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:	Kingsriver Community
Name of provider:	Kingsriver Community Holdings Company Limited by Guarantee
Address of centre:	Kilkenny
Type of inspection:	Unannounced
Date of inspection:	21 April 2026
Centre ID:	OSV-0002410
Fieldwork ID:	MON-0044310

About the designated centre

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

Kingsriver Community is a designated centre operated by Kingsriver Community Holdings CLG. It provides residential services to up to six adults, both male and female, with disabilities and complex medical needs, including stroke, dementia, physical disabilities and autism. The designated centre is comprised of two buildings. One is a large two story building comprised of large kitchen/dining room and communal sitting room which all residents can avail of. There is an self-contained apartment on the ground floor which is home to two residents and consists of two individual resident bedrooms, bathroom and open plan kitchen, sitting and dining room. On the first floor, there are three individual resident bedrooms and three individual living areas, one of which contains a kitchen. The centre is located close to a village in Co. Kilkenny. The other building is a bungalow for one resident with an open plan kitchen, dining area and sitting room. The designated centre is staffed by a person in charge, deputy person in charge, social care workers and healthcare assistants.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	6

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
Tuesday 21 April 2026	10:00hrs to 18:30hrs	Lisa Walsh	Lead
Tuesday 21 April 2026	10:00hrs to 18:30hrs	Tanya Brady	Support

What residents told us and what inspectors observed

This was an unannounced inspection, conducted to assess the provider's regulatory compliance in relation to the care and welfare of residents who were living in the centre. It was completed by two inspectors over the course of one day. The inspection was also completed to follow up on unsolicited information received which raised concerns about the provider's governance and management arrangements and possible impact on the quality and safety of care provided. The inspectors found that while the residents spoken with were happy living in the centre there were high levels of non-compliance with the regulations reviewed on the day of inspection. Significant gaps in oversight were identified which impacted on the governance systems in place and the quality and safety of care provided to residents.

On arrival to the centre, inspectors were greeted by three staff who remained in the centre during the day while residents attended their day service. Inspectors were informed that the person in charge was based in a separate office not located within the centre. However, staff stated that they attended the centre on some mornings. There was also a team leader working as part of the centre, however, they were also not part of the team located in the centre. Inspectors were informed that they attended the centre most mornings.

Since the last inspection, the provider had applied to vary the conditions of the centre's registration. This had been granted and a second house had been added to the footprint of the designated centre. The maximum occupancy had also been increased from five to six residents. The centre now comprises of two houses which were located a short drive from each other. One house had five residents living in it and the other house had one resident living in it. Both houses were located in a rural part of Co. Kilkenny. Inspectors completed a tour of both houses on the day of inspection and found that they were generally well maintained. However, some areas required cleaning and maintenance to ensure they were meeting the needs of the residents.

Each of the houses contained a kitchen-dining room, sitting room and bathrooms with access to outdoor spaces. One house was a large two-storey building that had been reconfigured as part of the provider's application to vary their registration conditions. An extension had been built; some residents' bedrooms and communal rooms had been relocated and reconfigured. Two previous bedrooms had been changed to games rooms for residents. However, on inspection it was observed that one of these games' rooms had been converted to an office for staff use without consultation with the Chief Inspector of Social Services. The second house was an open plan bungalow with two bedrooms, one for the resident and one for staff use. Both houses were pleasantly decorated and provided a homely atmosphere for

residents. Residents' bedrooms were decorated to their own taste and decorated with items of interest or activities they enjoyed.

All five residents residing in the large house attended day service five days a week. There were four residents in this house on the day of inspection with a fifth resident only present a couple of days a week as they were transitioning to live in the centre full time. Residents had already left for their day service when inspectors arrived to the centre. When they returned to the centre, inspectors greeted and chatted with them and spent time in the communal areas observing resident and staff engagement to gain an insight into residents' experiences of living in Kingsriver Community. The resident who lived in the second house was provided with a wrap-around service and had one-to-one staff with them throughout the day and could engage in activities of their preference at a time that suited them. Residents spoken with said they liked living in the centre and spoke about enjoying their day service or work placement they attended. Residents said they liked living with each other and spoke about activities they enjoyed doing. Residents also spoke about a new resident who was moving into the centre to live with them and had started staying a few days and nights a week.

Residents were engaging in activities in the community and observed to have an active life. On return to the centre from day services one resident was observed to unpack their belongings and put them away in the kitchen. Later they were observed to make a packed lunch for the following day. Another resident made a cup of tea and two residents sat with an inspector at the kitchen table to chat. Staff had plenty of time over the course of the day to have meals prepared and household tasks completed which meant when residents returned they were able to engage with them fully. Staff and resident interactions were observed to be kind with staff being familiar with residents' needs. Some areas of discussion with residents centred around things they liked to do every day and how they felt about having someone new move into their home.

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

Capacity and capability

Overall, the inspectors were not assured there were effective systems in place to manage and monitor the service provision within the centre on a consistent and robust basis. Local implementation of accountable oversight systems required attention.

Resources such as the consistent presence of the local management team required review to ensure there was effective oversight. Inspectors found that the staff team were often managing the day-to-day decisions in the centre with limited

management review. In addition, the systems for oversight, monitoring and auditing were not identifying areas of improvement and there were no plans in place on how to bring the service back into compliance in any type of systematic manner.

There was a stable staff team in place, however, it was not clear that there was an effective use of resources across the day to best support residents at times where they had increased needs.

Regulation 15: Staffing

The inspectors reviewed the staffing arrangements in place in the centre. This included speaking with staff members and a member of the management team, reviewing rosters and making observations across the day of inspection.

Staff spoken with were found to be kind, respectful and well known to the residents. An experienced staff member was on duty who outlined a lot of key working duties and gave good insight into how residents were being supported.

The provider had a full staff team in place with no vacancies. The centre was staffed with a person in charge, team leader, social care workers and healthcare assistants. The inspectors had the opportunity to meet with four staff members over the course of the day, three in the larger house and one in the other smaller home.

As the provider was currently supporting one resident to move into one house they had completed a review of staffing needs. During the day there was three staff present and by night two staff, in the second house one staff member was present 24 hours a day.

The centre currently does not utilise agency staff and manages to cover gaps on the roster created from planned and unplanned leave by core staff working additional hours or using the provider's relief staffing panel.

Judgment: Compliant

Regulation 16: Training and staff development

The inspectors asked to review the training matrix in place that accounted for all staff training within the centre. On review of this document it was found that there were significant gaps in the records of staff training across all areas of care and support. The manager present indicated that this was possibly not the most up-to-date record in place and as there were administrative support gaps the systems to ensure that staff were supported to carry out their roles was not robust.

Due to the gaps in the system, inspectors and the provider could not be assured that staff had completed or attended a required refresher for some mandatory training. For example, four staff were due to complete refresher training on a specific epilepsy medication administration in March 2026. However, inspectors could not clarify if they had attended this training or not, some residents living in the centre would require this support. There were an additional two staff who had never completed this training, and one staff had no training date identified.

The training policy in place also did not ensure that staff would have access to appropriate training in required timeframes, as these were not set out. Neither staff nor management were aware of the timeframes where refresher training was required for some mandatory training.

Judgment: Not compliant

Regulation 19: Directory of residents

The provider had maintained a directory of residents, which was available for review by inspectors. However, it did not contain accurate up-to-date information in respect of each resident. For example, a new resident who was currently transitioning into the centre was not included on the directory of residents. In addition, where a resident had been transferred to another designated centre temporarily and readmitted to this centre; this was also not detailed on the directory.

Judgment: Not compliant

Regulation 23: Governance and management

Before the inspection, the provider had informed inspectors that they had completed an internal audit of their governance and management systems after receiving unsolicited information. However, when inspectors arrived at Kingsriver Community they were informed that the audit had not been completed for this centre and had only been completed for two other centres that are part of the provider group.

The governance and management systems in place in this centre were not robust, comprehensive or fully effective on the day of inspection. Inspectors found systems failures around key areas of care and support. The absence of a person in charge on a regular basis in the centre was having a negative impact on provision of services to residents. There was a disconnect between the registered provider and the centre through an absence of the presence of clear and accountable management. While there was a defined management structure in place, inspectors were not assured

that the lines of authority and accountability for specific roles and responsibilities were clearly defined and implemented.

The provider had completed a six-monthly provider led audits in December and May 2025, which were both reviewed by inspectors. The audit in December 2025 had found full compliance with the regulations reviewed by the provider and the one in May 2025 had no information other than a note of compliant or not compliant. The one regulation reported as not compliant had no action plan in place to address this finding. These audits were ineffective in capturing and actioning key areas of concern in the centre highlighted during inspection, such as, fire safety, governance and management and individual assessment and personal plans. They were also not completed at least once every six months. Similarly, the provider's annual review did not identify areas of non-compliance and was not driving quality improvement. It was also not evident how residents were consulted in the annual review.

Other audits completed locally, such as the infection control, fire safety or medicines management did not identify actions that were required and had no associated action plan. For example, there was a designated smoking area at the front door of the centre. Inspectors observed a used ash tray that was place on a timber frame which had left burn and scorch marks. This had not been identified as a risk through audits and daily checks completed. On review of daily notes inspectors found that staff were making day-to-day decisions on matters that impacted residents, for example changes for a resident's environment following a fall, and these were not evidenced as reviewed or agreed with local management.

Inspectors found that there was not evidence that the person in charge was present in the centre to provide effective day-to-day oversight. This impacted governance and management systems which were not effective and had impacted the safety and quality of care provided to residents. On reviewing the staff rotas there was no evidence that the person in charge was present or where they were on a given day. Inspectors were informed that the person in charge would use the visitors sign-in book to demonstrate their attendance to the centre. On review of the visitors' book from February 2026 through to the day of inspection, there were only three days inspectors could confirm the person in charge had attended the centre. These were also not full days nor at times when residents were present in the centre.

While there were adequate staff resources available, inspectors were not assured that these were used effectively across the day to best support residents at times where they had increased needs. For example, as mentioned the residents residing in the larger house were in day service five days a week. During this time three staff resources were in place in the house. A new resident was also transitioning into this house, and staff had raised concerns about the need for two staff to support their mobility needs. However, this resident was funded for support of one staff. Inspectors also observed that the provider used some relief and permanent staff as part of the provider's contingency plan in covering planned and unplanned leave. Inspectors were informed that staff were contracted to work a maximum of 169 hours a month. On review of the month of March 2026, inspectors identified that seven staff worked over 169 hours in the month.

Staff spoken with reported feeling supported in their work and said they had supervision four times a year. While inspectors were informed that there were monthly staff meetings, inspectors were only provided with meeting minutes for January 2026 to review, which were facilitated by the team leader in the absence of the person in charge. Inspectors requested copies of additional meeting minutes, however the provider could not locate these for the inspectors to review. Inspectors were informed that there were no meetings held specifically for the person in charge and team leaders and that this was completed through supervision.

Judgment: Not compliant

Quality and safety

Overall the inspectors found that significant improvement was required to areas of care and support for residents, including personal plans and fire safety. Residents care and support was provided by a consistent staff team who were familiar with their needs however, this was in the absence of robust and safe oversight mechanisms. Changing needs for residents placed them at risk in the absence of consistent review.

The inspectors reviewed a number of key areas to determine if the care and support provided to residents was safe and effective. These included meeting residents and staff, a review of personal healthcare plans, risk documentation, fire safety documentation, and documentation in relation to medicines.

Regulation 17: Premises

This designated centre comprises two locations, one a large two storey premises set next to one of the provider's day services in a rural location. The other was a small bungalow set in a residential housing estate in a village setting. The two premises were about 15 minutes drive apart.

While the premises were generally designed and laid out to meet the number and needs of residents in the centre, some areas of the larger house required cleaning, maintenance and repair to ensure the premises was maintained to a good standard to meet the needs of the residents. For example, two rooms opened out onto steep steps. On the top of these steps were wooden plinths, both of which were cracked and could be a risk to residents tripping and falling. Some clinical equipment in toilets/ shower rooms were observed to be heavily rusted. In addition, some showers were observed to be mouldy. Inspectors were informed that management

completed environmental checks, however, these areas that required maintenance had not been identified.

As mentioned, the provider had applied to vary the footprint of the centre. Part of this application was to covert two bedrooms into two games rooms. While one room was converted into a games room, the second room had been converted into an office and was not aligned with the registered footprint of the centre.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

The provider's risk management systems required oversight to ensure they were accurate and effective.

The provider and person in charge were, for the most part, identifying safety issues and putting risk assessments and control measures in place. However, not all potential risks had been identified. For example, inspectors found that there were no window restrictors on some upstairs windows and one window restrictor that was present had been disconnected. In addition, the lack of robust local auditing in a number of areas, as outlined in fire safety or medicines management, did not provide assurance that risk assessments were effective.

The inspectors reviewed individual risk assessments for slips, trips and falls, sharps management, money management, cooking, time alone, seizure activity and specific medical needs. Control measures listed on the risk assessments were found to be in place however, some of these required review. For example, the risk assessment for spending time unsupported had not considered stranger awareness or fire safety. In another risk assessment, a vocabulary error in the control measures regarding a resident who had specific dietitary requirements could have had a significant negative impact. The control measure stated that staff should 'use snacks and drinks to help _ ingest gluten' when the measure should have read 'use snacks and drinks to help _ avoid gluten'. It was also not apparent that all risk assessments were reviewed following incidents. For example, where a risk assessment related to access of knives was in place, there was an incident where a resident accessed a knife in day services and used it to damage a vehicle at the centre. It was not apparent that this assessment had been reviewed following the incident.

The inspectors found that risk ratings were proportionate to the identified risks, however the ratings were not revised following the implementation of control measures. This meant that it was not clearly documented whether the risk had been mitigated following the implementation of support measures and whether these were effective.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Inspectors completed a walk through of all premises that make up the designated centre and carried out a manual check on all fire doors. Inspectors found that several doors were not fully closing when manually released. Other fire doors closed too quickly and were a potential health and safety risk.

Inspectors also found that a door in one house was not aligned to the frame when in a closed position, which in turn was leaving a large gap once fully closed. In addition, this door had no self-closing mechanism so did not automatically close when the fire alarm sounded. This door led into a small storage space that was used both for laundry, including a tumble dryer and storing files. It was also located adjacent the resident's bedroom on the escape route and posed a risk to fire containment.

The registered provider had taken adequate precautions against the risk of fire in the designated centre with suitable fire-fighting equipment. However, the arrangements in place for detecting and containing fires required review. For example, when inspectors arrived they observed a fire door wedged open and, therefore, could not automatically close in the event of the fire alarm being activated. There was a hole in the ceiling of one room at a light fitting, this could impact the spread of a fire and smoke. Inspectors observed some attic insulation also exposed at this area. As previously mentioned, there was an ashtray placed on a wooden shelf at the front door of the centre, which had left visible burnt scorch.

Inspectors reviewed fire drills completed in the centre and found that while the person in charge was ensuring regular fire drills were occurring in the centre, these fire drills did not record the number of residents involved, how long it took to evacuate and how effective the evacuation plan was. These were also not being reviewed and no learning could be taken from them to ensure residents could safely evacuate the centre in the case of an emergency. It was also not apparent that a drill had been completed with the maximum resident numbers and minimum staff supports.

Residents had personal emergency evacuation plans (PEEP's) in place; however, for one resident the PEEP was completed for the day service and there was no evidence of evacuation guidance in place for the designated centre. Staff when asked about the guidance in place to support this resident for the purpose of evacuating the centre stated that they could not recall the resident having participated in a drill.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

The systems in place in relation to the safe management of medicines and the oversight of these systems required review.

A review of medication administration records indicated that routine medications were administered as prescribed. For 'as required' (PRN) medicines however, there was limited information available to guide staff on when to administer these medicines. The provider's policy stated that 'each PRN must have a clear individualised PRN protocol, inspectors found these were not consistently in place. Where PRN medicines were signed by staff as administered, there was no evidence that these were reviewed by management and no oversight of how often PRN was used or trending of the reason why it was required. For one resident, the protocol in place for the administration of a medicine for periods of anxiety was unsigned by a medical professional and there was no review by either team lead or person in charge of times when this medicine was provided to the resident.

Where rescue medicines were in place, for example in the management of epilepsy, it was not apparent that these were reviewed as required. For one resident, their treatment protocol for the use of rescue medicine was dated October 2024 with the recommendation that it was for three monthly review. There was no evidence found that a more up-to-date protocol was in place.

Inspectors found that liquid medicines were not dated when opened and therefore audits were not identifying when these needed to be safely disposed of. For one resident, inspectors found two open bottles of the same eye medicine and it was not clear when either had been opened.

Residents had been assessed to manage their own medication and one resident was self-administering on the day of inspection. There were clear systems in place for staff to follow in supporting the resident.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

Inspectors found that the provider had not ensured that residents needs were appropriately assessed to ensure that there was safe and accurate guidance in place for staff to refer to. This was of particular concern in relation to one resident who had transitioned back to live in the centre following a period of ill health. While staff were endeavouring to support the resident to a safe standard, they were each engaging in slightly different practices due to a lack of information and guidance. This was observed in guidance on how often or how to check on a resident who was at risk of seizures; if the resident was on their own for personal care.

Where a resident had recently been admitted to the centre and was transitioning to live there full time, an assessment of their needs had not yet been completed to inform staff practice. For another resident who had been acutely unwell and required a period of enhanced medical support in another designated centre, there

had been no updated assessments or transfer of information to inform current health related care plans. The guidance on a specific health related procedure that had been in place when the resident had returned to the centre was no longer used and staff were supporting the resident with a previous regime. This change and the rationale for it were not documented. While the staff reported that they had linked with the general practitioner (GP), who was waiting for medical information, it was not clear who was following up or how. Staff spoken with stated that there was a 'lot of soft information' which was used when supporting residents.

Inspectors acknowledge that residents were happy living in the centre, led busy lives and were active and engaged in both their home and the community. For some residents, they opted not to engage in creating formal person centred plans and there was evidence that this was discussed on an ongoing basis and the resident's wishes respected.

For other residents, there were plans in place related to social goals, their aspirations and wishes. The daily and monthly reports completed by keyworkers showed progression towards achieving these.

Judgment: Not compliant

Regulation 8: Protection

The provider had a policy in place and staff had been in receipt of training to ensure they were knowledgeable in recognising and reporting safeguarding concerns.

There were no current active safeguarding plans in place on the day of inspection. The provider maintained a safeguarding tracker and review of this showed that where plans had been required they had been reviewed and followed up on in line with National and the provider's policies.

Residents had personal and intimate care plans in place however, as referenced in Regulation 5 some of these had not been updated following changes for residents, with one resident's plan dated August 2025 and significant health related changes had taken place since that time.

Residents were supported to manage their finances and their capacity to do so had been assessed. The provider had oversight mechanisms in place and it was clear that they were meeting with the resident and their representatives when they moved into the service to ensure that the individual had full access to their finances.

Where incidents had arisen the provider had responded to ensure residents were safe and well supported. For example, one resident was provided with Internet safety education following a period of uploading applications to their phone that posed a risk and another resident was supported by external therapeutic supports.

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 16: Training and staff development	Not compliant
Regulation 19: Directory of residents	Not compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 8: Protection	Compliant

Compliance Plan for Kingsriver Community OSV-0002410

Inspection ID: MON-0044310

Date of inspection: 21/04/2026

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

This document is divided into two sections:

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

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

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • An external consultant is currently reviewing the training policy to guide training frequency and development of staff team. This review will be completed by 31.07.2026 • Training Matrix was reviewed and updated on 22.04.2026. • All outstanding training has been scheduled and will be completed by 31.07.2026. • Two members of the Community Practitioners team have been identified to take responsibility for reviewing the training matrix by 20.06.2026. • These two members of the Community Practitioners team will take overall responsibility in maintaining up to date training matrix. • A Training Needs Analysis for the designated centre will by completed by 19.06.206 to identify centre specific training that is required.	
Regulation 19: Directory of residents	Not Compliant
Outline how you are going to come into compliance with Regulation 19: Directory of residents: The Person in Charge updated the Directory of residents on 02.05.2026	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The Provider has completed a robust review on the governance and management structure across the service and within each designated centre, the outcome of the review was communicated to the management team on 08.06.2026 · A new Person in Charge has been appointed and will commence in the centre on 06.07.2026 reducing the span of control on the current PIC.	

· The person in charge will be based in the centre and this will be reflected on the roster.
· Recruitment is currently underway to appoint a Senior Operations Manager who will focus on the overall operations and governance of the Designated Centre.
· A quality and compliance officer was appointed on 23.03.2026 to assess quality and compliance for the service.
· A health and wellbeing lead/RNID was appointed on 12.05.2026 to oversee personal development, health and well-being of people supported.
· All managers completed training in risk management on 26.05.2026.
· All managers completed refresher training in Regulations on 12.05.2026.
· A retrospective review of person supported records and incidents was completed by the provider on 2.06.2026.
· A review of the audit system was completed by the Innovation & Communication and the Compliance & Quality Officer on 05.06.2026
· The content of audits and audit schedule will be reviewed and amended by the Innovation & Communication Manager & Compliance & Quality Officer by 17.07. 2026
· An independent review was commissioned to verify roster data; formal written confirmation is expected from the roster service provider by 19.06.2026.
· A review of the roster and resources within the centre will be completed by 17.06.2026 to ensure there is appropriate resources in place to meet the assessed needs of people supported.
· A review of the assessed needs of the person supported transitioning into the service will be completed by 19.06.2026.
· A final transition meeting is scheduled for 27.07.2026. The person will be fully transitioned to the service by 31.07.2026.
· Innovation & Communication Manager developed guidance and updated minute template on Team Meetings, same sent to Person in Charge on 26.05.2026.
· PIC will use new guidance and template at June team meetings and Quality & Compliance Officer will review quality and sign off same by 10.07.2026
· PIC will add schedule of team meetings to year end in team meeting folder and inform all staff by 12.06.2026
· The Quality and Compliance Officer & Innovation & Communication Manager reviewed folder system in Designated Centre's and made recommendations of improvement to the CEO, these were approved and a new person supported and house folder system will be set up in each Designated Centre by 12.06.2026.
· Community Practitioner programme will commence on 15.06.2026, which will focus on health and well-being, governance, quality and compliance and best practice. This group of practitioners will be led by the Innovation and Communication manager and overseen at CEO level.
· Analysis and learning about incidents, accidents will be shared at monthly team meetings, will be reported to the quality and safety committee monthly who will report to the Board subcommittee on Quality and Safety on a quarterly basis.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• A review of the environmental checklist and will disseminate it into a series of checklists to guide staff's practices, this will be completed by 20.06.2026
• An external review of the fire safety in the Designated Centre was completed on 09.06.2026 by a fire safety specialist. The final report is expected to be available by

20.06.2026.
• Maintenance repaired the wooden plinths on the steps on 23.04.2026.
• Maintenance repaired the ceiling in the Designated centre on 28.04.2026
• Equipment found to be rusty on the day of the inspection was removed on 21.04.206.
• Application to vary to amend the floor plans will be completed by 12.06.2026.
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Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
• All managers completed risk management training on 26.05.2026
• A review of all centre risk assessments will be completed by 31.07.2026. All staff will be required to read and sign updated risk assessments by 31.08.2026.
• Risk assessments will be a standing item on each team meeting.
• A review of the audit system was completed by the Innovation & Communication and the Compliance & Quality Officer on 05.06.2026
• The content of audits and audit schedule will be reviewed and amended by the Innovation & Communication Manager & Compliance & Quality Officer by 17.07. 2026

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• An external review of the fire safety in the Designated Centre was completed on 09.06.2026 by a fire safety specialist. The final report is expected to be available by 20.06.2026.
• Full fire drill was completed on 26.04.2026
• PEEPs for all people supported have been reviewed and updated on 06.05.2026

Regulation 29: Medicines and pharmaceutical services	Not Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
• The CEO has commissioned an independent external review of medication management policy; this review was completed on 10.06.2026
• CEO, Innovation & Communication Manager & Health & Wellbeing Lead held meeting with external consultant on 10.06.2026 to discuss recommendations and agree an action plan.
• A new comprehensive streamlined medication management system will be introduced to the service. This new system includes:
- A significantly streamlined and simplified Medication Management Policy.
- Supporting Standard Operating Procedures (SOPs).
- Medication management templates and documentation.
- Medication audit tools and audit schedules.
- Competency assessment frameworks.
- Training requirements and implementation guidance.

• Training for the new system will commence in August 2026 starting with the management team and all staff will be scheduled to have this completed by 31.12.2026. • The provider is currently reviewing pharmacy arrangements with a view to increasing frequency of delivery and minimising medication stock on site. This review will be completed by 31.07.2026.

Regulation 5: Individual assessment and personal plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan: • A health and well being lead/RNID commenced in the service on 12.05.2026, with a focus on overseeing individual assessments and health needs for people supported. • All people supported personal plans are currently being reviewed and will be updated by 31.07.2026. • A person centred planning framework will be introduced to the service by 31.07.2026. • The health and well being lead is currently reviewing all health management plans and a referral to a private consultant for one person supported has been completed.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Not Compliant	Orange	31/07/2026
Regulation 17(1)(a)	The registered provider shall ensure the premises of the designated centre are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.	Substantially Compliant	Yellow	12/06/2026
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good	Substantially Compliant	Yellow	28/04/2026

	state of repair externally and internally.			
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Substantially Compliant	Yellow	28/04/2026
Regulation 19(3)	The directory shall include the information specified in paragraph (3) of Schedule 3.	Not Compliant	Orange	02/05/2026
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.	Substantially Compliant	Yellow	06/07/2026
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.	Not Compliant	Orange	06/07/2026
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the	Not Compliant	Orange	31/07/2026

	designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.			
Regulation 23(1)(d)	The registered provider shall ensure that there is an annual review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards.	Substantially Compliant	Yellow	31/07/2026
Regulation 23(1)(e)	The registered provider shall ensure that the review referred to in subparagraph (d) shall provide for consultation with residents and their representatives.	Substantially Compliant	Yellow	31/07/2026
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of care and support provided	Substantially Compliant	Yellow	31/07/2026

	in the centre and put a plan in place to address any concerns regarding the standard of care and support.			
Regulation 23(3)(a)	The registered provider shall ensure that effective arrangements are in place to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.	Substantially Compliant	Yellow	31/07/2026
Regulation 23(3)(b)	The registered provider shall ensure that effective arrangements are in place to facilitate staff to raise concerns about the quality and safety of the care and support provided to residents.	Substantially Compliant	Yellow	31/07/2026
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a	Substantially Compliant	Yellow	31/07/2026

	system for responding to emergencies.			
Regulation 28(1)	The registered provider shall ensure that effective fire safety management systems are in place.	Not Compliant	Orange	20/06/2026
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	06/05/2026
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.	Substantially Compliant	Yellow	06/05/2026
Regulation 28(4)(b)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Substantially Compliant	Yellow	26/04/2026
Regulation 29(4)(b)	The person in charge shall ensure that the designated centre has appropriate	Not Compliant	Orange	26/04/2026

	and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine which is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.			
Regulation 29(4)(c)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that out of date or returned medicines are stored in a secure manner that is segregated from other medicinal products, and are disposed of and not further used as medicinal products in accordance with any relevant national legislation or guidance.	Not Compliant	Orange	31/07/2026
Regulation 05(1)(a)	The person in charge shall ensure that a comprehensive	Not Compliant	Orange	31/07/2026

	assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out prior to admission to the designated centre.			
Regulation 05(1)(b)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out subsequently as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.	Not Compliant	Orange	31/07/2026
Regulation 05(2)	The registered provider shall ensure, insofar as is reasonably practicable, that arrangements are in place to meet the needs of each resident, as assessed in accordance with paragraph (1).	Substantially Compliant	Yellow	31/07/2026
Regulation 05(4)(a)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the	Not Compliant	Orange	12/05/2026

	resident which reflects the resident's needs, as assessed in accordance with paragraph (1).			