



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

## Issued by the Chief Inspector

Name of designated centre:	Suir Services Rathkeevin
Name of provider:	Corlann
Address of centre:	Tipperary
Type of inspection:	Announced
Date of inspection:	22 October 2025
Centre ID:	OSV-0005291
Fieldwork ID:	MON-0039807

## About the designated centre

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

The centre is registered to provide a full-time residential care service for adults. The centre is based in Co. Tipperary. The capacity of the centre is four people of mixed gender who have been diagnosed with an intellectual disability, including those with a diagnosis of autism spectrum disorder and challenging behaviour. The centre is a single-storey detached building with four bedrooms, a kitchen and living room. A section of the house is allocated for the sole use of one resident. There are large gardens around the premises and outdoor play equipment at the rear.

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

Number of residents on the date of inspection:	4
--	---

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
Wednesday 22 October 2025	09:00hrs to 17:00hrs	Sinead Whitely	Lead

## What residents told us and what inspectors observed

This was an announced inspection to monitor the designated centre's levels of compliance with the regulations and to inform the upcoming registration renewal decision. While overall residents appeared content on the day of inspection, the inspector found a number of issues that required significant improvements in areas such as staff training, compatibility of residents, and residents rights. Additionally improvements in areas such as safeguarding, medication management and fire safety were required.

There were four residents living in the centre on the day of inspection and the inspector had the opportunity to meet with three of the residents. One resident availed of a shared care arrangement in the centre and was at home on the day of inspection.

Residents used non-verbal methods to communicate and the inspector endeavoured to determine residents' thoughts and views on the service provided through engaging with residents, observing non-verbal communication methods, observing care practices and staff interactions, speaking with staff and reviewing supporting documentation such as residents' care plans and daily notes.

Two residents had already left for day service on the morning of the inspection day and the inspector met with one resident at this time. The resident lived in a self-contained living environment separate to the main house and was supported by three staff. The inspector greeted the resident and the resident responded with a smile and a thumbs up. They were watching a show on their projector and appeared happy and comfortable.

The inspector completed a walk around the resident's self-contained space and noted that the environment was minimal with few personal belongings. The inspector was told that this was in line with the resident's preferences and identified risks. Some pictures of the resident were noted in their home. The resident was an avid GAA supporter and staff communicated that the resident loved to watch GAA matches. The resident had an outdoor garden and seating area and staff communicated that the resident liked to sit out there every morning with their cup of tea and go for walks around their garden.

The inspector completed a walkaround of the remainder of the property. The centre is a single-storey detached bungalow with four bedrooms, a kitchen and living room. Padding was observed on some walls and this was in place to mitigate against specific risks. Some areas with outstanding maintenance work were observed around the house such as chips and marks in need of fresh paintwork and worn flooring. There was a large garden to the rear of the premises and this was accessible to all residents. The garden had a trampoline which two residents regularly used. The garden also had a paved walkway around its parameters. The

garden had a shed which had the centres laundry facilities and was which was also used for storage.

The staff team comprised of social care workers and care assistants. The centre had its full staff compliment on the day of inspection and there were no staff vacancies. There was minimal use of agency staff and there were high staffing levels in place at all times. Staff spoken with appeared very familiar with the residents' needs, preferences and identified risks.

Three residents attended day services daily and one resident had an individualised activation service. All residents had their own service vehicle. The four residents had individualised social goals in place and an annual circle of support meeting with their supporting staff, family and representatives to discuss their plans and wishes for the year ahead.

The inspector met with the other two residents returning home from day services in the evening. One resident came to the staff office and engaged briefly with the inspector. The resident appeared happy to look around the centres office and investigate different shelves, folders and drawers. The resident was active and moved from room to room regularly, supported by a staff member at all times. The second resident also came to the office and got their iPad and headphones from a drawer. They appeared content when they found this. Both residents were observed going between their rooms and the staff kitchen for the remainder of the evening. Staff were observed speaking with them and laughing and joking with them during the course of the evening. Staff presence and supervision between the residents was essential to ensure that residents were supported and that safeguarding plans could be implemented as required.

The four residents living in the centre had been supported by staff to complete satisfaction questionnaires sent to the provider as part of the registration renewal process. Staff advocated for residents when completing these. They highlighted areas for improvements in line with residents' wishes. One questionnaire noted that a resident would prefer their own home as the resident did not appear to like living with others and they did not like loud or busy environments. Another questionnaire noted that the resident would like a cover for their outdoor seating area coming into the winter months. Another resident noted that they cannot spend long periods of time in bath as per their wishes as they share their bathroom with peers. One resident's questionnaire stated that they required a gluten free diet and that staff accommodate this well.

The next two sections of the report presents the findings of this inspection in relation to governance and management of this centre and, how the governance and management arrangements impacted on the quality and safety of the service being provided.

## Capacity and capability

Overall, the inspector found that there were defined management structures in the centre. There were systems in place to regularly review and monitor the quality and safety of care and support in the centre and these had self-identified a number of areas noted for improvements on the inspection day. For example, the provider had identified that compatibility of residents was not suitable in this centre. However, on the day of inspection there was no plan in place on how this significant issued would be addressed.

The provider had failed to address issues regarding staff training. This had been identified in a previous inspection in March 2025. The actions taken to address this had failed to meet the requirements of Regulation 16: Training and Development.

### Regulation 15: Staffing

There were appropriate staffing levels in place to meet the assessed needs of the residents. The centre had high staffing levels in place at all times due to identified risks. All residents had a minimum of one to one support in place during the day. Some residents were supported by two or three staff members during the day. There were two waking night staff on duty every night. The staff team were a mix of social care workers and care assistants. The centre had its full staff compliment on the day of inspection and there were no staff vacancies.

There was a staff rota maintained and this was reflective of staffing levels and staff on duty. The centre had an internal relief panel available to fill shifts when required. The inspector spoke with both management and the staff working with residents throughout the inspection day and found them to be knowledgeable regarding the residents' individual needs.

Judgment: Compliant

### Regulation 16: Training and staff development

Poor findings were noted in this area. Compliance with Regulation 16: Training and development had been an outstanding action from the centre's most previous inspection in March 2025. The provider had committed to complying with this regulation before 31 October 2025 in their action plan response to the Office of the Chief Inspector and the training plan in place was not on schedule to adhere to this.

There was a staff training program in place and the inspector completed a review of the staff training records. Training was being completed in areas such as Fire Safety, First Aid, Medication Management, Epilepsy, Manual Handling, Safeguarding,

Infection control, Behaviour management and Epilepsy management. However, a number of staff refresher training was outstanding. One staff member was due refresher training in medication management, two staff were due refresher training in Manual Handling, and one staff member was due refresher training in safeguarding. Three staff members had no evidence of training in Infection Control. Furthermore, four new staff members had not yet completed initial mandatory training in a number of areas. These staff members were rostered to work with residents in the coming weeks. Not all staff had completed training in a specific communication method used by one resident.

A schedule was in place for all staff to receive formal one to one supervision annually with their line manager. However, it was noted that five staff members had not completed any supervision in over a year. A system was also in place to complete probation with any new staff in the centre every three months for the first year of employment. This was being completed for recently employed staff.

Judgment: Not compliant

## Regulation 23: Governance and management

There was a clear management structure in place. The person in charge was on temporary leave on the day of inspection and a competent person had been appointed to fill this role temporarily in their absence. The centre was supported by two team leaders. A senior area manager also had oversight of the centre and they were present on the day of inspection.

There was evidence of regular audits and reviews in the centre. A six monthly unannounced audit had been completed in April 2025 by a person nominated by the provider. This included consultation with the residents and a review of the centre's compliance in areas such as infection control, staff training and fire safety. An annual review of the quality and safety of care and support had been completed for 2024 by the provider's quality team. While audits were appropriately self-identifying areas in need of improvements, actions from these audits were not always fully addressed or in place. For example, the inspector noted high levels of outstanding staff refresher training on the day of inspection. Residents' compatibility was noted as an ongoing issue, however there was not yet any clear plan or time line in place to address this to any meaningful degree.

The person in charge was completing monthly site visits in the centre and these included a review of health and safety, medication management and infection control. Medication audits did not always fully identify issues such as gaps in administration records and errors in residents' medication support plans.

Judgment: Substantially compliant

### Regulation 3: Statement of purpose

The provider had prepared a statement of purpose and function for the designated centre. This had been submitted to the Office of Chief Inspector as part of the registration renewal process. The statement of purpose and function contained all of the information as required by Schedule 1 of the regulations and was found to be an accurate description of the service provided.

Judgment: Compliant

### Quality and safety

The inspector reviewed a number of areas to determine the quality and safety of the care provided to residents. This included a review of risk management documentation, care plans, the premises, safeguarding plans, fire safety records and medication management systems.

Some residents in the centre were not compatible to live together in the same designated centre. This had a direct impact on residents' rights and safeguarding with the centre. Some improvements were required to ensure that the premises was maintained in a suitable state of repair such as minor paintwork. In addition, improvements were required in the area of medication management.

### Regulation 17: Premises

The centre is a single-storey detached bungalow with four bedrooms, a kitchen and living room. Peeling was observed on some walls and this was secondary to an identified risk. One resident had a separate living environment and this was allocated for the sole use of this one resident. There was a large garden to the rear of the premises and this was accessible to all residents. The garden had a shed which had the centres laundry facilities and was which was also used for storage.

Some areas with outstanding maintenance work were observed around the house such as chips and marks on walls, door frames and skirting boards, which were in need of paintwork. Areas of worn flooring were also noted.

Judgment: Substantially compliant

## Regulation 26: Risk management procedures

Residents presented with a number of individual risks such as safeguarding risks, and behaviours of concern. The inspector found that the centre and the staff team were managing these risks well and mitigating potential risks daily. High staffing levels were in place due to residents assessed needs. Risk measures in place impacted residents' rights at times. This is addressed under the relevant regulation.

The centre maintained a risk register which identified any actual or potential risks in the designated centre such as environmental risks, safeguarding risks, or general health and safety concerns. This outlined mitigating measures in place and was subject to regular review by the management team. The centre maintained a log of any adverse accidents and incidents.

Judgment: Compliant

## Regulation 28: Fire precautions

From a walk around the centre and a review of documentation, the inspector found that in general there were appropriate fire management systems in place in the centre. A review of records indicated that all equipment was being serviced regularly.

Staff and residents were completing regular fire evacuation drills and these were demonstrating day and night time conditions. All residents had personal emergency evacuation plans (PEEPS) in place and these were regularly reviewed. Evacuation procedures were prominently displayed in the centre.

However, the location of the centres laundry systems had recently been moved to an external shed in the centre which was in close proximity to the centre. While the inspector noted there was a smoke detection system in place, it was not connected to the centre's main fire detection system. This containment and detection systems in this area had not yet been reviewed or certified for efficacy by a fire safety specialist.

The fire alarm system was activated on the day of inspection and the inspector completed a check on all fire doors in the centre. One fire door was not closing fully when activated. This posed a risk to containment measures in the event of a fire. Another fire door leading to a residents bedroom was observed propped open by an armchair on the day of inspection. Management communicated that a resident had done this. There was no mechanism in place to hold this fire door open. A review of fire containment measures was required to ensure they were fully effective if an outbreak of fire occurred.

Judgment: Substantially compliant

## Regulation 29: Medicines and pharmaceutical services

The inspector reviewed systems in place for medication management in the centre. There were safe systems in place for the storage of medication with a locked press and a secure location for keys. Storage systems were clean and organised. All medications were clearly labelled and residents had stock of all prescribed medications. The inspector observed staff preparing medication for administration to a resident at a specific time. Staff spoke confidently about the medication prescribed, time medications were due and why medications had been prescribed. Stock checks were being completed weekly by staff and these reflected the stock in place in the medication storage press.

A review of medication administration records found that there were some gaps where staff had not signed when they had administered medications. While some of these had been identified recently in management audits, not all gaps had been noted.

Residents had medication support plans in place. The inspector found that these were not always reflective of resident most current prescribed medication. One resident's plan detailed a medication that was no longer prescribed, furthermore the plan did not include an additional prescribed medication. This posed a risk of medication errors if these plans were used by unfamiliar staff.

Judgment: Substantially compliant

## Regulation 5: Individual assessment and personal plan

The four residents living in the designated centre had an assessment of need and personal plan in place. These were subject to regular review. There was good evidence of input from multi-disciplinary supports such as occupational therapy and behavioural therapy and recommendations were well documented and utilised by staff working with the residents daily. All residents had hospital passports in place for use in the event of transfer to an acute healthcare setting.

Residents had individualised social goals. An annual circle of support meeting was held with residents supporting staff, family and representatives to discuss their plans and wishes for the year ahead. Goals were realistic and were regularly reviewed and updated by key working staff. Staff regularly used key working sessions and social stories to support residents to achieve their goals.

Three residents attended day services Monday-Friday and one resident had an individualised activation service. Residents were also supported to attend various

activities at the weekends and these included visiting sensory rooms and sensory gardens, seeing GAA matches, going swimming, meals out, walks in local parks, going to petting farms and trampoline centres.

Judgment: Compliant

### Regulation 7: Positive behavioural support

Residents were supported to manage their behaviours. All residents had behavioural support plans and individualised risk assessments in place with clear rationale for the use of any restrictive practices in the centre. A restrictive practice register was also maintained and this was regularly reviewed. There was good evidence of regular input from behavioural therapy and mental health supports. Staff spoken with were familiar with individual protocols in place to support residents during times of dysregulation.

Judgment: Compliant

### Regulation 8: Protection

The inspector found that staff and the management team were managing safeguarding risks daily and action was being taken by staff following any safeguarding concern. However, due to the level of safeguarding risks posed in the centre, fully preventing further peer-to-peer safeguarding incidents and ensuring residents ongoing well-being proved difficult at times.

Peer impact from witnessing self-injurious behaviours and loud vocalisations was regular in the centre. High levels of these incidents were noted in the centre's accident and incident log. It had been identified by management that one resident would be better suited to a quieter low-arousal living environment and was not compatible to live with their peers.

There were nine open safeguarding plans on the day of inspection. These were available for review and staff were aware of these. The majority of these were in relation to peer-to-peer safeguarding risks. There was good evidence of engagement with the national safeguarding team following any safeguarding concern and safeguarding plans in place were clear and robust. Staff spoken with were familiar with reporting systems.

One staff member was due refresher safeguarding training as discussed under Regulation 16: Training and staff development.

Judgment: Substantially compliant

### Regulation 9: Residents' rights

Peer to peer compatibility issues impacted residents' rights in the centre at times. Peer behaviours and safeguarding risks meant that there were high staffing levels in the centre at all times and privacy and quiet times were limited.

There were high levels of incidents of self-injurious behaviours and loud vocalisations which impacted residents' sleep at times. High levels of restrictive practices were in place due to identified risks. It had been found by the provider during a recent audit that one resident would be better suited to living in a more individual environment and had also been noted in the resident's satisfaction questionnaire completed prior to the inspection. Two residents were not compatible living together. Access to communal areas was limited at times for residents due to one peer's behaviours. This impacted on residents' freedom of movement around their home. Overall, limited actions had been taken to address the compatibility needs of the residents to a meaningful degree.

Judgment: Not 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 15: Staffing	Compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Compliant
<b>Quality and safety</b>	
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Not compliant

# Compliance Plan for Suir Services Rathkeevin OSV-0005291

Inspection ID: MON-0039807

Date of inspection: 22/10/2025

## 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 16: Training and staff development	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 16: Training and staff development:</p> <ul style="list-style-type: none"> <li>• The provider has completed a training needs analysis for the centre for 2026. This has been shared with the training department and additional trainings have been requested to facilitate outstanding training, and to include refresher training, where identified.</li> <li>• Site specific training e.g. communication methods, have also been identified in completed Training Needs Analysis.</li> <li>• All new staff members to be supported to complete all initial mandatory training, in line with staff induction policy.</li> <li>• Employees who are out of date on their training and who do not attend training as planned will be managed through the HR process going forward for failure to attend mandatory and compulsory training.</li> <li>• Outstanding supervision meetings will be scheduled and going forward the PIC will ensure that they are happening on at least an annual basis.</li> </ul>	
Regulation 23: Governance and management	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 23: Governance and management:</p> <ul style="list-style-type: none"> <li>• As outlined under regulation 16, plans are in place to address outstanding training.</li> <li>• A PIC monthly report has been developed by the Provider which will ensure greater</li> </ul>	

oversight of completion of actions from audits. This report is to be submitted to the Service Manager (PPIM) each month.

- Daily Kardex checks will be carried out by the shift coordinator and where gaps arise this will be recorded as an error on the provider incident management system and escalated to the PIC. The PIC will have additional oversight through the monthly PIC audit.
- All medication support plans have now been reviewed and will be kept up to date with the Kardex going forward.
- Residents compatibility issues are being addressed through significant MDT supports, and individualised programmes.

Regulation 17: Premises

Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:

- Contractors have been sourced to carry out internal painting works, including all woodwork such as door frames and skirting boards. Works completed 09/12/2025.
- Installation of new flooring is scheduled for Q1 2026.

Regulation 28: Fire precautions

Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:

- Works to remedy the door that was not latching on the day were completed on 12/11/2025.
- A fire specialist/engineer has been on site 11/12/2025 to carry out an assessment of containment measures at the centre including the laundry systems in the external shed. The preliminary outcome of engineer's assessment is the site is compliant and a cert will be provided to the centre.
- A mag lock will be installed in one bedroom to prevent the person supported choosing to use furniture to hold the door right back/open, currently the mechanism in situ is a door closer. These works have been scheduled for January 2026.
- Lay out of the room has been adjusted in consultation with person supported

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:</p> <ul style="list-style-type: none"> <li>• Daily Kardex checks will be carried out by the shift coordinator and where gaps arise these will be recorded as an error on the Provider incident management system and escalated to the PIC. The PIC will have additional oversight through the monthly PIC audit.</li> <li>• All medication support plans have now been reviewed and will be kept up to date with the Kardex going forward.</li> </ul>	
Regulation 8: Protection	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 8: Protection:</p> <ul style="list-style-type: none"> <li>• Safeguarding plans will continue to be reviewed regularly by the Management and Monitoring Team and notified to HSE Safeguarding and Protection Team and HIQA as required</li> <li>• Interventions as outlined in IBSP and support plans to minimise negative interactions among peers will continue to be implemented by staff.</li> <li>• One staff who was outstanding in safeguarding refresher training has now completed this.</li> </ul>	
Regulation 9: Residents' rights	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 9: Residents' rights:</p> <ul style="list-style-type: none"> <li>• Staffing levels are based on the assessed needs of individuals supported and the level of support each of the residents require. Each resident has access to their own vehicle</li> </ul>	

and staff and each resident can be facilitated to do activities based on their likes and preferences.

- One resident lives in the residence part time. Another one in their own self-contained apartment within the residence. Three of the residents have access to all areas of the house and can freely choose to avail of any of the three main living areas – living room MSR and Kitchen.
- In line with BOC Procedure on Applications for Service/Supports, Transfers and Withdrawal of Services/Supports, a referral is currently being completed for one resident to determine if an alternative placement can be sought for this individual with a view to reducing peer to peer safeguarding issues within the centre.
- Staff will adhere to safeguarding plans to ensure residents dignity and privacy is respected
- Staff will continue to support individual's communications and understandings of other individual's rights and personal spaces, with support from MDT.
- Interventions as outlined in IBSP and support plans to minimise negative interactions among peers will continue to be implemented by staff.

## 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.	Not Compliant	Orange	30/04/2026
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	30/04/2026
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Substantially Compliant	Yellow	31/03/2026
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the	Substantially Compliant	Yellow	31/03/2026

	service provided is safe, appropriate to residents' needs, consistent and effectively monitored.			
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	31/03/2026
Regulation 29(4)(b)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine which is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.	Substantially Compliant	Yellow	31/03/2026
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Substantially Compliant	Yellow	31/01/2026
Regulation 09(3)	The registered provider shall ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and	Not Compliant	Orange	30/06/2026

	living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.			
--	---	--	--	--