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:	Announced
Date of inspection:	23 April 2026
Centre ID:	OSV-0002420
Fieldwork ID:	MON-0041662

About the designated centre

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

The Mill is a designated centre operated by Dundas Unlimited Company. The Mill 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. 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:	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
Thursday 23 April 2026	09:30hrs to 18:40hrs	Karena Butler	Lead

What residents told us and what inspectors observed

On the day of this announced monitoring inspection, the inspector found a relaxed atmosphere where the residents were receiving a good standard of person-centred care in their home. They were supported by a staff team who understood their individual needs.

However, the inspector found that there were some improvements required in relation to how records were maintained, in relation to oversight of certain areas in the running of the centre, and in relation to the activities on offer for some residents.

The inspector had the opportunity to meet four of the six residents that were living in the centre. At the time of this inspection, there was one vacancy. All four residents spoken with said they felt safe in the centre and liked the staff that worked in the centre.

Two residents shared brief pleasantries and communicated that they were happy and liked the staff that worked in the centre. They joked with each other pretending that one had gotten up to mischief and admitted they were only joking. Both were observed smiling at each other on several occasions.

Two residents spoke individually in more detail with the inspector. They both felt comfortable and safe living in the centre. They both felt the staff were nice and they felt supported by them. They communicated that they felt they got on okay with the residents in the other apartments. They both felt that they had choice provided in their daily life. One resident commented that while they did go on external activities, they would like more opportunities. They went on to explain that there were two particular activities that they would like to re-engage in that they previously used to participate in.

The fifth resident chose not to speak with the inspector and this decision was respected. The sixth resident was receiving support in hospital for a health condition and therefore the inspector did not have the opportunity to meet them.

On the day of the inspection, two residents went to Phoenix Park. One resident had a massage appointment and got their hair cut in the barbers. One resident had been for an overnight in a hotel and went shopping prior to their return to their apartment. They said they really enjoyed their mini-break. The remaining resident went out with a family member for coffee.

As part of this inspection process residents' views were sought through questionnaires provided by the office of The Chief Inspector of Social Services (The Chief Inspector). Feedback from the five questionnaires was returned by way of the residents themselves with staff members supporting them to record their answers.

Feedback was positive and questions were ticked 'yes' for happy when asked about the service and care provided. Comments related to reconfirming that they agreed with the statements, for example getting choice in their day.

In addition to the person in charge, there were eight staff members on duty during the day of the inspection. The inspector had the opportunity to speak with five staff members. The person in charge and staff members spoken with demonstrated that they were familiar with the residents' support needs and likes. They were observed to interact with residents in a relaxed and respectful manner. For example, one staff member asked a resident if they were willing to speak with the inspector at that time or if they wished the inspector to come back. Once confirmed that the resident was willing to speak with the inspector, the staff member tried to establish the resident's preference of where they would like to meet.

The provider had arranged for staff to have training in human rights. One staff member explained how they had put that training into everyday practice. They felt that since having the training that they were conscious to promote a resident's right to refuse. For example, if they chose to refuse a medication, the staff member would try to offer choices of when to take it and would explain why taking the medication was important. If the resident continued to refuse then they respected that choice and the staff member said they would highlight it to the nurse on duty or the manager.

The inspector had the opportunity to speak with two family representatives on the phone. Both felt their family members were very safe living in this centre. Neither had any concerns regarding the service and both stated they would feel comfortable raising a concern if they were to have one. One family representative said that they had recently raised some areas that they would like their family member to be supported with. They felt that steps had been taken and were awaiting to see if their family member was happy with the outcome. One said that 'the staff treated their family member with respect' and that 'they knew their family member'. They said that 'staff appeared to really care'. They went on to say that 'communication was good with the provider' and they 'always got a quick response'. The other stated that 'the staff were brilliant and treated people with respect'. They said 'they couldn't ask for better with this provider and wouldn't wish for their family member to be anywhere else, that they were amazing'.

The inspector conducted a walk around of the centre. It was made up of apartments around a shared courtyard setting. The inspector had the opportunity to see inside four of the six residents' apartments, finding them tidy and, for the most part, clean and in a good state of repair. Identified areas for improvement for the apartments were addressed on the day of this inspection by the provider.

At full capacity the centre could cater for five residents to have their own apartment and a further two residents sharing an apartment. At the time of this inspection there was one vacancy meaning one single apartment was not in use. Each resident had their own bedroom. Each had their own bathroom apart from the residents who shared an apartment, as they shared their bathroom facilities. From the four

apartments viewed, there were adequate storage facilities for their personal belongings.

At the time of this inspection there were no visiting restrictions in place other than visiting arrangements in line with one resident's preference of which staff supported them in line with this preference.

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 announced and was undertaken as part of the provider's application to renew the registration of the centre as well as part of ongoing monitoring of 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). This centre was last inspected in April 2025.

For the most part, the inspector found that there were effective governance and management arrangements in place at the time of this inspection in order to ensure a safe and effective service was provided for the residents. For example, the provider completed periodic audits of the service in order to ensure it was appropriate for the residents' needs. However, some improvements were required to certain aspects of oversight and this will be discussed further under the specific regulation.

The provider had ensured that the centre was adequately insured against risks to residents and property. In addition, the provider had suitable arrangements in place for the management of complaints.

A review of a sample of staff rosters across four months found that there were appropriate staffing levels in place to meet the assessed needs of the residents. In addition, staff had access to training appropriate to their roles, for example medication management training including a practical assessment of their competency.

Some improvements were required with regards to how records were maintained in order to ensure they contained all applicable information.

Regulation 14: Persons in charge

The registered provider had appointed a full-time, suitably qualified and experienced person in charge to the centre. They managed three designated centres. They visited this centre approximately three times per week in order to provider appropriate oversight.

While they had only recently taken over the role of person in charge for this centre, they were becoming familiar with the residents' needs and preferences.

They were also found to be aware of their legal remit in line with the regulations, such as to notify the Chief Inspector when adverse incidents occurred in the centre. They were also found to be very responsive to the inspection process.

Judgment: Compliant

Regulation 15: Staffing

This inspection demonstrated that there were sufficient staffing levels in place to meet the assessed needs of the residents.

The inspector reviewed a sample of rosters across a four-month period from January to April 2026. While the centre did not have a full staffing complement and required two staff positions to be filled, the person in charge had ensured that where possible consistent, familiar staff worked in the centre.

They also confirmed that safe staffing levels were always maintained and that there were sufficient staff available to meet the assessed needs of residents. The person in charge had escalated the need for additional staffing to the human resources department.

The residents were observed to be relaxed in the presence of the staff members on duty.

Staff personnel files were not reviewed at this inspection. However, the inspector reviewed a sample of two core staff members' Garda Síochána vetting (GV) certificates and their police clearance certificates. This demonstrated that safe recruitment practices were in place in line with best practice as the GV certificates were completed within the last three years.

Judgment: Compliant

Regulation 16: Training and staff development

Training identified as mandatory by the provider had been completed by all staff members. In addition, a range of non-mandatory training had also been completed by the staff team.

The inspector reviewed the training oversight system for training completed as well as a large sample of the staff teams' certification for six training courses completed. This review confirmed that staff received a suite of training in order for them to effectively support the residents.

Examples of the training staff had completed included:

- safeguarding vulnerable adults
- Children First
- epilepsy awareness and responding to seizures
- diabetes
- training related to positive behaviour support
- fire safety
- training related to IPC, such as hand hygiene.

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 the 'what residents told us and what inspectors observed' section of the report.

In addition, the provider had plans in place to commence English language courses, in the last six months of 2026, for staff members who would benefit from increasing their fluency and confidence. The director of services confirmed that the person in charge would explore this with the staff team for this centre through their supervision and prioritise staff as required.

From a sample of three staff members' supervision records, the inspector observed they were receiving formal supervision that was an opportunity for them to raise concerns should they have any.

Judgment: Compliant

Regulation 21: Records

All required records were for the most part adequately maintained and available for inspection, including records of staff meetings and supervision.

However, from a review of a resident's diabetes care plan, it did not guide staff on what signs and symptoms to look out for if the resident was to suffer from high or low blood sugars or what their normal blood sugar ranges were. While one staff on duty located some information related to the signs and symptoms to watch out for, this information was not known by all staff and it was not evident as to the normal blood sugar ranges for this resident. This could mean that the resident could be

placed at increased risk of their condition should staff not be aware of or appropriately guided with this information.

A resident's feeding, eating and drinking (FEDs) plan had not received a review since September 2024. The person in charge believed there were no changes to their presentation that would require alteration of their plan. However, improvement was required to how residents' care plans are maintained, in order to ensure they have an annual review as required by the regulations which would ensure that residents' information is up-to-date and appropriately supporting them.

In addition, the provider had ensured that residents had inventories of their belongings recorded in order to facilitate safeguarding of their belongings as well as oversight of ownership. However, the inventories were found to be vague in the description of items recorded. For example, a resident's inventory described that they had a mobile phone; however, the type of phone was not described which would make it difficult to identify or retrieve, if required.

Judgment: Substantially compliant

Regulation 22: Insurance

As per the requirements of the regulations, the provider had ensured that the centre was adequately insured against risks to residents and the property. Evidence of the insurance was submitted to the Chief Inspector.

Judgment: Compliant

Regulation 23: Governance and management

While the inspector found that the provider had many appropriate governance and management arrangements in place, improvements were required to some areas of oversight.

The provider had carried out an annual review of the quality and safety of the centre. However, while the annual review was completed in September 2025, it was not made available in the centre or to the person in charge until March 2026. Therefore, any actions that arose from this review were unable to be progressed in the absence of the relevant information. This had the potential to affect the effectiveness and consistency of the service being provided to the residents.

The inspector identified some issues with regard to the premises on this inspection, which were dealt with in a prompt manner once brought to the provider's attention. While the majority of the apartments were in good condition, some improvements were required to the provider's oversight of the premises as the identified issues on

this inspection were not known to the provider. For example, a hole in the flooring of one apartment and a gap in the external door of the bedroom. In addition, some areas were reoccurring issues that had been identified on the previous inspection, such as mildew in one apartment and a broken socket. Those areas had the potential to impact on the effectiveness of cleaning routines in the residents' apartments or compromise fire containment measures if left unaddressed.

Some improvements were required to the oversight of staff adherence to infection prevention and control (IPC) guidance issued by the provider. The inspector observed in one apartment, only one of three recommended colour code cleaning buckets was in use and two colour coded mop heads were being inappropriately stored in and on the bucket. This meant they could not be effectively dried. Non-adherence to IPC controls could put residents at risk of healthcare-related illnesses.

While the provider had ensured that the majority of notifications had been submitted to the Chief Inspector as required, they had not ensured that one required notification was submitted. While this was submitted on the day of this inspection, it was only completed once the inspector brought it to the provider's attention. Therefore, improvement was required to ensure the systems in place would always ensure the provider would fulfill their regulatory responsibilities.

The inspector reviewed a recent resident discharge to ensure it was conducted safely and appropriately. While evidence indicated that the resident was satisfied with the outcome and the external funder supported the transition of care, a significant gap in record-keeping was identified. Specifically, the provider failed to keep formal minutes for the final, key meeting where the actual decision to discharge was made. Although other applicable records were maintained, the provider must ensure that all critical meetings are formally documented moving forward. This improvement is necessary to provide clear evidence of the decision-making process, demonstrate accountability, track assigned responsibilities, and allow for effective monitoring.

There were arrangements for unannounced visits to be carried out on the provider's behalf every six months. The inspector reviewed the unannounced visit reports in June 2025 and February 2026. There were action plans in place for any areas identified as requiring improvement. In addition, there were regular audits being completed on different aspects of the service to facilitate a safe and effective service, such as governance monthly reports.

The inspector spoke with five staff and they communicated that they would feel comfortable going to the person in charge if they were to have any issues or concerns and they felt they would be listened to.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

The provider had adequate arrangements in place for the management of complaints. There was a policy in place to guide staff and there were designated complaints officers nominated. Staff had received training in how to handle complaints.

There had been a low level of complaints in the centre and any complaints made had been recorded, investigated and actions put in place to reach a resolution.

For example, the person in charge had arranged for a resident's social worker to call to the centre to discuss their options in relation to a specific area of concern for them. The person in charge had also applied for the resident to receive advocacy services to ensure their voice was being heard. They had received their first appointment in the days prior to this inspection.

Judgment: Compliant

Quality and safety

This inspection found that a good quality of service was provided to the residents living in the apartments.

The person in charge had ensured that residents had access to appropriate healthcare professionals and support where required.

The provider had ensured that there were suitable arrangements in place that helped protect residents from different forms of abuse. For instance, the staff team were trained in safeguarding vulnerable adults and a staff member spoken with was able to explain possible warning signs of abuse and how to respond should they observe those signs.

While residents were being offered opportunities for participating in external activities, there was limited evidence that all residents were being offered opportunities for alternative activities should they decline the original offer. Additionally, there was limited evidence to suggest that residents were offered in-house activities if they chose not to go out.

The inspector completed a walk-about of the premises and found that the apartments were tidy and improvements were observed to one apartment since the last inspection.

Regulation 13: General welfare and development

The inspector found from speaking with four residents, the staff on duty, and the person in charge, that for the most part residents were being supported to participate in activities in their community as well as other social outings.

From a review of two residents' goals, they were being supported to set goals for themselves to enhance their quality of life. For example, these included increasing gardening activity and sourcing a new pottery class.

Residents were also supported to maintain links with their family representatives as per their wishes.

However, in the case of one resident, the provider-led audit completed in February, identified that there was limited evidence to suggest the resident was being offered alternative activities if they declined to engage in the original activity offered.

The inspector found similar issues when reviewing the resident's daily records as well as another resident's records between 13 to 23 of April 2026. While the inspector was made aware that both residents often did not want to engage in external activities, there was limited evidence to suggest what activities were being suggested to encourage the residents to engage in internal and external activities. Therefore, improvement was required to ensure they were being offered alternative activities or regular opportunities to engage with others, facilitating a meaningful day.

Judgment: Substantially compliant

Regulation 17: Premises

At the time of the inspection, from the apartments observed, the layout and design of the apartments were appropriate for the assessed needs of the residents.

The centre was generally found to be clean and in a good state of repair. While some minor patches of mildew or stains were observed and repairs were required to a socket, three doors and a resident's floor, these areas were rectified prior to the end of the inspection. Oversight of premises issues was addressed under Regulation 23: Governance and management.

Each resident had their own bedroom and from the apartments observed, residents had adequate storage facilities for their personal belongings. One resident spoken with confirmed that they had enough room to store their belongings and clothes.

In addition, the apartments had fire containment doors, fire extinguishers and emergency lighting installed to ensure that the apartments would support the residents to be protected from the risk of fire while in their homes.

The apartments had access to a courtyard with picnic tables and benches for use in times of good weather.

Judgment: Compliant

Regulation 6: Health care

The inspector found that there were sufficient arrangements in place for residents to have their needs assessed and care provided in line with their assessed needs.

From a review of a sample of four residents' files, the inspector found that their healthcare needs were known and there were healthcare plans in place for identified needs to guide the staff team on the supports required. For example, epilepsy care plans and protocols for the administration of emergency medication, and hospital passports to guide hospital staff should they require a hospital stay. This would facilitate consistency of staff support and help ensure the residents received appropriate care in line with their assessed needs.

Residents had access to a general practitioner and a wide range of allied healthcare services, such as physiotherapy, chiropody, and occupational therapy.

While improvements were required in relation to a diabetes care plan and a formal review of a FEDs plan, this was addressed under Regulation 21: Records.

Judgment: Compliant

Regulation 8: Protection

There were arrangements in place to protect residents from the risk of abuse. For example, there was a safeguarding policy in place to guide staff on how to recognise and respond to potential abuse of residents.

The inspector reviewed the finance balance recording sheets for one month for two residents and found that the resident's money was being checked daily by staff. The person in charge performed a spot check of one resident's money balance in the presence of the inspector and the count was found to match that of the finance recording sheet. That meant that the oversight arrangements in place to safeguard residents' money appeared to be working appropriately.

Staff were found to be suitably trained to recognise and escalate any safeguarding concerns. There was a reporting system in place with a designated safeguarding officer (DO) nominated for the organisation.

It was found that concerns or allegations of potential abuse were reviewed and reported to relevant agencies, and where necessary a safeguarding plan was implemented to minimise the chances of recurrence.

A staff member spoken with was familiar with the steps to take should a safeguarding concern arise including a witnessed peer-to-peer incident or an unwitnessed disclosure. For example, in the case of an unwitnessed disclosure, the staff member explained that they would gather the facts, that they would not promise confidentiality, they would not ask leading questions, and they would report the potential safeguarding incident.

From a review of three residents' files, the inspector found that there were intimate care plans in place that guided staff as to supports residents required.

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 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 21: Records	Substantially compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 13: General welfare and development	Substantially compliant
Regulation 17: Premises	Compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for The Mill OSV-0002420

Inspection ID: MON-0041662

Date of inspection: 23/04/2026

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 21: Records	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records: The diabetes care plan referenced during inspection has been fully reviewed and updated in consultation with the relevant healthcare professionals. The updated plan now clearly outlines: The resident's normal blood glucose ranges, Signs and symptoms of hypo/hyperglycaemia, Required staff responses and escalation procedures. A staff team meeting was completed to ensure all staff are familiar with the updated diabetes management guidance. Staff knowledge and understanding will continue to be monitored through spot checks by the PIC/Nurses. An education and training session on Type 2 Diabetes is scheduled for 3rd June for all PIC's and Nurses. The resident's FEDs plan has now been reviewed by Speech and Language Therapist. The Mill's staffing model includes two staff nurses, and a structured system is in place to ensure all residents' care plans are reviewed and updated at least annually and whenever individual needs change. All residents have an annual Multidisciplinary Assessment of Need (AON) which assesses their met and unmet needs and the effectiveness of the personal plans in place. To track actions from AON, a care plan is developed by the Person in charge. All resident property inventories have been fully reviewed. Inventories are being updated to include detailed descriptions of personal belongings, including make, model, colour identification of residents' property.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The provider will ensure that the annual review is completed and shared with the PIC without delay. The PIC will ensure the review is accessible within the centre, available to residents and that all actions are followed up and completed within the required time	

frame.

All premises issues identified during inspection were addressed immediately following inspection. The Staff Nurse will ensure a weekly environmental audit is completed, and all identified actions will be proactively followed up with the maintenance team. A premises audit will be completed by the PIC every six months with all actions monitored and followed up to completion.

Infection Prevention and Control (IPC) practices were reviewed with staff following inspection. Additional staff guidance during monthly staff meeting and refresher discussions were completed regarding colour-coded cleaning systems, appropriate storage of cleaning equipment, and effective drying procedures. A quarterly IPC audit will be carried out by PIC to ensure full adherence to IPC standards. PIC will ensure all identified actions are followed up and completed.

PIC will ensure that all required notifications are sent to the Chief Inspector within the specified time frame. PIC will ensure that all meetings held during transition or discharge are fully documented, that all follow up actions are monitored and that all records are accessible in the centre in line with the organisation's discharge policy. Governance audits and six-monthly provider visits will continue to monitor compliance and ensure continuous quality improvement across the service.

Regulation 13: General welfare and development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 13: General welfare and development:

Staff team discussions and reflective practice sessions were completed at staff meeting following inspection regarding the importance of evidencing resident choice, alternative activity offerings, and meaningful engagement opportunities. Staff have been reminded of the importance of promoting meaningful activities and documenting all supports offered to residents throughout the day. Residents' goals and activity documentation will be reviewed on an ongoing basis by the PIC/Nurses to ensure ongoing oversight. The Assistant Director will also review residents' goals and both indoor and outdoor activities during monthly governance meetings to ensure each resident are supported to engage in meaningful activities of their choice.

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 13(2)(b)	The registered provider shall provide the following for residents; opportunities to participate in activities in accordance with their interests, capacities and developmental needs.	Substantially Compliant	Yellow	26/06/2026
Regulation 21(1)(b)	The registered provider shall ensure that records in relation to each resident as specified in Schedule 3 are maintained and are available for inspection by the chief inspector.	Substantially Compliant	Yellow	03/06/2026
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the	Substantially Compliant	Yellow	26/06/2026

	service provided is safe, appropriate to residents' needs, consistent and effectively monitored.			