



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

## Issued by the Chief Inspector

Name of designated centre:	Cnoc Gréine
Name of provider:	Health Service Executive
Address of centre:	Sligo
Type of inspection:	Unannounced
Date of inspection:	12 August 2025
Centre ID:	OSV-0007814
Fieldwork ID:	MON-0047504

## About the designated centre

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

Cnoc Gréine designated centre can provide support to up to two residents with an intellectual disability. The centre comprises a large bungalow that is designed into two separate living areas for each resident, and the use of a communal kitchen. There is an office for staff members with a separate side entrance. There is a large garden area front and back. Residents who use this service may also need assistance with their behaviours. A combination of nursing staff and health care assistants provide support to residents, with four staff members allocated during daytime hours and three waking night staff allocated during night-time hours. The centre is located in a rural location and transport is provided to assist residents in accessing their local community.

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

Number of residents on the date of inspection:	2
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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
Tuesday 12 August 2025	16:00hrs to 18:45hrs	Angela McCormack	Lead
Wednesday 13 August 2025	10:10hrs to 14:00hrs	Angela McCormack	Lead

## What residents told us and what inspectors observed

This inspection found that residents living in Cnoc Gréine designated centre were provided with good quality, person-centred care that promoted their wellbeing and protection.

This inspection was an unannounced inspection which focused on safeguarding. The Chief Inspector of Social Services issued a regulatory notice to providers in June 2024 outlining a plan to launch a regulatory adult safeguarding programme for inspections of designated centres. This inspection was completed as part of this programme.

This inspection was completed over two half days, one evening and the following morning. The inspector provided a document called 'Nice to Meet You' that inspectors use to support residents to understand about why they are visiting their home. The inspector met with the two residents who lived in Cnoc Gréine, in addition to three staff members and the person in charge.

On arrival to the centre on the first afternoon, the inspector met with one staff member. They explained that one resident was gone for a walk and another resident was having a rest as they were recovering from an illness. The person in charge arrived to the centre shortly afterwards and was available throughout the inspection.

The premises was nicely decorated inside and outside. The outside area included a large garden front and back, which was fully accessible and beautifully maintained. It included a poly tunnel, several potted flowers and shrubs and bird tables. Residents were reported to be involved in gardening projects and in designing and painting bird tables. The external area also had amenities for leisure including a basket-ball hoop and an area to play football.

Inside, the house was designed into two separate living areas for each resident. Each area was decorated in line with residents' interests and needs. For example, one resident's living room had pictures, ornaments and soft furnishings, while another resident's living rooms and bedroom had minimal furnishings in line with their individual needs and preferences. The house had a lock on the door between the two living areas, so that residents could have privacy from each other. This also protected residents from possible uninvited access to their living area and bedrooms. This design supported residents' privacy and protection from possible negative interactions that could occur.

Residents had access to a shared kitchen and separate laundry room which were clean and suitably equipped. Staff members reported that residents used to eat their meals separately from each other, but in recent times they have been sharing meal times. It was reported that this has been a positive experience for both residents and supportive of their relationship with each other. The management team spoke about plans for an extension in one area of the house to enhance the facilities and

which would allow residents to have their own separate kitchen facilities. However, these plans continued to be under review in order to further establish the suitability, and the benefit, of this for the resident who would be impacted by the building works. Reviews of these plans included members of the multidisciplinary team (MDT) and the residents' representative. This had also been reviewed by the provider's Human Rights committee.

This inspection found that residents were supported to do activities that were meaningful to them. One resident had access to an external day service for specific activities that may interest them. Another resident was reported to prefer doing their own activities supported by staff from Cnoc Gréine, They owned some farm animals which they looked after each day and which were located in a nearby field to the house.

Activities that residents enjoyed within their home included; gardening projects, baking, making bird houses, listening to music and watching video clips on the Internet. There were photographs in the kitchen area of residents taking part in activities, such as painting bird houses and baking apple pie. Residents also enjoyed visits from a reflexologist for therapy sessions. In addition, residents were supported to maintain contact with friends and family through telephone calls and visits. Visitors were welcome to the centre. One resident recently attended a family wedding, photographs of which were hung on the walls and showed the resident's enjoyment of this occasion.

Outside of the home, residents enjoyed a range of activities that suited their needs and interests. These included going to the gym, swimming, horse-riding, fishing, going to the cinema, going to sporting events, going on day trips and overnight stays. For example, one resident visited the aquarium in Galway and also enjoyed an overnight break in another county with support from their staff. Residents' personal plans also contained information and photographs about their goals for the future and goals that they had achieved.

Throughout the inspection one resident was observed coming and going to their home, while another resident chose to rest at home as they were recovering from a brief illness. It was clear from observations and discussions that the inspector had, that residents' choices about how they spent their day was respected and that they had the autonomy to make decisions. On the first evening of the inspection, one resident spoke with the inspector. They talked briefly about their interests and said that they were going fishing that evening. The resident appeared happy and content and they were observed chatting comfortably with the staff members. Another resident agreed to meet the inspector briefly; however the inspector did not get to spend much time with them as they were resting in their living room.

The inspector got the opportunity to talk with three staff members who were working at the time of inspection. One staff member went through a resident's communication plan and described to the inspector about how the resident was supported to make choices. Their choices each day were recorded in a 'preference log', where it could be seen what activities that the resident enjoyed or declined. This demonstrated good monitoring of residents' likes, dislikes, and presentation on

any given day, so that the best supports could be provided. Staff spoken with described residents' usual routines and said that this was important to them. They spoke about how incidents had greatly reduced in the centre and about how it was important that staff members were consistent and familiar.

Another staff member described to the inspector about how a resident is supported with behaviour management and with any potential triggers that could cause them upset when out in public. Two staff members spoke about the arrangements for safeguarding and reporting concerns. Overall, it was clear to the inspector that staff members knew residents very well and that this was a key factor in ensuring that residents felt supported, understood and respected.

Overall, the service was found to be person-centred, safe and promoted residents' protection and human rights.

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

## Capacity and capability

This inspection found that there were good systems in place to ensure that a person-centred and safe service was provided to residents. However, improvements were required in the completion of audits in line with the provider's schedule, and in ensuring that there is clear guidance about the reporting of behavioural incidents through the online reporting procedures.

There was a clear governance and management arrangement in place. At a local level, this included a person in charge and staff nurse. The staff nurse worked full-time and was based at the centre. The person in charge was responsible for one other designated centre and also was a designated officer for safeguarding for the area. The staffing levels and skill mix were found to meet the needs of residents. Staff members were provided with ongoing training to ensure that they had the skills to support residents with their needs.

The systems in place for the oversight and monitoring of the care provided included audits completed at local level and by the provider through unannounced visits. In general, they were effective in identifying areas for improvement. However, not all of the local management audits were completed in line with the provider's annual schedule.

Overall, the centre was found to be well managed and monitored to ensure that the centre met residents' needs. Improvements as noted under Regulation 23, would further enhance the monitoring and oversight of the centre.

## Regulation 15: Staffing

The centre was resourced with the numbers and skill mix of staff to meet residents' assessed needs. Staff rosters were in place to plan and document staffing arrangements.

The inspector reviewed seven weeks' rosters from 22 June to 09 August 2025. These were found to be well maintained and clear on who was working each day. They also showed that the required number of staff were on duty day and night to meet the needs of residents. While some agency staff were used to fill gaps, these were regular agency staff members. This ensured consistency of care provided to residents.

The inspector reviewed a sample of four staff members Garda Vetting reports, including two agency staff members, and found that staff had been vetted, as required. This helped to further ensure residents' safety and protection.

Judgment: Compliant

## Regulation 16: Training and staff development

The provider had good arrangements in place for staffing training and development. In addition, there was a comprehensive induction programme in place for new staff members. This helped to ensure that staff members had the necessary skills, competencies and support to carry out their role in supporting residents.

The current training matrix for the centre was reviewed by the inspector. This showed that all staff members had the required training related to safeguarding and the protection of residents including behaviour management, safeguarding and 'Children First'. Two staff members were due refresher training in behaviour management and this was scheduled for September 2025.

Some staff had also undertaken additional training programmes. These included; an introduction to sensory, human rights, consent and assisted decision-making. A sample of four staff members' training certificates were reviewed. These showed that training had been completed as required.

Staff members were supported through annual supervision meetings with their line manager. The inspector reviewed a sample of five staff members' supervision meetings which were completed in line with the provider's schedule. Staff spoken with said that they felt well supported by the management team.

Judgment: Compliant

## Regulation 23: Governance and management

The governance and management team were found to have the capacity and capability to ensure that a safe and good quality service was provided to residents. The centre was resourced with suitable numbers of staff and vehicles to enable residents to do individual activities of their choosing. However, some improvements were required in the oversight and monitoring in the centre, in particular in ensuring audits are completed as required and in ensuring that there was clear guidance available about the reporting of incidents

There were a range of policies and procedures in place to provide guidance and outline the procedures for safe care and support. These included policies and procedures as required under the regulations in addition, to others for example; 'safe use of Internet' policy. These were readily available in the centre.

The local management team carried out a suite of audits throughout the year which was set out in an annual schedule. The inspector reviewed these audits for 2025, where it was found that some improvements were required to ensure that all audits were completed in line with the provider's schedule for the centre. For example, audits on restrictive practices were required to be completed quarterly and staff safeguarding awareness audits were required to be completed monthly, however there were gaps in these audits for 2025.

The provider ensured that unannounced visits occurred every six months as required in the regulations. The last one occurred in May 2025 and was reviewed by the inspector. This included a comprehensive report with associated actions to improve the service. The annual review of the service was completed in July 2025 and was reviewed by the inspector. This included consultation with residents and their family representatives. Actions were also developed to improve the quality of the service provided, some of which included actions relating to enhancing staff and residents' awareness about safeguarding.

In addition, the provider had a 'sustainability plan', where a specific topic was reviewed by the service each quarter and the information was then collated by the provider to identify areas of good practice in centres and also to identify areas where improvements were required. Areas that were audited included 'safety and wellbeing for residents' and 'human rights'. This demonstrated that the provider was striving to ensure that a rights based culture was in place that protected residents from potential harm. The actions from this audit tool was then collated into the centre's quality improvement plan, from where it could be monitored with actions identified in other audits.

Team meetings occurred regularly. The inspector reviewed the minutes of the team meetings that occurred in May and June 2025, where it could be seen that there was a comprehensive discussion had which included safeguarding. In addition, regular person in charge meetings occurred for the area, where learnings were shared from incidents and discussions occurred on human rights approach to care.

The provider's arrangements for reviewing incidents included monthly meetings with the management team to review incidents and trends. The inspector reviewed the centre's incident records for 2025 where it was seen that there were no incidents recorded in 2025 to date. On discussion with the person in charge and assistant director of nursing (ADON) about an incident that occurred in January 2025, where a resident required the maximum amount of PRN (medicines only taken as required) medicines to support with behaviours, it was agreed that this should have been a reported incident. The documentation and procedures to guide staff did not provide clear direction on this.

The following required review:

- Clear guidance was required regarding the reporting of behavioural incidents, particularly incidents where the use of PRN medicines is used to support with the behaviours of concern.
- There were gaps in some local audits being completed, as it was found that the provider's audit schedule and relevant procedures were not always followed with regard to the frequency of audits completed in the centre, such as restrictive practices and auditing staff member's awareness of safeguarding.

Improvements in these areas would enhance the monitoring by the local management team and promote more effective oversight arrangements by the management team of risks that occurred in the centre.

Judgment: Substantially compliant

## Quality and safety

Cnoc Gréine was found to provide good quality, person-centred care and support to residents. A comprehensive assessment was completed on the health, personal and social care needs of residents. Personalised support plans were then developed based on residents' needs and these were kept under ongoing review. This ensured that the centre continued to meet residents' needs.

An holistic approach to care and support was evident in this centre, where residents, their representatives, staff members and members of the MDT were involved in personal planning and the review of support provided. Staff spoken with were knowledgeable about residents' needs and about how to best support them. These supports described by staff members were consistent with what was included on support plans.

Residents' rights and protection were promoted through staff training and discussions at team and residents' meetings about human rights and safeguarding. Residents had access to a range of easy-to-read documents and accessible material

to support their understanding of various topics.

In summary, the care and support provided to residents was found to be person-centred, safe and regularly monitored. This helped to ensure that it met residents' individual needs and was to a good quality.

## Regulation 10: Communication

The centre promoted a total communication approach and supported residents with their communication preferences. Care plans clearly outlined the communication supports that residents required to make choices in their lives.

The inspector reviewed two residents' personal plans and found that residents had communication assessments and care plans for supporting communication in place. The support plans provided guidance to staff on how to support residents with their communication preferences. Staff spoken with were aware and knowledgeable about residents' communication preferences and about how to support with this. One staff member went through the content of a resident's 'communication passport' with the inspector where it was clear that they knew the resident well.

Various methods of communication were used with residents in line with their assessed needs, such as social stories, objects of reference, pictures, visual schedules, gestures and verbal communication. This demonstrated that every effort was made to communicate with residents in a person-centred and meaningful way. Residents were supported with communication through access to the Internet, SMART televisions, music players, technological devices and mobile phones.

In addition, residents were supported to maintain contact with families and there was ongoing communication occurring between residents and their family members, sometimes daily. Family members and friends were welcome to visit the centre, and this occurred regularly.

Judgment: Compliant

## Regulation 17: Premises

The premises was laid out and designed to meet the individual needs of both residents. Each resident had their own living area and shared a communal kitchen. In addition, it was clear to the inspector that residents' living areas and bedrooms were designed to meet their needs and suit their individual preferences and choices. As mentioned previously, there were plans under review to develop a small kitchen area on one side of the house so that both residents had their own kitchen facilities. The MDT were involved in this review to ensure that any changes would need

residents' specific needs and that any changes would be suitable.

The design of the house promoted each residents' protection and safety. There were no safeguarding issue between residents since the last inspection by HIQA in March 2023. This showed how the environment and premises supported residents' protection and privacy.

Judgment: Compliant

### Regulation 5: Individual assessment and personal plan

There were good arrangements in place for the assessment, monitoring and review of residents' needs and care plans. Residents had access to members of the MDT to support with the development of plans of care, as required.

The inspector reviewed the two residents' care plans, which included assessments of their individual needs, care plans and minutes of their Annual Review and MDT meetings. Care and support plans were found to be kept under ongoing review so that any change could be identified. Minutes of meetings reviewed showed that an holistic approach to care was taken to ensure that residents were protected and supported with their needs and wellbeing. A collaborative approach to care was also evident, where residents and their family representatives were involved in reviews of the care and support provided. Residents were consulted about their care and their choices respected. For example; one resident was asked at their annual review about how they felt about staff checking them at night, and they agreed for this to occur.

Judgment: Compliant

### Regulation 7: Positive behavioural support

There were good arrangements in place for supporting residents with behaviours of concern. Staff training was provided to ensure that staff members had the skills and confidence to support residents. Residents had access to MDT supports as required.

The inspector reviewed the policies and procedures that the provider had for behaviour management and for restrictive practices. These were found to be up to date and accessible in the centre. They provided guidance about how to provide support to residents and about the roles and responsibilities of various staff members. However, it was unclear through discussions with the local management team, and through a review of various policies, about what type of behavioural incidents should be reported through the National Incident Management system. This required review to ensure that clear guidance is in place for staff when

reporting incidents. This covered under Regulation 23: Governance and management.

The inspector reviewed two residents' plans for behaviour support. These were found to be comprehensive and provided clear guidance to staff members about how to support residents with any distress. They also included how to respond if the strategies were not effective and there was a risk to residents and/or others. The plans were developed with input from the relevant MDT and were kept under ongoing review. One behaviour support plan was in progress of being updated by the relevant MDT member following a recent review in July 2025. It was clear to the inspector through a review of the support plans and through discussions with staff members, that every effort was made to establish the causes of behaviours displayed by residents, such as if it was linked to a form of communication or a sensory need. This demonstrated a person-centred and individualised approach to care.

There were some restrictive practices used in the centre for security reasons such as locked doors and windows at times of risk. These were found to be clearly assessed, with MDT input, and kept under ongoing review to ensure that they were the least restrictive measure. The management team spoke to the inspector about discussions that were had at management level about the use of a weighted blanket and the consideration of it being a restrictive practice. This showed how the service strived to ensure that residents' rights and risks to their wellbeing were monitored and supported.

Judgment: Compliant

## Regulation 8: Protection

The centre was found to have good processes and procedures to promote the protection of residents. Safeguarding was a regular topic for discussion at team and resident meetings.

The inspector reviewed the policies and procedures that the provider had in place for safeguarding vulnerable adults and for the provision of intimate and personal care. These were available to staff in the centre and found to be up to date. In addition, the provider had a policy relating to 'injuries of unknown origin' sustained by residents. This ensured that staff members had clear guidance on potential protection concerns.

Residents were protected through policies and systems that were implemented to protect their finances and personal property. The inspector reviewed two residents' 'Contracts of Care' where it could be seen that arrangements for the protection of residents' finances and property were agreed. The inspector also reviewed two intimate care plans that were in place. These were individualised and comprehensive, and were developed with input from residents and their family

representatives.

Training records reviewed by the inspector showed that all staff received training in safeguarding. The inspector spoke with two staff members about safeguarding arrangements. Staff spoken with were aware of the safeguarding procedures and what to do in the event of protection concerns. Staff spoken with were knowledgeable about the behaviour support needs of residents and about how to ensure safeguarding risks were minimised between residents. There were no open safeguarding plans at the time of inspection.

The management team monitored staff members' knowledge about safeguarding through 'Safeguarding Awareness audits' that were completed with a staff member each month. Records from January 2025 were reviewed by the inspector, however the audits were not completed as outlined in the audit schedule. These gaps are covered under Regulation 23: Governance and management.

Judgment: Compliant

## Regulation 9: Residents' rights

It was clear from documentation reviewed, discussions with staff members and observations by the inspector that the service promoted a rights based approach to care. Individualised person-centred care was provided, that showed respect for residents' choices about how they lived their lives. The systems that the provider had in place, such as staff training, audits and language used in policies, also promoted a culture of respecting rights. The staffing levels in the centre supported residents to have individual interests and to do activities of their choosing.

Residents were consulted about the running of the centre through resident meetings and daily conversations as appropriate. One resident was consulted daily as this was reported to best meet their needs. Another resident had weekly meetings with a staff member. The inspector reviewed a sample of seven meetings that occurred between May and August 2025. The notes from the meetings showed that discussions took place about safeguarding, financial abuse and other policies, such as the visitor policy. A recent meeting note included a link to a video on the Internet to support residents further in understanding how to keep safe. Residents were also asked at these meetings what activities they would like to do during the week and what items they would like from the shops. In addition, residents were asked if they had any concerns or worries, and what makes them happy.

The inspector was informed, and could see through documentation, that the provider had established a service-user policy development group, whose role was to support with the development of policies and to make them more accessible through easy-to-read and simple language documents. This demonstrated that the provider valued residents' contributions in developing and tailoring information so that it was more accessible and meaningful to other residents. A range of these

policies were available in the centre and it could be seen in the residents' meetings notes, that they were reviewed with residents on an ongoing basis.

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

# Compliance Plan for Cnoc Gréine OSV-0007814

Inspection ID: MON-0047504

Date of inspection: 13/08/2025

## Introduction and instruction

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

This document is divided into two sections:

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

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

A finding of:

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

# Section 1

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

**Compliance plan provider’s response:**

Regulation Heading	Judgment
Regulation 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>• The register provider has reviewed the Positive Behaviors of Support Schedule 5 Policy in line with the reporting and administrating of required PRN psychotropic medication (3/9/2025)</li> <li>• The Person in Charge now reports all incidents that requires PRN psychotropic medication in line with the National Incident Management System and the Schedule 5 Policy</li> <li>• The Person in charge has reviewed and completed Individual Psychotropic PRN protocols which clearly identifies the reporting procedure of PRN Psychotropic medication through the National Incident Management System. (3/9/2025 )</li> <li>• The person in charge has ensured that the provider audit schedule is adhered to, and has now completed the restrictive practice audit , and the auditing of staff member's awareness of safeguarding(completed 30/8/2025)</li> </ul>	

**Section 2:**

**Regulations to be complied with**

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

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

<b>Regulation</b>	<b>Regulatory requirement</b>	<b>Judgment</b>	<b>Risk rating</b>	<b>Date to be complied with</b>
Regulation 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	03/09/2025