



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

Issued by the Chief Inspector

Name of designated centre:	Harmony
Name of provider:	Health Service Executive
Address of centre:	Sligo
Type of inspection:	Unannounced
Date of inspection:	23 January 2026
Centre ID:	OSV-0005691
Fieldwork ID:	MON-0043150

About the designated centre

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

Harmony is a residential and shared care house which provides a service to both male and female adults over the age of 18. Residents of this service have a moderate to significant intellectual disability and may have a secondary diagnosis of autism. The service can also support residents with physical needs and palliative care needs. Harmony provides full-time care to four residents and shared care for two residents. The centre does not offer emergency admissions at present. The centre comprises of one large, single-storey house which is located within walking distance of a medium sized town where transport links such as buses, trains and taxis are available. Each resident has their own bedroom and there are appropriate bathroom facilities available for residents to use. The centre has a medium-sized kitchen and dining room and two separate sittings rooms are provided, which are all comfortably furnished. There is also a multisensory room and spacious back garden for residents to enjoy. The service is staffed with a mix of nursing staff and social care assistants and provides waking night cover to support residents.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	6
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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
Friday 23 January 2026	10:35hrs to 17:25hrs	Alanna Ní Mhíocháin	Lead

What residents told us and what inspectors observed

The service in this centre was person-centred. Residents' choices were respected. Residents received the necessary supports to meet their health, social and personal care needs. The provider had management systems in place to monitor the service. There was a reliance on agency staff in this centre that meant that staff changed frequently. This meant that not all staff working in the centre were consistent or familiar to residents. This required review. In addition, significant improvement was required in relation to the information available to staff in relation to residents' communication strategies. Staff training also required significant improvement to ensure that all staff had the necessary skills and knowledge to support residents. Improvement was also needed to the documentation relating to residents' assessments of need and risk assessments.

The centre was a large, single-storey building located on the edge of a town. The centre had six bedrooms. Three bedrooms were en-suite and there was a shared wetroom for use by the other residents. In addition, there were two sitting rooms, a dining room, kitchen, utility room, laundry room, multisensory room and a number of store rooms. The centre also had two offices, one for use by staff and one for the person in charge. Outside, there was a large area to the front of the building for parking. To the back of the house was a paved area with patio furniture and a swing with wheelchair platform.

The centre was warm and bright. It was nicely decorated and had a homely feel. Furniture in the centre was new and free from any damage. Where doors into resident bedrooms were open, it was noted that the rooms were decorated in individual styles. There was a pleasant atmosphere in the centre. Throughout the inspection, it was noted that televisions were tuned to shows and music that the resident's chose.

The centre was home to six residents. Some residents lived in the centre on a full time basis. Other residents stayed in the centre for a number of nights per week and in their family homes for the remainder of the week. Some residents had lived in this centre for a number of years. Other residents had begun living in the centre in recent months. All residents required care and support from staff in relation to their personal and intimate care needs. Some residents had health care needs, some residents required support with mobilizing and seating, some required positive behaviour support, and all required support with their communication. In addition, they each required staff support to access their local community to engage in the activities that they liked to do.

The inspector had the opportunity to meet with five of the six residents who lived in this centre. All residents were supported by a member of staff or family member when speaking with the inspector. Some residents engaged with the inspector through eye-contact, gesture and facial expression. Other residents responded

verbally to the inspector. When asked about the quality of the service in the centre, one resident used a thumbs-up gesture to indicate that they received a good service. This resident said that staff respected their rights, that they were happy in their home and that they felt safe. Residents were supported by staff to tell the inspector about their interests and hobbies.

The inspector also had the opportunity to speak with family members of a number of residents. Some family members met the inspector in-person in the centre and others spoke to the inspector on the phone. All family members said that staff in the centre were caring, kind and professional. Family members were assured that the residents received the necessary supports to meet their personal needs. Family members said that they would be happy raising issues or concerns with staff in the centre and they felt that residents were safe in this centre. Some family members had no concerns about the service. Others raised concerns about frequent changes in staff and said that they felt this was impacting on residents. Family members spoke about the importance of knowing residents well in order to meet their communication and behaviour support needs, and that this was difficult to achieve with frequent changes in staff members.

In addition to the person in charge, the inspector had the opportunity to meet with three staff members. These staff members had differing roles in the centre. All staff were clear on their roles and the duties they were assigned for the day. One staff member reported that they had last worked in the centre approximately two years previously and that they did not know when they would be rostered to work in the centre again. They said that that they had mostly been assigned roles that did not involve direct care of the residents; for example, cleaning and laundry duties. When supporting residents, they said that they worked with another member of staff who was familiar to the residents. All staff were knowledgeable on the steps that should be taken if a safeguarding incident occurred and the process that would be followed. Regular staff in the centre spoke about the communication strategies used by residents. They gave examples of how residents communicated their preferences and how they could decline choices offered to them; for example, how residents could let staff know that they did not like a particular meal. Regular staff spoke about how they maintained a presence near residents so that they could respond if residents needed help but that they also gave residents time alone if they wished.

Staff were observed speaking with residents in a caring manner. Interactions between residents and staff were comfortable. Staff responded to all of the residents' communicative interactions, both verbal and non-verbal. Staff were heard offering choices to residents.

The next two sections of this report present the inspection findings in relation to the governance and management in the centre and how this impacts the quality and safety of the service provided.

Capacity and capability

The provider had clear management structures in the centre. The provider had systems for the monitoring the quality of the service. Oversight of the service was maintained through unannounced provider-led visits and routine audits that were completed by staff in the centre. Some improvement was required to ensure that all audits were completed and that actions from audits were addressed.

Staffing numbers and the staff skill-mix were in line with the needs of residents. However, due to the reliance on a high number of agency staff, staff in the centre were not consistent and not always familiar to the residents. In addition, improvement was needed to ensure that all staff had the necessary training to meet the needs of residents.

Regulation 15: Staffing

The provider ensured that the required number of staff with the necessary skill-mix was on duty in the centre. However, improvement was required to ensure that staff working in the centre were consistent and familiar to the residents.

The inspector reviewed the rosters in the centre from 1 June 2025 to the day of inspection. The inspector noted that, in the main, the number of staff on duty was in line with the needs of the residents. The inspector noted one occasion where this staffing number was not met. This had resulted in a resident missing a medical appointment as there were not enough staff on duty to bring the resident to their appointment.

Based on the needs of the residents, the provider had identified that a nurse was required to be on duty in this centre both day and night. The review of rosters found that a nurse was on duty at all times.

The person in charge told the inspector that there were no staffing vacancies in the centre. However, despite this, the review of the rosters found that there was a significant reliance on agency staff in this centre. Agency staff covered regular hours and staff leave. While some agency staff members worked regular shifts in the centre and were familiar to the residents, the inspector noted that there was a high turnaround of staff within the centre. The inspector noted that some weeks up to 12 agency staff members worked in the centre. The rosters indicated that additional agency staff were required most weeks in the centre and that these staff changed frequently. The residents' care plans and risk assessments outlined that familiar staff were required when providing support to residents, particularly in relation to their communication needs and behavioural support needs.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Improvement was required to ensure that staff had up to date training in all modules that were relevant to the care and support of residents.

The inspector reviewed the training records maintained in the centre. These showed that the provider had identified mandatory training modules for staff. Additional training that was relevant to the specific care and support of residents in this centre was also identified. While all staff had up to date training in some modules; for example, fire safety, it was noted that a significant number of staff required refresher training and some staff had no recorded training dates in some modules. For example, seven of 14 staff required training in the course identified by the provider to support residents to manage behaviour that is challenging. Four of these staff members had no recorded dates to indicate that they had completed this training and three other staff members required refresher training. Similarly, six staff required training in cardiopulmonary resuscitation (CPR). Three staff had no recorded training dates and three staff required refresher training.

Judgment: Not compliant

Regulation 23: Governance and management

The governance and management arrangements in the centre ensured that there were clear lines of accountability. The provider had systems in place to monitor the quality of the service. However, improvement was required to ensure that all audits were completed in line with the provider's schedule and that all actions arising from audit were addressed within specified timelines.

The provider had clear management structures in this service. Staff knew who to contact should an incident occur and how to escalate any concerns. The inspector reviewed the incidents that had been recorded in the centre in 2025. These had been appropriately escalated as needed. The incidents were reviewed monthly by the person in charge to identify any trends.

The provider completed unannounced visits of the centre every six months in line with the regulations. The inspector reviewed the reports from the two most recent unannounced visits. These occurred in November 2025 and May 2025. These audits identified specific actions to improve the quality of the service with target timelines for completion.

The provider had also completed an annual report into the quality and safety of care and support in the centre in line with the regulations. This was completed in March 2025 and was reviewed by the inspector. Again, this report identified clear actions for improving the service. However, the inspector noted that not all actions were completed in line with the regulations. For example, the annual report outlined that

all staff would have completed refresher training by September 2025 and, on the day of inspection, a number of staff required refresher training as outlined under regulation 16: training and staff development.

In addition to provider-led audits, audits were completed within the centre. The provider had a schedule that outlined when these audits should occur. The audits completed in 2025 were reviewed by the inspector. It was noted that not all audits were completed in line with the schedule. For example, care plan audits had not been completed for all residents in 2025.

Judgment: Substantially compliant

Quality and safety

The service in this centre was person-centred. The centre was suited to the needs of the residents. Residents' choices were respected by staff. The health, social and personal care needs of residents were assessed. However, improvement was needed to ensure that all information relating to residents' assessments of need was accurate and up-to-date. Significant improvement was required to ensure that staff were given clear information on how to support residents in relation to their communication.

The provider had good systems in place to protect residents from abuse. Risk to residents had been identified but improvement was needed to ensure that risk were accurately assessed and appropriate control measures identified.

Regulation 10: Communication

Significant improvement was required to ensure that staff had the necessary information to provide appropriate supports to residents in relation to their communication.

Given the high-turnover of staff and the need for residents to have familiar communication partners, it was very important that the guidance to staff be very specific and informative. The inspector reviewed the documentation in two residents' personal plans that guided staff on how to support residents with their communication. The inspector found that these documents did not provide adequate information to ensure that residents were given information in a manner that they understood or that they were supported to express their needs and wishes.

Both residents had communication profiles that had been developed by a speech and language therapist. However, these documents were dated 2019 and 2020 and

it was not clear if the information contained had been reviewed and if it was still relevant to the residents.

These residents also had communication plans that had been developed within the previous 12 months. However, the information in these plans gave limited information to staff on how to support residents. The importance of staff being familiar communication partners for residents was highlighted in both plans.

Both residents also had communication passports. One passport was not dated or signed. Therefore, it was unclear if the information was developed by an appropriate individual and if it was still relevant. The other passport was dated 2019 and it was not clear if it had been updated in the intervening years. The passports outlined information relating to the residents' background, living arrangements, day services, information about food consistencies, and some of their preferences. However, the documents did not outline the meanings behind residents' words, vocalisations, gestures or facial expressions. This was despite the fact that both residents used specific communication strategies that were unique to them. For example, the inspector noted that one resident was heard repeating a phrase when they returned from day services. Staff familiar to the resident knew the meaning and significance of this phrase. Staff responded appropriately to give the resident the assurances they were seeking. Staff reported that this was a routine phrase and an interaction that the resident engaged in regularly. However, this was not outlined in the resident's communication passport or communication plan to guide new staff or unfamiliar staff. This was of particular concern given the high-turnover of staff in the centre in recent months.

Judgment: Not compliant

Regulation 17: Premises

The premises were suited to the needs of the residents. The centre was laid-out to meet the aims and objectives of the service.

As outlined in the opening section of the report, the centre was spacious, warm and comfortable. It was nicely decorated and in a good state of repair. There was ample space for residents to spend time together or alone, if they wished. The centre was fully accessible to all residents. There were level access points at all doorways. Doorways and hallways were wide so that residents could easily move through the centre. The centre had the equipment needed by residents for their daily activities.

Judgment: Compliant

Regulation 26: Risk management procedures

The provider had systems to identify and control risks to residents. However, improvement was required to ensure that all risks to residents were clearly defined and that control measures were specific to the residents' needs.

The inspector reviewed the risk assessments that had been developed for two residents. While some risk assessments were clear and specific, this was not the case for all assessments. In some cases, the specific risk to the resident had not been fully assessed and clearly defined; for example, in relation to the risks to residents from having access to the internet. As a result, the subsequent control measures were not specific and instead listed general policy documents. This meant that staff did not have clear guidance on how to appropriately support the resident to mitigate risks.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

The provider had completed assessments of the health, social and personal needs of residents. However, improvement was required to the documentation to ensure that it accurately reflected the residents' needs.

The inspector reviewed the assessments of need that had been developed for three residents. The inspector found that for two residents, these assessments had been accurately recorded and reflected the residents' needs as outlined in their care plans. The assessments were completed within the previous 12 months. However, for one resident, the date of the assessment was unclear. In addition, the information was inaccurate and unclear. For example, the resident's assessment indicated that the resident had coeliac disease and a tracheostomy but this was not the case. This had not impacted the resident and care plans were reflective of the resident's needs. However, the recording of inaccurate information presented a risk to the resident, particularly given the high turnover of staff in this centre as they would not be familiar with the residents.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

The provider had systems in place to support residents to manage their behaviour.

The inspector reviewed the behaviour support plans that had been developed for two residents. These had been developed by an appropriately qualified professional.

They were recently updated and gave clear guidance to staff on the supports that should be offered to residents.

Where restrictive practices were in use in the centre, these had been identified by the provider. The inspector reviewed the protocols that were in place for two residents in relation to restrictive practices. These showed that the reason for the use of the practice had been identified and that the practices were regularly reviewed. The provider's human rights committee had reviewed practices in use in the centre to ensure that they were the least restrictive options in use for the shortest duration of time.

Judgment: Compliant

Regulation 8: Protection

The provider had systems in place for the protection of residents from abuse.

When speaking with the inspector, staff demonstrated good knowledge of the steps that should be taken should a safeguarding incident occur.

The inspector reviewed the intimate care plans that had been developed for two residents. These gave very specific details to staff on how to support residents.

The provider completed regular audits of staff's knowledge of safeguarding procedures. The audits for 2025 were recorded and they showed that staff knew what constituted a safeguarding incident, how to respond and how to report it.

Judgment: Compliant

Regulation 9: Residents' rights

The rights of residents were promoted in this centre.

Familiar staff in the centre were knowledgeable of the residents' communication strategies and how to offer choices to residents. They spoke about how residents could decline choices that were offered to them; for example, meal choices and activities. They spoke about how they maintain close proximity to the residents to respond to residents' requests for assistance and, also, how they respected the residents' privacy.

The service in the centre was flexible to allow for residents to choose when they wanted to stay in the centre and when they wanted to stay in their family home. For example, in the week of the inspection, one resident chose to stay an additional

night in the centre rather than return to their family home. This choice was respected and facilitated by staff.

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	Substantially compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Substantially compliant
Quality and safety	
Regulation 10: Communication	Not 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	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Harmony OSV-0005691

Inspection ID: MON-0043150

Date of inspection: 23/01/2026

Introduction and instruction

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

This document is divided into two sections:

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

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

A finding of:

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 15: Staffing	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 15: Staffing:</p> <ul style="list-style-type: none"> • The Person in Charge has completed documentation for the replacement of staff nurse and health care assistant vacancies and escalated to the General Manager for approval. The Staff Nurse position was offered to the panel on 05/02/2026 – awaiting uptake. • The Person in charge continues to ensure consistent familiar HSE staff is targeted initially when offering extra/additional hours prior to using agency staff. • The person in Charge continues to restructure HSE staff to meet the needs of residents and reduce the usage of agency staff. • The Person in Charge continues to use consistent and familiar agency staff through the HSE's Service Level Agreement. All shifts including sporadic shifts are covered by familiar agency staff when required. 	
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"> • The Person in Charge has ensured that evidence of mandatory training undertaken by all staff is available within the centre. Completed 05/02/2026. • The person in charge has ensured that all staff have access to appropriate training, including refresher training, as part of a continuous professional development programme. To be completed by 30/04/2026. • The Person in Charge has a training schedule in place for mandatory training to ensure that the 7 staff requiring Studio III training is completed. The following dates have been scheduled: 2 staff are scheduled to attend the 2-day full training on the 11th and 13th March 2026. 2 are scheduled 28th and 29th April 2026, and 3 staff are scheduled for refresher training on the 19th March 2026. To be completed 29/04/2026. • The Person in Charge has ensured that refresher CPR Training is taking place for the 6 staff requiring training. To be completed 26/03/2026. 	

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"> • The Person in Charge has ensured that all Care Plan audits will be completed. To be completed by 31/03/2026. • The Registered Provider and Person in Charge will ensure that the revised audit schedule be implemented and completed as per the schedule for 2026 will. Completed 31/01/2026. • The Person in Charge has ensured that evidence of mandatory training undertaken by all staff is available within the centre. Completed 05/02/2026. • The person in charge has ensured that all staff have access to appropriate training, including refresher training, as part of a continuous professional development programme. To be completed by 30/04/2026. • The Person in Charge has a training schedule in place for mandatory training to ensure that the 7 staff requiring Studio III training is completed. The following dates have been scheduled: 2 staff are scheduled to attend the 2-day full training on the 11th and 13th March 2026. 2 are scheduled 28th and 29th April 2026, and 3 staff are scheduled for refresher training on the 19th March 2026. To be completed 29/04/2026. • The Person in Charge has ensured that refresher CPR Training is taking place for the 6 staff requiring training. To be completed 26/03/2026. • The Person in Charge has ensured that the action on refresher training identified in the 2025 Annual Report will be completed for 1 staff member by 26/03/2026. 	
Regulation 10: Communication	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 10: Communication:</p> <ul style="list-style-type: none"> • The Person in Charge will ensure that Communication Profiles will be reviewed by the Speech and Language Therapist and updated as appropriate. To be completed 27/02/2026 • The Person in Charge will ensure that the personal plans including the communication passport will be reviewed for all 6 residents to incorporate all recommendations from the communication profile and SALT. To be completed by 13/03/2026. • The Person in Charge will ensure that the communication passports will be updated in line with the communication profile and dated and signed once completed. To be completed by 13/03/2026. • The person in charge is currently reviewing all residents communication support plans to ensure that triangulation is completed and information is accurate. To be completed by 13/03/2026. • The Person in Charge will ensure that a communication profile review tool provided by SALT will be completed annually to identify any changes that would be required to the communication profile. 	
Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:

- The Person in Charge is currently reviewing all residents' risk assessments supported by CNM3 to ensure they are clear and that control measures adequately address the risk presented. To be completed by 13/03/2026.

Regulation 5: Individual assessment and personal plan	Substantially Compliant
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Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:

- The Person in charge has ensured that one resident's Assessment of Need is signed and dated by the named nurse. Completed 26/01/2026.
- The Person in Charge has completed a review of residents Assessment of Need to ensure it is clear for all staff in relation to each residents' health, social and personal care needs. This will continue to be monitored through audits, the centres QIP and staff meetings. Completed 13/02/2026. |

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 10(2)	The person in charge shall ensure that staff are aware of any particular or individual communication supports required by each resident as outlined in his or her personal plan.	Not Compliant	Orange	13/02/2026
Regulation 15(3)	The registered provider shall ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.	Substantially Compliant	Yellow	28/02/2026
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a	Not Compliant	Orange	30/04/2026

	continuous professional development programme.			
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	31/03/2026
Regulation 26(2)	The registered 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.	Substantially Compliant	Yellow	13/03/2026
Regulation 05(1)(b)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out subsequently as required to reflect changes in need and circumstances, but no less frequently	Substantially Compliant	Yellow	13/02/2026

	than on an annual basis.			
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