



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

## Issued by the Chief Inspector

Name of designated centre:	Grange Apartments - Sonas Residential Service
Name of provider:	Avista CLG
Address of centre:	Dublin 15
Type of inspection:	Unannounced
Date of inspection:	09 October 2025
Centre ID:	OSV-0003745
Fieldwork ID:	MON-0048003

## About the designated centre

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

Grange Apartments provide care and support for six adults who have a diagnosis of intellectual disabilities and / or autism / mental health difficulties and behaviours of concern. The centre is on a campus in west Dublin, and is made up of 6 separate apartments. The aim of grange apartments is to provide a supportive, individualised and low arousal residential environment, specifically tailored to each individual's needs. Each resident has their own apartment with a bedroom, bathroom and kitchen/living/dining area. The primary focus in grange apartments is to support each resident to engage in meaningful activities of their choice, with a strong emphasis on community integration. The centre is situated near many local and public amenities including good public transport links and there are a number of vehicles in the centre to support residents to engage community activities. Internally, there are a variety of activities the residents can avail of including a gym, a number of garden areas, and a number of multifunctional rooms. Staffing support is provided 24 hours a day, seven days a week by a person in charge, clinical nurse manager, staff nurses and care staff.

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

Number of residents on the date of inspection:	6
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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
Thursday 9 October 2025	11:00hrs to 18:00hrs	Karen Leen	Lead
Thursday 9 October 2025	11:00hrs to 18:00hrs	Brendan Kelly	Support

## What residents told us and what inspectors observed

This unannounced risk-based inspection was completed following receipt of solicited information and as the last inspection of this designated centre was carried out in July 2023. The inspection was completed by two inspectors over the course of one day. Overall, the inspection found high levels of compliance with the regulations. The inspectors found that the residents in the centre were in receipt of an individualised and person-centred approach to care. The person in charge, support team and multidisciplinary team were supporting residents to live active, meaningful lives with a focus on what is important to each resident when setting and achieving goals. However, inspectors found that improvements were required in relation to Regulation 15: staffing and Regulation 16: training and staff development.

The designated centre provides residential service for up to six adults with an intellectual disability and is based on a campus setting in West Dublin. The centre comprises of six individual apartments, and a number of communal spaces including an activity room equipped with gym equipment, arts supplies, books and jigsaws. Residents' individual apartments consisted of a living room, kitchen, dining area, and a bedroom with en-suite. The apartments had inner garden spaces which were fitted with garden furnishing as chosen by residents. The centre was also home to a pet dog belonging to the residents. Inspectors observed that residents enjoyed the companionship of their pet dog. Residents had framed pictures with their pet and pictures of walks with their pet in the local community or visiting neighbouring houses on the campus.

The inspectors found that the apartments that made up the designated centre were decorated in line with each individuals personal taste. Inspectors found that for some residents their apartments had been decorated in a manner which reduced stimulus for the resident and supported them to remain safe in their environment. Other residents chose to decorate their apartments with vintage car collectibles, pictures of family and friends, movie posters and seasonal decorations.

Residents in the centre were supported by the person in charge who was a clinical nurse manager grade two (CNM2), as well as two deputy managers with the grade of clinical nurse manager one (CNM1), staff nurses, healthcare assistants and an occupational therapist. The centre also had access to a dedicated multidisciplinary team including a clinical nurse specialist in behaviour support, psychology, psychiatry, physiotherapy and general practitioner. The inspectors found that the multidisciplinary team, the person in charge and support staff met on a monthly basis or sooner to review the support and care provided to residents in the centre.

The inspection was facilitated by the person in charge for the duration of the inspection. The inspectors used observations and discussions with a number of residents alongside a review of documentation and conversations with key staff and management to inform judgments on the residents' quality of life; Residents living in the centre used different forms of communication and where appropriate, their

views were relayed through staff advocating on their behalf. The inspectors had the opportunity to speak to two residents, a CNM1, four support staff, the clinical nurse specialist in behaviour support, the occupational therapist and the person participating in management during the course of the inspection. While inspectors found that support staff in the centre were using communication methods such as Lámh (modified sign language) to support residents, the inspectors identified that this skill had been learned through observing residents and that the provider had not completed any formal Lámh training to staff members.

The inspectors reviewed a range of activities completed by residents in the designated centre and found that the person in charge, support team and multidisciplinary team had a strong focus on achieving goals which were meaningful to each individual and which would lead to greater enhancement in individuals relationships with families and loved ones. The inspectors reviewed residents support plans and found them to have an in-depth step-by-step approach to support residents to achieve their identified goals. The achievement of each goal was reviewed each quarter or sooner if additional supports were required. The inspectors found that the individual residents were at the forefront of the plan. As part of the goal review process, each resident was invited to continue to adapt and enhance a goal or if they would like to stop as they had achieved their goal. Goals achieved by residents were captured in an accessible visual format for each resident.

Throughout the course of the inspection, inspectors observed the centre to be filled with activities and visitors. Residents had assistance of staff during the day to attend a range of activities both in the community and their home. Residents were seen to be relaxed and comfortable in the presence of staff. It was evident that staff were aware of the support needs of residents and could support the residents to communicate their needs. Inspectors reviewed a number of activities that residents like to participate in including meals out, shopping trips, gardening, walking the dog, visiting family members and nature walks.

The person in charge and support team had clear communication systems in place to ensure that residents and their representatives played an active role in the running of the designated centre. Family support was an important factor to residents and was incorporated into a number of support plans and daily routines in order to further enhance regular contact and maintain supportive and positive relationships.

Inspectors had the opportunity to meet with one resident. Prior to meeting the resident, inspectors were supported by staff in identifying topics which may cause upset or lead to the resident's day being effected. Inspectors were guided by staff verbal and non verbal prompts throughout their communications and found that the resident was relaxed in the presence of support staff. The resident told the inspectors that they love their home and that they had been trying a number of new activities. The resident discussed that they had been doing some cookery with the help of the centre's occupational therapist and that they were enjoying participating. They discussed that at times they will refuse to participate in some activities and that this is respected by their support staff. The resident explained that other options are discussed. The resident informed the inspectors that they were looking

forward to Halloween and that they had recently gone out shopping to buy a Halloween costume. The inspectors observed the resident laughing and joking with the person in charge and support staff throughout. The resident also discussed with the inspectors how they required staff and visitors to follow specific guidance when leaving their home. This information had been shared with the inspectors prior to visiting their home by support staff.

The inspectors met with another resident on their return from an outing with support staff. The resident greeted the inspectors using Lámh, their primary form of communication. They showed the inspectors the decorations they had hand made for the kitchen in their apartment for Halloween and their bedroom. The resident was seen communicating with staff about the lunch that had been prepared for them and what they wanted to do after lunch. The inspectors observed that the environment had been fully adapted to assist the resident following a recent fall in their home. Inspectors also reviewed documentation that demonstrated a multidisciplinary approach to ensure that the resident was supported in their home to ensure that their recent fall did not affect their ability to live as independently as possible in their home and ensure that they did not require staff supervision when they would prefer time alone.

Overall, inspectors found that the residents were being supported to live their lives in a manner that was in line with their needs, wishes and personal preferences. There were systems in place to ensure residents were safe and in receipt of good quality care and support. Residents were supported to maintain and develop meaningful relationships with family and friends with the support of a dedicated staff team.

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 on the quality and safety of the service being delivered.

## Capacity and capability

This section of the report sets out the findings of the inspection in relation to the leadership and management of the service, and how effective it was in ensuring that a good quality and safe service was being provided. Overall, the inspectors found that the centre was well governed and that there were systems in place to ensure that risks pertaining to the designated centre were identified and progressed in a timely manner. However, inspectors found that improvements were required in relation to Regulation 16: training and staff development in order to further enhance the support provided to residents in relation to specific areas of a residents diagnosis or to further enhance a residents communication style.

Inspectors found that the centre was operating on 3.5 whole-time equivalent (WTE) staff vacancies. While the inspectors acknowledge that the provider had completed a

number of recruitment campaigns the centre was reliant on a number of agency staff in order to complete safe staffing levels for the centre. The provider had identified this centre as a priority area for staffing due to the assessed needs of residents and the need for familiar staff team. The inspectors found that there was a contingency plan in place in the event staff could not report for duty.

There was a clearly defined management structure in place and staff were aware of their roles and responsibilities in relation to the day-to-day running of the centre. The service was led by a capable person in charge, supported by a staff team, who were knowledgeable about the support needs of the residents living in the centre. The person in charge worked full-time and was supported in their role by a clinical nurse manager grade three.

The registered provider and person in charge had implemented satisfactory management systems to monitor the quality and safety of service provided to residents. Overall, the governance and management systems in place were found to operate to a good standard in this centre.

Six-monthly unannounced visits of the centre were taking place to review the quality and safety of care and support provided to residents. The reviews included an action plan to address any concerns regarding the standard of care and support provided.

#### Regulation 14: Persons in charge

The provider had appointed a person in charge for the centre that met the requirements of Regulation 14 in relation to management experience and qualifications. During the inspection the inspectors reviewed the systems they had for oversight and monitoring and found that they were effective in identifying areas of good practice and areas where improvements were required.

Through interactions, the inspectors found them to be aware of their legal remit with regard to the regulations, and were responsive to the inspection process. Furthermore, the inspectors found that the person in charge had a clear understanding of each resident's assessed needs, goals and supports required in order to fully enhance their lived experience both in their home, local community and was assisting residents to enhance family connections. The inspectors found that the person in charge promoted a staff culture which promoted and protected the rights and dignity of residents through person-centred care and support.

Judgment: Compliant

#### Regulation 15: Staffing

On the day of the inspection, the designated centre was operating on a 3.5 WTE staff vacancy. Where possible, the person in charge was attempting to use regular relief and agency staff. Inspectors reviewed rosters in the centre from August and September 2025 and found that on average for the months of August and September, 10 shifts per week were required to be covered on the roster by agency staff. The inspectors acknowledged that the person in charge had ensured that the required agency shifts to be covered were completed during day shifts in order to ensure that there was regular permanent staff and senior management available to support agency and relief staff in the centre. The provider had completed a number of recruitment campaigns, however the inspectors found the reliance of agency was effecting the continuity of support for residents in the centre.

The inspectors found the person in charge and support staff to be highly experienced in the support needs of each individual in the designated centre. The inspectors found that the support given by staff in the centre was creating a encouraging and inclusive atmosphere in the centre. Inspectors found that staff offered support and guidance to residents in order to enhance their daily experience and promote their relationships with family, friends and the local community.

Judgment: Substantially compliant

## Regulation 16: Training and staff development

While the inspectors found that the provider had provided mandatory training for staff in a number of key areas such as fire safety, manual handling and safeguarding vulnerable adults, the inspectors found that improvements were required in training provided to staff which would further enhance residents quality of life. For example, a number of residents in the designated centre used Lámh (modified sign language) with some residents using this system as their main form of communication. On review of the centres training records inspectors found that on the day of inspection no staff had received training in Lámh. Furthermore on review of the centres up coming training schedule inspectors identified that 13 out of 21 staff had been identified to complete the training. This was discussed with the person in charge and inspectors were informed that no further Lámh training was planned to be completed for the remaining eight staff. The inspectors acknowledged that staff working with residents demonstrated the ability to communicate with residents using Lámh as they had been thought and instructed by residents in the centre. Inspectors found that in order to further enhance the development of staff and new staff induction in the centre, residents would benefit from staff receiving formal training in Lámh.

Inspectors found that residents had access to enhanced multidisciplinary team supports in the centre, which included regular review of mental health diagnosis and supports required in relation to residents supports associated with a diagnosis of Autism with the multidisciplinary team and support staff. Inspectors found that there

was no formal training available to staff in the area of supporting residents with a mental health diagnosis or Autism supports.

The person in charge had developed an induction plan for all staff in the centre, including new permanent staff, agency and relief. This induction included an overall induction to the designated centre with supports available to residents and staff both during regular working hours of 9am to 5pm but also, out of hours supports available including senior management and multidisciplinary support. Furthermore, the person in charge completed an individual induction plan for each resident in the designated centre in order to enhance staff practice when supporting each individual.

The inspectors found that regular supervision was taking place in the designated centre. The person in charge was supported by two CNM1s, who were actively participating in formal and informal supervision. The inspectors reviewed the supervision records of eight support staff and found them to be detailed in relation to key worker responsibilities, residents' current support needs and identified training for staff.

Staff meetings were occurring regularly in the centre, inspectors found that staff meetings were reflective of residents' current goals and achievements and what supports were required to further enhance residents quality of life. Furthermore, the centre was conducting regular multidisciplinary meetings which included participation from psychiatry, psychology, occupational therapy, speech and language and behavioural specialists.

Judgment: Substantially compliant

### Regulation 23: Governance and management

The provider had arrangements in place to ensure that a safe, high-quality service was being provided to residents in the centre. There was a clear management structure in place with clear lines of accountability. It was evidenced that there was regular oversight and monitoring of the care and support provided in the designated centre and there was regular management presence within the centre. Inspectors had the opportunity to speak to one resident who could clearly identify the management supports available in the centre and who they would talk to if they had a concern or required support. Furthermore, inspectors found the person in charge to be knowledgeable of the individual needs of each resident and the supports required in the centre in order to provide a safe and quality service.

An annual review of the quality and safety of care had been completed for 2024 which consulted with residents, their families/representatives and staff. Positive feedback from families included, "*The service is excellent. Staff are excellent*" and "*The manager or keyworker are always available*". The annual review had also identified some actions which would further support residents in their home, the

inspectors found that these actions had been assigned completion dates and were in place. For example, the annual review discussed the restrictions in place in the centre and how staff can actively review restrictive practices with a review to reduce where possible in the centre. The inspectors observed a number of incidents where staff were actively reducing restrictive practices in the centre or attempting to identify periods of the day where certain restrictions could be reduced.

Local governance was found to operate to a good standard in this centre. Good quality monitoring and auditing systems were in place. The person in charge demonstrated good awareness of key areas and had checks in place to ensure the provision of service delivered to residents was of a good standard. The provider also had in place a suite of audits, which included; medicines, infection prevention and control and health and safety checklists.

The person in charge had implemented additional oversight tools to monitor the care and support in the centre. For example, the person in charge had completed additional inductions packs for new staff which supported them to support residents in their home and the wider community.

Staff team meetings were taking place regularly and provided staff with an opportunity for reflection and shared learning. The inspectors reviewed staff meetings occurring in the centre in June, August, September and October 2025 and found that there was a standing agenda in place with clear actions set out if deemed necessary following the meeting. The agenda included residents' update, update for senior management or external stakeholder meetings, person-centred planning and goal overview, fire safety update and restrictive practice review.

Judgment: Compliant

## Quality and safety

This section of the report details the quality and safety of the service for the residents who live in the designated centre.

The inspectors found that the person in charge and staff were aware of residents' needs and knowledgeable in the person-centred care practices required to meet those needs. The inspectors found that the centre incorporated a multidisciplinary approach to care and support with members of the multidisciplinary team working closely with each resident and their support staff.

Residents were facilitated and empowered to exercise choice and control across a range of daily activities and to have their choices and decisions respected. Residents were encouraged and supported to direct how they lived on a day-to-day basis according to personal values, beliefs and preferences. Residents were supported to maintain and continue to build upon personal relationships with family and friends.

Positive behaviour support plans were developed for residents, where required. The plans were up-to-date and readily available for staff to follow. Staff had also completed training in positive behaviour support to support them in responding to behaviours of concern.

There were arrangements in place to manage risk, including an organisational policy and associated procedures. The inspectors found that risk was well managed. All identified risks were subject to a risk assessment, with control measures in place to support residents and minimise risks to their safety or well being. Risk control measures were found to be proportionate, and supported residents to safely take positive risks. The person in charge was aware of all identified risks in the centre and was ensuring that staff treated identified risks as interchangeable with the need for regular review.

## Regulation 13: General welfare and development

Residents had access to a range of opportunities for recreation and leisure. Residents were supported to engage in learning and development opportunities with residents participating in a number of educational and employment opportunities.

The inspectors observed supports in place to ensure that residents could continue to maintain and develop personal relationships and links with the wider community in accordance with their wishes. As previously discussed, the inspectors found that goals for each individual were closely supported in order to ensure that step-by-step guidance was available to staff in order to ensure that goals could be achieved. The inspectors found that if residents or staff team had identified a barrier to completing a goal, a team review was called in order to identify the supports required for the resident to achieve the next step in their plan. Inspectors found that activities were person centred and meaningful for each resident and included the people that mattered in residents lives. Inspectors found that family were included in support plans as per residents' expressed wishes.

Inspectors found that the person in charge and support team were creating an environment that encouraged residents to identify goals outside of their home. Inspectors found the person in charge, support staff and multidisciplinary team were upholding the centre's statement of purpose by supporting residents to identify possible community-based living environments and were developing transition plans which included residents and their family members.

In addition, inspectors found that the centre's multidisciplinary team were working with residents and support staff in order to ensure that residents could avail of opportunities in their local community or to attend local hospitals for screening programmes or regular reviews in line with a medical diagnosis. For example, support staff had identified a change in one resident's assessed needs and their mobility presentation. In order to fully support the resident in identifying the possible cause of this change a number of hospital appointments and reviews were deemed necessary. As a hospital setting can be a difficult transition for residents,

the behavioural support specialist and occupation therapist had completed work with the hospital in order to ensure reduced anxiety for the resident. For example, the behavioural support specialist had visited the hospital clinic in order to work the number of transitions from transport to appointment that the resident would be required to complete. They had also met with members of the hospitals consultant team in order to ensure that they would be ready for the appointment time.

Judgment: Compliant

## Regulation 26: Risk management procedures

The provider had suitable systems in place for the assessment, management and ongoing review of risk including a system for responding to emergencies.

The provider had ensured consistent implementation of the risk management systems which it had in place in the centre. For example, there was a risk register in place which was regularly reviewed. Residents had individual risk assessments in place with appropriate control measures in place to ensure that residents had the opportunity to participate in activities of their choosing.

Adverse incidents were found to be documented and reported in a timely manner. These were trended on a monthly basis by management to ensure that any trends of concern were identified and actioned. The inspectors found that accidents and incidents were discussed at staff meetings and plans were put in place to reduce potential risk of possible recurrence and to support residents to continue to develop relationships in the community in a safe manner. Furthermore, the inspectors reviewed minutes of team meetings held in June, August and September 2025, these minutes demonstrated that the person in charge was ensuring that the risk register was regularly discussed which assisted support staff to engage residents in activities which incorporated positive risk taking both in the centre and the community.

Judgment: Compliant

## Regulation 7: Positive behavioural support

The inspectors found that where required, residents had a positive behaviour support plan in place. The inspectors reviewed four positive behaviour support plans and found that they were individual to the needs of each resident. The inspectors found that positive behaviour support plan guided staff practice and were linked to integral support plans such as communication needs, sensory supports, wellbeing and mental health supports, community supports and family relationships.

The inspectors found that restrictive practices in place within the centre were subject to regular review by the person in charge and support team. The person in charge and the multidisciplinary team meet regularly to discuss and review restrictive practices that were currently in place in the centre with the view to reduce where possible and ensure that the least restrictive measure was in place. Furthermore, the person in charge and support staff meet every three months to discuss possible human rights' infringements of residents that could occur due to the use of restrictive practices.

Inspectors found that staff had received training in positive behaviour support to further enhance their practices. Additionally, the inspectors found that staff were in receipt of support and debrief following the implementation of strategies for residents. Support plans were also subject to review by the behavioural support team and members of the multidisciplinary team annually or sooner should there be a requirement. The inspectors had the opportunity to meet with the centre's clinical nurse specialist in behaviour support, they outlined the supports in place for each resident in the designated centre and the step-by-step approach to supporting each resident to maximise their quality of life and lived experience in their home and community.

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>	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Compliant
<b>Quality and safety</b>	
Regulation 13: General welfare and development	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 7: Positive behavioural support	Compliant

# Compliance Plan for Grange Apartments - Sonas Residential Service OSV-0003745

Inspection ID: MON-0048003

Date of inspection: 09/10/2025

## 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 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: Recruitment open day was held on 19th November. Successful Candidates commencing offer of employment and on boarding process will be implemented to fill all current vacancies. Recruitment will continue for any remaining positions. Regular relief and agency will continue to be supported in their role to ensure continuity of care to supported individuals during recruitment of permanent staff.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: The PIC will ensure that all staff have completed the Autism Awareness Training module available on HSEland by end of February 2026 and Mental Health Awareness training dates have been scheduled for January 2026. The PIC has linked with the training department to schedule additional Lamh training in quarter 1 of 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 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Substantially Compliant	Yellow	30/03/2025
Regulation 15(3)	The registered provider shall ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.	Substantially Compliant	Yellow	30/03/2025
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate	Substantially Compliant	Yellow	30/03/2025

	training, including refresher training, as part of a continuous professional development programme.			
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