



**Health
Information
and Quality
Authority**

An tÚdarás Um Fhaisnéis
agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Older People.

Issued by the Chief Inspector

Name of designated centre:	An Teaghlach Uilinn Nursing Home
Name of provider:	Knegare Nursing Home Holdings Ltd
Address of centre:	Kilrainey, Moycullen, Galway
Type of inspection:	Unannounced
Date of inspection:	18 June 2026
Centre ID:	OSV-0000309
Fieldwork ID:	MON-0050842

About the designated centre

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

An Teaghlach Uilinn Nursing Home is a purpose-built designated centre for older people. Residents are accommodated in single and twin bedrooms. A variety of communal rooms are provided for residents' use, including sitting, dining and recreational facilities. The centre is located close to Moycullen village, Galway. Residents have access to a secure enclosed courtyard. The centre provides accommodation for a maximum of 53 male and female residents, over 18 years of age. The service provides care to residents with conditions that affect their physical and psychological function. Each resident's dependency needs are regularly assessed to ensure their care needs are met.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	52
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How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (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 18 June 2026	13:00hrs to 17:30hrs	Sean Ryan	Lead
Thursday 18 June 2026	13:00hrs to 17:30hrs	Catherine Sweeney	Support

What residents told us and what inspectors observed

Overall, residents who spoke with inspectors were complimentary about the staff working in the centre and described them as caring, kind and responsive to their needs. Residents told inspectors that staff knew them well and worked hard to support them. However, some residents expressed concerns regarding communication and information sharing within the centre. Residents told inspectors that they were not always kept informed about changes occurring within the service that affected them. Residents also reported that they were not always aware of who was accessing the centre and stated that this had impacted on their sense of safety and security.

Inspectors arrived at the centre unannounced and were met by the assistant director of nursing and the operations manager. Both members of management demonstrated a comprehensive knowledge of residents' assessed needs and the systems in place to support care delivery.

The designated centre is registered to accommodate 53 residents, with accommodation provided for 43 residents on the ground floor and 10 residents on the first floor. During the walk-around, inspectors found evidence that unauthorised persons had been accommodated in the centre on the night prior to this inspection. As a result, inspectors sought additional information from staff and management regarding the circumstances regarding this finding and the arrangements in place to safeguard residents and monitor access to the designated centre.

Inspectors observed that the centre was visibly clean and well-maintained. Interactions between staff and residents were observed to be respectful and person-centred. Staff spoken with demonstrated good knowledge of residents' individual preferences, assessed needs and care requirements.

Capacity and capability

The findings of this inspection identified significant deficits in the provider's governance and management arrangements for safeguarding. Inspectors found inadequate oversight at all levels of the organisation regarding the implementation, monitoring and effectiveness of systems intended to safeguard and protect residents. This included deficits in the identification, management and escalation of safeguarding risks.

As a consequence, an urgent compliance plan request was issued to the provider. The provider's initial response did not provide adequate assurance that the identified risks had been addressed. The provider was requested to attend an urgent warning meeting, at which they were advised that, should they fail to achieve compliance with the Health Act (2007) as amended, the regulations and standards made thereunder, the Chief Inspector may proceed with regulatory action, including the cancellation of the registration of the designated centre. The provider was also afforded a further opportunity to submit a revised urgent compliance plan, which was subsequently accepted.

Knegare Nursing Home Holdings Limited is the registered provider of this designated centre. It is a company comprised of five directors, one of whom represents the registered provider. On the day of this inspection, none of the directors were available to meet with or speak to inspectors.

Inspectors found that significant changes to the management structure had recently occurred within the designated centre and that a number of management personnel were due to leave their roles in the near future. New employees had recently been recruited to fill the posts of person in charge, assistant director of nursing and a clinical nurse manager. Two days prior to this inspection, the Chief Inspector had been notified of the departure of the person in charge and the appointment of a new person to this role. Inspectors were informed that further changes to the management structure within the centre were planned, resulting in substantial turnover across the management team within a relatively short period. This presented a significant risk to the continuity of management arrangements within the service.

The provider had failed to ensure effective arrangements were in place to support the transition in leadership. Inspectors found that there had been no handover between the outgoing person in charge and the person recruited to fill this post and that the induction arrangements in place were not sufficient to support new management personnel to assume responsibility for the service. Staff working in the centre had not been informed of changes to the management structure within the centre and were unclear regarding management roles, reporting arrangements and decision-making responsibilities within the centre. This impacted on leadership, accountability and oversight arrangements within the centre.

Lines of accountability and responsibility within the designated centre were not clearly defined, communicated or understood. As a result, there was a lack of clarity regarding the personnel who held responsibility for key operational and clinical functions within the centre. This resulted in ineffective oversight of a number of critical areas, including safeguarding and protection of residents, risk management, incident management and record management. Inspectors found that information was not effectively communicated through the management structures, and there was limited evidence of effective monitoring and oversight of these areas by the provider. Consequently, the provider failed to ensure that there were effective systems in place to identify, escalate and respond to risks affecting residents' safety and welfare.

Inspectors identified serious failures in the provider's safeguarding arrangements, including the implementation of policies and procedures designed to safeguard and protect residents. These included instances where individuals, who were neither resident nor employees of the centre, were accommodated within the designated centre without evidence of appropriate assessment, authorisation, Garda vetting, or other necessary safeguarding checks being completed. In addition, inspectors found that a newly recruited staff member had commenced employment and was actively engaged in the delivery and oversight of resident care in advance of the completion of Garda vetting and without all required recruitment documentation and records being available to provide assurance regarding their suitability for the role.

The provider had failed to implement effective record management systems within the centre. Inspectors were unable to readily access a range of records required for the operation and oversight of the service. This included records relating to residents' finances and staff personnel files. A review of some records identified incomplete documentation to demonstrate compliance with the regulations, while inaccuracies were also found in the staff rosters.

Overall, the findings of this inspection evidenced a significant failure at provider, regional and centre management level to effectively implement, monitor and oversee safeguarding practices, record management systems and governance arrangements.

Regulation 21: Records

The management of records was not in line regulatory requirements. For example;

- Staff personnel files were incomplete and did not contain all of the information required under Schedule 2 of the regulations. For example, one staff member had commenced employment before all required pre-employment documentation was available. In addition, personnel files reviewed did not consistently contain the required vetting disclosure, evidence of relevant qualifications and training, a complete employment history accounting for gaps in employment, or two satisfactory written references, including a reference from the staff member's most recent employer.
- Staff rosters did not reflect the staffing levels on the days of inspection or on the days prior to the inspection and did not include all staff working in the designated centre, as required by Schedule 4(9). Rosters did not accurately record the attendance of members of the senior management team, including the dates and times they were present in the centre. As a result, the provider could not demonstrate an accurate record of staffing or management oversight.

Judgment: Not compliant

Regulation 23: Governance and management

The registered provider had failed to ensure that the management resources within the centre were appropriately planned, organised and managed to support the safe and effective delivery of care to residents. Inspectors found that significant changes to the management structure were in progress. There was no evidence that these changes had been effectively planned or managed to ensure continuity of leadership, governance or oversight. There was no evidence of structured handover or induction arrangements to support newly appointed members of the management team, resulting in deficits in leadership, communication and management responsibilities within the centre.

The registered provider failed to ensure there was an effective management structure, with clear lines of accountability and responsibility in place. Staff members and residents were unclear as to who was the person in charge of the centre. This impacted on lines of accountability and responsibility for the oversight and monitoring of key aspects of the service, including risk management, incident management and the management of staffing resources. Although the provider was aware of significant management changes within the centre, there was poor oversight arrangements in place during the period of transition to ensure effective leadership, continuity of management or safeguarding and protection of residents.

The poorly defined organisational structure impacted on the management systems in place to ensure the service provided was safe and appropriately monitored. This was evidenced by;

- A failure to implement the centre's risk management systems, to monitor and manage known risks with the potential to impact safety and welfare of residents living in the centre. Known risks, including those arising from ineffective governance and management, had not been assessed, recorded, or managed in accordance with the centre's risk management policy.
- A failure to ensure effective implementation of policies and procedures developed to safeguard residents. Deficits in the implementation of systems intended to support the recognition, reporting, assessment and management of potential safeguarding risks and concerns resulted in inadequate oversight of safeguarding arrangements in the centre.
- Record management systems were ineffective. The provider had failed to ensure that records pertaining to staff rosters and staff personnel files were accurately maintained, appropriately monitored or subject to effective oversight.
- The system of communication within the centre was ineffective. Residents and staff had not been appropriately informed of changes to the management structure, resulting in uncertainty regarding leadership and reporting arrangements. While inspectors were informed that these changes had been discussed and agreed at provider level, a review of management

meeting records did not evidence any discussion, planning or communication relating to the management changes within the centre.

Judgment: Not compliant

Regulation 4: Written policies and procedures

The registered provider had failed to adopt and implement policies and procedures designed to protect residents. This included the policies in relation to;

- Safeguarding of vulnerable adults.
- Risk management.
- Records management.

Judgment: Not compliant

Quality and safety

The inspectors found that the interactions between residents and staff was kind and respectful throughout the inspection. On the day of inspection, the resident's care needs were observed to be attended to appropriately and residents were observed to be content and felt safe in their environment. Nonetheless, the quality and safety of care provided to residents was impacted by inadequate oversight and implementation of the management systems and policies in place to protect residents.

The provider had safeguarding policies and procedures in place that were intended to guide staff in recognising, responding to and reporting safeguarding concerns to ensure residents were protected from the risk of abuse. Staff who spoke with inspectors demonstrated their understanding of the provider's safeguarding procedures and were familiar with the process for reporting and escalating concerns. Staff provided examples of concerns that had been reported through the provider's reporting structures. However, the findings of this inspection were that the governance and oversight arrangements in place did not ensure that safeguarding concerns were consistently managed or subject to effective organisational oversight. Consequently, the provider was failing to take reasonable action to ensure residents were safeguarded and protected.

Inspectors reviewed a sample of residents' care records and found that care plans did not consistently reflect residents' assessed safeguarding needs. As a result, the care plans did not contain sufficient information to guide staff in providing

consistent, person-centred care that reflected the resident's individual needs and circumstances.

The civil rights of residents were not consistently upheld. Residents who were dependent on the registered provider for support and assistance to manage their finances, were not facilitated to access funds held by the provider on their behalf, in a timely manner.

Regulation 5: Individual assessment and care plan

A review of a sample of residents' assessment and care plans found that they were not in line with the requirements of the regulations.

Care plans were not developed following a comprehensive assessment of need. For example, Where a resident had a known history of safeguarding concerns and required ongoing support, this information was not reflected within the resident's care plan.

Care plans were not updated, to reflect the provider's role in supporting the management of the resident's personal finances or to provide guidance to staff regarding the arrangements in place to support the resident.

Judgment: Not compliant

Regulation 8: Protection

The registered provider failed to take all reasonable measures to ensure residents were safeguarded and protected from the risk of abuse.

Safeguarding arrangements were ineffective. This was evidenced by the provider's failure to implement measures to ensure that all individuals providing services within, or accessing the designated centre were appropriately authorised and subject to the required safeguarding controls. Consequently, residents were exposed to potential risk.

Judgment: Not compliant

Regulation 9: Residents' rights

Residents' civil rights were not upheld, as they were not supported to access or manage their personal finances in a timely manner. This was compounded by a lack

of clear arrangements in place to facilitate residents' to access their financial information or funds held by the provider on their behalf. This impacted on residents autonomy, choice, and supporting residents' financial independence.

Judgment: Substantially 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 Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 4: Written policies and procedures	Not compliant
Quality and safety	
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for An Teaghlach Uilinn Nursing Home OSV-0000309

Inspection ID: MON-0050842

Date of inspection: 18/06/2026

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 Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

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	Not Compliant
Outline how you are going to come into compliance with Regulation 21: Records: Following the inspection, the HR Manager carried out a full review of internal recruitment and staff-file systems and identified the points at which required checks had not been completed. A meeting was held on 23 June 2026 with senior nursing management, the HR Department and the Senior Management Team, at which revised controls were agreed. A review of Garda vetting for all persons working in the centre was completed by the HR Department on 19 June 2026, confirming that all held valid vetting. A full audit of staff personnel files against Schedule 2 was then completed, and any gaps in vetting disclosures, qualifications and training records, employment history and references have been addressed. Each file is signed off as complete and closed by HR. SOP-004 Staff Files was approved and came into effect in June 2026. It provides that staff files are opened and closed by the HR Department only, and that no file is closed until the following are in place: interview notes, conditional job offer, CV with any gaps in employment verified, ID, proof of address, Garda vetting, relevant qualifications, professional registration, two verified references, and mandatory training certificates. Only once HR has closed the file a start date is arranged. The HR Manager delivered training to the centre's administrators on the recruitment and vetting process on 3 July 2026, and will provide refresher training every two years or on any change in practice or personnel. Under SOP-004, the HR Manager completes a monthly audit of new staff files and a bi-annual audit of all staff files. Audit results are recorded and reviewed by the Senior Management Team. Completed files are held on the group eSystem. The roster has been revised so that it records all staff working in the designated centre, including agency staff and members of the senior management team, and reflects both	

actual hours worked V's planned attendance.

All senior management and Head Office personnel report their arrival and departure times to reception on each visit, so that attendance is captured on both the paper roster and on electronic system.

The Person in Charge reviews the roster to confirm it reflects the staff actually on duty, and rosters are audited weekly as part of the centre's governance arrangements.

Regulation 23: Governance and management

Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:

A new Person in Charge was appointed and commenced in the centre on 18th August. A documented handover was completed with the Chief Governance, Risk and Compliance Officer, covering governance, risk, safeguarding, incidents, complaints, records and staffing.

All newly appointed management personnel, including the Person in Charge, Assistant Director of Nursing and Clinical Nurse Manager, complete a structured induction which is signed off by the GRC Officer and or PIC on completion.

Any planned change to the management team is agreed and recorded at provider level in advance, and handover and induction arrangements are confirmed before the change takes effect.

An organisational chart has been completed setting out the management structure, reporting lines and deputising arrangements. It is displayed in the centre and included in the staff induction pack.

Named responsibility for risk management, incident management, safeguarding, records management and rostering is assigned in the relevant job descriptions and posters are displayed in the Centre with the details of the Complaints and Safeguarding Officer.

The name of the Person in Charge is displayed at reception and on each unit. Staff were informed of the management structure at the staff handovers and safety pauses and residents at the residents' meeting on August 13th.

Management meetings are held monthly and minuted, with standing agenda items on risk, safeguarding, incidents, staffing and any planned change to the management structure. Minutes are reviewed by the CGR Officer.

Changes within the centre that affect residents are communicated at residents' meetings.

Changes affecting staff are communicated at staff meetings and at handover. The provider carries out frequent governance audits and unannounced visits to the centre. Findings are issued as a time-bound action plan with named owners, and completion is verified at the next visit.

Risk management: see response under Regulation 4: Written policies and procedures.
Implementation of safeguarding policies and procedures: see responses under Regulation 8: Protection and Regulation 4: Written policies and procedures.
Records management, staff rosters and personnel files: see response under Regulation 21: Records.

Regulation 4: Written policies and procedures	Not Compliant
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Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:

Following the HIQA inspection findings, the registered provider has undertaken a review of the policies and procedures identified within the inspection findings, specifically Safeguarding of Vulnerable Adults, Risk Management and Records Management, to ensure that they are current, appropriate and provide clear guidance to staff in protecting residents and managing identified risks.

The relevant policies have been reviewed and communicated to the management and care teams. Staff are being reminded of their responsibilities in relation to the implementation of these policies in day-to-day practice.

The safeguarding policy has been reviewed with particular emphasis on the identification, reporting, management and monitoring of safeguarding concerns. Staff are reminded of their responsibility to recognise and report any concern or allegation of abuse without delay and to ensure that appropriate immediate measures are taken to protect the resident.

Safeguarding concerns are documented, investigated and monitored in accordance with the provider's safeguarding procedures, with safeguarding care plans and risk assessments updated where required.

Ongoing staff education, handover discussions and management oversight will be used to reinforce safeguarding responsibilities and ensure the policy is consistently implemented in practice.

The risk management policy has been reviewed and staff are being reminded of the requirement to identify, assess and manage risks associated with residents, the environment and service delivery.

Resident-specific risk assessments are reviewed following any incident, significant change in condition, change in circumstances or identified new risk. Where a risk is identified, appropriate control measures are documented and reflected in the resident's care plan to

provide clear guidance to staff.

Management will continue to monitor risk assessments and care plans through regular audits and clinical governance processes.

The records management policy has been reviewed and staff are being reminded of the requirements for accurate, timely, complete and contemporaneous documentation.

Records, including assessments, care plans, progress notes, incident documentation, safeguarding records and other relevant clinical documentation, are monitored to ensure that they accurately reflect the care and support provided to residents.

Clinical documentation audits will continue to be undertaken, with any identified gaps addressed promptly and feedback provided to the relevant staff.

The PIC and management team will monitor the implementation of these policies through regular audits, supervision, staff meetings, handovers, safety pauses and quality and safety review processes.

Where audits identify gaps in compliance, an action plan will be developed, responsibilities assigned and completion monitored by management.

Staff will receive ongoing education and reminders regarding the relevant policies and procedures, with particular focus on translating policy requirements into consistent practice.

Regulation 5: Individual assessment and care plan	Not Compliant
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Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:

Following the findings identified during the inspection, the provider undertook a comprehensive review of residents' assessments and care plans to ensure that they accurately reflect each resident's assessed needs, risks, safeguarding requirements, personal preferences and required supports.

All residents' care plans have been reviewed. Particular attention was given to residents with identified safeguarding concerns to ensure that relevant safeguarding information, required supports, risk management measures and staff guidance are clearly reflected in the resident's care plan.

A further review of care plans is currently ongoing to ensure that documentation remains accurate, person-centred and reflective of residents' current needs. Any identified gaps are being addressed as part of this review process.

All first-quarter care plan reviews were discussed with the resident and/or their NOK/representative, as appropriate. The second-quarter care plan review process is currently ongoing, with residents and/or their NOK/representatives being involved in the review process.

In relation to residents where a pension agent arrangement is in place, all relevant residents now have a care plan documenting the arrangement and providing clear

guidance regarding how the resident can access their finances and the support available to them. This is reviewed in accordance with the resident's assessed needs and wishes.

The PIC and clinical management team will continue to monitor compliance through scheduled care plan audits and reviews. Care plans will also be updated following any significant change in a resident's needs, risks, circumstances or preferences.

Ongoing audits will specifically check that:

- assessments are comprehensive and inform the care plan;
- safeguarding concerns and required supports are clearly documented;
- care plans provide clear guidance to staff;
- personal finance/pension agent arrangements are appropriately documented where applicable; and
- residents and/or their representatives are involved in the care planning and review process.

Any identified gaps will be addressed promptly, with learning and required actions communicated to the relevant staff.

Corrective actions commenced and implemented. Second-quarter care plan review and ongoing monitoring are in progress.

Regulation 8: Protection	Not Compliant
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Outline how you are going to come into compliance with Regulation 8: Protection: Following the HIQA inspection findings, the registered provider has strengthened safeguarding arrangements to ensure that all reasonable measures are taken to protect residents from the risk of abuse and to ensure that all individuals providing services within, or accessing, the designated centre are appropriately authorised and subject to the required safeguarding controls.

A review of the arrangements for all staff, agency staff, contractors, volunteers, students, external service providers and other individuals accessing the centre has been undertaken. The provider is ensuring that appropriate identification, authorisation and safeguarding requirements are completed prior to individuals providing services or accessing areas of the designated centre, in accordance with the provider's policies and regulatory requirements.

Particular attention is being given to ensuring that appropriate staff vetting and safeguarding documentation is completed and verified before staff commence duties. Agency and temporary staff are also subject to the required checks and confirmation of authorisation prior to working within the centre.

Access to the designated centre is being monitored, with visitors and external service providers required to follow the centre's visitor/access procedures. Where external contractors or service providers require access to resident areas, access is controlled and appropriately supervised where required.

The safeguarding policy and procedures have been reviewed and communicated to staff. Staff are reminded of their responsibility to remain vigilant regarding residents' safety and to immediately report any safeguarding concern or allegation of abuse in accordance with the centre's safeguarding procedures.

Where a safeguarding concern is identified, immediate protective measures are implemented, the concern is appropriately documented and escalated, and the resident's safeguarding care plan and risk assessment are reviewed and updated where required.

The PIC and management team will maintain oversight of safeguarding arrangements through regular audits and checks, including:

- verification of staff and agency staff safeguarding/vetting documentation;
- confirmation of appropriate authorisation before individuals commence work or access the centre;
- review of visitor and external service provider access arrangements;
- monitoring of safeguarding concerns and actions taken;
- review of safeguarding care plans and risk assessments; and
- ongoing staff supervision, education and safeguarding discussions.

Any identified gaps will be addressed promptly, with actions assigned to the appropriate person and completion monitored by the PIC/management team.

The provider has strengthened safeguarding controls to ensure that residents are protected from potential abuse and that individuals accessing or providing services within the designated centre are appropriately authorised and subject to the required safeguarding controls. Ongoing audit, monitoring, staff education and management oversight will be used to ensure that these arrangements are consistently implemented and sustained.

Regulation 9: Residents' rights	Substantially Compliant
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Outline how you are going to come into compliance with Regulation 9: Residents' rights: The resident has been informed that, where he/she wishes to have cash withdrawn from the pension agent account held on his behalf, the centre will facilitate this. A Standard Operating Procedure (SOP-FIN-01) has been developed setting out a controlled process for providing cash to a resident from funds held on their behalf, including how a request is made, who authorises it, the timeframe for release, receipting, and the record kept.

Each resident for whom the centre acts as pension agent is provided with a written statement of the monies held on their behalf and of all transactions on a monthly basis, without the need to request it. A statement can also be provided at any time on request, either by the resident or by their nominated representative where the resident wishes, and is issued without delay. A running record of all lodgements, withdrawals and purchases made on the resident's behalf is maintained, with receipts retained, so that

the balance and transaction history of each pension agent account can be produced at any point.

Residents of whom the Centre acts as Pension agents have been informed of these arrangements, including how to request their funds or a statement.

In addition, Residents are supported to access independent advocacy through SAGE where they wish to manage their own accounts or where difficulties arise with an external financial institution.

Resident finances, including all pension agent accounts, are audited monthly by the Person in Charge and Admin Team, with results reviewed by the Senior Management Team. Any delay in a resident accessing their funds or financial information is recorded, escalated and addressed.

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 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.	Not Compliant	Orange	03/07/2026
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Not Compliant	Orange	18/08/2026
Regulation 23(1)(b)	The registered provider shall ensure that there is a clearly defined management structure that identifies the lines of authority and accountability,	Not Compliant	Red	18/08/2026

	specifies roles, and details responsibilities for all areas of care provision.			
Regulation 23(1)(d)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Red	18/08/2026
Regulation 04(1)	The registered provider shall prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.	Not Compliant	Orange	30/06/2026
Regulation 5(3)	The person in charge shall prepare a care plan, based on the assessment referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the designated centre concerned.	Not Compliant	Orange	30/09/2026
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after	Not Compliant	Orange	30/09/2026

	consultation with the resident concerned and where appropriate that resident's family.			
Regulation 8(1)	The registered provider shall take all reasonable measures to protect residents from abuse.	Not Compliant	Red	30/06/2026
Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.	Substantially Compliant	Yellow	30/06/2026
Regulation 9(3)(d)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may be consulted about and participate in the organisation of the designated centre concerned.	Substantially Compliant	Yellow	30/06/2026
Regulation 9(3)(e)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise their civil, political and religious rights.	Substantially Compliant	Yellow	30/06/2026