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:	The Mill
Name of provider:	Dundas Unlimited Company
Address of centre:	Meath
Type of inspection:	Unannounced
Date of inspection:	09 April 2025
Centre ID:	OSV-0002420
Fieldwork ID:	MON-0046792

About the designated centre

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

The Mill is a supported living accommodation complex which is situated near a village in Co. Meath. The Mill can support up to seven residents between seven apartments. All but one apartment is single occupancy, with one apartment suitable to meet the accommodation needs of two residents. Each resident has their own bedroom, kitchen-dinner and bathroom facilities. The Mill aims to provide a residential service for adults, both male and female, over the age of 18 years with intellectual disabilities, acquired brain injuries, mental health difficulties and/or medical difficulties. Residents are supported to engage in activities of daily living in a home like environment providing access to laundry, cooking and personal care facilities. Residents are supported by health and social care workers. Staff are allocated and resourced based on the individual assessed needs of the residents in the service. Residents living in The Mill are also encouraged and facilitated to avail of other facilities within the Talbot Group service and also within the local area and neighbouring communities. The aim of the centre is to provide care and support to maximise quality of life and well being though person centred principles within the framework of positive behaviour support. The centre is staffed by team leads, support workers and a person in charge.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	7

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
Wednesday 9 April 2025	10:00hrs to 18:30hrs	Karena Butler	Lead
Wednesday 9 April 2025	10:00hrs to 18:30hrs	Raymond Lynch	Support

What residents told us and what inspectors observed

This was an unannounced inspection conducted with a specific focus on how residents were safeguarded in the centre. From what inspectors observed, it was evident that efforts were being made to promote a holistic safeguarding culture and to ensure residents were safeguarded in their home.

However, inspectors did find that improvements were required under two regulations. Particularly in relation to protocols for guiding staff administration of emergency medication and the premises where some areas required further cleaning or repair. These areas will be discussed further, later in this report.

The inspectors had the opportunity to meet four of the seven residents living in the centre. The other three went out for the day and had not returned prior to the end of the inspection.

In order to gather information for this inspection, the inspectors spoke with three residents, observed interactions between some residents and staff, spoke with the person in charge and three staff members, and reviewed documentation over the course of the inspection. One of the four residents the inspectors met with did not wish to speak to them to share their views on the service and this preference was respected.

Shortly after inspectors arrived to the centre, four of the seven residents left the centre for the day. One attended a healthcare appointment, one went for a walk and the other two went to a forest followed by lunch out and shopping.

It was clear from speaking with two residents in more depth and from observations, that residents were comfortable with staff members, and that they were being supported in accordance with their needs and preferences. Staff were observed on different occasions to actively listen to residents, give them time to talk and not rush them.

The provider had arranged for staff to have training in human rights. One staff member spoken with was asked about how they were putting this training into everyday practice to promote the rights of the residents. They explained, they weren't long in the area of social care and, that the training instilled in them that residents should be provided choice in all aspects of their lives.

The inspectors conducted a walkabout of some of the apartments that made up the centre and found for the most part the apartments were well maintained and clean. Some attention was needed to the cleanliness in two apartments and some areas were in need of repair. There was a courtyard with garden seating for communal gathering on nice days. The inspectors observed some residents and staff sitting out chatting and enjoying the sun.

One of the inspectors reviewed the complaints log, and found that there were no complaints related to safeguarding. Any complaints lodged were found to be appropriately reviewed and resolved. Where residents had made complaints they communicated that they were happy with how the complaints were dealt with.

Feedback from the residents' and family questionnaires as part of the annual review of the service were found to be complimentary. For example, one resident said they were happy with their home and loved the gardens. Another said they felt they had a 'lovely choice of food'. Another said that they were 'very happy that their daily routine was respected regarding choice'. Another felt that 'privacy was respected and dignity promoted'. All had communicated that they felt safe in the centre. Such feedback suggests the centre is successfully implementing a person-centred approach which would enhance residents' quality of life and sense of control, which is integral to feeling safeguarded.

Family feedback was returned by three family representatives and were found to be positive. One family representative said "I have nothing but praise for staff, they are kind and caring. They go above and beyond the call of duty." All three family representatives believed the residents' needs were being met in the centre.

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

Capacity and capability

This inspection was an unannounced inspection with a focus to review the arrangements the provider had in place to ensure compliance with the S.I. No. 367/2013 - Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (the regulations) and the National Standards for Adult Safeguarding (2019). It followed a regulatory notice issued by the Chief Inspector of Social Services (The Chief Inspector) in June 2024 in which the safeguarding of residents was outlined as one of the most important responsibilities of a designated centre and fundamental to the provision of high quality care and support. Furthermore, that safeguarding was more than the prevention of abuse, but a holistic approach that promoted people's human rights and empowered them to exercise choice and control over their lives.

Overall, it was apparent that any concerns were taken seriously, appropriate actions and investigations were undertaken as required, and safeguarding was given high priority by the provider, the management team, and the staff team.

The inspectors reviewed the provider's governance and management arrangements and noted that, there were appropriate systems in place in order to ensure the quality and safety of the service. For example, there was a clearly defined management structure in place and two staff spoken with were familiar with the

reporting structure should they have a concern.

In the months prior to this inspection, the office of the Chief Inspector of Social Services (The Chief Inspector) received unsolicited information of concern relating to staffing and these matters were followed up on inspection. Following a review of documentation and speaking with staff members on duty and the person in charge, inspectors found that the concerns raised could not be substantiated.

There were sufficient staff available, with the required skills to meet the assessed needs of residents. One of the inspectors observed that, staff were in receipt of appropriate training including refresher training.

Regulation 15: Staffing

One of the inspectors reviewed staffing arrangements in place and found that the provider had appropriate arrangements in place.

From a review of a sample of rosters since February 2025, the inspector found that, there was a planned and actual staff roster in place maintained by the person in charge. The review demonstrated that, there were sufficient numbers of staff to meet the needs of residents over both the day and the night.

New staff to the centre received an induction to ensure they had the required information to appropriately support the residents and to reduce the likelihood of incidents.

There was a full complement of staff for the centre and a staffing contingency plan in place if required in order to ensure continuity of care was provided to all residents and to promote a safe environment.

The inspectors spoke with the person in charge and three staff members during the course of the inspection, and found them to be knowledgeable about the support needs and any safeguarding requirements for the residents. Interactions between staff and residents were observed to be gentle and professional.

In order to assess if the provider had obtained all of the required information as per Schedule 2 of the regulations, one of the inspectors reviewed a sample of two staff members' personnel files. In addition, the inspector observed a third staff member's Garda Síochána (police) vetting (GV) certificate. The review demonstrated to the inspector that the information required was present and that the provider had arrangements for safe recruitment practices.

Judgment: Compliant

Regulation 16: Training and staff development

An inspector viewed the staff training matrix and the training system that described each staff member's pass rate of the courses undertaken. This demonstrated that staff had received training in key areas of service provision in order to ensure staff knew how to safeguard and protect residents.

Training provided to staff included:

- safeguarding of vulnerable adults
- children first
- food safety
- first aid
- feeding, eating, drinking and swallowing
- fire safety
- positive behaviour support.

In addition, staff were able to discuss the learning from various aspects of these trainings. For example, one staff spoke to an inspector about various forms of abuse, signs to look out for and what to do should they have a concern.

In addition, staff completed a number of trainings related to infection prevention and control (IPC), for example hand hygiene. Those trainings would ensure that staff had the necessary skills and up-to-date knowledge in key areas of IPC. This was in order to safeguard residents from the risk of developing healthcare associated infections and manage infection control risks should they occur.

Staff had received additional training to support residents. For example, staff had received training in human rights. Further details on this have been included in 'what residents told us and what inspectors observed' section of the report.

Judgment: Compliant

Regulation 23: Governance and management

There were sufficient management systems in place for oversight of the safety of the residents in the centre. For example, there was a clearly defined management structure in place and a staff spoken with was able to confirm the reporting structure to an inspector. Two staff explained they would be comfortable reporting any concern to management if one arose.

There were various monitoring and oversight processes in place in relation to the safeguarding of residents. It was evident that, any safeguarding concerns or allegations were responded to appropriately and in a transparent manner.

One of the inspectors reviewed the organisation's policy folder for the Schedule 5 policy that was present in the centre. The regulatory requirement is that Schedule 5 policies were required to be in place, were made available to staff and were reviewed every three years or sooner if needed. All required policies where found to be present and within the three year review period. Up-to-date polices ensure staff are appropriately guided in line with best practice on how to support and keep residents safe. Therefore safeguarding them from inappropriate practices.

Monthly staff meetings were held and, from a review of the last three months minutes of meetings, safeguarding was a standing item at each of these meetings.

Discussions included the following:

- what was safeguarding
- zero tolerance for abuse
- to report immediately if someone has a concern.

Incidents were also reviewed at meetings, and any shared learning was discussed with the staff team. In addition, discussions were held around restrictive practices, fire safety, IPC, and the on-going safety of residents in all areas of daily life, for example residents' behaviour support needs.

Judgment: Compliant

Quality and safety

This inspection found that residents received a good quality service which respected and promoted their rights. However, some improvements were required in relation to individual assessment and personal plan, and the premises.

The provider assessed the residents' needs and support plan guidance documents were developed as applicable, to help staff support the residents in the best possible way. However, one personal plan was found to be limited in the guidance it provided and also conflicting information was observed. This will be discussed in more detail under Regulation 5: individual assessment and personal plan.

The inspectors observed that some improvements were required to the premises in order to ensure if provided a safe environment for the residents to live in, for example mildew was observed on one resident's apartment.

From one inspector's review, it was found that the provider was facilitating positive behaviour support in the centre. This was in order to safeguard residents, as far as possible, from any negative consequences of their behaviour towards themselves or others.

While there were restrictive practices in place, for example sharps locked away, they

were observed to be in place for the safety of the residents.

It was found that concerns or allegations of potential abuse were investigated and reported to relevant agencies.

The inspectors observed that, the individual choices and preferences of the residents were promoted and supported by staff. Communication was promoted in relation to safeguarding as well as all aspects of daily life. Staff were found to be familiar with the ways in which the residents communicated, for example when a resident wished to end a conversation.

Risk management arrangements ensured that risks were identified and monitored. For example, when a new fire safety risk arose the person in charge ensured additional control measures were introduced to minimise the chances of re-occurrence of an incident.

Regulation 10: Communication

On the day of the inspection, inspectors saw that there were adequate arrangements in place to promote communication. Inspectors saw staff interact with the residents in a dignified and person-centered manner.

An inspector found that two residents had received speech and language therapy (SALT) input so as to maximise effective communication. From a review of two residents' files, one inspector observed that there were communication profiles and passports in place which detailed residents' preferred style of communication and how best to support them to communicate their needs. They outlined some strategies and guidance for staff to use to promote effective communication with residents. For instance, it guided staff if a resident could understand questions posed to them or whether they needed them to be phrased more simply.

Two staff spoken with were knowledgeable as to how residents communicated and how staff should communicate with them. They provided examples to an inspector, such as particular conversations one resident liked to discuss regularly.

Information was available for residents in an easy-to-read format in order to promote their understanding. For example, there was information on safeguarding, my choices-supporting my decision, guide to voting, staying safe online and social media.

In addition, residents had access to a television, radio, and the Internet.

Judgment: Compliant

Regulation 17: Premises

For the most part, the safeguarding of residents included providing a safe living environment. Some issues were identified with the premises on this inspection with some having the potential to pose a risk to residents. These issues will be discussed in more detail throughout this regulation.

The inspectors observed that the courtyard was a place that the residents could meet up on during nice weather. The inspectors were informed that residents on occasions invited each other into their own apartments for socialising.

The facilities of Schedule 6 of the regulations were available for residents' use. For example, residents had access to cooking and laundry facilities.

Two residents shared a two bedroom apartment and the remaining residents had their own apartments. An inspector had the opportunity to observe three apartments and they were decorated individually to suit each resident's preference.

One apartment was in a good state of repair and cleanliness. For the most part, the two bedroom apartment was aesthetically well kept and clean. However, further cleaning was required in the bathroom with the shower tray and one wall beside the toilet observed to have staining or residue. Additionally, the frame of one resident's fire containment door was coming loose which had the potential to allow for the spread of smoke or fire in the event of an emergency.

The third apartment viewed required more attention. While the provider was aware of this, on the day of this inspection no set date was scheduled to undertake the required works. Identified actions required included:

- a socket in the resident's bedroom was broken which posed an electrical risk to the resident
- the bathroom walls had some holes
- new blinds were required for the bedroom windows
- some painting was required to different areas of the apartment, for example some windowsills like the kitchen were observed to be scuffed.

The bathroom had a significant amount of mildew in different places but mainly on the ceiling and the bedroom had some mildew around the windows. The mildew was required to be treated and cleaned as mildew can pose a risk to a person's respiratory health.

Furthermore, one inspector found that the water temperature in the taps for the apartments was very hot and had the potential to cause a burn. This was escalated to the person in charge on the day.

A senior manager provided assurance post inspection that the socket was repaired, the water temperature issue was resolved and the two apartments requiring

cleaning had been cleaned.

The inspector was also provided with a date of the commencement of the works on the apartment that required the most attention with an aim that the works would be finished by the 30 April 2025.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

There were appropriate processes and procedures in place to identify, assess and ensure ongoing review of risk. This included, ensuring that effective control measures were in place to mange centre specific risks and support residents' safety within the centre and the community.

One of the inspectors reviewed a sample of accidents and incidents which had occurred in the centre in the months prior to the inspection. They were found to be reviewed by the person in charge and learning from adverse incidents was shared with the staff at team meetings.

The provider had ensured a risk management policy was in place and subject to periodic review. The current policy was next due for review October 2025.

There was a risk register and associated risk assessments in place for identified risks both centre specific and risk assessments for individuals as required. Risk assessments contained control measures that were in place to minimise or prevent the likelihood of the risk occurring and reduce the impact on individuals. For example, the provider had determined what the safe minimum staffing levels were required to be on duty. From a review of a sample of rosters over a three month period it was found that the centre had never operated below the required safe minimum staffing requirement.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

While the provider had systems in place for the assessment of residents' needs and ensured that personal plans were in place as required, the inspectors observed some areas that required improvement.

One of the inspectors reviewed a sample of the assessment of need and personal plans of three of the residents. Topics of the assessment of need included mental health, independence, restrictive practices, health, and behaviours of concern. There

were personal plans in place for people who required support in specific areas.

An example of plans included:

- feeding, eating and drinking
- epilepsy
- high cholesterol
- iron deficiency.

All plans reviewed by the inspector had received a review date within the last year to ensure information provided to staff was accurate. However, one resident's plan did not guide staff fully with regard to their epilepsy management. It was found that they had three different epilepsy care plan protocols in place of when to administer emergency medication. While a staff member spoken with was familiar as to when to administer the first dose of the medication they were unsure when to administer the second. With conflicting protocols in place, this had the potential for staff to administer the medication not as it was intended for the resident. While this was amended prior to the end of the inspection, the inspectors were not assured that all plans in place would contain all applicable information and accurately guide staff. The person in charge communicated that all plans would be reviewed to ensure accuracy.

From a sample of the other plans reviewed, the guidance provided for staff in order to support the residents was found to be clear. Staff spoken with could explain their role in ensuring the safety of residents in those areas. For example, in relation to high cholesterol and the need to follow a low fat diet.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

Residents were provided with the necessary support to manage behaviours that may cause distress to themselves or others and in turn provide appropriate safeguards. For example, residents had access to a behaviour support specialist.

Where required, residents had a positive behavioural support plan in place which was reviewed by a behaviour specialist. From a review of three residents' plans they had clearly documented reactive de-escalation strategies that were incorporated as part of residents' behaviour support planning and included post incident guidance to staff.

Staff had received training in positive behaviour support. The person in charge and a staff member spoken with, were knowledgeable as to how to respond to residents with proactive strategies, how a resident may present when distressed and what responses were appropriate under the circumstances.

While there were some restrictive practices in place, such as the main gate to the

courtyard for the apartments has a key code access and the majority of residents did not have the code, these were in place to ensure the safety of the residents due to poor road safety awareness. Any restrictive intervention had been assessed to ensure its use was in line with best practice and they were subject to periodic review.

Overall, the use of positive behaviour support in this centre served as a key safeguarding mechanism by focusing on understanding needs and promoting well-being, rather than solely reacting to incidents.

Judgment: Compliant

Regulation 8: Protection

An inspector reviewed the safeguarding arrangements in place and found that the provider had appropriate arrangements in place to protect residents from the risk of abuse. There were clear lines of reporting and any potential safeguarding risk was escalated and investigated in accordance with the provider's safeguarding policy. Potential safeguarding risks were reported to the relevant statutory agency and where required safeguarding plans were developed and reviewed to ensure they were effective.

Staff had received specific training in order to support and safeguard residents in their home. Training included:

- safeguarding vulnerable adults
- communicating effectively through open disclosures
- trust in care.

Two staff spoken with confidently spoke about their role in ensuring the safety of residents. They were aware of the various types of abuse, the signs of abuse that might be of concern, and their role in responding to any concerns. Additionally, they confirmed that they would feel comfortable reporting any concerns they may have. They were aware of who the designated officer for safeguarding in the centre was.

Residents' finances were safeguarded through the various checks and audits completed. For example, from a review of two residents' money balance sheets, two staff completed daily balance checks twice per day and the sheet was signed off by staff. An inspector reviewed the money balance for one resident and found that their money balance sheet matched the amount of money in place. This demonstrated to the inspector that there was appropriate safeguards and oversight of residents' finances.

One inspector reviewed two intimate care plans and found they guided staff appropriately as to supports residents required in that area. This ensured they were afforded the correct supports in the right manner to promote independence, dignity,

and their safety.

Judgment: Compliant

Regulation 9: Residents' rights

Overall, the inspectors found that there were suitable arrangements in order to uphold the rights of residents. From speaking with two residents, the person in charge, and two staff members, residents were supported to make their own decisions and choices about their daily lives. For example, what they wanted to eat and what they wanted to do each day.

Residents were also supported to have visitors in line with their preferences and staff respected and upheld their wishes in this area. For example, one resident in their feedback questionnaire to the provider commented that they were 'happy with the visiting arrangements and that staff always check if they wanted to receive their visitors.'

Feedback from consultation with the residents completed by the provider was complimentary. For example, one resident stated that "staff are respectful and listen to me". Another stated that "staff support my right to independence".

There were weekly residents' meetings taking place. From a more in depth review of the minutes from the meetings held on the 30 March 2025, the minutes demonstrated to an inspector that different topics were discussed in order to keep residents informed and aware of areas that may impact them. Topics included, fire safety, rights, safeguarding, complaints, advocacy, restrictive practices, and the provider's resident council.

The inspectors also observed that easy-to-read information was available to residents in order to promote their understanding of topics. For example, there was simplified version of the safeguarding from abuse policy in place. There was also information on human rights, assisted decision making, and the use of restrictive practices.

In addition to receiving training on human rights, staff had received training around the assisted decision making act in order to promote a supportive culture and promote residents' rights.

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	Compliant
Regulation 23: Governance and management	Compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for The Mill OSV-0002420

Inspection ID: MON-0046792

Date of inspection: 09/04/2025

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 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: Immediate actions post inspection. • Plug socket has been replaced. • A deep clean of mildew in bathroom was completed. • A deep clean of shower in apartment six was completed. • The door frame in bedroom in apartment 6 was secured. • Temperatures checks performed and thermostat adjusted to ensure hot water was in line with recommended temperature. A full refurbishment of the bathroom in apartment 3 has been completed. A new set of blinds that had been ordered has been fitted in the bedroom. Cleaning checklists have been reviewed and discussed at the April staff meeting. PIC discussed the importance of ensuring premises were clean. PIC also asked staff to raise any concerns regarding work completion with PIC so she could follow up with allocated staff. A review of the weekly environmental checklist was also completed, and PIC/Team Lead/Staff Nurse will check apartments daily to ensure levels of cleanliness are up to standard. A further IPC audit to be completed by the end of quarter 2	
Regulation 5: Individual assessment and personal plan	Substantially Compliant
Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan: A review of the resident's epilepsy care plan and PRN protocol was completed on 10/4/25	

to ensure all information was correct and both the care plan and prn protocol duplicated each other. The PIC and staff nurse reviewed this information. All staff read and signed protocols. At the April staff meeting the care plans and PRN protocols were discussed fully to ensure all staff read and understand both documents. An opportunity was given for staff to raise questions or concerns they may have.

Medication Management is on the standing agenda for staff meetings.

All PRN protocols have been reviewed, and the information has now been typed onto documents to avoid any difficulty with handwriting and to ensure they are easy to read.

PIC requested a Governance and medication management Audit to be completed by Community Nurse Manager.

This was completed on 29/4/25 to ensure full compliance. Any actions that had been raised have been closed off.

PIC has also asked Nurses to review care plans after medical appointments to ensure they reflect any change in support needs.

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 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	30/06/2025
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Substantially Compliant	Yellow	16/05/2025
Regulation 05(6)(d)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall take into account changes in	Substantially Compliant	Yellow	16/05/2025

	circumstances and new developments.			