Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

## Issued by the Chief Inspector

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| Name of designated centre: | Avalon |
| Name of provider: | Avista CLG |
| Address of centre: | Dublin 15 |
| Type of inspection: | Unannounced |
| Date of inspection: | 01 April 2026 |
| Centre ID: | OSV-0003728 |
| Fieldwork ID: | MON-0050076 |

## About the designated centre

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

Avalon is a large bungalow on a campus setting which provides care and support to two residents with an intellectual disability and underlying medical needs whom are currently residing on a temporary basis for 12-18 months while their future permanent homes are undergoing renovation works. The two individuals are supported in their own individualised apartments and have shared kitchen facilities. The house has two separate living areas with a shared kitchen and visitors room. There are sufficient bathrooms and shower facilities available for residents. There are also laundry facilities available and a number of communal areas. Residents are supported 24 hours a day, 7 days a week by a staff team led by of a person in charge, clinical nurse managers, staff nurses, care staff and household staff are available to support residents.

**The following information outlines some additional data on this centre.**

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| Number of residents on the date of inspection: | 2 |

## How we inspect

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

As part of our inspection, where possible, we:

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

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

**1. Capacity and capability of the service:**

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

**2. Quality and safety of the service:**

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

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

**This inspection was carried out during the following times:**

| Date | Times of Inspection | Inspector | Role |
|---|---|---|---|
| Wednesday 1 April 2026 | 10:45hrs to 17:50hrs | Erin Clarke | Lead |

## What residents told us and what inspectors observed

The purpose of this inspection was to assess the provider's progress in implementing the compliance plan submitted following the previous inspection in September, at which six regulations were found to be not compliant. These included findings relating to staffing, governance and management, premises, and risk management.

Since that inspection, the provider had applied to reduce the registered capacity of the designated centre from three residents to two. This followed findings that one area of the centre was not suitable to meet the needs of a long-term resident. In response, the provider had updated the statement of purpose and floor plans to reflect the revised layout of the centre. During the course of the inspection, the inspector observed that works were underway in the area that had been removed from the designated centre and that this area had been blocked off from use.

The designated centre is located within a large, congregated, mixed-use campus accommodating a total of 72 residents across a number of designated centres. The centre under inspection comprised one house and was registered to accommodate a maximum of two residents. In addition to residential services, the wider campus included administration buildings, a day service, a canteen with an industrial kitchen, a church, children's disability services, training facilities, and other ancillary support services.

Both residents had transitioned to the designated centre from other services within the provider's organisation when the reconfigured centre became operational in June 2025. This move was part of a planned transition, as residents awaited the completion of their permanent homes in the community. The provider's statement of purpose, dated February 2026, outlined that the centre was intended to operate on a temporary basis for a period of 12 to 18 months while renovation works to residents' future homes were being completed.

On arrival to the centre, the inspector observed staff supporting residents with their morning routines. One resident was scheduled to attend their day service programme; however, they indicated a preference to remain in bed for a longer period. This choice was respected by staff, who adapted the morning routine accordingly. Another resident was observed engaging in skills development activities, supported by staff and a student allied health professional. Interactions between staff and residents were calm, respectful, and responsive to residents' individual preferences and needs. Both residents were observed to appear relaxed and comfortable in the presence of staff.

Staff spoken with during the inspection reported that they had recently commenced working in the centre but had prior experience within the organisation. They demonstrated awareness of the findings from the previous inspection, in particular

the need to establish a consistent core staff team to support one resident. Staff reported that improvements in staffing consistency had resulted in more positive outcomes for the resident. For example, they described how the resident had recently been supported to attend a medical appointment in a manner that reduced stress and promoted a more positive experience.

Overall, the inspector found that residents were supported to live in a safe and supportive environment while awaiting to move to their new homes, with improvements evident since the previous inspection. However, the inspector found that local governance arrangements within the centre had declined since the previous inspection and required strengthening to ensure that quality and safety systems were effectively overseen and consistently maintained.

The next two sections of this report will discuss those governance and management arrangements and how they did or did not ensure and assure the quality and safety of the service.

## Capacity and capability

This inspection found that while the provider had made some improvements since the previous inspection, concerns remained regarding governance, management oversight, and the sustainability of those improvements. As a result, the centre was found to be non-compliant in key areas, including governance and management.

The provider had taken steps to respond to findings from the previous inspection in September 2025, including reducing the registered capacity of the centre and the layout of the premises. However, the systems in place did not consistently demonstrate effective oversight or sustained compliance.

Governance and management arrangements were not sufficiently robust to ensure the safe and effective delivery of care. While audits and reviews were taking place, there was an absence of a structured audit schedule, and actions arising from audits were not consistently tracked, time-bound, or subject to regular review. The six-monthly unannounced visit had identified similar issues, including limited access to previous audit findings and unclear progress on actions. In addition, inconsistencies were identified in oversight processes, such as a lack of awareness of the completion of the annual review. These findings indicated that management systems were not operating cohesively to drive quality improvement.

The arrangements for the person in charge did not provide sufficient assurance of effective leadership and oversight. The centre had been without a full-time person in charge since January 2026, with the role assigned to a person participating in management who held responsibility for multiple designated centres.

Staffing arrangements had improved to some extent, with efforts made to increase permanent staffing levels and reduce reliance on unfamiliar agency staff. However, vacancies remained, and the centre continued to rely on relief and agency staff to cover a number of shifts. Oversight of staffing, including the maintenance of accurate rosters and identification of shift leads, required further improvement. These factors, combined with management capacity issues, impacted on the provider's ability to ensure consistent delivery of care.

Systems for training and staff development were in place, and staff had completed key training, including positive behaviour support. Improvements were also noted in the structure and frequency of team meetings.

## Regulation 14: Persons in charge

The provider had failed to ensure that the designated centre was managed by a person in charge with the capacity and resources to effectively oversee the service and ensure consistent regulatory compliance.

At the time of inspection, the centre had been without a full-time person in charge since 16 January 2026. The provider had appointed a person participating in management, at CNM3 grade, to the role. However, this individual held responsibility for four additional designated centres and had a significant management remit across the organisation. The inspector found that there were no dedicated management hours allocated to this centre, and there was no additional layer of local management in place to support the person in charge in fulfilling their responsibilities.

Given the complexity of the service, including the assessed needs of residents, the ongoing reliance on agency staffing, and the number of actions required following the previous inspection, these arrangements did not provide sufficient assurance that the centre was being effectively managed. The absence of a clearly defined and consistent management presence impacted on oversight of key areas, including staffing, care planning, and the implementation and monitoring of actions arising from audits.

Judgment: Not compliant

## Regulation 15: Staffing

There had been some improvement in staffing arrangements since the previous inspection, and the provider had taken steps to increase the number of permanent staff working in the centre. However, staffing continued to require improvement to ensure consistency of care and appropriate oversight of the service.

The staffing complement in the centre comprised social care workers and healthcare assistants. At the time of inspection, one resident required two-to-one staffing support during the day and waking night support, while the second resident required one staff support by day and sleepover support at night. These arrangements reflected the assessed needs of residents. However, the centre continued to rely on agency and relief staff to cover a significant number of rostered shifts.

At the previous inspection, the centre had been found to be heavily dependent on agency staff, with only three core staff assigned to the centre on the day of inspection, one of whom was an agency worker. Inspectors had reviewed nine weeks of rosters and found that 33 different agency and relief staff had worked in the centre during that period. This level of inconsistency did not support the delivery of safe, person-centred care. It had also been found that the night staffing team worked separately from the day staff team, impacting continuity and communication across the service.

Since that time, the provider had transferred some staff within the wider service and had successfully recruited one regular agency staff member into a full-time post. The number of permanent staff assigned to the centre had increased from two to six. Notwithstanding this, staffing vacancies remained. Of the 10.6 whole-time equivalent staff required in line with the statement of purpose, four vacancies remained at the time of inspection and these posts were still under recruitment. A review of the previous four weeks' rosters found that between eight and 17 shifts per week required coverage through relief or agency arrangements.

The inspector also found that relief and agency staff continued to be used predominantly to cover night duty. While this provided necessary cover, it did not fully address the previous concerns regarding continuity of care and consistency of staff support to residents.

The maintenance of rosters also required improvement. This had been identified both on the previous inspection and through the provider's own auditing processes. Rosters did not consistently include the full names of all staff working in the centre, particularly where relief or agency staff had covered shifts, and shift leads were not clearly identified when the person in charge was off duty. As a result, there was not always a clear and accurate record of who had worked in the centre or who held responsibility on a given shift.

Judgment: Substantially compliant

## Regulation 16: Training and staff development

The provider had established a structured system for staff supervision and training; however, improvements were required to ensure that these arrangements were consistently implemented and effectively monitored.

The provider's policy outlined that staff should receive formal supervision twice annually. However, at the time of inspection, it was unclear when supervision had last been completed for all staff members.

There was also evidence of improvement in the frequency and quality of team meetings. Meetings were taking place more regularly, with structured agendas and documented discussions, supporting communication within the staff team.

A revised induction process had been introduced, including a new induction checklist to support staff new to the centre or unfamiliar with residents' needs. However, this process had not been consistently implemented, and not all staff files reviewed contained completed induction documentation. This meant that the provider could not fully demonstrate that all staff had received appropriate induction and training to carry out their roles effectively.

The training matrix had not been updated and therefore did not provide clear or reliable oversight of training completed by staff. This limited the provider's ability to effectively monitor compliance with mandatory training requirements and identify gaps in staff competencies.

Notwithstanding this, the inspector was informed that all staff had completed positive behaviour support training, which had been identified as a required action following the previous inspection.

Judgment: Substantially compliant

## Regulation 23: Governance and management

The provider had systems in place to monitor the quality and safety of care and support in the centre, including a six-monthly unannounced visit, an annual review, and a range of local audits. However, improvement was required to ensure these systems were sufficiently robust, consistently maintained, and effective in driving sustained improvement in the centre.

The most recent six-monthly unannounced visit had been completed in November 2025. This review identified that the previous six-monthly audit, completed in August 2025, was not available in the centre and that the status of actions arising from this audit could not be reviewed. While the November 2025 audit evidenced that a number of audits had been completed, including a health and safety audit, fire register audit, incidents audit and financial audit, the quality of action planning required improvement. For example, actions arising from audits were not always sufficiently informative, did not consistently include dates of completion, and had not been regularly reviewed by the person in charge to ensure progress was being made.

Oversight and support arrangements for the centre had also changed since January 2026. The centre had been without a full-time person in charge since 16 January

2026, when the provider appointed the person participating in management, a CNM3, as person in charge while a full-time person in charge was recruited. This person also held for four other designated centres. The inspector found that they had no dedicated management hours assigned within this house, and there was no additional layer of local management in place to support them in carrying out the responsibilities of the role. Given the complexity of the centre and the ongoing actions required following the previous inspection, these arrangements did not provide sufficient assurance that the centre was adequately managed.

The inspector found that audits were taking place in the centre, but there was no formal schedule of audits in place to support oversight and consistency. This had also been identified in the providers' six-monthly visit and annual review.

The inspector also found that some improvements highlighted by management had not yet been implemented in practice. For example, a number of actions within one resident's personal plan required update and review. It had been identified in November 2025 that an audit of care plans was required but had not been completed at the time of the inspection.

Judgment: Not compliant

## Regulation 3: Statement of purpose

The statement of purpose had been recently reviewed and updated in February 2026 to reflect changes within the centre. It accurately described the current layout of the premises, including the reconfiguration of living spaces and the removal of one area from use, which was consistent with what was observed on the day of inspection.

However, a minor amendment was required to ensure that the statement clearly outlined how the centre supports and respects the religious beliefs and preferences of all residents. While the document referenced the facilitation of all religious practice, it did not fully reflect the lived experience within the centre, including the presence of Catholic practices on the wider campus, such as audible church bells. The provider was required to ensure that this section accurately described how residents' individual beliefs, choices, and preferences are supported in practice. This was submitted and received post inspection.

Judgment: Compliant

## Quality and safety

This inspection found that residents were supported to live in a generally safe environment and that improvements had been made since the previous inspection in areas such as risk management and behavioural supports.

Residents were supported in a manner that promoted their safety and welfare. The centre operated on a single-occupancy basis, which reduced the potential for peer-to-peer impact and supported a more stable living environment. There was evidence that safeguarding measures were in place, and staff demonstrated an awareness of residents' needs and how to support them appropriately. While some practices identified on previous inspection required follow-up, the inspector was assured that these had been addressed and were no longer in place.

There were systems in place to support residents with behaviours of concern. Residents had access to multidisciplinary supports, and there was evidence of improved behavioural interventions, including on-site specialist input to observe behaviours and develop strategies for staff. Staff had completed training in positive behaviour support, and improvements were noted in how residents were supported, including better planning for potentially stressful events such as medical appointments.

Risk management procedures had improved since the previous inspection. The provider had systems in place to identify, assess, and review risks, and the risk register had been updated to reflect current risks within the centre. There was evidence that multidisciplinary input informed risk assessments, and improvements had been made to the environment, including the removal of previously identified risks in one resident's outdoor area.

The premises were generally suitable to meet the needs of residents, with appropriate private and communal spaces available. Residents had access to individualised living areas which promoted privacy, dignity, and comfort. However, improvements were required in relation to environmental controls. The centre was observed to be excessively warm during the inspection, and staff did not have direct control over heating systems, which required input from maintenance personnel.

## Regulation 17: Premises

Overall, the design and layout of the premises were generally suitable for the delivery of care in line with residents' assessed needs. However, the provider was required to ensure that the heating was appropriate and could be effectively controlled in all areas of the designated centre used by residents, in line with regulatory requirements.

The centre comprised three bedrooms in total, two of which were designated for residents and one for staff use. The residential areas were divided into two distinct sleeping and living spaces, with access between individual resident areas controlled

by swipe-door systems. This layout supported privacy while maintaining appropriate levels of safety and oversight.

Both residents were accommodated in bedrooms of sufficient size to allow for personalisation and storage of personal belongings. Each resident had access to an en-suite bathroom, and while bedroom sizes and layouts varied, they were observed to promote residents' privacy, dignity, and comfort.

During the inspection, the centre was observed to be excessively warm. The temperature within the building was noted to be uncomfortable, particularly in the context of warm weather. The inspector requested that the heating be reduced on a number of occasions, as all radiators were hot and all windows in the centre were open in an effort to regulate the temperature.

The inspector was informed that staff did not have direct control over the heating system within the centre and that adjustments required input from maintenance personnel. This arrangement did not support a responsive approach to maintaining a comfortable living environment for residents.

Judgment: Substantially compliant

## Regulation 26: Risk management procedures

The inspector reviewed the centre's risk management systems, including risk assessments, the risk register, and incident records, and found that improvements had been made since the previous inspection. Overall, the provider had systems in place to identify, assess, manage, and review risks within the centre.

Some risks had reduced, in part due to a decrease in the use of restrictive practices and improved environmental controls. For example, improvements had been made to one resident's outdoor living area, where risks identified on the previous inspection had been addressed. There was also evidence that multidisciplinary team input informed risk management, including physiotherapy supports and occupational therapy involvement in relation to sensory needs and mobility concerns.

The risk register had been reviewed and updated in January 2026 and included relevant risks such as medication errors, risk of electrocution, and risks associated with behaviours of concern, including bruising secondary to self-injurious behaviour. The inspector also observed that "safety pause" discussions were incorporated into staff handovers. Improvements were also noted in the oversight of incidents, with further embedding of these systems required to ensure consistency.

Judgment: Compliant

## Regulation 7: Positive behavioural support

There was also evidence of increased autonomy, with one resident supported to manage their own finances within their apartment and to independently access the centre through the use of a swipe card system. Restrictive practices had been reviewed by the restrictive practice committee in November 2025.

There was evidence that additional behavioural supports had been introduced, including on-site specialist input to observe behaviours and develop strategies for staff. Residents were also supported in preparing for appointments through desensitisation work. While these were positive developments, further work was required to ensure that all emerging risks and environmental factors, such as ongoing maintenance works within the centre, were consistently reflected in residents' risk assessments and support plans. This is actioned under Regulation 23.

In addition, the inspector followed up on a practice observed at the previous inspection, where physical redirection had been used to guide a resident away from entering another resident's apartment. This practice had not been authorised as a restrictive intervention for the resident at that time. There was no documented evidence that this specific practice had been formally reviewed by the restrictive practices committee; however, the person in charge informed the inspector that this had since been addressed with the staff team and was no longer in use.

Judgment: Compliant

## Regulation 8: Protection

Residents were generally supported in a manner that promoted their safety and welfare within the centre. The inspector found that residents were living in single-occupancy arrangements, which reduced the potential for peer-to-peer impact and supported a safer living environment.

There was evidence that safeguarding measures were in place, including access to multidisciplinary supports and behavioural interventions to manage risks. Improvements in staffing consistency and the reduction of restrictive practices had also contributed to more stable and predictable care environments for residents.

Judgment: Compliant

## Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended) and the regulations considered on this inspection were:

| Regulation Title | Judgment |
|---|---|
| **Capacity and capability** | |
| Regulation 14: Persons in charge | Not compliant |
| Regulation 15: Staffing | Substantially compliant |
| Regulation 16: Training and staff development | Substantially compliant |
| Regulation 23: Governance and management | Not compliant |
| Regulation 3: Statement of purpose | Compliant |
| **Quality and safety** | |
| Regulation 17: Premises | Substantially compliant |
| Regulation 26: Risk management procedures | Compliant |
| Regulation 7: Positive behavioural support | Compliant |
| Regulation 8: Protection | Compliant |

# Compliance Plan for Avalon OSV-0003728

## Inspection ID: MON-0050076

## Date of inspection: 01/04/2026

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

This document is divided into two sections:

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

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

A finding of:

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

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

## Section 1

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

**Compliance plan provider's response:**

| **Regulation Heading** | **Judgment** |
|---|---|
| Regulation 14: Persons in charge | Not Compliant |
| Outline how you are going to come into compliance with Regulation 14: Persons in charge:<br>A person in charge with suitable qualifications and experience has been recruited and is being progressed under the recruitment process and due to commence by 31/07/26<br>Protected time of 4 hours per week will be given to the current PIC to support governance in the area.<br>A fulltime supernumerary CNM1 will be place on the 7/06/26 to support PIC in fulfilling their responsibilities until full time PIC commences .The CNM1 will support consistent management presence and will be supported by PIC and PPIM. The CNM1 will support the PIC in relation to oversight of Key areas re staffing care planning and the implantation and monitoring of action arising from audits .<br>WTE 3.26 vacancy is currently under recruitment. One full time care staff is currently completing onboarding process. This care staff has been secured by an agency to provide consistency of care until commencement by 30/06/26.<br>The provider has also secured the use of regular , relief and agency staff for vacant shits where possible .<br>A compliance log has been completed and a supervision schedule implemented in line with regulation | |
| Regulation 15: Staffing | Substantially Compliant |
| Outline how you are going to come into compliance with Regulation 15: Staffing:<br>WTE 3.26 vacancy is currently under recruitment. One full time care staff is currently completing onboarding process. This care staff has been secured by an agency to provide consistency of care until commencement by 30/06/26.<br>The provider has also secured the use of regular , relief and agency staff for vacant shits | |

where possible . An open day has been scheduled for SCW for 24/06/26 and care staff recruitment remains active
The provider has ensured there is an hour handover from day into nightshift . This enables day staff can give an adequate handover to night staff and ensures the service users needs are met.
Rosters have been reviewed to ensure that names of relief and agency are in place on the unit each week until current vacant posts are filled. A shift leader is now identified on each shift.
A person in charge with suitable qualifications and experience has been recruited and is being progressed under the recruitment process and due to commence by 31/07/26
A fulltime supernumerary CNM1 will be place on the 7/06/26 to support PIC in fulfilling their responsibilities until full time PIC commences

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| Regulation 16: Training and staff development | Substantially Compliant |

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
The staff training matrix has been reviewed, gaps identified plan of action put in place. All mandatory training has been scheduled. The training matrix for staff will monitored monthly and updated as required to ensure all staff have received appropriate training to carry out their role effectively.
The manager will ensure the induction checklist is fully completed with all new staff and the checklist will be signed and available onsite.
All staff will receive and have been scheduled supervision in line with policy.

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| Regulation 23: Governance and management | Not Compliant |

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

A person in charge with suitable qualifications and experience has been recruited and is being progressed under the recruitment process and due to commence by 31/07/26
Protected time of 4 hours per week will be given to the current PIC to support governance in the area.
A fulltime supernumerary CNM1 will be place on the 7/06/26 to support PIC in fulfilling their responsibilities until full time PIC commences .The CNM1 will support consistent management presence and will be supported by PIC and PPIM. The CNM1 will support the PIC in relation to oversight of Key areas re staffing care planning and the implantation and monitoring of action arising from audits .
The provider has also secured the use of regular , relief and agency staff for vacant shits where possible .
A compliance log has been completed and a supervision schedule implemented in line with regulation
Care plan audits will be completed by 14/06/2026
Six monthly unannounced visited will be complete by May 31st and will identify all areas for improvement. A robust action plan will be implemented to ensure improvements in all identified areas in the center. This will be reviewed monthly
All audits will be reviewed to ensure all actions plans are SMART and actions are being completed.
All staff will read and sign all audits to ensure they are aware of the actions to be completed

| Regulation 17: Premises | Substantially Compliant |
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Outline how you are going to come into compliance with Regulation 17: Premises:
The heating system has been repaired and the is set to respond to external temperatures. The provider will ensure a comfortable living environment is maintained for all residents and all issues will be report to management immediately.

## 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 14(4) | A person may be appointed as person in charge of more than one designated centre if the chief inspector is satisfied that he or she can ensure the effective governance, operational management and administration of the designated centres concerned. | Not Compliant | Orange | 31/07/2026 |
| 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. | Substantially Compliant | Yellow | 30/09/2026 |

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| Regulation 16(1)(a) | The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme. | Substantially Compliant | Yellow | 30/06/2026 |
| Regulation 16(1)(b) | The person in charge shall ensure that staff are appropriately supervised. | Substantially Compliant | Yellow | 14/08/2026 |
| Regulation 17(7) | The registered provider shall make provision for the matters set out in Schedule 6. | Substantially Compliant | Yellow | 02/06/2026 |
| Regulation 23(1)(b) | The registered provider shall ensure that there is a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision. | Not Compliant | Orange | 31/07/2026 |
| 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 | Not Compliant | Orange | 30/07/2026 |

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| | and effectively monitored. | | | |