Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	Kare DC3
Name of provider:	KARE, Promoting Inclusion for People with Intellectual Disabilities
Address of centre:	Wicklow
Type of inspection:	Unannounced
Date of inspection:	21 August 2025
Centre ID:	OSV-0001984
Fieldwork ID:	MON-0046477

About the designated centre

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

This designated centre provides full time residential support to a maximum of four male or female adults with an intellectual disability. Person centred supports are provided to meet the physical, emotional, social and psychological needs of each person living in the home. The home is a dormer bungalow situated on the outskirts of a town in Co. Wicklow and in walking distance to many local amenities. Each resident has their own bedroom, access to bathrooms, living room and kitchen/dining room. The staffing complement includes social care leaders, social care workers and social care assistants.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	3

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Thursday 21 August 2025	16:10hrs to 21:20hrs	Gearoid Harrahill	Lead
Thursday 21 August 2025	16:10hrs to 21:20hrs	Brendan Kelly	Support

What residents told us and what inspectors observed

On the day of inspection, inspectors spoke with all three residents living in the designated centre. Inspectors were also able to observe interactions and practices of the person in charge and front-line staff team. Inspectors also read documents the registered provider had in place to guide staff in supporting the residents, and evidence to indicate the lived experiences of the residents in the centre. Overall, inspectors found that the residents were safe in their home, happy and content in each others' company, and supported by a knowledgeable staff team who promoted a rights based environment for the residents. Some improvements were needed in terms of ensuring suitable accessibility for all residents in their home with the provider behind on their timeline for upgrades to be completed. Timely implementation of supported communication methods was also required to optimise residents' ability to engage with their supports.

Residents spoke highly of the person in charge and of the staff team. All residents were happy to show inspectors around their home and their bedrooms, and inspectors observed each resident to be comfortable in their home with each bedroom personalised with family photos and evidence of individualised hobbies for each resident. Some improvements were needed to fix damage resulting from previous leaks, however, the provider had a plan in place to complete a suite of renovation works, with the residents due to move to another premises to facilitate these remedial works.

Residents commented on the many aspects of their home that they liked. One resident spoke about being happy with the staff team, commenting that they could always talk to staff if they had an issue. Another resident spoke about how they are involved in the day to day decision making in their home. A resident was able to show the inspector minutes from house meetings that outlined individual activities that were taking place. Another resident informed inspectors that they were very happy with their bedroom, they enjoyed watching tv in their room and informed inspectors that if they chose to go to their room this was always respected by the staff team, the resident also indicated they were looking forward to renovations that were soon going to happen in their bedroom.

Two of the residents indicated they were aware of when and how to report any concerns they may have. Information was on display that outlined safeguarding procedures. Inspectors asked residents what this meant to them and they talked the inspectors through their understanding of safeguarding and human rights. They told the inspectors that they did not have to tolerate feeling unsafe or being bullied in their own home, and knew they had a right to make their choices, be treated with respect and politeness. Residents understood that there were rules to follow when sharing a house with others and this involved respect for private space and not getting impatient with housemates. They discussed with inspectors examples of what may be reported as a concern and who the primary contacts would be if residents felt unsafe or disrespected. Residents understood that it was better to

speak up when anxious or distressed and that their concerns would be taken seriously. The inspectors observed some examples of how residents had been supported to engage with safeguarding processes, including situations in which residents were required to speak with An Garda Síochána.

Residents were supported by two staff each day with one staff on a day duty and one staff on a sleepover and there was access to a wheelchair accessible transport vehicle to support outings and day trips. Inspectors observed a culture within the designated centre of positive risk taking. One resident had been at work on the day of inspection and chatted about their job to inspectors when they got home. Another resident also wanted a job and told the inspectors to where they had submitted applications. A resident spoke very proudly about currently preparing for the driving theory test and that it was a dream to drive a car; the resident explained how the staff team were supporting the resident in the evenings to prepare for this. All residents were fully engaged in their local communities including one resident who was a member of the local motorcycle club. One resident was a member of a local art society and met with them regularly for drinks and meals out. They were also invited to events and exhibitions to display their work. They also had a regular art station in their day service.

Residents were supported to live in a restraint-free environment, and the provider had retired environmental restraints which controlled risks which were not relevant to the current service users. All three residents had financial accounts in their own name, into which their income was deposited, and residents were being supported to manage their finances and budget their spending. Residents were supported to vote in their local constituency, with one resident registered to vote in the upcoming election, and another having discussions to understand but opting not to participate.

Residents attended meetings for "Voice for Kare" advocacy group and showed inspectors minutes of recent meetings. These included meaningful information such as video conferences on human rights and supporting accessibility, news related to the local area and the day services, upcoming summer events and movies in cinemas, and residents celebrating big birthdays. One resident told inspector how they had an overnight break for their birthday, and had plans to go to a concert with an overnight stay in Dublin later in the year.

The next two sections of the report outline in more detail the findings in relation to governance and management arrangements and how the arrangements impacted on the quality and safety of the service provided to support each resident.

Capacity and capability

This inspection was unannounced and completed to review the arrangements the provider had to ensure compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the National Standards for Adult Safeguarding (Health

Information and Quality Authority and the Mental Health Commission, 2019). In the main, the inspectors found that this service was ensuring that residents' human rights of fairness, respect, and dignity were upheld by the provider and front-line staff. Improvement was required in the timeliness of identified premises works to enhance the accessibility of the house by its residents to protect their autonomy and equality in the service.

The provider had arrangements in place to ensure that residents were supported by a familiar and consistent staff team. At the time of inspection there were no vacancies in the designated centre, and inspectors observed limited use of agency staff and a familiar relief panel when permanent staff were unavailable. Deputation arrangements were set out for days on which the person in charge was not present, however inspectors were not assured that the provider had optimally supported their staff to carry out these duties.

The person in charge supervised the performance, competency and key-working duties of staff through regular one-to-one meetings. An identified development of these meetings was having knowledge and practices related to adult safeguarding as a standing agenda item, with the outcome of reducing potential or actual safeguarding concerns being reported late or categorised incorrectly.

Regulation 15: Staffing

Inspectors reviewed eight weeks of rosters from July and August 2025. Rosters reviewed by inspectors outlined clear shift patterns of a sleepover staff and day duty staff for each day. Shift leaders were also identified on rosters reviewed. There were no staff vacancies in the designated centre at the time of inspection, and there was no evidence observed of high reliance on agency staff for the weeks reviewed. The staff team consisted of permanent and regular relief staff which mitigated the impact on continuity and quality of care to the residents during annual leave or other absences.

The registered provider had ensured the designated centre was adequately resourced with a staff team who had the appropriate skill mix to support the assessed needs of the residents. The person in charge outlined how they can access a familiar relief panel to ensure a continuity of care in the event of permanent staff being absent.

Inspectors observed throughout the day a relaxed atmosphere in the residents' home where positive interactions between the staff team and all residents were also observed. Inspectors observed residents to be comfortable in the company of staff with staff responding to residents' needs in a timely and appropriate manner.

Judgment: Compliant

Regulation 23: Governance and management

The inspectors reviewed the most recent annual report for the designated centre, dated November 2024. This highlighted significant events, achievements, changes and challenges in the residents' lives in this centre, and reflected on the findings of audits, incident trends, and feedback from residents. Inspectors reviewed the reports from provider inspections carried out in December 2024 and June 2025. These audits and reports were collated in an action plan for 2025.

Inspectors were not assured that the provider was addressing areas of non-compliance in a timely fashion and in line with commitments made following previous audits and inspections. The provider remained out of compliance regarding the accessibility of the premises for a wheelchair user, with examples described later in this report. This finding had been identified in the previous regulatory inspection in January 2024, with a date submitted to the Chief Inspector that accessibility works would be completed by August 2024. These works had not started as of the date of this inspection in August 2025, a year later. The same inspection also found that the provider did not have assurance that the evacuation route of the house was protected from the spread of fire or smoke originating in the attic space. The provider submitted a compliance plan for this inspection that action would be completed January 2024, and the provider's internal action plan noted that this action was completed January 2025. However, inspectors were provided evidence from the facilities manager which indicated that this action was also not completed. Neither the annual review nor the most recent six-monthly provider inspection had identified that the accessibility and fire safety works remained outstanding, with the annual review reporting full compliance with the requirements on Regulation 17:Premises and Regulation 28:Fire Precautions.

The inspectors were not assured that all staff were supported to engage with the management structure in the designated centre. Prior to the arrival of the person in charge, the shift leader who deputised them was unable to provide information required to demonstrate regulatory compliance such as audit reports. The deputy advised inspectors that they had not attended any staff meetings in the three years they had worked in this centre team, and did not have access to the minutes to review what had been discussed or highlighted to the staff team. This did not provide assurance that the shift leader had been appropriately supported and facilitated to cover the day-to-day operations of the designated centre as described in the statement of purpose.

Inspectors were provided a sample of minutes of performance development meetings between the person in charge and four members of front-line staff. Discussions in these meetings included staff relations and progress in residents' support objectives. These also included information on career development goals such as attending 'train the trainer' courses. In two of the four records reviewed staff indicated that they wanted additional training and support in recognising and responding to potential or actual safeguarding concerns. Provider audits and notifications to the Chief Inspector included examples of improvements in recognising safeguarding matters was required to reduce risk of incidents being

recorded incorrectly or retroactively. The person in charge and inspectors discussed adding the topic of adult safeguarding as standing agenda item to enhance this knowledge and practice.

Judgment: Not compliant

Quality and safety

The inspectors found evidence through conversation with residents and staff, observing staff practices and interactions with residents, and through review of key documents such as care plans, that residents in the main were in receipt of a quality and safe service. Some improvements were needed in communication supports for one resident's assessed needs. Also in the timely upkeep and upgrading of the centre, in particular for one resident who required a wheelchair to mobilise in their home and whom the premises was not fully supporting, with outstanding actions which had not yet commenced a year after their planned completion date.

Inspectors observed a resident group who were immersed in their local community and were supported to take positive risks either through their employment, day service or active membership of community groups. Residents' personal plans were found to be person-centred, reflective of assessed needs and informed by evidence and input from health and social care professionals, to support residents' assessed needs. Inspectors found improvement was needed in the area of communication, with not all staff having received the requisite training to implement the communication support requirements identified in care plans and risk assessments for one resident's assessed needs.

Inspectors found evidence of a focus on rights promotion and protection. All residents were active members of the provider's resident advocacy group, residents were aware of safeguarding protocols and procedures, and gave examples of how and when they would utilise these services. Residents were supported to attend regular meetings regarding the key decisions made in their own home and planning for future activities.

Regulation 10: Communication

Inspectors observed that the registered provider had communication passports in place for each resident to support staff members including relief personnel to be aware of residents' communication needs. However, one resident had an assessed need that required staff to be trained in Lámh (a manual sign system used by children and adults with intellectual disability and communication needs in Ireland) to enhance the resident's communication. On the day of inspection not all staff had completed this required training, therefore inspectors could not be assured the

registered provider was meeting all the requirements of the regulation. The requirement for Lámh training to be completed by all staff had been identified in the providers own six-monthly audits, and was featured in the resident's care and support plans, individual risk assessments and the annual review. The person in charge confirmed that staff outstanding in Lámh training have been scheduled to attend the required sessions.

All residents had access to communication devices such as mobile phones and electronic tablets. On the day of inspection one resident was able to spend time alone on a video call with family members using their electronic tablet. All residents spoken with on the day of inspection confirmed with inspectors that they have excellent family communications and relationships with which staff continue to support them. All residents had smart televisions in their bedrooms which were connected to the Internet; residents confirmed to inspectors that they can use their televisions as they wish.

Judgment: Substantially compliant

Regulation 17: Premises

Inspectors observed the premises to be featured with suitable living and dining room spaces, a large kitchen, and private bedrooms which had been decorated to the residents' preference. Since the last inspection, one resident who had lived in the smallest bedroom showed inspectors that they had moved to a larger room with more space for their furniture and belongings and an en-suite bathroom. All three residents were happy to show the inspectors how they had been supported to set up their rooms how they liked. Residents' bedrooms were in a good state of maintenance, however inspectors observed walls in communal and hallway areas which required plaster and paint work following a water leak, and large cracks in the living room ceiling.

In the previous inspection in January 2024, the inspector found that work was required to optimise accessibility for a resident who required a wheelchair to mobilise, with the provider having submitted a referral to the occupational therapist to identify the full extent of the works required, with a submitted date of completion of August 2024. At the time of this inspection, the issues related to safe and efficient accessibility on the premises had not yet started. The inspectors were provided an occupational therapist report dated August 2024 which outlined the accessibility concerns in detail. This included internal doorways which were too narrow to easily pass through, door thresholds which were not flush with the ground which created an obstacle, ground surfaces which were not suitable for use in the external areas and garden, and limited space in the bathroom and shower area. The occupational therapist identified works required which were essential to optimise accessibility, including but not limited to creating a wetroom area and widening doors and ramps to facilitate navigation and turning space.

The residents and staff told inspectors that there were upcoming plans to temporarily move to another designated centre in the coming weeks to allow the works to be completed, though the date had not yet been confirmed as the location was being used for another purpose and the person in charge required assurance that that location would be suitable for all residents.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

On the day of inspection care plans were reviewed for all three residents in the centre. Care plans were found to contain a comprehensive assessment of need for each resident that fed into corresponding care and support plans. The care and support plans provided clear guidance for staff in terms of daily supports for residents. All care plans were found to have been developed with residents' involvement alongside the relevant members of the multidisciplinary team, and were subject to regular review by the person in charge.

Key risks had been identified for each resident including self-injurious behaviour and increased anxiety. Control measures were found to be effective in managing and mitigating risk. Risk assessments had also been reviewed by the person in charge. Staff met with on the day of inspection were aware of the key risks for each resident and were able to discuss in detail the control measures for each risk assessment.

Inspectors reviewed the social goals in place for residents and these were found to be individualised to each resident. Goals were subject to regular review from key workers and the person in charge, and were also observed to involve residents at all stages from identification and development.

As well as each resident's care plan being stored electronically, each resident had the option to have a copy of their own plan with which they could engage kept in their bedrooms. Inspectors discussed this with residents and each resident indicated they preferred to have a copy of their care plan in the room and were happy to show it to the inspectors.

Judgment: Compliant

Regulation 7: Positive behavioural support

The inspectors reviewed plans for supporting residents who may respond to anxiety or distress in a manner which presented a risk to themselves or others, and found that the centre had comprehensive plans in place that were individual to each resident. Plans were observed to provide clear guidance to staff in proactive and

reactive strategies in mitigating identified risks. Staff who spoke with inspectors demonstrated their knowledge of both the aims and specifics of each residents plan.

Therapeutic interventions were in place as part of the behaviour support plans to mitigate the requirements for any restrictive practices. The person in charge confirmed there were no restrictive practices in effect, and this was in line with notifications submitted to the Chief Inspector from the registered provider.

The provider had ensured that all behaviour support plans had been subject to regular review from an appropriate member of the multidisciplinary team and the person in charge, with all plans reviewed in April 2025. The behaviour support plans reviewed ensured that residents continued to access their local communities in a meaningful and engaged way.

Judgment: Compliant

Regulation 8: Protection

The inspectors reviewed incidents with the person in charge, of alleged, witnessed or suspected abuse of the residents in this centre which had been notified to the Chief Inspector. Inspectors observed evidence that these incidents were subject to preliminary screening to determine if there were grounds for concern to progress to a full investigation. Where investigations had been carried out there was a clear record of how evidence was gathered to come to conclusions and take action to reduce future risk. Where relevant, the provider demonstrated evidence that they had engaged with external parties including the Health Service Executive Safeguarding and Protection Team, or An Garda Síochána. The inspectors were provided evidence related to a resident who had recently been supported to engage with the Gardaí themselves and how they had been prepared and facilitated to do so in a suitable manner based on their needs and communication requirements.

The provider had reviewed safeguarding matters in one of their two most recent six-monthly provider inspections, and conducted a retrospective review of where matters recorded in daily notes should have been reviewed as a safeguarding issues. The inspectors observed some examples of this then being discussed with relevant staff members in their supervision meetings, or objectives going forward being to support further understanding of adult safeguarding. The inspectors and person in charge discussed having safeguarding standards as a regular topic of discussion with staff.

Residents told the inspectors that they felt safe in the centre and said what they would do if that was to change. They showed inspectors a simple-language booklet on display in the kitchen "I will not tolerate abuse". When inspectors asked what this meant to them, two residents commented that they know they don't have to accept feeling bullied or being treated rudely, and that they could tell staff if someone did or said something which upset them.

Judgment: Compliant

Regulation 9: Residents' rights

The inspectors found that residents were involved in the day to day running of their home and making key decisions, and that staff had a continued focus on residents' rights and working with a rights-led approach. Residents showed inspectors the processes involved for areas such as meal planning and shopping. Residents spoke about how they exercised choice about their home, for example, on the day of inspection a resident informed staff that they did not want the agreed meal for dinner and the resident was able to choose something else instead. Residents also discussed with inspectors that they can choose to go to their bedrooms as they wish outlining that staff would knock before entering bedrooms.

Residents were able to speak confidently about safeguarding processes in their home. Residents inspectors spoke with were confident in pointing out safeguarding signage in the centre and explained the roles of the safeguarding officer, with one resident identifying bullying as a reason they would contact the safeguarding officer.

All residents in the centre were members of the provider's advocacy group, and one resident was able to show inspectors a certificate of 15 years membership of the group. Residents showed inspectors the minutes of their last meeting outlining the key discussion points.

Inspectors observed evidence of positive risk being taken in attempt to enhance and support residents' rights. For example, one resident expressed a wish to learn to drive, and inspectors found evidence of this resident being supported to study for their driving theory test.

Inspectors observed information regarding assisted decision making in the designated centre. Inspectors spoke to staff on duty regarding assisted decision making and staff were able to discuss additional training they had undertaken and discuss with inspectors how the training was used to inform their practice.

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	Compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 10: Communication	Substantially compliant
Regulation 17: Premises	Not 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 Kare DC3 OSV-0001984

Inspection ID: MON-0046477

Date of inspection: 21/08/2025

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	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
Shift leader changed to always be contracted staff in this location from September 2025 roster.

Relief staff have regular supervision meetings with the PIC. Regular relief staff are invited to staff team meetings ongoing from September 2025.

Safeguarding discussions added to staff team meeting agenda as standing order item from September 2025.

The provider intended that the OT report would be conducted by August 2024. It was unknown what actions would be identified and therefore the provider would not have been in a position at that time to determine the timeline for any works which might have been required.

Following the completion of the OT report on the 7th of August 2024, the recommendations were reviewed and a plan for refurbishment which included seeking grant funding was developed. At the time of this inspection, the PIC was able to inform the inspectors of this information and that the indicative date for people to move out of the house to complete the works was mid-September 2025. This did occur on the 15th of September 2025.

The works in this house related to improving accessibility will be completed by the 31st of October 2025.

A separate heat detector was installed in the attic area - COMPLETED FEBRUARY 2024.

The threshold in bedroom double doors were causing difficulties in evacuation of the bed. On review and inspection, the door did not need to be replaced but works were

carried out to reduce the threshold height and enable evacuation with the bed. COMPLETED START JULY 2024.

The fire rated attic hatch has been installed at DC3 on the 22nd August 2025 as an additional fire safety measure.

DC3 has fire doors installed throughout. It also has a fit for purpose fire alarm and emergency lighting system which are tested for compliance by independent experts on a quarterly basis with certificates issued.

Regulation 10: Communication	Substantially Compliant

Outline how you are going to come into compliance with Regulation 10: Communication:
All remaining contracted front line staff in this location have completed LAMH training on the 18th of September 2025.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
The residents in this location moved temporarily to a different designated centre on the 15th of September 2025. They remain in this location at present due to return to the designated centre on the 30th of October 2025.

While the house was vacant the following works were completed:

- Walls in communal and hallway areas which required plaster and paint work following a water leak, and large cracks in the living room ceiling repaired by 31st of October 2025.
- Improvement to the Resident wet room area and widening doors and ramps to facilitate navigation and turning space completed during renovation works. Final steps to be completed by the 31st of October 2025.

The works in this house related to improving accessibility will be completed by the 31st of October 2025.

A separate heat detector was installed in the attic area - COMPLETED FEBRUARY 2024.

The threshold in bedroom double doors were causing difficulties in evacuation of the

bed. On review and inspection, the door did not need to be replaced but works were carried out to reduce the threshold height and enable evacuation with the bed. COMPLETED START JULY 2024.

The fire rated attic hatch has been installed at DC3 on the 22nd August 2025 as an additional fire safety measure.

DC3 has fire doors installed throughout. It also has a fit for purpose fire alarm and emergency lighting system which are tested for compliance by independent experts on a quarterly basis with certificates issued.

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(1)	The registered provider shall ensure that each resident is assisted and supported at all times to communicate in accordance with the residents' needs and wishes.	Substantially Compliant	Yellow	18/09/2025
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Substantially Compliant	Yellow	31/10/2025
Regulation 17(6)	The registered provider shall ensure that the designated centre adheres to best practice in achieving and promoting accessibility. He. she, regularly reviews its	Not Compliant	Orange	31/10/2025

	accessibility with reference to the statement of purpose and carries out any required alterations to the premises of the designated centre to ensure it is accessible to all.			
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Substantially Compliant	Yellow	31/10/2025
Regulation 23(1)(b)	The registered provider shall ensure that there is a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.	Substantially Compliant	Yellow	30/09/2025
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.	Not Compliant	Orange	31/10/2025