector spoke with the person in charge and two staff nurses during the inspection. The nurses were well informed on the residents' various and complex health, communication, behaviour, nutrition, and intimate care needs and associated plans, as well as the fire safety and infection prevention and control procedures. They spoke warmly about residents, and demonstrated a good understanding of their individual personalities, preferences and interests. They told the inspector that residents were happy and safe in the centre, and were listened to and well cared for by staff. They said that they could raise concerns to the management team. They and the person in charge were concerned that one resident's specialised equipment was not suitable to their needs and posed a risk to the resident's and staff safety.

The person in charge was satisfied with the staffing arrangements, and said that residents could access multidisciplinary team services as needed, including psychiatry, psychology, occupational therapy, and speech and language therapy. They said that there had been no complaints from residents or their families about the centre. The inspector and person in charge discussed information in governance reports regarding a barrier to achieving residents' social goals due to lack of access to a vehicle dedicated for the use by residents of this centre. From speaking with the person in charge, the inspector found that this matter required better assessment. The inspector also reviewed the staff training log and supervision records, and found that these areas both required improvement.

Overall, the inspector found that residents appeared to be content in their home, and received good care and support from staff. The centre was well resourced under most aspects and there were clear management arrangements. However, improvements were required under regulations 10, 16, 17 and 23.

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

Capacity and capability

This inspection found that there were clearly defined management systems and a consistent and familiar staff team who knew the residents and their assessed needs well. However, improvements were required to ensure that risks relating to the quality and safety of care were effectively assessed and managed, and to ensure

that all staff were in receipt of supervision as frequently as defined by the provider's policy.

The management structure was clearly defined with associated responsibilities and lines of authority. The person in charge was full-time, and met the requirements of regulation 14. They reported to a service manager, and there were effective arrangements for them to communicate. The provider and person in charge had implemented management systems to monitor the quality and safety of service provided to residents. Audits, including annual reviews and six-monthly reports, had been carried out in the centre to identify areas for quality improvement. However, risks associated with barriers to residents' social goals and the use of specific equipment required better assessment to ensure that appropriate control measures were in place.

The person in charge was satisfied that the staff skill-mix and complement was appropriate to the assessed needs of the current residents. The person in charge maintained planned and actual rotas. The rotas clearly noted the staff on duty and the hours they worked.

Staff were required to complete a wide range of training as part of their professional development. However, the training log showed that some staff were overdue refresher training. This posed a risk to the quality and safety of the care and support provided to residents. The person in charge also told the inspector that some staff had completed training in human rights; however, it was not recorded on the centre's training log.

The inspector also reviewed three staff member's 2025 formal supervision records, and found that they had not been carried out in line with the provider's associated policy.

Additionally, the person in charge told the inspector that staff team meetings usually took place every two months. Team meetings provide a forum for staff to raise concerns. However, there were no meeting minutes available from a six month period in 2025.

Regulation 14: Persons in charge

The registered provider had appointed a full-time person in charge. The person in charge was suitably skilled and experienced for their role, and possessed relevant qualifications in nursing and management. They demonstrated a good understanding of service to be provided in the centre.

Judgment: Compliant

Regulation 15: Staffing

The registered provider had determined that the staff complement and skill-mix of nurses, direct support workers, and a social care worker was appropriate to the number and assessed needs of the residents living in the centre at the time of the inspection.

The person in charge was satisfied with the staffing arrangements, and said that there was enough staff on duty. Three staff worked during the day and two at night, and there was always a nurse on duty. The inspector reviewed the December 2025 and January 2026 rotas. The rotas were well maintained and recorded the names of staff and the hours they worked, and showed that planned staffing levels were maintained.

Staff spoken with, spoke warmly about residents, and demonstrated a rich understanding of their preferences and needs. The inspector also observed them kindly engaging with residents; for example, they spoke with them about their interests and promptly responded to their needs.

Staff Schedule 2 files were not reviewed as part of this inspection.

Judgment: Compliant

Regulation 16: Training and staff development

The implementation of the provider's staff supervision policy required improvement. The provider's policy was that staff received formal supervision four times per year. The inspector reviewed three staff member's 2025 supervision records with the person in charge, and found the following:

- One staff member had not received supervision in 2025.
- One staff member had received supervision twice in 2025.
- There were no supervision records available for one staff member.

These deficits posed a risk staff support and development, and thus the quality and safety of the services they deliver.

Staff were also required to complete a range of training as part of their professional development. The inspector reviewed the staff training log with the person in charge and found that some staff required refresher training in different areas; for example, in relation to infection prevention and control, positive behaviour support, manual handling and medication management. Some of the outstanding training was scheduled. However, six staff required refresher training in positive behaviour support, and the person in charge was awaiting dates for the training from the

provider. Gaps in the upkeep of refresher training further posed a risk to the quality and safety of care and support provided to residents.

Judgment: Not compliant

Regulation 23: Governance and management

Overall, the inspector found that the centre was well resourced in line with the statement of purpose. For example, multidisciplinary team services were available and the staffing levels met the residents' needs. There were also management systems to deliver and monitor the quality and safety of the service provided to residents. However, the assessment of risks which impacted on the safety and quality of service provided to residents required improvement, and, as noted under regulation 16, the provider's supervision policy had not not been fully implemented.

There was a clearly defined management structure in the centre with associated lines of authority and accountability. The person in charge was full-time, and reported a service manager. There were arrangements for the management team to communicate, including scheduled meetings and informal communications.

The person in charge also completed monthly governance reports that they shared with the service manager. The inspector reviewed a sample of the reports from 2025. They included information on residents' assessments and plans, risk assessments, incidents, complaints, notifications, staffing matters, fire safety, and restrictions. The January 2026 and December 2025 reports noted that some resident's goals had not commenced due to staffing issues, and that sharing a vehicle with another centre posed a barrier to residents' social outings. The July 2025 unannounced visit report also noted barriers due to sharing a bus. However, the impact of these issues on residents had not been assessed. This matter required further review to ensure that any adverse impacts were identified, assessed and appropriately managed.

Additionally, as noted elsewhere in the report, a resident's specialised equipment was deemed unsuitable to their needs. An associated risk assessment regarding the risk to staff from using the equipment was scored as a 'red' risk. However, staff and the person in charge told the inspector that there was also a risk to the resident's safety, which was not reflected in a risk assessment. This required improvement to ensure that all necessary control measures were in place.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

The provider had prepared an effective complaints procedure. The procedure was underpinned by a written policy, and had also prepared in an easy-to-read format to make it more accessible to residents.

There were no recorded complaints; however, the recent annual review had consulted with residents' representatives, and they indicated they had no complaints and were satisfied with the care and support their loved ones received in the centre.

Judgment: Compliant

Regulation 4: Written policies and procedures

The registered provider had prepared written policies and procedures on the matters set out in Schedule 5. These policies and procedures were available on the provider's electronic information system.

The inspector reviewed a sample of the policies, including those relating to medication management, complaints, safeguarding residents from abuse, intimate care, the use of restrictive practices, communication with residents, and risk management. The policies had been revised in line with the requirements of this regulation.

Judgment: Compliant

Quality and safety

The inspector found that the residents' wellbeing and welfare was maintained by a good standard of person-centred care and support in the centre. Residents appeared content in their home and with the care they received from staff, and the inspector observed a homely and relaxed atmosphere.

Residents communicated using various means. Communication care plans had been prepared which outlined how they expressed their needs and preferences. The inspector found that one resident's care plan required revision, and two residents were due communication assessments.

The provider had implemented effective arrangements to safeguard residents from abuse, including staff training and a written policy to inform practices. The inspector reviewed the safeguarding concerns recorded in 2025, and found that they had been appropriately reported and managed.

The premises comprises a one-storey house. It contains residents' bedrooms, a staff office, bathrooms, two sitting rooms, a kitchen and dining room, a store room, and a utility room. The house was seen to be homely, comfortable, clean, and nicely decorated. However, one of the sitting rooms could not be used as it was being used for storage. Additionally, one resident's specialised equipment was no longer suitable to their needs and required replacement.

The inspector observed good fire safety precautions. For example, there was fire-fighting and detection equipment, and emergency lighting throughout the house, and the fire doors were observed to close when the alarm activated. Fire drills were regularly carried out to test the effectiveness of the evacuation plans.

Regulation 10: Communication

The registered provider had arrangements to assist and support residents to communicate in their own individual means. The supports were underpinned by its total communication policy.

The residents communicated using different means. Some residents did not verbally communicate and used gestures and body language to express their needs and preferences. Staff were found to have a good understanding of residents' non-verbal communication, such as their body language. Information on how residents' communicated was reflected in their care plans for staff to refer to. The inspector reviewed all five communication plans. One plan was found to require a minor update. The inspector also read that two residents required a review of their communication assessments to ensure that the plans in place were effective.

The provider had ensured that residents could access different media forms in their home, including televisions and the Internet to stream entertainment.

Judgment: Substantially compliant

Regulation 11: Visits

Residents could freely receive visitors in their home. The provider had prepared a visitors policy, and the arrangements were also noted in the residents' guide. There were communal spaces to accommodate visitors. Feedback from residents' representatives in the recent annual review noted that they felt welcome in the centre.

Judgment: Compliant

Regulation 17: Premises

The centre comprises a large one-storey house close to many amenities and services. Generally, the premises were found to be appropriate to the needs of the residents living in the centre at the time of the inspection. However, the storage arrangements required review and specialised equipment used by a resident required replacement.

The house was seen to be clean, bright, homely and comfortable. There was sufficient communal space including bathroom facilities, a kitchen and dining room, and two sitting rooms. There was also a storage room, a utility room and an office. The residents' bedrooms were nicely decorated and personalised to their tastes and interests. However, the inspector saw that one sitting room, which also served as a sensory room and visitors' space, contained archiving boxes and unused mobility equipment that prevented residents from using the room. This required improvement to ensure that residents could freely use the facilities in their home, especially those residents who had sensory needs.

Specialised equipment, including electric beds, ceiling hoists, shower trays and wheelchairs were available to residents. However, one resident's specialised equipment was deemed not suitable to their needs, and posed a risk to staff and the resident. This issue had been risk rated as red, and escalated to the multidisciplinary and senior management teams.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The registered provider had implemented good fire safety precautions in the centre. There was fire detection and fighting equipment, and emergency lights throughout the house. These systems were regularly serviced to ensure that they were maintained in good working order. The fire panel were addressable and easily found in the front hallway. The inspector observed good fire containment measures; fire doors, including the kitchen, sitting rooms and bedroom doors all closed when the alarm sounded.

Staff completed fire safety checks to ensure that the precautions were in place. The provider's fire safety officer had also recently visited the centre to provide training for staff and to audit the fire safety measures.

There was an evacuation plan for the centre and individual evacuation plans for residents. Fire drills, including drills reflective of night-time scenarios, were carried out to test the effectiveness of the fire plans. Staff told the inspector that residents evacuated well during drills.

Judgment: Compliant

Regulation 8: Protection

The registered provider and person in charge had implemented good systems to safeguard residents from abuse. The provider had prepared a written policy on the safeguarding of residents. It was readily available in the centre. Staff had also completed safeguarding training to support them in the prevention, detection, and response to safeguarding concerns.

Staff spoken with were aware of the procedures for managing safeguarding concerns. The provider's social work department had also completed a safeguarding audit in March 2025 to review the arrangements in the centre. The inspector found that four safeguarding concerns recorded in 2025 had been appropriately reported and managed.

Intimate care plans had been prepared to support staff in delivering care to residents in a manner that respected their dignity and bodily integrity. The inspector reviewed all five residents' plans. Overall, the plans were up to date and readily available to guide staff. However, one resident's plan required review and cohesion to ensure that it was comprehensive.

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 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 10: Communication	Substantially compliant
Regulation 11: Visits	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 28: Fire precautions	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for The Laurels OSV-0003602

Inspection ID: MON-0045268

Date of inspection: 26/01/2026

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • The person in Charge has developed a supervision schedule for all staff in line with organizational policy Date: 27/01/2026 Completed. • Records of all supervision meetings will be maintained by the PIC and securely stored in line with SMH policy Date: 31/03/2026. • All staff have been scheduled for the relevant in-person training o Manual Handling – all relevant staff have now completed manual handling training. Date: 19/02/2026 Completed o Positive Behavioural Supports: 6 staff have been scheduled for PBS training. Date: 26/05/2026 o 1 staff has completed IPC training since the inspection. The remining 1 staff has been allocated protected time to complete IPC training. Date: 20/02/2026. o All relevant staff have now completed their Safe Administration of Medication training. Date: 31/01/2026 Completed • Ongoing monitoring of training compliance will occur through monthly governance reports. Date: 28/02/2026. • Training will be discussed with all staff at quarterly supervision meetings to ensure mandatory training is kept up to date. Date: 31/03/2026 • Training will be included as a fixed agenda item at all staff meetings Date: 19/03/2026.	
Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
• The person in Charge has developed a supervision schedule for all staff in line with organizational policy Date: 27/01/2026 completed.

• Records of all supervision meetings will be maintained by the PIC and securely stored in line with SMH policy. Date 31/03/2026

• The Person in Charge will review any delayed goals or cancelled social outings to identify if residents have been adversely affected. Where an impact is identified, this will be documented with agreed actions recorded. Date: 31/03/2026

• The Person in Charge has reviewed and updated the current risk assessment to ensure that all risks associated with the specialist equipment, including potential risks to both resident and staff are clearly identified, fully assessed and control measures put in place. Date: 30/01/2026 Completed.

• A multi-disciplinary team meeting (MDT) was convened on 19/02/2026 to explore all available options for sourcing the specialised equipment required for the resident. A number of follow up actions were identified and allocated to different team members. Date: 19/03/2026 Completed

• A follow up MDT meeting will be scheduled to review progress on the agreed actions and determine the next steps. Date: 31/03/2026

Regulation 10: Communication	Substantially Compliant

Outline how you are going to come into compliance with Regulation 10: Communication:
• All residents' communication plans have been reviewed to ensure they accurately reflect current communication needs of the residents. Date: 09/02/2026 Completed.

• Referrals have been made to Speech and Language Therapy for two of the residents requiring a review of their communication assessments. Date 19/02/2026 Completed

• Communication plans will be updated to reflect any updated recommendations/ changes to guidance in line in with communications assessments. Date: 30/04/2026

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• The sitting room had been used for storage has now been cleared of archived documentation. Unused equipment has all been removed to ensure residents can fully access and use this space. Date: 13/02/2026 Completed

• A review of storage arrangements will be completed to ensure appropriate and safe storage solutions are in place without impacting communal areas. Date: 30/04/2026

• An MDT meeting was convened on 19/02/2026 to explore all available options for

sourcing the specialised equipment required for the resident. A number of follow up actions were identified and allocated to different team members.
Date: 19/03/2026 Completed

• A follow up MDT meeting will be scheduled to review progress on the agreed actions and determine the next steps. Date: 31/03/2026

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 10(1)	The registered provider shall ensure that each resident is assisted and supported at all times to communicate in accordance with the residents' needs and wishes.	Substantially Compliant	Yellow	30/04/2026
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	26/05/2026
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	31/03/2026
Regulation 17(4)	The registered provider shall ensure that such equipment and facilities as may be	Substantially Compliant	Yellow	30/04/2026

	required for use by residents and staff shall be provided and maintained in good working order. Equipment and facilities shall be serviced and maintained regularly, and any repairs or replacements shall be carried out as quickly as possible so as to minimise disruption and inconvenience to residents.			
Regulation 17(6)	The registered provider shall ensure that the designated centre adheres to best practice in achieving and promoting accessibility. He. she, regularly reviews its accessibility with reference to the statement of purpose and carries out any required alterations to the premises of the designated centre to ensure it is accessible to all.	Substantially Compliant	Yellow	30/04/2026
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	Substantially Compliant	Yellow	31/03/2026

	safe, appropriate to residents' needs, consistent and effectively monitored.			
Regulation 23(3)(a)	The registered provider shall ensure that effective arrangements are in place to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.	Substantially Compliant	Yellow	31/03/2026