Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	Cliff House
Name of provider:	Stepping Stones Residential Care Limited
Address of centre:	Dublin 3
Type of inspection:	Unannounced
Date of inspection:	24 March 2026
Centre ID:	OSV-0003257
Fieldwork ID:	MON-0050047

About the designated centre

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

The designated centre consists of two houses with the capacity to provide full-time residential care and support for four children with an intellectual disability and autistic spectrum disorder. The centre is situated in a suburban area of Dublin with access to a variety of local amenities such as shops, train stations, bus routes, churches and the city centre. There are vehicles available to enable residents to access school and local amenities. There are two premises in the designated centre. The first house is a three-bedroom, split level, terraced home. The second house is a two bedroom, terraced split level house over three stories, situated within walking distance of the other house. Each resident has their own bedroom all of which are single en-suite rooms. Each resident is actively encouraged to personalise their own bedroom. Residents in the centre are supported 24 hours a day, seven days a week by a staff team comprising of a person in charge, person participating in the management of the centre, and healthcare workers. Staffing numbers are adjusted as the dependencies of the residents change.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	3

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Tuesday 24 March 2026	06:50hrs to 16:50hrs	Jennifer Deasy	Lead
Tuesday 24 March 2026	06:50hrs to 16:50hrs	Sarah Mockler	Lead

What residents told us and what inspectors observed

This was an unannounced risk inspection carried out over the course of one day by two inspectors. The designated centre is comprised of two houses and inspectors visited each house and had the opportunity to meet with all three of the children and young people who lived there. Inspectors also spoke with staff, family members and Tusla social workers (in respect of children in care) as part of the inspection process. In addition, the inspectors completed a thorough inspection of the premises and reviewed documentation. Inspectors used this information to inform judgments on the quality and safety of care.

Overall, inspectors found that there were numerous deficits which were impacting on the safety of the service and the quality of care provided to the children. There was a high level of non-compliance with the Regulations and, in response to this inspection, the provider was required to attend a cautionary meeting with the Chief Inspector of Social Services.

The centre comprises two houses located in North Dublin. One house was home to one child, and the other house provided care to two young people. Inspectors arrived at both houses in the early morning and spent the morning meeting the children and the staff on duty, and spending time observing the care and support provided. Inspectors saw practices in respect of fire safety and food and nutrition which raised concerns. The premises of both centres were also seen to require upkeep and improvements to ensure they were decorated in an age-appropriate manner for the children and young people living there.

In both houses, inspectors found that it took considerable time for waking night staff to admit them to the centre and concerns were raised in respect of the supervision of waking night staff. In the larger house, the inspector knocked on the door; however, as there was no answer, the inspector looked in the sitting room window and observed a staff member lying on the couch with a blanket over them. The inspector knocked on the window to get their attention; however, the staff member did not move from their position as they appeared sleeping. The inspector then rang the bell and waited again. It took approximately 15 minutes for another staff member to come and answer the door. The staff member who answered the door was the sleepover staff and they had come from downstairs to open the door. This was immediately flagged as a concern to centre staff and management.

In the smaller house, the inspector rang the doorbell and waited for a response. It took three doorbell rings and a considerable length of time before the door was opened. The staff on duty explained that they were not expecting visitors so early in the morning.

Overall, the inspectors were not assured that the staffing arrangements at night were in line with the requirements of the assessed needs of the children due to the

observed unresponsiveness of waking night staff. An urgent action was issued to the provider to seek assurances on the supervision of waking night staff. This meant that the provider had to provide immediate written assurances to the Chief inspector, in respect to their supervision arrangements around the staffing requirements.

In both houses, inspectors saw that there were risks to the emergency evacuation routes. In the larger house, the inspector noted a safety chain which was located in a very high position on the door frame. The inspector saw that this safety chain was in use as staff members had to remove it in order to open the door in the morning. In the smaller house, the inspector saw that the front door had three locking mechanisms, one of which required a key. Behind the front door was a hall door which also required a key to open it. Staff were seen carrying bunches of keys with 11 keys on the keyring. These locks on the final exit doors posed a serious risk to the fire evacuation arrangements of both houses as they would delay any emergency evacuation.

Other fire risks were also identified. Due to the concerns raised around these poor fire safety measures immediate actions were issued to the provider. This required the provider to remove a safety chain on a door, remove items stored on or beside fire extinguishers to ensure they could be accessed without delay and to remove a door wedge which was holding a fire door permanently open.

Inspectors had the opportunity to meet with all of the young people who were living in the centre. Inspectors met the young people as they were going about their morning routines, having breakfast and getting ready for school. Inspectors saw that the breakfasts offered in both houses did not appear sufficient to meet the nutritional needs of the young people. In the larger house, the young people ate small breakfasts of one brioche type bread or a small omelette. In the other house, the child living there, was seen to have a plate of digestive biscuits for breakfast.

Inspectors were told by staff that some young people were not very hungry in the morning and choose to eat small meals at this time. In the smaller house, the inspector was told that the child had a very limited diet as was their choice. However, as will be discussed further in the quality and safety section of the report, inspectors were not assured that there was adequate oversight of their food intake to ensure that it was sufficient to meet their needs.

In the larger house, the young people were prompted to complete their morning routines. For example, the inspector observed one young person write out their daily routine on a white board. Staff were heard giving the young person choices around activities and supporting them to choose what to write. They chose activities such as watching their tablet device or television and also wrote down everyday activities they had to complete. The other young person in the centre was prompted to get dressed and staff were seen help them fix their clothes.

Both young people in this house primarily used non-speaking methods to communicate. The inspector observed some visuals on the wall that were used for one young person and the staff stated that the other young person primarily used

some limited adapted sign language to communicate their immediate needs and other non-speaking cues. The inspector observed the young person use a sign for school to gain reassurance from the staff that they would be attending school later in the day. In the kitchen, on the wall there was a 'Lamh' sign of the week on display. The inspector asked a staff member what this sign was and the staff was unsure. It was unclear if this visual was being practiced with the young person in the centre.

Later in the morning the inspector observed the young people gather their belongings and go to school. Both young people were collected to go to school by school escorts and buses. One school escort called to the day and collected one young person, while another school escort rang the centre's phone and the young person was brought out to the bus. The young people were observed to get their belongings such as school bags and coats and appeared content to leave and go to their school bus.

In the smaller house, when the child woke up, they greeted the staff and the inspector and came to the sitting room for breakfast. The child set a timer for 10 minutes and staff told the inspector that this was part of their routine, and indicated when the child could use their tablet device. The child was clearly familiar with the staff on duty. They were seen to be affectionate towards the staff and said goodbye to the night staff when they were leaving, and greeted the day staff by name on arrival.

The inspector was told that this child was not currently attending school and that, for the last two years, their school attendance generally had been poor. While there were plans to meet with the child's school to discuss them returning to school, there was no established plan or timeframe for when this return would occur, and staff told the inspector that there was no educational programme in place in the interim. The inspector spoke with this child's social worker over the phone. They confirmed that there was a meeting scheduled with the child's school. The inspector spoke with staff about this child's care plans and daily activities. They were told that the child liked to go for drives and were shown daily records which showed the activities that the child enjoyed including bowling, driving to shopping centres or walking on the beach.

The inspectors completed a walk around of all aspects of the houses as part of the inspection process. Improvements were seen to be required to both of the houses to ensure they were homely and child-centred. Furniture was damaged in both of the houses, including couches which were seen to be worn or stained, a coffee table which had been defaced and some wardrobes were missing doors. The sitting room in one house had limited soft furnishes and overall the room presented with general wear and tear. Attention to detail and cleanliness also required improvement in one bedroom.

The play facilities in the smaller house needed significant improvements. There was no access to the back garden due to a bin blocking the way, and the steps to the garden appeared damaged. The garden was overgrown with weeds. The playroom of this house did not have a rug or carpet to cover the tiles. Colourful floor mats

were stuck on walls in both houses. In one house, when the inspector asked about the mats they were told they had been in place for a former young person who no longer lived in the home. The suitability of this type of decor required review considering that two teenage boys lived in the home.

The next two sections of the report will describe the governance and management arrangements and how effective these were in ensuring the quality and safety of care.

Capacity and capability

This section of the report describes the oversight arrangements of the centre. This inspection found that the arrangements in place were ineffective in ensuring that the service was complying with regulations and in driving service improvements. There were numerous deficits identified which were impacting on the safety of the service and on the quality of care. While a recent provider audit had identified a number of these deficits, sufficient action had not been taken. In addition, other audits had been ineffective in identifying risks and in implementing timely action plans to achieve better outcomes for the children and young people.

There were gaps in the local management systems due to the absence of the person in charge. The inspection found that the interim arrangements were ineffective in ensuring oversight of the service. Information governance arrangements, including local and provider audits, were ineffective in identifying all risks and in implementing timely action plans to ensure the safety of care.

There was a failure to provide the local management team with appropriate training and support when fulfilling person in charge duties. Deficits were identified in respect of the supervision of waking night staff, and in the staff team's implementation of policies relating to food and nutrition. Staff members spoken with were not fully informed of children's care plans and of where to locate important documents in the service including, for example, records of fire drills.

Overall the systems in place, at the time of inspection, had failed in ensuring the service was safe, of good quality and that deficits in care and support were identified and addressed in a timely manner.

Regulation 15: Staffing

On a review of the staffing arrangements, it was found that, while there were sufficient staff in place with suitable experience and qualifications, these arrangements were rendered ineffective by the observed unresponsiveness of a

waking night staff on the morning of inspection. The impact of this was that staff were not available to meet the young people's needs should they wake up and require support.

Inspectors raised concerns with managers on the day of inspection regarding the arrangements to supervise and performance manage waking night staff. Inspectors were told that waking night staff were required in the houses as a control measure on the fire risk assessments. Additionally, one child was known to have an "exceptionally high risk of absconding" as per their transition plan dated December 2025. Inspectors saw, on arrival to one of the houses, that a waking night staff appeared to be asleep on the couch. In the second house, it took a considerable time for waking night staff to answer the door. The provider responded to an urgent action in writing and detailed measures they intended to take to performance manage waking night staff.

Judgment: Not compliant

Regulation 21: Records

Inspectors reviewed the Schedule 2 files for seven staff members. Inspectors saw that, for each staff member, there was a copy of an up-to-date photographic identification, an up-to-date Garda vetting disclosure, copies of at least two verified references and information on their qualifications and child care experience. All of the staff were seen to have a suitable qualification and experience in working with children or vulnerable persons.

Judgment: Compliant

Regulation 23: Governance and management

The management systems of the service required enhancement. There were a high number of deficits identified on this inspection which posed risks to the safety of the children and young people. Immediate actions were issued on the day of inspection, and an urgent action was issued in writing the day after the inspection. The provider's responses gave assurances that those immediate and urgent risks had been mitigated; however, there remained significant areas for improvement and a high level of non compliance with the regulations.

Arrangements to supervise staff also required improvements. On a review of staff supervision records the inspectors saw that not all staff were in receipt of supervision in line with the provider's policy. On review of three staff member's supervision records it was noted that they received formal supervision in September 2025 with the next supervision not occurring until January or February 2026. The

provider's policy stated that supervision was to occur at eight week intervals and this had not occurred for all staff. The inspectors acknowledge that supervision had commenced again for staff in 2026.

The centre had been without a person in charge (PIC) since October 2025 due to a planned absence. The inspectors found that the interim management arrangements were ineffective in ensuring the quality and safety of care. Concerns were identified on this inspection in respect of the performance management of staff, the oversight of fire safety risks, and the oversight of children's assessments and care plans.

The provider's Director of Service audit dated 18 March 2026 identified some of these deficits. For example, it identified that there was under-reporting of risks by local management and that the interim management arrangements, which were in place during the absence of the PIC, needed review and more formal governance contingency arrangements. The audit also identified a number of other deficits including in respect of risk management and safety oversight. However, while the deficits were identified on this audit, they had not been previously identified and the inspectors found that there were risks to the quality and safety of care which had been present for a number of months.

Other provider level audits were inaccurate in some of the detail that they provided. A six monthly audit from November 2025 set out that the team leader had additional training to ensure they were fully equipped to manage the role of acting up as the person in charge; however, inspectors were told that this training took the form of on-site support from the regional manager and that there was no formal training provided. The director of services audit from March 2026 also found that there was a reliance on informal or responsive oversight than than consistently documented and structured supervision, which was weakening the overall accountability of the service.

Changes had been made to the footprint of the smaller of the houses. A bedroom had been swapped with a multi-purpose room. An application to vary the footprint had not been submitted to the Chief Inspector. A child had been admitted to this house in January 2026; however, the initial admission assessment for the child had determined that the designated centre was not a suitable placement given their high risk of absconscion. The child was however admitted and additional restrictive practices had been installed as control measures. These restrictive practices posed numerous risks to the safe evacuation arrangements. These risks had not been identified through the provider's own audits.

Judgment: Not compliant

Quality and safety

This section of the report describes the quality of the service and how safe it was for the children and young people who lived here. Inspectors found significant deficits in the quality and safety of service, with all regulations in this part of the report found as not compliant. In particular, improvements were required to the fire safety arrangements and to the multidisciplinary assessment of children's health and social care needs. Immediate actions were issued on the day of inspection to mitigate against fire risks. The provider confirmed, prior to the end of the inspection, that these actions had been completed.

The centre provides care to three children and young people across two houses. Both houses were seen to be in need of upkeep in order to ensure that they were homely, child-friendly and provided age-appropriate and dignified spaces for them to play, rest and meet with important people in their lives. In particular, the play facilities, both indoors and outdoors, of one of the houses required improvement. In the other house, bedroom furniture required replacement or repairs to allow young people to store their belongings and clothes in a dignified manner.

Children's personal plans failed to comprehensively detail their needs and outline the supports required to maximise their personal development and quality of life. Care plans, while informed by family members, were not completed in consultation with a multidisciplinary team. Care plans were found to be inaccurate and were not specific to each child and their needs. An assessment of one child's educational attainment targets had not been completed as part of their admission and there was no care plan in place to detail the supports that they required to achieve these.

The provider's policy in respect of monitoring children's weight was not being implemented. Concerns were identified regarding the food offered to children and young people. Records reviewed were insufficiently detailed in order to establish if children were offered sufficient nutritious foods.

Regulation 17: Premises

The premises of both houses were seen to require upkeep, in particular in respect of furniture and the play equipment. In the smaller of the houses, the back garden was inaccessible and was seen to be very overgrown with weeds. A trampoline was in the garden but this had green mildew around the edges and was not accessible at the time of inspection. The wooden decking and steps leading to the garden appeared slippy and damaged. There was a steep drop behind the railing of the decking and the inspector was not assured that this was a safe and suitable way for children to access the play facilities. Additionally, the decking was used to store bins and mops and a bin was seen to obstruct the steps to the garden.

The couches in both houses required replacement. Two couches in one house were seen to be stained and the coffee table had also been drawn on and had dried

poster paint on one side. The couches in the other house were very well used and were sagging in the middle.

The play room in the smaller of the houses was not presented in a manner which encouraged play; for example, the floor was tiled and there were no rugs on the ground. There was a musty smell noted in this room in spite of the two windows being open. There was also limited child-centred decor in the larger of the houses including in the sitting room and visitors room.

The laminate counter top in the smaller house was damaged in one area. This was unsightly and meant that the counter top could not be effectively cleaned.

There was an item of furniture in the smaller house which did not belong to the child who was living there. The inspectors were told that this had belonged to a former resident. It was unclear why it continued to be stored in the living room as it was unsuitable for the current child.

In the larger of the houses it was seen that wardrobes present in the young person's bedrooms had no doors or doors were missing. One young person's locker had a broken drawer. One young person's bedroom had an accumulation of dust and dirt present on shelving and on items displayed on the shelving

There were colourful soft mats stuck on one part of the centre, the functionality and young person's preferences in having this type of decor in the home was unclear. Conflicting information on the purpose of the mats was presented to the inspectors.

Overall, a number improvements were required to the upkeep of the designated centre internally and externally to ensure it was child-centered and in line with the young people's preferences and assessed needs.

Judgment: Not compliant

Regulation 18: Food and nutrition

Records of food offered to residents were not maintained in a manner which enabled the inspectors to verify that food offered was nutritious and sufficient to meet the dietary needs of the children and young people living in the centre. Issues were also identified in respect of the storage of food in the centre’s fridge.

In one house, the inspector was told that the child had a limited diet and mostly chose to eat biscuits, chicken nuggets, chips and bread. The inspector saw that this child had a plate of digestive biscuits for their breakfast. The fridge in this house contained very little fresh food, and of the fresh food that was there, the inspector was told that much of this belonged to the staff.

The inspector saw that a packet of yoghurts was out of date and asked the staff to remove them from the fridge. A bowl of a mince-based dish was covered with cling

film and was unlabelled or dated. The staff team initially told the inspector that this was staff food, but later said that they had prepared it the night before and offered the child some for dinner. While staff said that this was offered, this choice was not recorded in the child's daily notes.

While the staff team were aware that the child had a very restricted diet they stated that they were not attending a dietitian. The staff team were unsure if a referral had been made to a dietitian. The inspector reviewed the daily notes for this child from the 16th to 23rd March 2026. It was seen that the child mainly consumed bread, chicken nuggets and crisps. On three days it was detailed that the child was offered other foods which included salmon and rice, burger and chips and an egg sandwich. It was not detailed on other days if the child was offered other meals as the notes simply said, in respect of food choices, "all the choices that were available in the house". However, on the day of inspection, the inspector saw that there was very limited fresh food available in the house. The inspector enquired if the child was on any additional supplements or multivitamins and was told they were not.

Overall, the approach to ensuring meals were nutritious and met the young people's dietary needs was lacking in formal assessment, review and guidance.

Judgment: Not compliant

Regulation 26: Risk management procedures

Overall the inspectors were not assured that suitable risk management systems were in place in the centre.

The inspectors asked to see incidents in the centre over the last four month period. The inspectors reviewed the incidents that were recorded on the on-line system and saw that four incidents were recorded in January and February 2026. These incidents described occurrences of self-injurious behaviours, and incidents whereby a young person was upset. The provider's systems required that incidents were reviewed on a monthly basis. On review of the notes of the incident review that had occurred on the 16th March 2026 it was found that six incidents were reviewed and only three of these incidents were recorded on the provider's incident recording system. For example, there were four incidents described in the review notes whereby a young person had engaged in self-injurious behaviours. However, on the provider's incident recording system only one of these incidents was described. It was unclear where the other three incidents had been recorded. This did not provide assurances that incidents were being identified, recorded and reviewed in a systematic manner.

On review of the risk register the inspectors were not assured that risk assessments were reflective of actual risks within the centre or that control measures were in place as described. The inspectors reviewed the individual risk assessments in place for the three young people in the centre. One young person, who had recorded

incidents that related to self-injurious behaviours, had a risk assessment in place and it was reviewed in March. The risk rating in place was not reflective of the actual risk and it had been updated based on time as opposed to the frequency and intensity of incidents occurring. There was limited evidence that the control measures had been considered or updated following incidents.

In addition, this young person had an identified risk of ingesting non-edible items. A number of the control measures in place in the risk assessment were not in place in the centre. For example, the risk assessment stated that all kitchen cabinets required locks, these were not in place. There were at least four other control measures listed on this risk assessment that were not in place on the day of inspection. A lack of adherence to control measures was also identified in another child's risk assessment around choking. The risk assessment stated that all new foods introduced had to be assessed. There was no formal assessment in place on the day of inspection and it was unclear how staff were choosing new food items. Overall, it was found that the risk assessments in place were not guiding staff practice.

Judgment: Not compliant

Regulation 28: Fire precautions

Serious risks were identified in respect of the fire management systems in the centre. The fire management systems posed a risk to the safety of the children. Immediate actions were issued on the day of inspection in order to mitigate for some of these risks.

The designated centre is comprised of two houses. Both of these houses were seen to have final exit doors which required keys to open them. Both final exit doors also had safety chains attached to them.

In the larger house, the inspector issued an immediate action to the provider in relation to the use of a chain on the front door as it was a significant risk in the event of a fire. The front door was one of the main exits used if there was a fire on the premises. When the use of this chain was discussed with the management present they stated the chain was never used but this did not align with the observations on the morning of inspection, where staff were seen to remove the safety chain to admit the inspector. The inspector requested information in relation to review of this practice by a suitably qualified fire expert or if any risk assessments had been completed in relation to the use of the chain. It was confirmed that this was not in place or had not occurred. The chain was removed from the door before the end of the inspection day.

The smaller house had a final exit door which had a key lock, a latch-style lock and a safety chain attached to it. Behind this door was another hall door which also required a key to unlock it. Staff in this house were seen carrying a bunch of keys

which contained 11 keys including the ones required to unlock the emergency exit door. One staff member told an inspector that it can take new staff some time to locate the correct key on the key bunch. This posed a risk to the staff team's ability to safely and quickly evacuate children in the event of a fire.

Fire extinguishers in two of the houses were seen to be obstructed. One fire extinguisher case was blocked by a small chair and had a keyboard and coats stored on top of it. Staff would be required to remove these items, before removing the pins and safety belts on the case to release the fire extinguishers. This posed a risk that fires could not be dealt with in an efficient manner. Immediate actions were issued in relation to ensuring fire extinguishers were fully accessible at all times

The provider had installed additional restrictive practices since the admission of a child to the smaller of the houses. These included an additional key-locked hall door and fixed wooden shutters on the basement playroom window. The impact of these on the fire evacuation arrangements had not been risk assessed.

A fire door in an office in one of the houses was seen to be wedged open. An immediate action was issued to remove this door wedge as this posed a serious risk to the fire containment facilities.

Fire drills were being completed; however, there was no guidance for staff on what constituted a safe evacuation time. Inspectors saw that two fire drills in October 2025 took approximately 10 minutes to evacuate one child. It was not established if this was a safe evacuation time. The inspectors were told by management that usually additional drills would be completed to try to improve the evacuation time; however, there were no such actions detailed on the fire drill records.

Foam floor mats were used as decoration (and as a protective measure in one house due to self-injurious behaviours) on walls in the centre. These included in the playroom of one house and on the fire evacuation corridor on both. It was unclear whether these mats were fire retardant and if they were suitable to be used in this manner.

In both houses, electric plug-in heaters were in use in staff bedrooms. In one bedroom an extension lead had three plugs inserted including to a phone charger, a lamp and an electric heater. These practices also posed a fire risk.

Overall, the inspectors were not assured that safe practices in relation to mitigating fire risks were in place in the designated centre.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

The inspectors reviewed two of the children’s personal plans and, in particular, focused on the assessment for one of the children who had been recently admitted.

Inspectors found that there were significant deficits in respect of the individual assessment of children's health, social care and education needs. Assessments were not informed by up-to-date multidisciplinary reports. Personal plans contained details which were not specific to the needs of each child and which were, at times, inaccurate. Recommendations for specific health needs were being made without clear guidance from allied healthcare professionals. It was also found that the provider was not implementing their policy in respect of monitoring children's nutrition and weight.

One child's individual assessment was informed by a multidisciplinary assessment which had taken place in 2017. This was very out of date given the significant time period that 9 years is in a child's life and the changes that may have occurred since then. This assessment from 2017 recommended that the child have access to speech and language therapy, occupational therapy, and psychology; however, these were not in place in the centre. The child's care plans were not specific, for example it detailed "I may receive support or guidance from an OT (occupational therapist). OT recommendations may include...". There was no up-to-date assessment from an occupational therapist on file and it was unclear what these recommendations were based on. The provider had failed to ensure that a comprehensive assessment of the child by appropriate healthcare professionals was carried out prior to the child's admission to the centre.

The provider had met with important individuals in the child's life and had gathered information as part of the admission process. Care plans had then been written based on this information. However, care plans for specific healthcare needs were not written by appropriate healthcare professionals. For example, a choking, aspiration and swallow care plan was written by a member of the provider's management team. This plan detailed that the child presented with specific choking and swallow risks including holding food in their mouth and coughing while eating. It gave guidance to staff on monitoring for suspected aspiration. This guidance was not provided by a suitable allied healthcare professional, and was not based on an assessment of their feeding, eating, drinking and swallowing (FEDS) needs.

Other personal plans were not specific to the child's assessed needs. For example a personal plan stated that the child required door alarms to be kept safe; however door alarms were not used in the centre. Another school plan detailed how to support the child in attending school; however, the child was out of school at the time of inspection and had been for some time. Some care plans were inaccurate; for example, information on the child's communication detailed that the child does not use words; however, the inspector heard this child communicating verbally. The inspectors were told that this information had been gathered as part of the admission process; however, the provider had failed to adequately assess the child's needs and to use this information to put together comprehensive personal plans within 28 days of admission.

Personal plans were signed with a signature however there was no legible written name or title and so it was not established who was responsible for reviewing and for assessing the effectiveness of plans.

A young person had their weight taken weekly. Inspectors noted that the weight appeared low and enquired about the young person's Body Mass Index (BMI). The provider's nutrition and hydration policy set out that young people should have their BMI calculated on admission in consultation with a dietitian or general practitioner and thereafter, should be reviewed annually as part of the annual health assessment. The policy also detailed that a Malnutrition Universal Screening Tool (MUST) should be completed annually. Inspectors found that no BMI had been calculated and the MUST had not been completed. Inspectors therefore could not verify that the child's BMI was suitable for their age.

There was a lack of guidance for staff in respect of monitoring weight. Staff were taking children's weights weekly but it was unclear for what purpose and what they should do if there were any concerns in respect of weight. For example, in June 2025 a young person lost 2.7kg in the course of a week. This was not escalated for review and it was not detailed what kind of weight loss would necessitate a review or further investigation.

Overall, the guidance in place posed a risk to the young people and the inspectors were not assured that the children's needs had been adequately assessed.

Judgment: Not compliant

Regulation 8: Protection

Notwithstanding the clear safety issues already highlighted pertaining to staffing and governance, procedures for the reporting of child protection and welfare presented as adequate. There were systems in place for reporting child protection and welfare concerns in line with C*hildren First: National Guidance for the Protection and Welfare of Children (2017).* The centre had a safeguarding statement in place and on display in the kitchen of the centre. There was the designated liaison person (DLP) appointed. The staff who inspector spoke with had a clear understanding of the role and responsibilities of the DLP.

There had been one notification of a child protection incident in the last 12 months. The inspector saw evidence that this had been reported to to the Child and Family Agency (Tusla) as required under the legislation. In addition, a safeguarding plan had been developed to mitigate the risks associated with this concern. This included taking immediate actions to safeguard the child, completing an investigation and reporting in line with relevant national guidance and legislation.

The inspectors reviewed two care plans related to personal care. These plans had recently been updated and upheld the children's rights to privacy and dignity while ensuring there care needs were met in a safe manner.

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	Not compliant
Regulation 21: Records	Compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 18: Food and nutrition	Not compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 8: Protection	Compliant

Compliance Plan for Cliff House OSV-0003257

Inspection ID: MON-0050047

Date of inspection: 24/03/2026

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 15: Staffing	Not Compliant

Outline how you are going to come into compliance with Regulation 15: Staffing:

Following the inspection, the Registered Provider undertook an immediate and comprehensive review of waking night staffing arrangements across Cliff House and wider service provision to ensure that staffing arrangements were fully effective in meeting the assessed needs of residents at all times, particularly during night-time hours.

A full performance management review and investigation was initiated in relation to the concerns raised on inspection. All waking night staff were formally re-briefed regarding their roles, responsibilities and expectations while on duty, including requirements relating to active supervision, environmental vigilance, prompt responsiveness, and maintaining waking night status throughout the entirety of their shift. The Waking Night Policy was reviewed and strengthened to provide clearer operational guidance for staff and management, with explicit expectations regarding alertness, supervision of residents, fire safety responsibilities, and immediate response requirements.

To provide measurable oversight and strengthen assurance, the provider has implemented the OK Alone lone working monitoring application across all designated centres. This system now requires waking night staff to complete scheduled welfare check-ins at predetermined intervals throughout their shifts. Failure to respond triggers immediate escalation procedures. The system provides real-time monitoring and retrospective oversight through a centralised dashboard accessible by Persons in Charge and senior management, ensuring clear evidence of staff alertness, responsiveness, and compliance with waking night requirements.

In addition, unannounced night-time spot checks have been introduced by local management, senior management, and provider representatives to directly monitor staff practice, supervision standards, and environmental safety during night shifts. Formal supervision and performance management arrangements for staff have also been strengthened to ensure more frequent and structured oversight, with specific focus on

waking night performance.

These actions collectively provide strengthened governance, improved staff accountability, and demonstrable oversight of waking night arrangements. The provider is satisfied that staffing arrangements are now robust, effectively supervised, and aligned with the assessed safety, supervision, and support needs of all residents. Continuous monitoring systems are now in place to ensure sustained compliance under Regulation 15.

Regulation 23: Governance and management	Not Compliant

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

Following the inspection, the Registered Provider completed an immediate and comprehensive review of governance, management, and oversight systems within Cliff House to address the significant deficits identified and to ensure the service is effectively governed, monitored, and managed in full compliance with Regulation 23.

Recognising that the prolonged absence of the registered Person in Charge from October 2025 had weakened local governance arrangements, the provider has now transitioned an experienced and suitably qualified Person in Charge into the centre to provide direct operational leadership, oversight, and regulatory accountability. This appointment has significantly strengthened day-to-day governance, ensuring that the centre is led by an experienced manager with the competence, authority, and regulatory understanding required to oversee all aspects of service delivery, resident safety, staff supervision, and compliance management. Formal contingency arrangements for future management absences have also been developed to ensure sustained leadership continuity.

The provider undertook a full review of management structures and implemented enhanced governance systems to ensure clearly defined lines of authority, accountability, and escalation. This included strengthened oversight from senior management and the Director of Services, with increased frequency of unannounced visits, structured governance audits, and formal quality assurance reviews. Senior Managers are now operating under an intensified oversight schedule, with weekly centre visits, environmental audits, documentation reviews, and compliance monitoring to ensure timely identification and escalation of deficits.

Staff supervision systems were comprehensively reviewed and strengthened. All staff supervision schedules have now been reset and brought back into alignment with organisational policy, ensuring formal supervision occurs at required eight-week intervals. A robust supervision tracker and monitoring system has been introduced to ensure compliance is maintained. Supervision sessions now place enhanced focus on accountability, professional performance, safeguarding, fire safety, personal planning, and implementation of policies and procedures. Management oversight of supervision completion has also been strengthened at provider level.

In response to the deficits identified in provider auditing systems, all audit tools and

governance frameworks have been reviewed and revised to improve accuracy, accountability, and effectiveness. Provider audits now include enhanced scrutiny of risk management, fire safety, restrictive practices, admissions, staffing oversight, and regulatory compliance. Findings from audits are now linked to formalised Quality Improvement Plans with clearly assigned responsibilities, deadlines, and escalation pathways. The March 2026 Director of Services audit findings have been used as a service-wide learning framework to strengthen governance across all designated centres.

In relation to environmental and registration governance, immediate review was undertaken regarding the unapproved changes to the smaller house footprint. Appropriate regulatory processes have now been initiated to ensure all environmental changes are formally notified and approved by the Chief Inspector as required. Admissions, restrictive practices, and environmental risk controls have also been reviewed to ensure all future admissions are fully aligned with assessed compatibility, risk management, fire safety, and regulatory requirements prior to placement.

The provider acknowledges that while internal audits had identified some deficits prior to inspection, systems for timely escalation and resolution were insufficient. These governance failures have now been addressed through strengthened provider oversight, more rigorous audit systems, clearer management accountability, enhanced operational leadership, and improved regulatory governance structures.

Collectively, these measures have significantly strengthened governance and management arrangements within Cliff House. The provider is satisfied that the centre now has improved operational leadership, effective oversight systems, robust staff supervision arrangements, strengthened auditing processes, and formal governance contingency planning in place to ensure the quality and safety of care is consistently monitored and sustained.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:

Following the inspection, the Registered Provider undertook a comprehensive premises improvement programme across both houses within Cliff House to address all environmental, maintenance, safety, and child-centred deficits identified under Regulation 17. All identified actions have now been completed to ensure that both houses are maintained to a high standard, are safe, appropriately decorated, and reflective of the young people's assessed needs and preferences.

A full external grounds and garden restoration was completed in the smaller house. The overgrown garden was fully cleared, weeds removed, and all outdoor areas restored to ensure safe accessibility. The trampoline was professionally cleaned and reinstated for use. Wooden decking and steps were repaired, treated, and made safe, with slip risks addressed. Environmental safety controls were strengthened in response to the steep drop identified near the decking area, ensuring safe access for young people to recreational spaces. All inappropriate storage of bins, mops, and maintenance items was removed from recreational areas, and dedicated storage arrangements were introduced to ensure outdoor spaces remain child-centred, safe, and accessible at all times.

Furniture replacement and refurbishment works were completed across both houses. Damaged, stained, worn, or sagging couches were replaced, and unsuitable or damaged furniture items, including the marked coffee table and obsolete furniture belonging to previous residents, were removed. Bedroom furnishings, including damaged wardrobes, missing doors, and broken storage units, were repaired or replaced to ensure all residents have dignified, functional, and age-appropriate personal spaces.

The smaller house playroom underwent significant enhancement to ensure it is developmentally appropriate, welcoming, and conducive to play. Both houses have also undergone redecoration and environmental enhancement to ensure décor is age-appropriate, personalised, and reflective of current residents' preferences rather than previous placements.

Deep cleaning and environmental hygiene interventions were completed throughout the designated centre, including all bedrooms, communal areas, and storage spaces. Issues relating to dust accumulation, cleanliness standards, and maintenance of surfaces such as damaged countertops were fully addressed.

The provider also implemented strengthened premises oversight systems, including:

• Increased environmental audits by local and senior management
• Scheduled preventative maintenance programmes
• Enhanced housekeeping and cleaning monitoring systems
• Regular child-centred environmental reviews to ensure spaces remain homely, personalised, and responsive to residents' evolving needs

The provider acknowledges that the inspection identified significant environmental deficits; however, all required improvements have now been fully completed. Cliff House has undergone substantial internal and external upgrades to ensure the premises are safe, well-maintained, child-centred, and fully aligned with regulatory requirements and best practice standards. These improvements are now supported by strengthened governance systems to ensure sustained compliance moving forward.

Regulation 18: Food and nutrition	Not Compliant

Outline how you are going to come into compliance with Regulation 18: Food and nutrition:

Following the inspection, the Registered Provider undertook a full review of food and nutrition practices across Cliff House to ensure that all residents' nutritional needs are formally assessed, appropriately supported, and consistently monitored in line with Regulation 18.

Immediate action was taken to address food storage, stock management, nutritional oversight, and recording systems within both houses. Comprehensive food safety and kitchen audits were completed, with all out-of-date food removed, food storage systems reorganised, and robust processes introduced regarding food labelling, dating, stock rotation, and fridge management. Clear separation of staff food and resident food has

now been implemented, with enhanced oversight systems to ensure residents' food availability is consistently prioritised and monitored.

In relation to the resident with a restricted diet, a full nutritional review was completed, including formal referral to and assessment by a qualified dietitian. Dietetic oversight is now in place to assess nutritional adequacy, support dietary progression where possible, and provide evidence-based guidance regarding supplementation, meal planning, and monitoring of dietary intake. This ensures that the resident's restricted eating patterns are clinically assessed and managed appropriately, while continuing to respect their autonomy, sensory needs, and food preferences.

Recording systems for meals offered and consumed have been significantly strengthened. Daily records now require detailed documentation of all food options offered, resident choices made, and nutritional intake to ensure clear oversight and evidence of efforts to provide varied, nutritious meals. This addresses the previous lack of clarity regarding meal offerings and staff efforts to encourage dietary variety.

Fresh food availability has been prioritised through improved shopping schedules, stock management systems, and management oversight to ensure that nutritious food choices are readily available at all times.

The provider acknowledges that previous systems lacked sufficient formal oversight and consistency; however, significant improvements have now been fully implemented. Residents' nutritional needs are now supported through formal dietetic assessment, strengthened care planning, improved staff guidance, enhanced food safety systems, and robust governance oversight.

These measures ensure that all residents are provided with nutritious, sufficient, and choice-led meals that are consistent with both their assessed needs and personal preferences, while also ensuring compliance with Regulation 18 moving forward.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:

Following the inspection, the Registered Provider completed a full review and overhaul of risk management systems within Cliff House to ensure that all risks are accurately identified, appropriately assessed, consistently recorded, and effectively managed in line with Regulation 26.

An immediate audit of all incident reporting systems, risk registers, individual risk assessments, and control measures was undertaken. This review identified inconsistencies in incident recording, escalation, and documentation, which have now been comprehensively addressed. All historical incidents were retrospectively reviewed, reconciled, and accurately recorded within the provider's formal incident management system to ensure complete oversight and regulatory compliance. A strengthened incident reporting protocol has now been implemented, requiring all incidents to be recorded

promptly, reviewed systematically, and formally escalated through management governance structures. Monthly incident reviews have been redesigned to ensure full cross-referencing between incident records, behaviour monitoring, safeguarding concerns, and risk assessments.

To strengthen provider oversight, management review processes have been enhanced, including:

• Weekly incident and risk review by local management

• Monthly formal risk and incident governance reviews

• Senior management oversight of all incident trends

• Director of Services audits focused on risk governance and implementation

All resident-specific risk assessments have now been fully reviewed and updated to ensure they accurately reflect current presenting risks, behaviours, and support needs. Risk ratings are now informed by actual incident frequency, severity, and presenting patterns rather than time-based review alone. Control measures have been reassessed for relevance, practicality, and implementation, with all required controls now operational in practice.

Where gaps were identified between written risk assessments and operational practice, these have been fully corrected.The provider has also introduced strengthened admission and transition risk governance processes to ensure all identified risks, including historical risks, are fully assessed, mitigated, and reviewed with multidisciplinary input wherever possible.

The Registered Provider acknowledges that previous systems did not consistently provide sufficient assurance regarding systematic risk oversight. However, significant corrective actions have now been completed to ensure that risk management systems are robust, dynamic, reflective of actual resident needs, and effectively embedded into daily practice. These improvements ensure that Cliff House now operates with strengthened systems for the assessment, management, review, and mitigation of risk, thereby significantly improving resident safety, staff guidance, and regulatory compliance under Regulation 26.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:

Following the inspection, the Registered Provider undertook an immediate and comprehensive fire safety review across both houses within Cliff House to address all identified deficits and ensure full compliance with Regulation 28. Due to the seriousness of the findings, immediate actions were completed on the day of inspection, followed by a wider service-level fire safety improvement programme.

All unsafe door security measures that could impede emergency evacuation were

immediately removed or amended. Safety chains were removed from final exit doors, restrictive locking arrangements were reviewed, and emergency exit routes were fully reconfigured to ensure rapid, unobstructed evacuation. The master key and access systems across both houses were fully reviewed and simplified, with key management protocols strengthened to ensure immediate access to exits in emergency situations. Staff now have access only to clearly identified emergency keys, and all staff have been re-trained in emergency exit procedures.

All fire safety hazards identified during inspection were fully addressed, including:

• Removal of door wedges compromising fire doors
• Removal of obstructions to fire extinguishers
• Reorganisation of environmental layouts to ensure immediate access to fire equipment
• Removal or strict control of portable heaters and unsafe electrical arrangements
• Review of extension lead use and staff bedroom electrical safety

Comprehensive environmental fire safety audits have now been introduced across the centre, supported by routine senior management oversight.

Where previous drills indicated delays, additional drills have been completed to improve staff performance and resident evacuation outcomes. Fire drill documentation and governance oversight have been significantly improved to ensure measurable progress and accountability.

To further strengthen night-time safety, waking night supervision arrangements have been enhanced through the implementation of the OK Alone monitoring system, supporting real-time assurance of staff alertness and responsiveness during hours of reduced staffing.

The provider acknowledges that the inspection identified serious deficits in fire safety systems and governance. However, all immediate risks have been fully mitigated, significant environmental and operational improvements have been completed, and robust fire governance systems are now in place.

These actions collectively ensure that Cliff House now operates with strengthened fire safety management systems, safer premises, improved evacuation readiness, enhanced staff competency, and formal governance oversight, thereby ensuring the safety of residents and sustained compliance under Regulation 28 moving forward.

Regulation 5: Individual assessment and personal plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:

Following the inspection, the Registered Provider undertook a comprehensive review and full redevelopment of assessment, care planning, and multidisciplinary support systems within Cliff House to ensure full compliance with Regulation 5 and to ensure that each child's health, social care, education, communication, behavioural, and developmental

needs are comprehensively assessed, accurately documented, and appropriately supported.

A full audit of all resident personal plans, admission assessments, healthcare plans, education plans, communication supports, and multidisciplinary records was immediately completed. This review identified outdated, inaccurate, or insufficiently individualised plans, all of which have now been comprehensively revised.

The provider has now ensured that all available current referral information, professional reports, family input, and stakeholder guidance will be consolidated into a revised and comprehensive assessment framework. Where immediate external MDT access remains dependent on statutory services, robust interim care plans have been developed based on known risks and best available information, with clear escalation for formal professional oversight.

All personal plans have been fully reviewed and rewritten to ensure:

- Accuracy and resident specificity
- Current information reflective of actual presentation and needs
- Clear linkage to assessed risks
- Alignment with current placement circumstances
- Resident-centred and practical guidance for staff
- Clear review dates, authorship, and accountability

Plans previously containing inaccurate or generic information, such as outdated communication profiles, inappropriate environmental controls, or incorrect educational supports, have been corrected to accurately reflect each child's present needs and supports.

Specific healthcare plans, including choking, aspiration, swallowing, nutrition, behaviour support, and physical health monitoring plans, have now been reviewed and strengthened, with MDT oversight sought wherever possible. Interim plans are now clearly identified as temporary safeguards pending specialist input, ensuring staff are guided safely while awaiting external assessment.

Education planning has also been strengthened. For residents not currently attending school, formal educational oversight arrangements, stakeholder meetings, interim educational planning, and clearer transition pathways are now documented to ensure educational needs are actively monitored and progressed.

Governance around care planning has also been significantly strengthened through:

- Formal care plan audit tools
- Quarterly personal plan reviews
- Enhanced local management oversight
- Senior management auditing
- Improved multidisciplinary coordination
- Clear authorship, sign-off, and accountability structures

The Registered Provider acknowledges that previous care planning systems did not consistently provide sufficient assurance that children's needs were comprehensively assessed or accurately reflected in care documentation. However, significant corrective actions have now been fully implemented.

Cliff House now operates with strengthened systems for admission assessment, multidisciplinary referral, health and educational planning, nutritional oversight, and personal plan governance. These improvements ensure that each child's needs are comprehensively assessed, accurately documented, regularly reviewed, and appropriately supported, thereby significantly improving resident safety, quality of care, and sustained compliance under Regulation 5 moving forward.

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 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Not Compliant	Orange	01/05/2026
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Not Compliant	Orange	01/05/2026
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre	Not Compliant	Orange	01/05/2026

	are clean and suitably decorated.			
Regulation 17(3)	The registered provider shall ensure that where children are accommodated in the designated centre appropriate outdoor recreational areas are provided which have age-appropriate play and recreational facilities.	Not Compliant	Orange	01/05/2026
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Not Compliant	Orange	01/05/2026
Regulation 18(2)(b)	The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which are wholesome and nutritious.	Not Compliant	Orange	01/05/2026
Regulation 18(2)(c)	The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which offers choice at mealtimes.	Not Compliant	Orange	01/05/2026
Regulation 18(2)(d)	The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which	Not Compliant	Orange	01/05/2026

	are consistent with each resident's individual dietary needs and preferences.			
Regulation 23(1)(b)	The registered provider shall ensure that there is a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.	Not Compliant	Orange	01/05/2026
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	01/05/2026
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a	Not Compliant	Orange	27/03/2026

	written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.			
Regulation 23(3)(a)	The registered provider shall ensure that effective arrangements are in place to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.	Not Compliant	Red	01/05/2026
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Not Compliant	Orange	01/05/2026
Regulation 28(1)	The registered provider shall ensure that effective fire safety management	Not Compliant	Red	01/05/2026

	systems are in place.			
Regulation 28(2)(b)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Not Compliant	Orange	01/05/2026
Regulation 28(2)(b)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Orange	01/05/2026
Regulation 05(1)(a)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out prior to admission to the designated centre.	Not Compliant	Orange	01/05/2026
Regulation 05(2)	The registered provider shall ensure, insofar as is reasonably practicable, that arrangements are in place to meet the needs of each resident, as assessed in accordance with paragraph (1).	Not Compliant	Orange	01/05/2026
Regulation 05(4)(a)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre,	Not Compliant	Orange	01/05/2026

	prepare a personal plan for the resident which reflects the resident's needs, as assessed in accordance with paragraph (1).			
Regulation 05(4)(b)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which outlines the supports required to maximise the resident's personal development in accordance with his or her wishes.	Not Compliant	Orange	01/05/2026
Regulation 05(6)(a)	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 be multidisciplinary.	Not Compliant	Orange	01/05/2026