



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

Issued by the Chief Inspector

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| Name of designated centre: | Cherry Orchard Hospital |
| Name of provider: | Health Service Executive |
| Address of centre: | Dublin 10 |
| Type of inspection: | Unannounced |
| Date of inspection: | 11 March 2026 |
| Centre ID: | OSV-0003730 |
| Fieldwork ID: | MON-0045266 |

About the designated centre

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

The designated centre is based in Dublin and operated by the Health Service Executive. It consists of one building, within a hospital campus. Care and support is provided for up to seven adult residents, both male and female with a physical, sensory or neurological disability. The building comprised of seven large bedrooms with en-suite facilities. There is also a large sized day room, family room and industrial styled kitchen. The centre is managed by a full-time person in charge. Support is provided for residents over a 24 hour period by registered nurses and healthcare assistants.

The following information outlines some additional data on this centre.

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| Number of residents on the date of inspection: | 7 |
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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 11 March 2026 | 10:15hrs to 17:00hrs | Michael Muldowney | Lead |

What residents told us and what inspectors observed

This unannounced inspection was carried out as part of the regulatory monitoring of the centre. The inspector used observations, conversations with staff and residents, and a review of documentation, to form judgments on the quality and safety of the care and support provided to residents in the centre.

The inspector found that the centre was operating at a mixed level of compliance. Residents were safe, and staff spoken with were found to be well informed on their care and support needs. However, some improvements were required under most of the regulations inspected, and in particular, Regulation 13: General Welfare and Development.

The centre accommodated seven residents, and comprises a large single-storey building located on the grounds of a large hospital campus. The building was warm, bright, and appeared to be well maintained. However, as noted in previous inspections of the centre, aspects of the layout and design of the building presented an institutional aesthetic; for example, it contained long corridors, offices and staff rooms, and an industrial style kitchen. However, efforts had been made to make the building more homely. There were photos of residents displayed in the living room, the entrance hall was decorated for St. Patrick's Day, and the residents' bedrooms were personalised to their preferences and tastes. There was also a nice outdoor space at the rear of the building for residents to use. The inspector observed good fire safety precautions, such as fire detection and fighting equipment. However, as discussed in the quality and safety of the report, some of the associated documentation required minor improvements.

The inspector also observed that residents' food, including cooked meals, and drinks were provided by a central kitchen on the hospital campus. A menu was provided for residents to choose from. However, there was insufficient visual aids to support their decision-making. For example, there was not a picture of one of the menu options for the day of the inspection. The person in charge told the inspector that there were plans to improve the visual aids available to residents. The inspector also found that the arrangements to verify that staff had completed relevant training to safely prepare residents' food and drinks required improvement. These matters are discussed further in the quality and safety of the report.

The inspector met six residents during the inspection. They had various communication means. Four residents did not express their views to the inspector, but some of them briefly engaged through some words and eye contact. Three of the residents were observed in the day room watching television, while one was resting in bed. One resident briefly spoke about a family member.

One resident briefly spoke with the inspector and a nurse while they were resting in their bed. They said that they did not like living in the centre, but did not elaborate

further as to why. They said that they wanted tea and a snack, and the nurse facilitated the request. The resident then said that they did not want to speak any further with the inspector. The person in charge told the inspector, that there were plans for this resident and two other residents to move to a more suitable and community-based centre that would better suit their needs. Residents' representatives, including independent advocates, were involved in the planning.

Another resident was happy to speak with the inspector in their bedroom. They said that they liked living in the centre and felt safe there. They said that they liked the premises, and their bedroom and said that they had enough space for their belongings. They said that there was enough staff on duty and that they were very nice. They had no concerns, but said that they could speak with staff if they had. They liked the food in the centre, and said that they could have snacks whenever they wanted and often had their favourite meals. They told the inspector that they choose their own routine, such as what time they got up at in the morning and went to bed at night, and that staff facilitated their requests. The resident liked to spend time with their family, go to shopping centres, watch television and do crafts. They were also looking forward to an upcoming St. Patrick's Day party in the centre.

On the day of the inspection, one resident was visited by their family members. The family members did not wish to speak with the inspector. However, the inspector reviewed the centre's 2025 compliment logs, which recorded compliments from families about the care and support their loved ones received. Four families had also provided feedback as part of the annual review of the centre, and were positive about residents' care, activities, plans, and the premises.

Later in the day, the centre's activities coordinator told the inspector that an outing planned for that day was postponed because, transport was unavailable due to staffing arrangements. They told the inspector that three residents were having a relaxation class with head massage, one would be having their nails and hair attended to, and another would be having a haircut. These activities were all within the centre. Another resident was sleeping during most of the day. The inspector found that documentation to record if residents were provided with opportunities to participate in meaningful activities required improvement, and this matter is discussed further in the quality and safety section of the report.

The inspector spoke with different members of staff during the inspection, including the person in charge, two nurses, and the activity coordinator. They were found to be well informed on the matters discussed, such as the safeguarding arrangements and residents' support needs. They also spoke warmly about residents, and were observed engaging with them in a friendly and respectful manner.

Overall, the inspector found that residents were in receipt of safe care and support. However, some improvements were required in relation to the statement of purpose, the development and review of residents' plans, staff training and development, the fire safety precautions, and the arrangements for residents' general welfare and development.

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

Capacity and capability

This unannounced inspection was carried out as part of the regulatory monitoring of the centre. The previous inspection in June 2024 found non-compliance under Regulations 3: Statement of purpose, 14: Person in charge and 23: Governance and management. This inspection found improvements under those regulations; however, some further action was required to bring Regulation 3: Statement of purpose into full compliance. This inspection also found that the implementation of the provider's staff supervision policy in the centre required improvement to ensure that staff were in receipt of formal support and supervision as part of their professional development.

The management structure was clearly defined with associated responsibilities and lines of authority. The person in charge was full-time, and found to be suitably skilled, experienced, and qualified for their role. The person in charge reported to a general manager, and there were arrangements for them to communicate and escalate information. The person in charge told the inspector that residents received good quality and safe care and support in the centre.

The provider and person in charge had implemented management systems to monitor the quality and safety of service provided to residents. Annual reviews and six-monthly reports, as well as various audits had been carried out in the centre.

The staff skill-mix consisted of nurses and healthcare assistants. The person in charge was satisfied that the skill-mix was appropriate to the assessed needs of the current residents, and said that staff working in the centre knew residents' needs and personalities well. The inspector reviewed a sample of the recent staff rotas, and found that they were well maintained.

Staff were required to complete training as part of their professional development. The inspector reviewed the staff training log and found that staff were up to date with their training needs. There were arrangements for the support and supervision of staff working in the centre, such as management presence and formal supervision meetings. However, formal supervision was not carried out in line with the provider's associated policy, and this posed a risk to their development and the quality of the care and support they provided to residents.

Regulation 14: Persons in charge

The registered provider had appointed a full-time person in charge. The person in charge was based in the centre to support their oversight of the quality and safety of the service provided to residents.

The person in charge was suitably experienced and skilled for their role, and possessed relevant qualifications in nursing and management.

Judgment: Compliant

Regulation 15: Staffing

The skill-mix consisted of nurses and healthcare assistants. The person in charge was satisfied with the skill-mix and said that appropriate staffing levels were maintained at all times. Residents could also access multidisciplinary team services as required. Staff leave was covered by permanent staff working additional hours to ensure consistency of care and support for residents.

The inspector spoke with different members of staff during the inspection, including nurses and healthcare assistants, about residents' care and support needs. They were found to be well informed on the matters discussed.

The inspector reviewed a sample of the January, February and March 2026 rotas with the person in charge, and found that they were well maintained and clearly recorded the names of staff and the hours they worked in the centre.

The inspector did not review staff Schedule 2 files during this inspection.

Judgment: Compliant

Regulation 16: Training and staff development

The person in charge had ensured that staff had access to appropriate training as part of their professional development and to support the delivery of effective care and support to residents. However, the arrangements for the formal supervision of staff required improvement to ensure that they were in line with the provider's associated policy.

There were arrangements for the support and supervision of staff, including informal support and formal supervision meetings. The provider's policy outlined that formal supervision was to take place four times per year. The inspector reviewed three staff supervision records, and found that they had received supervision in 2026. However, records were not made available to the inspector to show that they staff had received formal supervision four times in 2025. This posed a potential risk to their

development and the quality and safety of the care and support they delivered to residents.

The inspector reviewed the training log with the person in charge. The log showed that staff had completed relevant training programmes, including on the safeguarding of residents from abuse, fire safety, behaviour support, infection prevention and control (IPC), manual handling, and assisted decision-making. However, as discussed under Regulation 18: Food and Nutrition, records were not available to verify if all relevant staff had received training in supporting residents with their meals and drinks.

Judgment: Substantially compliant

Regulation 23: Governance and management

The provider had implemented management systems to ensure that the service provided to residents in the centre was appropriately resourced, safe and monitored.

There was a clearly defined management structure in the centre with associated lines of authority and accountability. The person in charge was full-time, and reported to a general manager. The person in charge was supported in managing the centre by two nurse managers. There were arrangements for the management team to communicate, including meetings between the local management team and the person in charge and the general manager.

The provider and person in charge had implemented systems to monitor and oversee the quality and safety of care and support provided to residents in the centre. The provider carried out annual reviews and six-monthly unannounced visit reports which consulted with the residents. Within the centre, the management team and members of the multidisciplinary team completed medication, complaint, infection prevention and control, and health and safety audits. The person in charge had also recently implemented additional quality improvement initiatives, such as preparing summary versions of the centre's policies to make them more accessible to staff.

Judgment: Compliant

Regulation 3: Statement of purpose

The statement of purpose, dated May 2025, was available in the centre, and contained the information outlined in Schedule 1. However, there were some discrepancies that required revision. For example, the management details required

updating and the description of the premises did not include all rooms outlined in the floor plans.

Judgment: Substantially compliant

Quality and safety

The inspector found that residents' safety was maintained by a good standard of care and support. However, some improvements were required in relation to food and nutrition, fire precautions, residents' care plans, and to ensure that residents' general welfare and development needs were provided for.

There were good arrangements to safeguard residents from abuse, such as staff training, and a written policy to inform their practices. Staff spoken with were aware of the procedures for responding to and reporting any safeguarding concerns. They also told the inspector that they had no concerns for residents' safety.

The inspector reviewed a sample of two residents' care plans and found that improvements were required, for example: a behaviour support plan was overdue review, and activity goal plans were not in a specific or accessible format. Furthermore, there was a lack of detail and information in residents' daily notes and activity log records on if and how they were provided with regular opportunities to engage in meaningful social and leisure activities as part of their general development and welfare.

The residents' food and drinks were supplied by a central kitchen located on the hospital campus. A menu was used; however, not all of the menu options were in an accessible format. Records were also not available to show that all relevant staff in the centre had completed training to safely prepare residents' food and drinks in line with their assessed needs.

There were fire safety precautions in place, such as fire-fighting and detection equipment. Staff had also completed fire safety training, and evacuation plans had been prepared to guide them in the event of an emergency. Minor improvements were required to the detail in some of the individual evacuation plans and the fire drill records.

Regulation 13: General welfare and development

Residents were supported by staff in the centre, including a dedicated activity coordinator, to participate and engage in social and leisure activities. The inspector found that records of the activities offered to residents and their level of

engagement was insufficiently detailed to demonstrate if sufficient support was provided for their general welfare and development. Additionally, recommended training for staff to support residents' social engagement had not been progressed, which posed a risk to their wellbeing.

The inspector reviewed two resident's daily notes from the previous four weeks. For one resident, the notes recorded that they left the hospital campus on three occasions. The rest of their activities comprised of watching television, 'music therapy' on two occasions, a family visit, medical appointments and two 'activities in their room'; those activities were not described. For the other resident, they had left the centre to visit their family, and on two occasions to visit a shopping centre. The inspector also read and was told by staff about other activities that residents enjoyed, such as going to the park, beach and cinema, but it was not recorded if these activities had been offered to them in the previous four weeks.

Activity logs were also maintained; however, they lacked detailed and were not kept up to date. For example, retrospective entries about previous activities were made by staff during the inspection, and an entry of a 'one-to-one session' provided no detail on what the session involved. Overall, the records required improvement to better show how residents had opportunities to take part in activities that promote their wellbeing and socialisation.

The inspector read in the annual review that staff were to attend a specific information session in 2025; which would support residents to develop social opportunities. However, the person in charge told the inspector that the session had not been organised. This did not demonstrate that all efforts were made to support residents' general welfare and development as part of their overall wellbeing.

Judgment: Not compliant

Regulation 18: Food and nutrition

Residents' food, meals and drinks were provided by a central kitchen located on the hospital campus. Some residents were assessed as requiring modified and specialised diets, and there were associated plans on their individual needs. However, the inspector found that some improvements were required to ensure that residents were provided with accessible information to help them choose their meals, and to ensure that all staff supporting residents with their food and drinks had completed relevant training to safely do so.

Residents' nutrition needs had been assessed, and there was associated guidance from a speech and language therapist (SALT) on the diets they required. The person in charge had also prepared information on the residents' food preferences for staff to follow. One resident told the inspector that they liked the food in the centre, and the inspector also read that residents said during a February 2026 house meeting that they liked the food.

The menu was in written format. Staff also used pictures of foods to help residents choose their meals. However, there were no pictures available of some of the menu options on the day of the inspection. This required improvement to ensure that residents had sufficient information to help their decision-making. The person in charge told the inspector that there were already plans to enhance the visual aids.

While the majority of the residents' meals were prepared in the main kitchen, staff on occasion prepared drinks and snacks for residents, such as when they were on outings. Some of the staff spoken with told the inspector that they had completed associated training, and they were found to be knowledgeable of the residents' modified plans. However, training records were not available to verify that they had completed up-to-date training to safely prepare food and drinks for residents. The absence of such up-to-date training posed a potential risk to the quality and safety of the support provided to residents. For example, a risk of aspiration if modified diets were not appropriately prepared.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Overall, the registered provider had implemented good fire safety precautions in the centre. However, some improvements were required to meet full compliance.

There was fire detection, fighting and containment equipment, and emergency lights throughout the centre, and it was serviced to ensure that it was maintained in good working order. Staff also completed scheduled fire safety checks. The fire panel was accessible and found in the front hallway.

There was an evacuation plan for the centre and individual evacuation plans for the residents. The individual plans were up to date, and readily available to staff. However, they required minor improvements to ensure that they were in a consistent format and that the relevant information relating to residents' individual evacuation needs was clearly detailed for staff to refer to in the event of an emergency evacuation.

Regular fire drills were carried out to test the effectiveness of the fire evacuation plans. The inspector reviewed the records from 2025 with a nurse, and found that the records required improvement to demonstrate that all residents could be safely evacuated with minimal staffing levels.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

There were arrangements to assess residents' health, social and personal care needs, and for the development of associated care plans on the care and support they required. However, improvements were required to ensure that the files were appropriately prepared and maintained.

The inspector reviewed a sample of two residents' care plans, and found that some improvements were required. For example, one resident's behaviour support plan was overdue review and referred to interventions that were not used, such as visual aids. The plan required review to ensure that it contained up-to-date and appropriate interventions to effectively guide staff in supporting the resident to manage their behaviours. Additionally, residents' individual activity goal plans had not been reviewed in line with the frequency described in the statement of purpose. The plans were also not in a specific or measurable format to ensure that they could be effectively reviewed, and were also not in an accessible format for residents. The previous inspection of the centre had similar findings.

Judgment: Substantially compliant

Regulation 8: Protection

The registered provider and person in charge had implemented systems to safeguard residents from abuse.

The provider had prepared a written policy on the safeguarding of residents. It was readily available in the centre for staff to refer to. There was also additional guidance, such as the safeguarding statement displayed in the front entrance and posters on advocacy and safeguarding in the day room.

Staff working in the centre completed safeguarding training to support them in the prevention, detection, and response to safeguarding concerns. Staff spoken with were aware of the procedures for responding to and reporting any safeguarding concerns. One resident spoken with also told the inspector that they felt safe in the centre, and could speak up if they had any concerns.

The inspector reviewed two safeguarding concerns since the previous inspection, and found that they had been appropriately reported and that actions had been taken to safeguard residents.

Intimate care plans had been prepared to support staff in delivering care to residents in a manner that respected their dignity and bodily integrity. The inspector reviewed two plans, and found that they were up to date and readily available to guide staff.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

| Regulation Title | Judgment |
|---|-------------------------|
| Capacity and capability | |
| Regulation 14: Persons in charge | Compliant |
| Regulation 15: Staffing | Compliant |
| Regulation 16: Training and staff development | Substantially compliant |
| Regulation 23: Governance and management | Compliant |
| Regulation 3: Statement of purpose | Substantially compliant |
| Quality and safety | |
| Regulation 13: General welfare and development | Not compliant |
| Regulation 18: Food and nutrition | Substantially compliant |
| Regulation 28: Fire precautions | Substantially compliant |
| Regulation 5: Individual assessment and personal plan | Substantially compliant |
| Regulation 8: Protection | Compliant |

Compliance Plan for Cherry Orchard Hospital OSV-0003730

Inspection ID: MON-0045266

Date of inspection: 11/03/2026

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 16: Training and staff development | Substantially Compliant |
| <p>Outline how you are going to come into compliance with Regulation 16: Training and staff development:</p> <p>Formal supervision/ Performance achievement:</p> <p>It was identified during the inspection that some staff had not received formal supervision on three occasions in 2025.</p> <p>All staff have completed their initial Performance Achievement meeting in early 2026. Mid-year and end-of-year reviews have been scheduled in the calendar.</p> <p>In addition, a four-monthly audit has been introduced to ensure ongoing compliance with supervision requirements. This will be documented on the electronic file.</p> <p>Dysphagia Training:</p> <p>It was identified during inspection that records did not clearly demonstrate that all relevant staff had received training in supporting residents with eating and drinking.</p> <p>Dysphagia training has since commenced for all relevant staff, with 82% having completed a 3-hour training session since the inspection. Plans are in place for the remaining staff to complete training by 02/05/2026.</p> <p>Dysphagia training has also been added to the training tracker to support ongoing monitoring and compliance.</p> | |
| Regulation 3: Statement of purpose | Substantially Compliant |
| <p>Outline how you are going to come into compliance with Regulation 3: Statement of purpose:</p> | |

A full review of the Statement of Purpose has been completed, and all identified discrepancies have been addressed. Recent changes to the management team have been incorporated, and additional rooms, in line with the current floor plan, have been included in the description of the premises.

Future reviews will take place every six months or as required. |

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| Regulation 13: General welfare and development | Not Compliant |
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Outline how you are going to come into compliance with Regulation 13: General welfare and development:

Social Valorisation training has been scheduled for all staff on 14th April 2026 to enhance staff awareness and support residents' social inclusion, participation, and engagement.

A staff meeting has been held to review and improve the recording of resident activities. As a result:

- Additional activity options have been incorporated into the electronic health record system to support more accurate and comprehensive documentation
- Staff will record, in greater detail, activities offered to residents, including where activities are declined, to reflect resident choice and participation
- Activity logs will be maintained consistently and updated promptly following each activity

These actions aim to improve the quality, accuracy, and oversight of activity provision, ensuring residents' social, recreational, and developmental needs are effectively supported and documented. |

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

A new Food Menu Board has been ordered to improve the accessibility of daily menu options for all residents.

The Person in Charge is working in collaboration with the catering team to ensure that all menu items are represented visually to support residents in making informed choices.

Dysphagia training has commenced for all relevant staff, with plans in place to ensure full completion by 02/05/2026.

Dysphagia training has also been incorporated into the training tracker to support ongoing monitoring, compliance, and governance oversight. |

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

A comprehensive review of all residents' Personal Emergency Evacuation Plans (PEEPs) has been completed. Additional detail has been incorporated to better support staff in

responding effectively in the event of an emergency evacuation.

A review of fire drills within the unit has also been undertaken. Staff have been informed of the enhanced documentation requirements following each drill. Fire drill records will be reviewed and monitored by management after each drill to ensure compliance and support ongoing quality improvement. |

Regulation 5: Individual assessment and personal plan

Substantially Compliant

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

A comprehensive review of all residents' support plans will be undertaken, and any areas identified for improvement will be addressed and implemented in a timely manner.

Residents' goals will be reviewed and updated every six months, or more frequently as required, to ensure they remain relevant, person-centred, and reflective of each resident's preferences, will, and aspirations. Key Workers and Nurse Managers will engage with residents and their families to ensure that goals are meaningful and individualised.

A visit to another disability service has been planned to identify best practices and opportunities to further enhance goal setting and care planning within the unit.

A Principal Social Worker is currently involved in supporting the review process and identifying opportunities to strengthen person-centred goal setting for residents.

All staff have been requested to complete the HSELand module Towards Excellence in Person-Centred Planning (1.5 hours) to support knowledge and practice in this area. |

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

| Regulation | Regulatory requirement | Judgment | Risk rating | Date to be complied with |
|---------------------|---|-------------------------|-------------|--------------------------|
| Regulation 13(1) | The registered provider shall provide each resident with appropriate care and support in accordance with evidence-based practice, having regard to the nature and extent of the resident's disability and assessed needs and his or her wishes. | Substantially Compliant | Yellow | 15/05/2026 |
| Regulation 13(2)(b) | The registered provider shall provide the following for residents; opportunities to participate in activities in accordance with their interests, capacities and developmental needs. | Not Compliant | Orange | 15/05/2026 |
| Regulation 13(2)(c) | The registered provider shall provide the | Substantially Compliant | Yellow | 15/05/2026 |

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| | following for residents; supports to develop and maintain personal relationships and links with the wider community in accordance with their wishes. | | | |
| Regulation 16(1)(b) | The person in charge shall ensure that staff are appropriately supervised. | Substantially Compliant | Yellow | 07/04/2026 |
| 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. | Substantially Compliant | Yellow | 15/05/2026 |
| Regulation 18(3) | The person in charge shall ensure that where residents require assistance with eating or drinking, that there is a sufficient number of trained staff present when meals and refreshments are served to offer assistance in an appropriate manner. | Substantially Compliant | Yellow | 15/05/2026 |
| Regulation 28(1) | The registered provider shall ensure that effective fire safety management systems are in place. | Substantially Compliant | Yellow | 15/04/2026 |
| Regulation 28(2)(b)(iii) | The registered provider shall | Substantially Compliant | Yellow | 15/04/2026 |

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| | make adequate arrangements for testing fire equipment. | | | |
| Regulation 03(1) | The registered provider shall prepare in writing a statement of purpose containing the information set out in Schedule 1. | Substantially Compliant | Yellow | 08/04/2026 |
| Regulation 03(2) | The registered provider shall review and, where necessary, revise the statement of purpose at intervals of not less than one year. | Substantially Compliant | Yellow | 08/04/2026 |
| Regulation 05(4)(a) | 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 reflects the resident's needs, as assessed in accordance with paragraph (1). | Substantially Compliant | Yellow | 15/05/2026 |
| 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. | Substantially Compliant | Yellow | 15/05/2026 |

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| Regulation 05(5) | The person in charge shall make the personal plan available, in an accessible format, to the resident and, where appropriate, his or her representative. | Substantially Compliant | Yellow | 15/05/2026 |
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