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:	St. Vincent's Residential Services Group B
Name of provider:	Avista CLG
Address of centre:	Limerick
Type of inspection:	Unannounced
Date of inspection:	11 August 2025
Centre ID:	OSV-0003925
Fieldwork ID:	MON-0047774

About the designated centre

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

The centre provides residential accommodation for six adults with an intellectual disability. The centre is located in a campus-based setting providing various facilities for people with intellectual disabilities in addition to residential accommodation. Accommodation is in a single storey attached house. The house has one sitting room, a kitchen-dining room, six bedrooms, wheelchair accessible sanitary facilities, office and storage facilities. The designated centre is staffed with a team of nurses, care staff and a service manager by day with waking staff in the designated centre by night.

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 11 August 2025	08:20hrs to 15:30hrs	Kerrie O'Halloran	Lead

What residents told us and what inspectors observed

This inspection was an unannounced focused regulatory inspection to review the arrangements the provider had in place to ensure compliance with the Care and Support of Residents in Designated Centres for Persons with Disabilities Regulations (2013) and the National Standards for Adult Safeguarding (2019). Safeguarding of residents is an important responsibility of a designated centre and fundamental to the provision of high quality care and support.

The inspection was facilitated by the staff nurses on duty in the centre that day and the on call clinical nurse manager 3. Both the person in charge and person participating in management were not on duty on the day of the inspection. The inspector had the opportunity to speak to the three staff members on duty during the course of the inspection. Five residents lived in this centre. Some residents had supports in the area of positive behavioural support, while all residents were supported with their social care and health care needs. Some residents had assessed need in health care such as, postural support and had support from staff along with heath care support plans in place with these aspects of their care. The designated centre had an emphasis on promoting and supporting resident's independence, communication and integration within their local community.

On arrival the inspector was greeted by a staff nurse on duty. The inspector introduced themselves and signed into the visitor's book of the centre, shortly after this the inspector was introduced to two other staff members who were on duty. All residents were in bed when the inspector arrived and staff were preparing to support residents with their morning routines. The inspector was shown the main communal areas of the centre. Once the residents had been supported with their morning routines the inspector had the opportunity to see resident's bedrooms. One resident brought the inspector to their bedroom, while the inspector visited another resident in their bedroom as they were enjoying watching a movie. Each resident had their own bedroom. Residents also had two bathroom facilities available, which were noted to be clean and accessible for the residents living in the centre. A new bath had recently been put in place and the staff informed the inspector that two residents really enjoyed having this facility in their home. A member of household staff was also on duty on the day of the inspection, the centre was noted to be clean and tidy throughout and well maintained.

The inspector had the opportunity to meet four of the residents living in the centre. The residents communication needs varied, some residents did not verbally communicate with the inspector, while others had verbal interactions. Other communication supports were in place to support residents with their communication needs such as expressions, gestures and varied forms of communication technology. One resident came to greet the inspector and asked the staff for some pictures. The staff informed the inspector the resident enjoys colouring and other table top activities. The inspector asked the resident were they happy in their home and they said yes, they appeared happy and relaxed

throughout the inspection. Later in the afternoon, the resident was supported by a staff member to go to a routine hospital appointment. Another resident was being supported to attend their day service which was located on the grounds of the provider's campus. The resident appeared happy and the staff informed the inspector about what the resident enjoyed, the resident was smiling during this.

One resident attended a day service, while other residents received support from a day service staff in their home which was in place five days a week. On the day of the inspection the day service staff in place was on planned leave, but the residents were supported with staff on duty to complete activities of their choice. Some residents enjoyed going for a walk, going to the shop, watching a movie, completing table top activities, along with being supported to medical appointments.

Residents were supported and encouraged to maintain connections with their family and friends. Visiting to the centre was facilitated. There was space for residents to meet with visitors if they wished. Some residents enjoyed visiting their family members at home. Telephone calls, messages and video calls were also used to stay in contact with family members.

Residents' rights were promoted and residents had access to information in a suitable format. Important information such as the complaints process, safeguarding information, advocacy services, assisted decision making information as well as staffing information was made available to the residents. These were displayed and discussed regularly with residents in monthly resident house meetings. There was evidence of on-going communication with residents on a daily basis through activity planners. Residents were also supported with annual person centred planned meetings.

It was evident throughout the inspection that person centred approach to care and support was important, and that residents were supported to have choice and to make their own decisions. The provider had system in place to protect residents from abuse, and that there were robust systems in place to respond to any allegations in a way that ensured the residents safety was maintained.

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 section of the report describes the governance and management arrangements and how effective these were in ensuring a good quality and safe service.

There was a clear organisational structure in place to manage the service. The management systems in place ensured that service's approach to safeguarding was appropriate, consistent and effectively monitored. The person in charge worked full-

time and was responsible for the day to day operation of the service. An on-call system was in place and a clinical nurse manager 3 was on duty on the day of the inspection to support the centre in the absence of the person in charge. The staff on duty informed the inspector that they are supported in their role.

The provider had ensured the staff numbers and skill mix were in line with the assessed needs of the residents and appropriate to meet the safeguarding needs of residents. The inspector noted adequate staffing levels were in place on the day of the inspection. The inspector reviewed rosters from April to August 2025.

Staff working in the designated centre completed an orientation programme which included instruction and guidance on information regarding the centre. The inspector reviewed a sample of the orientation records for three staff members and for one student who was on placement in the centre. These were found to be fully completed. An orientation folder was in place which provided staff with details regarding the centre, for example, restrictive practices, residents in the centre and the fire evacuation plan.

Overall, this inspection found that systems and arrangements were in place to ensure that residents received care and support that was safe, person-centred and of good quality. Some review is required under Regulation 16: Staff training and development and Regulation 23: Governance and management.

Regulation 15: Staffing

The provider had ensured that the staff numbers and skill mix were in line with the assessed needs of the residents and appropriate to meet the safeguarding needs of residents.

There were sufficient numbers of staff to meet the needs of the residents both day and night. The roster reviewed showed that the planned numbers and skill mix of staff was maintained and that there was a consistent staff team who were known to the residents. From the rosters reviewed the centre had some leave, this was being covered by internal relief staff. This leave was being filled with regular internal relief staff, so they were familiar to the residents and continuity of care was being supported.

The inspector spoke to the staff members on duty and they were found to be knowledgeable in their role and the support needs of residents. They were also familiar and knowledgeable in questions relating to safeguarding of residents. They were also knowledgeable about the ways to respond to behaviours of concern.

During the course of the inspection the inspector observed and overheard staff interacting with residents in a caring and professional manner, and in accordance with their assessed needs. It was evident that residents were comfortable with the staff supporting them and that they were familiar with them. Throughout the inspection staff were heard giving residents choice with regard to their meals and

activities. For example, one resident requested a different meal for dinner and this was facilitated by staff.

Judgment: Compliant

Regulation 16: Training and staff development

The inspector reviewed the training matrix for the centre. The provider had ensured that all staff who worked in the centre received training in areas such as safeguarding, children's first and fire safety to reduce the risk of harm and promote the well being of residents.

Some review was required to ensure all staff had training completed to ensure the assessed need of the residents were being supported. On the day of the inspection the training matrix in place was seen to have no dates identified for some staff members. This included:

- One staff required manual handling training.
- Two staff required understanding and responding to behaviours of concern.
- One staff required managing challenging behaviour training

A staff training record for relief staff who were covering leave in the centre as mentioned in Regulation 15: Staffing, was not available on the day of the inspection. This required review to ensure all staff working in the centre at night had training completed. This was requested on the day of inspection by the inspector. The inspector was informed by the clinical nurse manager 3 it would be requested from the night supervisor and assurance would be forward to the inspector. This had not been received two days after the inspection.

A staff supervision record was in place for 2025. This identified staff to receive supervision twice a year. From a review of this 3 staff members had completed supervision once in 2025. This required review.

Judgment: Substantially compliant

Regulation 23: Governance and management

There were management arrangements in place to govern the centre and to ensure the provision of a good quality service and to ensure that residents were safeguarded. The provider had ensured that the designated centre was resourced in terms of staffing and other resources to ensure the effective delivery of care and support in line with the assessed needs of the residents.

The provider and local management team had systems in place to maintain

oversight of the safety and quality of the service including an annual review of the service, which had taken place for 2024. There was evidence of ongoing consultation with residents and their representatives in this. The provider had ensured six-monthly unannounced audits had taken place in the centre. This had been completed in June 2025. Both the annual review and six-monthly unannounced audit contain action plans. For the most part these actions were seen to be completed or time lines were in place for actions to be achieved. For example in the annual review an action was in place for consistent relief staff to be made available, this was seen to be in place on the day of the inspection.

Where safeguarding incidents had taken place, investigations had commenced immediately and immediate steps had been taken to ensure the safety of all residents. Control measures and reviews had been in place and recorded on safeguarding plans regularly. There were no open safeguarding plans on the day of the inspection. Team meeting were taking place in the centre. The inspector reviewed team meetings which took place in October 2024 and January, April and May 2025. Safeguarding incidents had taken place in October and December 2024, it was found that these incidents had not been discussed at team meeting in January 2025. From the closed safeguarding plans reviewed control measures were in place that the incidents would be discussed at team meeting. From the team meeting minutes reviewed it was seen that safeguarding incidents had not been discussed, however incidents were a regular agenda item with some team meetings reviewing the incidents that occurred that month. Control measures seen in two safeguarding plans that were closed indicated team meetings would take place on a monthly basis and six/eight weekly basis. This required review to ensure team meetings were occurring as per the control measures identified and these were being consistently and effectively monitored. The team meeting prior to January 2025 had occurred in October 2024, to note this meeting happened before the safeguarding incidents that occurred in October in the designated centre.

Judgment: Substantially compliant

Quality and safety

This section of the report details the quality and safety of service for the residents living in the designated centre. This inspection found that systems and arrangements were in place to ensure that residents received care and support that was safe and person-centred. The provider, person in charge and staff were endeavouring to ensure that residents living in the centre were safe at all times. Some review was required in Regulation 5: Individual assessment and personal plans, Regulation 7: Protection and Regulation 26: Risk management procedures.

Staff and management spoken with were familiar with and knowledgeable regarding residents' health care and support needs. Residents had access to general practitioners, out of hours general practitioners service and a range of allied health

services. The inspector reviewed the files of three residents. Support plans in place including those to guide the specific health care needs of residents were found to be informative. Residents had also completed annual person centred planning meetings. These meeting reviewed resident's achievements and planned goals and aspirations for the residents for the coming year ahead. This will be discussed more under regulation 5, individual assessment and personal plan.

Where some residents' required behavioural support, the provider had ensured these residents received regular multi-disciplinary reviews, as and when required. A behaviour support specialist was accessible to the centre to review this aspect of residents' care. Each resident had a positive behavioural support plan in place. The inspector reviewed two of these, they were found to provider clear information for staff and had been recently reviewed.

Regulation 10: Communication

The inspector reviewed three of the resident's communication plans. These plans were clear and contained information specific to the communications needs of the residents. Residents in this centre presented with assessed communication needs. Residents used various methods to communicate including verbal communication, gestures, pictorial communication aids, objects of reference and other communication aids. Staff discussed how they were supporting one resident with the use of communication applications and the resident was enjoying this. The resident also had pictures in place to support staff to give choice about activities and meals to the resident. The inspector viewed a communication book that was in place in the residents bedroom and the staff discussed how the resident would indicate their choice.

Residents had access to speech and language therapy. Recommendations made were available in residents support plans. These recommendations were clear and informative for staff. Staff spoke to the inspector about these recommendations, visual schedules were in place for residents.

One resident had a communication dictionary developed in their personal plan, this clearly identified words the resident may communicate and what these words mean. The staff spoken with informed the inspector how informative this was and it supported staff in facilitating the resident's communication needs. During the course of the inspection the resident verbalised to the inspector one of the words identified on the communication dictionary and this allowed the inspector to interact with the resident.

The inspector saw that communication of all forms was respected and responded to. The inspector saw kind and caring interactions between residents and staff and staff were able to use their knowledge of residents and their routines to promote responses.

Judgment: Compliant

Regulation 17: Premises

The premises was comfortable and suitably decorated. It was found to be clean throughout. Each resident had their own bedroom and access to communal areas in each house such as living room, kitchen and dining room. The centre had laundry facilities in place and adequate storage facilities. Residents' bedrooms were personalised for resident with items of importance for residents displayed, such as pictures of family and friends.

Judgment: Compliant

Regulation 26: Risk management procedures

The registered provider had systems and processes in place for risk management at this centre. The centre had a risk register in place and these risks had been reviewed by the person in charge. Resident's had individual risk assessments in place, where risks to their well being and safety such as abuse was identified and assessed. For one resident, some individual risk assessments in place required review. The risk assessment in place for exposure to behaviours of concern and another risk of impact to the resident due to a peer had not been reviewed as identified. The risk assessments indicated that these risks were due for review in November and December 2024.

Risk assessments in place had control measures in place to alleviate from the identified risk. For example a risk of fire occurring had controls measures in place such as, staff have fire training completed, and exits are not obstructed. This was seen to be in place on the day of the inspection.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Overall residents' health and social care needs were regularly assessed and care plans were developed, where required. These plans reviewed by the inspector were found to be individualised, clear and informative. Staff spoken with were knowledgeable regarding the care and support needs of residents. For example, one staff member discussed the supports required for one resident while resting which included postural support. The resident had supports in place which included

pictures to support the resident with their care.

Residents were supported to identify and achieve personal goals. Annual person centred planning meetings were held with residents. These had been completed in 2025. The documentation reviewed for three residents was found to clearly identify meaningful goals for the residents. However, some review was required to ensure resident's goals that had been set for the coming year were being record. A goal progress/recording sheet was in place however, for some residents who had goals set a record was not being maintained on progress of their goals. For example, a goal for one resident had been set in April 2025 to support and enhance their role as an enthusiast in visual arts. The resident had steps in place to achieve the goal such as attend the cinema every 6-8 weeks, attend the theatre and attend a panto show at the end of the year 2025. However the progress recording sheet had not been completed therefore it was not clear if progress had been made on this goal.

Another resident had a goal set to complete a digital life story, the inspector seen that some records of progress had been documented for this goal.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

Residents that required support with behaviours of concern were being supported appropriately, had access to specialists in behaviour management and behaviour support plans were in place. Staff received training in order to support residents manage their behaviour. One staff required training in this area and this was discussed under Regulation 16: Staff training and development. The behaviour support plans in place outlined supportive strategies, information about triggers and guidance for staff on managing situations with responsive strategies. It was evident that there was sufficient detail in the positive behaviour support plans and that staff were familiar with these plans to ensure that residents were protected and supported. The inspector reviewed two of these plans and both had been recently reviewed in October and December 2024.

The restrictive practices for this centre are to be reviewed on an annual basis by the provider to ensure that they continued to be required, and where required, that consideration was given to ensuring that they were the least restrictive and therefore least impact on residents' rights. Staff were knowledgeable of the restrictive practices in place, the process and rational in place for each. The inspector reviewed a restrictive practice database which was in place in the centre. The record in place was for restrictive practices for 2023/2024. It documented that the last meeting to review the restrictive practices in place was in July 2023 and also that restrictive practices are discussed, with individual personal plans updated. The inspector reviewed the personal plans of two residents with regard to this and evidence of restrictive practices in place relating to these residents were not in place in the residents personal plans. Updated and reviewed documentation was not

available in the centre. During feedback from the inspection, the clinical nurse manager 3 provided the inspector with minutes of restrictive practice meetings that had taken place for each resident and this identified restrictive practices had been reviewed in November 2024, with review required again in November 2025. This required review to ensure documents are updated regularly and information is available in the centre for staff to access and in residents personal plans.

Judgment: Substantially compliant

Regulation 8: Protection

The provider had taken measures to safeguard residents from being harmed or suffering abuse. All staff had received training in the protection of vulnerable people to ensure that they had the knowledge and the skills to treat each resident with respect and dignity and were able to recognise the signs of abuse and/or neglect and the actions required to protect residents from harm.

Staff spoken with were aware of the various types of abuse, the signs of abuse that might alert them to any issues and their role in responding to any concerns. Staff were confident that any concerns raised would be listened to, taken seriously and acted upon. he staff spoken with on this inspection were aware that they could raise any concerns with the local management team.

On the day of the inspection there was no open safeguarding plan in place. The inspector reviewed closed safeguarding plans in place that were in place in residents personal plans. This plans had been clearly recorded and reviewed. It included strategies to protect the resident from harm. The plans had identified two different time lines for team meetings to take place which were not consistent. his was discussed under Regulation 23: Governance and management.

Residents had intimate care plans in place which were seen to be regularly reviewed. These plans provided clear guidance to staff and the supports required for each resident living in the centre.

Judgment: Compliant

Regulation 9: Residents' rights

In this designated centre there was an emphasis on ensuring that residents were supported to make their own choices and that their right to live safety was recognised. The staff discussed with the inspector that meal planners are completed with the residents and residents had a choice of meals they would like, if a resident requested a change of meal this is accommodated. The inspector observed a

resident being provided with a different meal as they requested on the day of the inspection.

Residents had easy-to-read information in place. The inspector reviewed these and contained information on safeguarding, complaints, charter of rights and how to access Health Information and Quality Authority (HIQA) reports.

Residents were supported with monthly residents meetings. These meetings discussed complaints, safeguarding, social roles, environmental updates and advocacy.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

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

Compliance Plan for St. Vincent's Residential Services Group B OSV-0003925

Inspection ID: MON-0047774

Date of inspection: 11/08/2025

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: Training matrix has been updated with completed dates and scheduled dates. Outstanding training has been completed or planned and place confirmed where required. PIC has now sent list of training dates for relief staff to the inspector. All staff will have received supervision and the PIC has plan in place to ensure supervision is completed at least every six months.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: All safeguarding incidents will be discussed at team meetings going forward. Team meeting held on 6.08.2025 had included discussion regarding safeguarding and the PIC has minutes of this meeting now available. Safeguarding is part of the standing agenda for team meetings.	

Regulation 26: Risk management procedures	Substantially Compliant
Outline how you are going to come into compliance with Regulation 26: Risk management procedures: The PIC has ensured that all risk assessments have been updated and the risk matrix also updated on 13.08.2025. Risk assessments also discussed at team meeting 06.08.2025 and noted in the minutes.	
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: Goal tracking has been updated for all individuals and PIC will ensure that goal tracking be completed monthly going forward.	
Regulation 7: Positive behavioural support	Substantially Compliant
Outline how you are going to come into compliance with Regulation 7: Positive behavioural support: All restrictive practices are in date and reviewed annually. The heading of the restrictive practices database had the incorrect year and same has been amended.	

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	03/09/2025
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	22/09/2025
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Substantially Compliant	Yellow	13/08/2025
Regulation 26(2)	The registered	Substantially	Yellow	13/08/2025

	provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Compliant		
Regulation 05(6)(c)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall assess the effectiveness of the plan.	Substantially Compliant	Yellow	30/08/2025
Regulation 07(3)	The registered provider shall ensure that where required, therapeutic interventions are implemented with the informed consent of each resident, or his or her representative, and are reviewed as part of the personal planning process.	Substantially Compliant	Yellow	13/08/2025