



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

## Issued by the Chief Inspector

Name of designated centre:	Lus Na Gréine
Name of provider:	Clann Mór Residential and Respite Company Limited by Guarantee
Address of centre:	Meath
Type of inspection:	Unannounced
Date of inspection:	12 February 2026
Centre ID:	OSV-0004928
Fieldwork ID:	MON-0041342

## About the designated centre

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

Clann Mór Residential 1 comprises three community-based residential homes outside a large town in Co. Meath. Two of the houses are adjoining, while the third is within walking distance. The centre supports nine residents both male and female with intellectual disabilities, some of whom live semi independently and others who require staff support on a 24 hour basis. All properties are currently based on single-bedroom occupancy, with access to the normal domestic dwelling facilities typically available in the local community. All houses have access to garden areas for recreation and leisure. The staff team is primarily made up of healthcare assistants. Community employment workers are also in place who work under the supervision of staff in the centre.

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

Number of residents on the date of inspection:	9
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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 12 February 2026	09:00hrs to 17:00hrs	Maureen Burns Rees	Lead

## What residents told us and what inspectors observed

From what the inspector observed and what residents told the inspector, it was evident that the nine residents living in the centre received quality care in which their independence was promoted. Appropriate governance and management systems were in place which ensured that appropriate monitoring of the services provided was completed in line with the requirements of the regulations. Overall the inspection found high levels of compliance with the regulations which reflected the delivery of a person centred and high quality service. However, it had been identified that the staffing arrangements at night in one of the houses was not appropriate to the number and assessed needs of the residents living in that house.

This report outlines the findings of an unannounced inspection of this designated centre. The inspection was conducted to assess compliance with the regulations so as to inform an application made by the provider to renew the registration of the centre.

The centre comprises three separate houses. Two of the houses were located adjacent to each other in a residential estate and were home to three residents each. The other house was located a short drive away and was also home to three residents. Each of the houses were within walking distance of local amenities and transport links. The first house comprised of a sitting room, small toilet, kitchen, a resident's bedroom and a wet room downstairs. Upstairs there was a staff sleepover room, two more resident bedrooms and a shared bathroom. The second house comprised of a kitchen, toilet and a large sitting room downstairs. While upstairs there were three residents' bedrooms and a shared bathroom. The third house comprised of a sitting room, toilet and kitchen downstairs. Upstairs were three resident bedrooms and a shared bathroom. Each of the houses had access to well maintained back garden with tables and chairs for outdoor dining. The first two houses had a shared back garden for residents use. It included an outdoor room which was used by one of the residents as an art studio.

Each of the three houses were found to be comfortable, accessible and in a good state of repair. All areas were welcoming and provided pleasant spaces for the residents to relax. Each of the residents had their own bedroom which reflected the individual resident's tastes and was a suitable size and layout for residents' individual needs. This promoted the residents' independence and dignity, and recognised their individuality and personal preferences. Pictures of each resident and important people in their lives and other memorabilia were on display in each of their respective homes.

The centre was registered to accommodate nine adult residents and there were no vacancies at the time of inspection. There had been one recent new admission to the centre and the resident was considered to have settled well to their new home. On the day of inspection, one of the residents was on extended holidays abroad

with family and consequently there were only eight residents present. The residents in one of the houses lived semi independently while the majority of residents in the other two houses required low levels of support with activities of daily living and many aspects of their day.

The inspector visited all three of the houses and met with each of the eight residents present on the day of the inspection. Each of the residents met with, told the inspector that they 'loved' their respective homes, felt safe and that their rights were upheld. These residents spoke fondly of the other residents who they were living with and of the staff team who supported them. The residents individually told the inspector that the other residents were their friends who they enjoyed spending time with in the centre and out in the community. The residents living semi independently in one of the houses told the inspector that they were very happy with the level of staff cover and support provided for them and that they 'cherished' the level of independence that they had in their home. It was evident that each of the residents were very proud of their homes and particularly their bedrooms which they had personalised. Residents told the inspector that they were looking forward to participating in replanting the gardens for the summer ahead. One of the houses had a plaque on display which they had achieved some years previous for the 'best garden' in a competition held by the provider across a number of houses. The residents told the inspector about the many activities they were involved with within the local community. One of the residents attended a monthly market where they held a stall to sell some of their own art work.

The inspector observed warm interactions between the residents and staff members caring for them on the day of inspection. Staff were observed to interact with the residents in a respectful and supportive manner. For example, knocking and seeking permission to enter a resident's bedroom and providing individual residents time and space to express their feelings and talk about the events of their day. One of the residents told staff that they had had a 'bad day' and sought to have a chat with the person in charge. The resident was noted to be in good form following the chat and was observed laughing and chatting with staff. Overall the residents were considered to get along well together and enjoyed each others company. However, it had recently become apparent that the behaviours of a small number of residents in one of the houses could on occasions be difficult for staff to manage in a group living environment. Overall, incidents were well managed and the provider's behaviour support specialist visited the centre on a monthly basis.

There was evidence that the residents and their representatives were consulted and communicated with, about decisions regarding the running of the centre. The inspector did not have an opportunity to meet with the relatives of any of the residents but it was reported that they were happy with the care and support that the residents received. The provider had completed a survey with the residents and their relatives as part of their annual review which indicated that residents and family representatives were satisfied with the care and support being provided.

Residents were supported to engage in meaningful activities on an individual basis. There was evidence that the residents from each of the houses also chose to engage in numerous activities together . Each of the nine residents were engaged in

a formal day service programme. A small number of the residents held part time jobs. Examples of activities that residents engaged in included, cooking, walks to local scenic areas, social club, special olympics, swimming, bowling, attending mass, library visits, beauty pampering sessions, exercising in a local gym, dancing and family home visits. A small number of the residents independently used public transport. Two of the residents were engaged in martial arts classes through their day service programme and attended competitions through out the year.

The residents' rights were promoted by the care and support provided in the centre. The residents had access to the national advocacy service and information about same was available for residents in the resident's guide. There was evidence of active consultations with each resident and their families regarding their care and the running of the centre. The provider had an advocacy group which met on a regular basis. There was a complaint policy in place. There had been no recorded complaints in the preceding 12 month period. The inspector observed staff to interact with the residents in a respectful, dignified and supportive manner. Easy to read documents were available in each of the houses on areas such as safeguarding and complaints. Staff had attended training regarding residents rights.

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

## Capacity and capability

There were management systems and processes in place to promote the service provided to be safe, consistent and appropriate to each resident's needs. The provider had identified through their own assessments and audits that the staffing arrangements at night was not appropriate to meet the changed needs of residents living in one of the houses. Funding for additional staff cover arrangements had been sought but not yet granted.

The centre was managed by a suitably qualified and experienced person in charge. They presented with a strong knowledge of the assessed needs and support requirements for each resident. The person in charge had taken up the position in August 2023. They held a degree in psychology, a diploma in behaviour analysis and a certificate in management. At the time of inspection the person in charge was in the process of completing a a certificate in leadership and management. They had 25 years experience of working within the disability sector and more than four years management experience. The person in charge was in a full time position and was not responsible for any other centre. They were supported by house lead staff in two of the three houses. The person in charge reported that they felt supported in their role and had regular formal and informal contact with their manager.

There was a clearly defined management structure in place that identified lines of accountability and responsibility. This meant that all staff were aware of their responsibilities and who they were accountable to. The person in charge reported to the service manager who in turn reported to the chief executive officer. The person in charge and service manager held formal meetings on a regular basis.

#### Regulation 14: Persons in charge

The person in charge was found to be competent, with appropriate qualifications and management experience to manage the centre and to ensure it met its stated purpose, aims and objectives. The Inspector reviewed the Schedule 2 information which the provider submitted for the person in charge. These documents demonstrated that the person in charge had the required qualifications and experience relevant for the role. They were in a full time position and were not responsible for any other centre. The person in charge presented with a good knowledge of the requirements of the regulations and demonstrated good oversight of three houses which the centre comprised of.

Judgment: Compliant

#### Regulation 15: Staffing

Overall, the staff team were found to have the right skills, qualifications and experience to meet the assessed needs of residents. However, the staff cover arrangements at night in one of the three houses, was not considered appropriate to the number and assessed needs of the residents living in that house. The provider had identified, through their own assessments and audits, that the staffing arrangements at night was not suitable to meet the changed needs of residents living in one of the houses. Funding for additional staff cover arrangements had been sought but not yet granted.

In the two houses located adjacent to each other, the roster showed staff support each day, with sleepover staff support in one of the houses at night. The residents in the second house could contact the staff via their mobile phones and a call bell system which had been installed in two of the three resident bedrooms. It was noted that in the preceding period there had been a change in the behavioural presentation of a small number of residents living in that house and increased healthcare needs for another resident. The provider had sought funding for additional staffing resources at night but this had not yet been granted. The third house had staff support for a small number of hours each day, in line with residents' assessed needs and expressed choice.

The full complement of staff were in place at the time of inspection, although a staff member was on extended leave. A small number of regular relief staff were used to cover the absence and other leave. The inspector reviewed the rosters for the preceding two month period to the inspection date. The actual and planned duty rosters were found to be maintained to a satisfactory level. The majority of the staff team had been working in the centre for a prolonged period. This meant that there was consistency of care for the residents and enabled relationships between the residents and staff to be maintained. The inspector noted that the residents' needs and preferences were well known to staff met with, the person in charge and the service manager on the day of this inspection.

Judgment: Not compliant

### Regulation 16: Training and staff development

Training had been provided to staff to support them in their role and to improve outcomes for residents. The inspector reviewed the training matrix and found that staff had attended all training deemed as mandatory by the provider in areas such as fire safety, safeguarding, manual handling, infection control and rights. Suitable staff supervision arrangements were in place. The inspector reviewed the supervision schedule and found that staff had received supervision in line with the provider's supervision policy. A staff member spoken with told the inspector that supervision with their manager was supportive for their role.

Judgment: Compliant

### Regulation 23: Governance and management

There were suitable governance and management structures and arrangements in place. The inspector reviewed the provider's annual review of the quality and safety of the service and unannounced visits to review the quality and safety of care completed on a six monthly basis as required by the regulations. The inspector reviewed minutes of regular staff meetings and management meetings. It was evident that appropriate information was being shared across the team to ensure that staff had up to date information to carry out their respective roles. The inspector reviewed a sample of audits completed in the centre on a regular basis. These included, health and safety checks, fire safety, medication, finance, healthcare plans, wellness plans and hygiene. There was evidence that actions were taken to address issues identified in these audits and checks.

Judgment: Compliant

### Regulation 24: Admissions and contract for the provision of services

There had been a recent admission to the centre which had been determined on the basis of transparent criteria in line with the provider's admission policy and the centre's statement of purpose. There was evidence that the resident had been appropriately supported to transition and live in the centre, including a number of opportunities to visit the centre before admission. Contracts of care were in place for each of the residents. These included details of the terms on which the individual resident would reside in the centre, including details of fees to be paid.

Judgment: Compliant

### Regulation 3: Statement of purpose

There was a statement of purpose in place which had recently been reviewed. It was found to contain all of the information set out in Schedule 1 of the regulations and to clearly detail the services and facilities provided.

Judgment: Compliant

### Regulation 31: Notification of incidents

Notifications of incidents were reported to the Chief Inspector of Social Services in line with the requirements of the regulations. The inspector reviewed records of all incidents occurring in the preceding three month period. Overall, there were low levels of incidents occurring in the centre.

Judgment: Compliant

### Regulation 4: Written policies and procedures

The centre had implemented a suite of policies and procedures on the matters set out in schedule 5 of the Regulations. These policies and procedures were readily available to staff in each of the houses and had each been reviewed in line with the requirements of the Regulations.

Judgment: Compliant

## Quality and safety

The residents appeared to receive care and support which was of a good quality, person centred and promoted their rights. It was noted that the behaviours of residents in one of the houses could on occasions be difficult for staff to manage in a group living environment and particularly at night time when there was minimal staff cover in one of the houses.

Overall, the residents' well-being, healthcare and welfare was maintained by a good standard of evidence-based care and support. A personal support plan reflected the assessed needs of individual residents and outlined the support required to maximise their personal development in accordance with their individual health, personal and social care needs and choices. Residents' communication needs were being met and supported. The inspector reviewed suitable communication support plans for residents identified to require same and communication aids such as picture boards to support communication were available and in use. An annual personal plan review had been completed in the last 12 months in line with the requirements of the regulations for each of the residents.

The health and safety of residents, visitors and staff were promoted and protected. There was a risk management policy and environmental and individual risk assessments and individual safety assessments for residents. These included assessments relating to residents spending periods in the centre on their own and of potential risks relating to an identified shortfall of staffing in one of the houses at night. Measures put in place to control and manage the risks identified were recorded. The provider had implemented a protocol for residents that identified different levels of direct support that residents could avail off when staff were not physically present in their home. Health and safety audits were undertaken on a regular basis with appropriate actions taken to address issues identified. There were arrangements in place for investigating and learning from incidents and adverse events involving residents. This promoted opportunities for learning to improve services and prevent incidences. The inspector reviewed a record of all incidents and accidents in the centre in the preceding three month period. These were reviewed by the person in charge and where required, learning was shared with the staff team and risk assessments were updated to mitigate against any re-occurrence.

## Regulation 17: Premises

The centre comprises three separate houses with two located adjacent to each other and the third a short distance away. Each of the houses were found to be homely, accessible and in a good state of repair. The provider had a maintenance team in place and records showed that they responded promptly to all maintenance requests. It was noted that new flooring had recently been fitted in one of the

houses along with a refitted bathroom. Each of the houses were found to be a suitable size and layout for the residents living in the respective house. Each of the residents had their own bedroom which the inspector observed they had personalised according to their individual tastes and preferences.

Judgment: Compliant

### Regulation 28: Fire precautions

Suitable precautions had been put in place against the risk of fire. Self-closing devices had been installed on doors. There were adequate means of escape and a fire assembly point was identified to an area to the front of each of the houses. A procedure for the safe evacuation of the residents was prominently displayed in each house. Personal emergency evacuation plans, which adequately accounted for the mobility and cognitive understanding of individual residents were in place. Fire drills involving the residents in each house had been undertaken at regular intervals and it was noted that each of the houses were evacuated in a timely manner. There was documentary evidence that the fire fighting equipment, emergency lighting and the fire alarm system were serviced at regular intervals by an external company and checked regularly as part of internal checks.

Judgment: Compliant

### Regulation 5: Individual assessment and personal plan

The inspector reviewed personal support plans for a sample of residents in each of the houses. These reflected the assessed needs of the individual residents and outlined the support required to maximise their personal development in accordance with their individual health, personal and social care needs and choices. An annual personal plan review had been completed in the last 12 months in line with the requirements of the regulations. Each of the residents had an assigned key worker. Meaningful goals had been identified for the majority of residents and there was evidence that progress in achieving identified goals was being recorded and monitored. A number of residents had indicated in writing their choice not to have a recorded goal which was respected by the staff team.

Judgment: Compliant

### Regulation 8: Protection

The inspector found that there were measures in place to protect the residents from being harmed or suffering from abuse. However, in the preceding period it was noted that the behaviours of a small number of residents in one of the houses were difficult on occasions for staff to manage in a group living environment and had the potential to have a negative impact on other residents living in that house. The provider had identified through their own assessments and audits that the staffing arrangements at night was not appropriate to meet the changed needs of residents living in that house. Funding for additional staff cover arrangements had been sought but had not yet been granted. All allegations or suspicions of abuse were appropriately responded to. The provider had a safeguarding policy in place and the person in charge and a staff member spoken with, were aware of safeguarding procedures.

Judgment: Substantially 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	Not compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Compliant
Regulation 24: Admissions and contract for the provision of services	Compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 4: Written policies and procedures	Compliant
<b>Quality and safety</b>	
Regulation 17: Premises	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 8: Protection	Substantially compliant

# Compliance Plan for Lus Na Gréine OSV-0004928

Inspection ID: MON-0041342

Date of inspection: 12/02/2026

## 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 15: Staffing		Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: See corrective and preventive actions above in response to regulation 8		
Regulation 15:		
Identified Issue / Risk	Regulatory Requirement	Response
Night time staffing levels in submitted in Windtown 14 were insufficient demonstrate to meet assessed needs attempts to secure additional HSE funded staff	Provider must ensure adequate numbers of staff at all times	Business cases 2025 and 2026 proactive
Lack of structured contingency staffing protocol plan for emergencies across Athlumney multiple locations remain safely staffed during emergencies	Staffing arrangements must ensure continuity of safe care	Cross location ensures Windtown, and Dunloe
Risk of Athlumney being left without adequate night cover transition to when staff are redeployed duties when	Provider must maintain safe staffing in all designated Centres	Sleepover staff in automatically waking night

needed

Lack of clarity for staff on outlines roles and responsibilities covers, and how responsibilities shift during emergencies

provider must ensure that staff understand their duties

The protocol clearly who attends, who

This plan demonstrates structured, needs based staffing, ensures continuity of safe supervision, and demonstrates the taking of systematic action to address previously identified non compliance

Regulation 8: Protection

Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:

1. Business case submitted to HSE in February 2025 outlining the need for extra staff support at night time in Windtown 14. Updated business case was resubmitted to HSE in February 2026 outlining the continued requirement for extra staff support in windtown 14 at night.

2. Should an emergency situation present itself in Dunloe, on call manager will be contacted and attend or make arrangements for another member of the management team to attend the location.

Waking night staff from Athlumney will attend to windtown allowing staff from windtown to support residents in Dunloe while awaiting arrival of member of SMT. Sleepover staff in Athlumney will act as waking night staff while waking night staff is away from house. This new protocol will be effective from 23.03.26. A trial run will take place on 19.03.26 involving staff in windtown, staff in Athlumney and on call manager.

3. In the event of an unplanned evacuation at night time in Windtown, staff from Windtown 5 will verbally prompt residents in Windtown 5 before attending to resident 18 in windtown 14 and assisting him with safe evacuation

4. Risk escalated to board level and recorded on corporate risk register.

Corrective Actions

1. Submitted Updated Business Case to HSE (Feb 2026)

- Demonstrates proactive action to secure additional night time staffing aligned with assessed needs.

2. Implemented a Cross Centre Night Time Emergency Protocol

- Clear escalation pathway: on call manager attends or assigns member of management.

- Waking night staff from Athlumney attend Windtown 14.
- Windtown staff support Dunloe residents until manager arrives.
- Athlumney sleepover staff assume waking night duties during redeployment.
- Effective from 23.03.26.

### 3. Established a Dedicated Evacuation Plan for Resident 18

- Staff from Windtown 5 will prompt their own residents and then assist Resident 18 from Windtown 14 during any unplanned night time evacuation.

#### Preventive Actions

##### 1. Trial Run

- Full rehearsal scheduled for 19.03.26 with Windtown, Athlumney, and on call manager to test and refine the protocol.

##### 2. Staff Training & Role Clarification

- All relevant staff are being briefed on responsibilities, communication pathways, and emergency procedures.

##### 3. Ongoing Governance & Monitoring

- Monthly review for first 3 months, then quarterly.
- Monitoring includes incident reviews, evacuation drills, and staff feedback.

#### Regulation 8:

Identified Issue / Risk	Regulatory Requirement	Response
Delays in emergency pathway: response at night due to attends or limited staffing in Windtown 14 attend; 14 staff can immediately support Dunloe	Residents must be protected through timely, effective responses to emergencies	Clear escalation On call manager arranges manager to Windtown
Insufficient staff capacity to night staff safely manage simultaneous Windtown 14; risks across locations staff and support to maintain safety	Provider must ensure residents are safeguarded through adequate supervision assume waking night duties	Athlumney waking redeployed to Athlumney sleepover
Risk to Resident 18 during 5 unplanned evacuation verbal emergencies residents and then assist Resident 18 with safe evacuation	Residents must receive appropriate assistance during prompts to their own	Staff from windtown provide immediate

Lack of tested procedures  
run on  
proactive risk management  
is tested, refined, and  
operationally sound before  
going live

Provider must demonstrate

A scheduled trial

19.03.26 ensures the protocol

This plan strengthens resident protection, ensures rapid emergency response, and provides clear, rehearsed procedures that reduce risk and demonstrate compliance with safeguarding expectations

## Section 2:

### Regulations to be complied with

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

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

<b>Regulation</b>	<b>Regulatory requirement</b>	<b>Judgment</b>	<b>Risk rating</b>	<b>Date to be complied with</b>
Regulation 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.	Not Compliant	Orange	23/03/2026
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Substantially Compliant	Yellow	23/03/2026