



# Report of an inspection of a Designated Centre for Older People.

## Issued by the Chief Inspector

Name of designated centre:	St Carthage's House
Name of provider:	St. Carthage's House Company Limited by Guarantee
Address of centre:	Townspark East, Lismore, Waterford
Type of inspection:	Unannounced
Date of inspection:	06 November 2025
Centre ID:	OSV-0000687
Fieldwork ID:	MON-0045179

## About the designated centre

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

St Carthage's House is located on a large site on the outskirts of Lismore town, Co Waterford. It is owned and managed by a voluntary organisation with charitable status through a voluntary board of directors. It is a single-storey purpose built centre and was opened in its current location in 1994. It was set up by local people to provide support with activities of daily living to residents with a low to moderate dependency needs who do not require full-time nursing care. Residents are charged a weekly fee, an annual grant is allocated to the centre via statutory funding and additional funds are raised through on-going local fund raising. It is currently registered to provide residential care to 42 older people. There is a large communal sitting room, two smaller sitting rooms in the main building along with a dining room and a small Oratory. Accommodation in the premises comprises four "Courts". Oakland accommodates 14 residents in single bed rooms and two residents in one shared bedroom. Woodvale accommodates 17 residents in single bedrooms. The main court contained one single bedroom. Elm Way is adjoined by a glass corridor to the rear of the main building and comprises eight single en-suite bedroom flats. St Carthage's house is a residential setting catering for the residents to live independently with supportive care. The centre is specific in its criteria and facilitates older adults to continue independent living. The centre does not provide 24 hour nursing care but a registered general nurse is responsible and accountable for the daily running of the centre and nursing staff administer medication during the day and at night time. The staffing structure includes nursing, care staff, household and catering staff and maintenance staff.

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

Number of residents on the date of inspection:	37
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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 Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (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 6 November 2025	09:50hrs to 17:50hrs	Mary Veale	Lead
Thursday 6 November 2025	09:50hrs to 17:50hrs	Sinead Corbett	Support

## What residents told us and what inspectors observed

The overall feedback from residents who spoke with the inspectors was that they were very happy and liked living in St Carthage's House. Residents were highly complimentary of the centre and the word kindness in relation to staff was spoken by many on the day of the inspection. During the day, the inspectors met with most of the residents living in the centre and spoke to seven in more detail. The inspectors spent time observing daily life in the centre to gain an insight into the lived experience of residents in St Carthage's House. Residents praised the staff and management team and one resident stated that "the staff were marvellous", with another resident saying that "you couldn't find a better place".

St Carthage's house is located in the town of Lismore in Co. Waterford. The centre is located within walking distance of the local shops and amenities. Residents had access to local community groups. The centre was registered to accommodate 42 residents. There were 37 residents living in the centre of which two residents were in hospital.

The design and layout of the premises met the individual and communal needs of the residents'. The centre is a single storey building. The building was well lit, warm and adequately ventilated throughout. Residents have access to a large day room, a dining room, a small sitting room, a visitors lounge, and an oratory. The centre was homely and clean. The large day room had recently been decorated with a large scale mural painted by a local artist. The dining room walls displayed the resident's artwork of paintings and tapestries. The inspectors were told that the residents had displayed these artworks at an exhibit in Lismore castle.

Bedroom accommodation is set out around three courts named Oakland, Woodvale and Elm Way. Oakland accommodates 16 residents in 14 single bedrooms and one twin bedroom. Woodvale accommodates 17 residents in single bedrooms. The provider had enhanced two of the bedrooms in Woodvale since the previous inspection. These two bedrooms had been reconfigured to include en-suite wash hand basin, toilet and shower facilities. Residents in Oakland and Woodvale share communal toilets and shower facilities. Elm Way is registered to accommodate eight residents in single-bedroom flats, all individually named. Seven of the flats has en-suite facilities that include a shower, toilet and wash hand basin. One flat has an en-suite toilet and wash hand basin only, meaning this resident was required to avail of showering facilities in Woodvale. Two of the flats were unoccupied on the inspection day, having been recently refurbished to convert the sleeping and living areas to open-plan. The provider had renovated six of the eight flats.

All bedroom accommodation throughout the centre had a television, call bell, wardrobe, seating and locked storage facilities. Residents had personalised their

bedrooms with photographs, artwork, religious items and ornaments. The size and layout of the bedroom accommodation were appropriate for resident needs.

The main building and the flats in Elmway were connected by a link corridor to a central courtyard. The centre of the main building was the hub of the centre, where the main entrance, most communal areas and kitchen are located. The centres laundry, maintenance work shop, boiler room and storage rooms were located in two separate building.

Residents had access to a large green field garden which wrapped around the centre. There were three well maintained internal courtyards. The gardens and courtyards were tidy, well-maintained and had level paths.

Residents were very complimentary of the home cooked food and the dining experience in the centre. Residents' stated that the quality of food was excellent. The menus for all meals and snacks were displayed on each table. The inspectors observed the dining experience at dinner time. The dinner time meal was appetising and well present and the residents were not rushed. The dinner time experience was a social occasion where residents were seen to engage in conversations and enjoying each others company.

The activities schedule was displayed in the reception hall. In the morning residents participated in a group exercise art session with a professional artist. Residents told inspectors that they enjoyed attended a movie night in the local school which had been organised the week prior to the inspection by the students there. A number of residents had their own car and one resident had a bicycle which allowed the residents to maintain their independence, visit family and local towns.

Residents had access to radios, television and Internet services. There were advertisements within the centre for independent advocacy services. Residents could receive visitors in the centre's communal areas or their bedrooms. Roman Catholic Mass was celebrated in the centre weekly. Outside of mass, the centre's oratory provided a space for prayer and quiet reflection. Residents' views and opinions were sought through resident meetings and satisfaction surveys and they felt they could approach any member of staff if they had any issue or problem to be solved.

There was an on-site laundry service where residents' clothing, towels and bed linen were laundered. This area was observed to be clean and tidy. Residents spoken with were complimentary about the laundry service received in the centre.

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

## Capacity and capability

The inspectors found that St Cartages House was a well-managed centre where the residents were supported and facilitated to have a good quality of life. This was an unannounced inspection to monitor ongoing compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulation 2013 (as amended), review the registered provider's compliance plan from the May 2024 inspection and follow up on notifications submitted to the office of the Chief Inspector. Improvements were found to the premises and fire safety. On this inspection, the inspectors found that areas of improvement were required in relation to care planning, the directory of residents, governance and management and infection control.

The registered provider of St Carthages House is St Carthages House Company Limited by Guarantee. The company has six directors who work in a voluntary capacity. The company chairperson represents the provider in regulatory matters. The company chairperson arrived to the centre in the morning to support the person in charge on the inspection day.

The centre provides care for low to medium dependent residents who do not require full time nursing care in accordance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 as amended. The person in charge reported to the board, worked full time in the centre and was supported by a deputy manager and a team of nursing, care and support staff.

There were sufficient staff on duty to meet the needs of residents living in the centre on the day of inspection. The centre had a well-established staff team who were supported to perform their respective roles and were knowledgeable of the needs of persons in their care and respectful of their wishes and preferences.

There was an ongoing schedule of training in the centre and management had good oversight of mandatory training needs. An extensive suite of mandatory training was available to all staff in the centre and training was up to date. There was a high level of staff attendance at training in areas such as fire safety, manual handling, safeguarding vulnerable adults, and infection prevention and control. Staff with whom the inspectors spoke with, were knowledgeable regarding safeguarding, infection control procedures and fire procedures. Fire training was scheduled to take place in the weeks following inspection.

Improvements were found in the centres audit system since the previous inspection. There were good management systems in place to monitor the centre's quality and safety. There was evidence of a comprehensive and ongoing schedule of audits in the centre, for example; call-bell response, infection prevention and control, falls, and safeguarding audits. Audits were objective and identified improvements. Records of board and staff meetings which had taken place in 2025 were viewed on this inspection. Agenda items on meeting minutes included discussing of weekly key performance indicators (KPI's), fire safety, training, resident feedback, activities, links with the community and infection prevention. It was evident that the centre was continually striving to identify improvements and learning was identified on feedback from resident's meetings and audits.

An annual review of the quality and safety of care delivered to residents took place in 2024 in consultation with residents and their families. Residents and families had been consulted in the preparation of the annual review through surveys and the residents' forum meetings. Notwithstanding this good practice, further improvements were required in the oversight of the changes made to the footprint of the centre. This is discussed further under Regulation 23: Governance and management.

Incidents and reports as set out in schedule 4 of the regulations were notified to the Chief Inspector of Social Services within the required timeframes. The inspectors followed up on incidents that were notified since the previous inspection and found these were managed in accordance with the centre's policies.

### Regulation 15: Staffing

On the inspection day, staffing was found to be sufficient to meet the residents' needs. There was a minimum of two health care assistants on duty at all times for the number of residents living in the centre.

Judgment: Compliant

### Regulation 16: Training and staff development

Staff had access to training appropriate to their role. Staff had completed training in fire safety, safeguarding, managing behaviours that are challenging and, infection prevention and control. There was an ongoing schedule of training in place to ensure all staff had relevant and up to date training to enable them to perform their respective roles. Staff were appropriately supervised and supported by nurse management.

Judgment: Compliant

### Regulation 19: Directory of residents

The registered provider had established a directory of residents. However, a review of the directory of residents was required as some information was not routinely recorded as outlined in Schedule 3 of the regulations. For example: addresses for each next of kin, the date of discharge of residents, the date of transfers to hospital, and the date, time and cause of death for deceased residents were missing from a number of the residents individual directory.

Judgment: Substantially compliant

### Regulation 23: Governance and management

Management systems were effectively monitoring quality and safety in the centre. Audits were routinely completed and scheduled, for example; falls, nutrition, and medication management. These audits informed ongoing quality and safety improvements in the centre. There was a proactive management approach in the centre which was evident by the ongoing action plans in place to improve safety and quality of care.

Notwithstanding this good practice, changes made to the premises were not in line with the statement of purpose, which St Carthages House Company Limited By Guarantee was registered against and had not been communicated to the Office of the Chief Inspector. For example:

- The provider had reduced the Oakland sitting room space by installing an adjacent store room.
- The door to the sluice room had been moved to the corridor opposite bedroom 34.
- Bedroom 26 had been reduced to provide en-suite facilities for bedrooms 26 and 27.

Judgment: Substantially compliant

### Regulation 31: Notification of incidents

Incidents and reports as set out in schedule 4 of the regulations were notified to the office of the Chief Inspector within the required time frames. The inspectors followed up on incidents that were notified and found these were managed in accordance with the centre's policies.

Judgment: Compliant

### Quality and safety

The inspectors were assured that residents living in St Carthages House enjoyed a good quality of life. Staff were observed to be respectful and courteous towards residents. There were good positive interactions between staff and residents

observed during the inspection. There was a rights-based approach to care; both staff and management promoted and respected the rights and choices of residents living in the centre. Residents lived in an unrestricted manner according to their social needs.

The inspectors viewed a sample of residents' electronic nursing notes and care plans. There was evidence of improvements in care plans since the previous inspection. Residents were comprehensively assessed prior to admission to ensure the centre could meet their needs. The inspectors viewed a sample of residents' care plans and found that care plans were person-centred. Care plans were routinely reviewed and updated in line with the regulations and in consultation with the resident. Notwithstanding this good practice, improvements were required to care planning, this is discussed under Regulation 5: Individual assessment and care planning.

There was policy in place to inform the management of responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort with their social or physical environment) and restrictive practices in the centre. There was evidence that staff had received training in managing behaviour that is challenging which included restrictive practices. At the time of inspection there were no bed rails in use nor were there any residents who exhibited behaviours that were challenging.

There were systems in place to safeguard residents and protect them from the risk of abuse. Staff were supported to attend safeguarding training. Staff demonstrated an appropriate awareness of the centres' safeguarding policy and procedures, and demonstrated awareness of their responsibility in recognising and responding to allegations of abuse. All interactions by staff with residents were observed to be respectful throughout the inspection. Residents reported that they felt safe living in the centre. The provider acted as a pension agent and held personal monies for one of the residents' living in the centre. Records reviewed found that the pension monies and resident monies were lodged into the residents' account to ensure the residents' finances were safeguarded. The provider had a transparent system in place where all lodgements and withdrawals of residents' personal monies were signed by two staff and logged. The provider also audited the balances on a regular basis in line with the centre's policies.

There was a rights-based approach to care in this centre. Residents' rights, and choices were respected. Resident feedback was sought in areas such as activities and meals. Records showed that items raised at resident meetings were addressed by the management team. Information regarding advocacy services was displayed in the centre. Residents had access to daily national newspapers, weekly local newspapers, Internet services, books, televisions, and radios. Mass took place in the centre each week. Residents had access to an Oratory room in the centre.

The inspector found that the overall premises were designed and laid out to meet the needs of the residents. Bedrooms were personalised and residents had space for

their belongings. Overall, the general environment including residents' bedrooms, communal areas and toilets appeared visibly clean and well maintained.

Improvements were found in infection prevention and control since the May 2024 inspection. There were appropriate sluicing and storage facilities. Oversight of cleaning practices had improved and the centre was observed to be clean. There was good work routines and schedules for cleaning and decontamination. Intensive cleaning schedules had been incorporated into the regular cleaning programme in the centre. Alcohol hand gel was available in all bedrooms, communal rooms and corridors. Personal protective equipment (PPE) stations were available on corridors to store PPE. There was evidence that infection prevention control (IPC) was an agenda item on the minutes of the centre's staff meetings. IPC audits were carried out by the person in charge. There was an up to date IPC policies which included guidance on COVID-19 and multi-drug resistant organism (MDRO) infections. Intensive cleaning schedules had been incorporated into the regular cleaning programme in the centre. Notwithstanding the many good practices observed, improvements were required to the layout of the laundry. This is discussed under Regulation 27: Infection prevention and control.

Improvements were found to fire safety since the May 2024 inspection. The provider had made changes to the footprint an apartment in Elm way, this apartment no longer had an inner room. Equipment such as wheelchairs and trolleys were no longer stored on corridors. The provider had effective systems in place for the maintenance of the fire detection, alarm systems, and emergency lighting. There were automated door closures to all bedrooms and all compartment doors. All fire safety equipment service records were up to date and there was a system for daily and weekly checking, of means of escape, fire safety equipment, and fire doors to ensure the building remained fire safe. Fire training was completed annually by staff and records showed that fire drills took place regularly in each compartment with fire drills stimulating the lowest staffing levels on duty. Records were detailed and showed the learning identified to inform future drills. Each resident had a personal emergency evacuation plan (PEEP) in place which were updated regularly. The PEEP's identified the different evacuation methods applicable to individual residents and staff spoken with were familiar with the centres evacuation procedure. There was evidence that fire safety was an agenda item at meetings in the centre.

### Regulation 17: Premises

The premises was appropriate to the needs of the residents and promoted their privacy and comfort.

Judgment: Compliant

### Regulation 27: Infection control

Action were required to ensure the environment was as safe as possible for residents and staff. For example;

- Some surfaces throughout the centre were observed to be damaged and, therefore, could not be effectively cleaned; for example,

A review of skirting boards under sinks in a number of bedrooms was required as they had been damaged by water. This posed a risk of cross contamination as staff could not effectively clean these surfaces.

- A review of the centres flooring was required as areas of the floor were observed to be damaged and worn.
- The layout of the on-site laundry required review. Although the the centres laundry had a work way flow for dirty to clean laundry, dirty linen was brought through a storage area which contained items such as stocks of paper hand towels which posed a risk of cross contamination.

Judgment: Substantially compliant

### Regulation 28: Fire precautions

Measures were in place to ensure residents' safety in the event of a fire in the centre and these measures were kept under review. Fire safety management servicing and checking procedures were in place to ensure all fire safety equipment was operational and effective at all times. Daily checks were completed to ensure fire exits were clear of any obstruction that may potentially hinder effective and safe emergency evacuation. Each resident's evacuation needs were regularly assessed and the provider assured themselves that residents' evacuation needs would be met with completion of regular effective emergency evacuation drills. All staff had completed annual fire safety training specific to St Carthages house and were provided with opportunities to participate in the evacuation drills.

Judgment: Compliant

### Regulation 5: Individual assessment and care plan

Care plans were available in digital format. A sample of care plans were noted to be person-centred and reflected the assessed care needs of the residents. The care plans were reviewed at intervals not exceeding 4 months and involvement of the resident was recorded. Notwithstanding this good practice, one resident did not

have their care plan prepared based on an assessment no later than 48 hours after their admission to the centre.

Judgment: Substantially compliant

### Regulation 7: Managing behaviour that is challenging

The person in charge ensured that staff had up-to-date knowledge, training and skills to care for residents with responsive behaviours (how residents living with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment) and restrictive practices. There were no residents with responsive behaviour living in the centre. There were no bed rails in use in the centre.

Judgment: Compliant

### Regulation 8: Protection

Measures were in place to protect residents from abuse including staff training and an up to date policy. Staff were aware of the signs of abuse and of the procedures for reporting concerns.

Judgment: Compliant

### Regulation 9: Residents' rights

Residents' rights and choice were promoted and respected in this centre. There was a focus on social interaction led by staff and residents had daily opportunities to participate in group or individual activities. Access to daily newspapers, television and radio was available. Details of advocacy groups was on display in the centre.

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 Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (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	Compliant
Regulation 19: Directory of residents	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 31: Notification of incidents	Compliant
<b>Quality and safety</b>	
Regulation 17: Premises	Compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

# Compliance Plan for St Carthage's House OSV-0000687

Inspection ID: MON-0045179

Date of inspection: 06/11/2025

## 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 Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

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 19: Directory of residents	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 19: Directory of residents:</p> <p>Reg: 19 Directory of Residents Page 9.            Directory of Residents has been reviewed, updated to include information that was missing, all staff aware of importance of maintaining Directory of Residents up to date with Transfers/Discharges etc.            Date of Completion:29/01/26</p>	
Regulation 23: Governance and management	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 23: Governance and management:</p> <p>Governance and Management Page 9            Statement of Purpose requires updating, Engineer attended and repeat measurements have been taken, a/w up to date maps and then these will be used to up date Statement of purpose. Application to vary will be completed once all required information acquired.            Expected Date of Completion:30/04/26</p>	

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Regulation 27: Infection control	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 27: Infection control:  Reg. 27 Infection Control Page 12  Ongoing Maintenance works ongoing throughout the building, Vanity Units had already been purchased but have been installed since inspection to those areas were damage present. Quotes have been sought and once all returned and supplier agreed on work will begin on resident's bedroom flooring.  Advice has been sought from an Independent ICP re layout of On-site laundry space, once report/advice received necessary works will be completed.</p> <p>Expected Date of completion:30/04/26</p> <p>]</p>	
Regulation 5: Individual assessment and care plan	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:  Reg 5 Individual Assessment and Care Plans Page 13  Individual mentioned Careplan updated.  All Nursing Staff aware of need to have Careplans prepared no later than 48 hours after admission.</p> <p>Date Completion:29/01/26</p> <p>]</p>	

## 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 19(3)	The directory shall include the information specified in paragraph (3) of Schedule 3.	Substantially Compliant	Yellow	29/01/2026
Regulation 23(1)(d)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Substantially Compliant	Yellow	30/04/2026
Regulation 27(a)	The registered provider shall ensure that infection prevention and control procedures consistent with the standards published by the Authority are in place and are implemented by staff.	Substantially Compliant	Yellow	30/04/2026

Regulation 5(3)	The person in charge shall prepare a care plan, based on the assessment referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the designated centre concerned.	Substantially Compliant	Yellow	29/01/2026
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