Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	Meath Westmeath Centre 2
Name of provider:	Muiríosa Foundation
Address of centre:	Westmeath
Type of inspection:	Unannounced
Date of inspection:	22 July 2026
Centre ID:	OSV-0003958
Fieldwork ID:	MON-0050972

About the designated centre

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

The designated centre is a spacious bungalow in close proximity to the nearest town and to public transport facilities. The service provides care and support to up to five adults with an intellectual disability. Each resident has their own bedroom decorated to their individual style and preference, and the designated centre is designed and laid out to meet the needs of people with high support needs. There are various communal areas throughout the house including well maintained garden areas. Transport is also available to meet the needs of residents and avail of social activities. Staffing was provided in accordance with the assessed needs of residents, including nursing support. Additional staff were made available if or when required.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	5

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 22 July 2026	09:00hrs to 17:30hrs	Brendan Kelly	Lead

What residents told us and what inspectors observed

This unannounced inspection was carried out to monitor the designated centre's compliance with relevant regulations. The inspection was also aimed at informing a decision on the provider's application to renew the registration of the designated centre.

Overall, the inspection showed that the residents were happy in their home and supported by a competent staff team. The inspection identified improvements however, were required in a number of regulations, namely, staffing, training and development, governance and management, premises, personal possessions and fire safety. The findings for each of these regulations are discussed in greater detail through this report.

The designated centre is a large bungalow that is located just outside a quiet town in Co. Westmeath. The centre is a large spacious bungalow that is currently registered for up to five adults with an intellectual disability. On the day of this inspection there were no resident vacancies. The centre consists of five resident bedrooms, two of which were en-suite. There was two accessible bathrooms, a well equipped kitchen, dinning room, recreation room, sitting room, store rooms, a utility space and an outside garage.

On the day of this inspection the inspector used conversation with residents, staff and management, as well as observation and the review of documentation to help form judgements on the regulations reviewed. The inspector observed all of the residents living in the centre and spoke with two residents. The inspector also met with and spoke to the centres person in charge, a member of the provider's senior management team and one of the front line staff on duty.

On arrival at the centre the inspector was met by a member of the staff team, the inspector completed a walk around of the centre with the staff member. The inspector observed that the centre was homely and warm and each resident had their bedrooms decorated individually to their own choosing. The inspector observed personalised items in each room such as family photographs and evidence of resident hobbies. One resident told the inspector they were very happy with their bedroom and proudly showed the inspector their room.

The inspector spent time through the day of inspection observing the care and support provided by the staff to the residents. The inspector observed care being delivered in a caring person centred manner. For example on the day of the inspection it was a resident's birthday and the staff had decorated the house in banners. The resident had received a number of gifts and happily told the inspector about their party that evening. The inspector observed the staff team to meet the

assessed needs of all residents in the centre including residents who had significant medical needs requiring complex care and support.

Residents in the centre appeared happy and comfortable in their home and in the presence of the staff team. One resident told the inspector they lived "in a five star hotel". The resident also discussed their health care needs with the inspector saying that they have "never felt better". The inspector observed the residents to be compatible throughout the day. Residents were observed to be singing together and clearly enjoying each others company.

The inspector observed that the residents were supported by the providers mutli-disciplinary team in line with their assessed needs. For example, on the morning of the inspection the providers physiotherapist was in the centre to review one of the residents physiotherapy programme.

Staff who met with the inspector were knowledgeable regarding key resident plans in the centre. Some of the residents in the centre required complex medical care and staff were aware of key details in care plans that allowed residents to remain in their homes rather than require moves to hospital settings.

Capacity and capability

This inspection showed that while the provider had a clearly defined governance structure with specific roles and responsibilities to manage the centre, improvements were required within some of the oversight systems. The centre had a full-time permanent person in charge who reported to a person participating in management. Improvements were identified as required terms staff training and the oversight systems for resident meetings, staff checks and, resident finances.

While the centre did have the appropriate skill mix to meet the assessed needs of the residents, the inspector was not assured that the staffing compliment was maintained at an appropriate level across each week. The centre was also not resourced adequately with suitable transport.

The provider had strong systems in place in terms of reporting and the centre had the required suite of Schedule 5 policies in place. The centres statement of purpose adequately informed all stakeholders of the details for centre management and of the services offered by the provider.

Regulation 15: Staffing

While the provider did have the appropriate skill mix in the staff team to meet the assessed needs of the residents, they did not provide the required staffing levels to meet the assessed needs of the residents at all times.

The inspector reviewed rosters from May and June 2026 and observed that the provider reduced staffing numbers at weekends and also on a regular basis during the week where cover could not be sourced. Centre management told the inspector that appropriate staffing numbers were three staff during the day and two waking night duty staff. The inspector observed through a review of the rosters that the current staffing arrangements were:

- Monday to Friday three day duties with one of the day duties a split shift from 09:00-16:30 and 16:00-21:00
- Saturday's staffing plan was two day duties from 08:00-21:00 and a third from 08:00-18:00
- Sunday's staffing plan was two day duties from 08:00-21:00 and a third from 08:00-16:00

The inspector observed consistent times over the rosters reviewed where the provider was not in a position to cover full shifts leaving the staff team with two staff on duty during the day. Due to the medical needs in the house the inspector was not assured that this was a sufficient staffing level to meet the assessed needs of the residents. For example, four of the residents were wheelchair users. One resident required the support of two staff for all transfers and personal care. One resident was receiving palliative care. Also, the lack of appropriate staffing at weekends in particular was a barrier to residents accessing the community as two residents required 2:1 staffing in the community and two residents required 1:1 supports in the community. Although community access and access to activities was being facilitated as much as possible a review of staffing arrangements was required to ensure this remained sustainable.

Judgment: Substantially compliant

Regulation 16: Training and staff development

While the provider had a comprehensive training matrix in place that evidenced high levels of compliance with mandatory and centre specific training, the provider had not ensured that all staff had been in receipt of training required to support the assessed needs of all residents.

On the day of this inspection the inspector reviewed the centre's training matrix and observed that not all staff had completed diabetes training and there was no plan in place for the staff to attend the training. This was of importance in this centre as residents had a diagnosis of diabetes and were supported with medications to maintain their health.

In reviewing the training matrix, the inspector observed the staff team had completed training in the following areas:

- safeguarding
- feeding, eating, drinking and swallowing
- human rights
- epilepsy
- fire safety
- dementia
- medication management

The person in charge also maintained a supervision schedule for the staff team. The inspector reviewed the supervision schedule for 2026 and the supervision records for three staff working in the centre. The inspector observed that supervision sessions were completed in line with the schedule. Agenda items for the sessions included communication, organising and planning, flexibility and, agreed objectives.

Staff who met with the inspector were complimentary of the supervision process. This was of particular importance as the centre had recently suffered resident bereavements. Staff told the inspector they felt supported through these times.

In summary, while the staff team had been in receipt of the majority of the required training to support the needs of the residents, some staff still required diabetes training. Supervision processes in the centre were strong and staff were in receipt of regular meaningful supervision.

Judgment: Substantially compliant

Regulation 23: Governance and management

The provider had a robust governance structure in place that outlined clearly defined roles and responsibilities for each level of management in the centre. However, a number of oversight systems were found to require improvement from this inspection. Improvements were required to ensure the centre was adequately resourced with both staffing and transport. Improvements were also required in the oversight of resident finances and daily fire safety checks and, the use of resident meetings that ensure residents are involved in key decisions regarding their home.

The centre was managed day-to-day by a competent person in charge who had the required experience and qualifications to fulfill their role. The person in charge reported to the person participating in manager, who in turn reported to the regional manager.

The provider had systems in place to monitor and audit the centre. These systems included an annual review, provider led unannounced audits that occurred every six months, governance meetings, team meetings and, audits completed by the person in charge and local staff team. On the day of this inspection, the inspector reviewed

documentation from all of the aforementioned systems. The inspector observed that each meeting or audit had a corresponding action plan that was time bound and identified persons responsible for completing actions.

In reviewing the minutes of meetings that occurred in the centre, the inspector observed consistent agenda items being discussed such as:

- safeguarding
- risk management
- training
- resident updates
- care plan reviews
- incident reviews

The inspector observed evidence of identified actions being completed in line with agreed time lines such as:

- supervisions now completed in line with the provider's policy
- learning outcomes in place following incident reviews
- residents' care plans and risk assessments being updated

While the inspector observed evidence of actions completed in a timely manner, the inspector also observed evidence of actions that had been identified over repeat audits that had, on the day of inspection, yet to be completed. For example, the centre had one vehicle assigned that could only carry one wheelchair. This was despite four of the residents requiring the use of wheelchairs. The inspector observed that in team meetings from May and June the lack of appropriate transport was a barrier to residents accessing the community.

The provider had identified in their own unannounced audit in April 2026 an issue with residents' meetings. Resident meetings had not been occurring on a weekly basis. On the day of this inspection, the inspector reviewed the resident meetings that had been occurring in the centre since the issue had been identified. The inspector observed that only three weekly meetings had occurred since April. This meant that residents were not being involved in planning and decision making in their home.

The inspector also observed evidence of identified actions yet to be completed in relation to resident finances, and fire safety. These findings are discussed in greater detail through this report.

The evidence observed by the inspector showed that the provider's governance systems were identifying issues that require addressing in the centre. However, additional work was required by the provider that these issues were addressed in line with the agreed time lines.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The statement of purpose is an important governance document that outlines to all stakeholders the roles and functions within the premises that ensure it will meet the needs of the residents.

Prior to the inspection, the inspector reviewed the statement of purpose and found that it met the requirements of the regulation. The statement of purpose described resources in key areas such as staffing and the governance structure. It also outlined the provider's policies and operating procedures in areas such as complaints, safeguarding, fire safety, admissions and ensuring residents engage with their local communities. The inspector also observed the statement of purpose in the centre and it was last reviewed by the provider in January 2026.

Judgment: Compliant

Regulation 31: Notification of incidents

The provider had notified the Chief Inspector of all incidents occurring in the centre in line with the requirements of this regulation. Prior to the inspection, the inspector reviewed the notifications submitted by the provider such incidents that had occurred, restrictive practices and injuries to residents. The inspector reviewed incident report forms and details of restrictive practices in the centre and confirmed that all required notifications had been submitted.

The inspector observed that the reporting systems in the centre were effective.

Judgment: Compliant

Regulation 4: Written policies and procedures

The provider had a suite of policies in line with the regulatory requirements that helped inform and guide practices in the centre. On the day of the inspection the inspector reviewed the provider's Schedule 5 policies.

The inspector observed policies in place in areas such as:

- admissions
- staff training and development
- risk management
- complaints

- safeguarding

The inspector observed that all policies had been reviewed in line with the regulatory requirements For example, the safeguarding policy was in date and was not due to be reviewed until April 2028. The policies were also available to staff via the provider's online sharepoint system. The inspector also noted policies and procedures were regularly discussed at centre meetings.

Judgment: Compliant

Quality and safety

The inspection showed that actions identified in a previous inspections compliance regarding residents finances had not been implemented. Practices that were identified in this previous inspection were observed to still be in place today.

Improvements were also identified as required in ensuring that all fire safety checks were being completed as required.

The provider had effective systems in place regarding risk management and despite a lack of resources in terms of adequate transport and staffing numbers, residents were supported with meaningful activities.

Care plans were supporting and guiding staff in meeting the day-to-day and health care needs of residents

Regulation 12: Personal possessions

The provider had not ensured that all residents in the centre had access to their own bank accounts or had complete access to their finances as and when they wished.

Following a previous inspection the provider had committed to ensuring appropriate actions were taken to ensure residents access to their finances were not impeded. However, the findings of this inspection indicated that the provider had failed to bring about the required improvements.

On the day of this inspection, the inspector observed that three of the residents living in the centre did not have their own bank accounts. The residents had a weekly allowance provided to them. Although this amount had increased slightly, the residents full access to their finances were impeded by the systems in place.

Due to these ongoing practices residents were not in a position to have full access to their finances as and when they wished. If purchases were required over a certain amount, staff were required to submit a request on the residents behalf and wait one week until the monies could be collected from the provider.

Judgment: Not compliant

Regulation 13: General welfare and development

The inspection showed that, despite resource issues with staffing and transport, residents living in the centre were being supported as much as possible to have a meaningful day with activities of their choosing.

The inspector reviewed the person centred plans for two of the residents. The inspector observed that residents had monthly key working sessions where goals and activities were planned for the month ahead. The inspector observed plans for residents to attend family graves, attend street fairs, go on day trips, overnight stays and plan for birthdays.

The inspector observed photographic evidence of residents participating in all of the aforementioned goals and activities. The inspector observed that residents had spent a weekend away at Centre Parks including residents who require significant medical supports.

The inspector observed that residents maintained strong family connections in line with their wishes. It was clear from talking to residents that family was important and residents were able to tell the inspector how the provider supports them to maintain these important relations.

The inspector also observed residents had access to smart technology such as internet, mobile phones, televisions and electronic tablets as they wished.

Judgment: Compliant

Regulation 17: Premises

On the day of this inspection, the inspector completed a walk around of the centre. The inspector observed that the premises was homely, warm and in the main laid out to meet the assessed needs of the residents. Residents had their own bedroom with each room decorated individually to residents choosing.

The inspector observed however, that a number of areas of the premises required repair. For example, flooring in the sitting room and hallway was scratched and damaged and was in need of repair.

One resident was not in a position to use the shower in their en-suite bathroom. This was due to the lip on the shower tray in the en-suite. Due to mobility and manual handling concerns it was deemed as not safe for the resident to use. The inspector observed in personal care plans that the resident had a preference to use their en-suite bathroom. Although the provider was aware of the issues and assessments had been completed to rectify this there was no no timeline for when the provider planned to have the issue resolved.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

The provider had systems in place to identify, assess, mitigate and review risk management in the centre.

The provider had a risk management policy in place that guided staff practice in the area of risk management. The provider had risk registers in place for the centre and also individual risk registers for residents. The risk registers were maintained by the person in charge, reviews were completed by the person in charge and person participating in management. The inspector also observed that risk management was an regular agenda item for all centre meetings.

On the day of this inspection, the inspector reviewed the risk registers in place, a sample of centre-specific and residents risk assessments and, spoke to staff regarding key areas of risk in the centre.

In reviewing the risk assessments in place the inspector observed risk assessments for areas such as:

- accidents
- fire safety
- manual handling
- falls
- catheter care
- choking
- specific medical conditions

The inspector observed that reviews of all risk assessments were occurring on a regular basis. For example, the inspector observed that all centre-specific risk assessments were reviewed by centre management in June 2026. The inspector also observed that a resident specific risk assessment for catheter care was reviewed in July 2026 and a resident's choking risk assessment was reviewed in June 2026.

The inspector observed that control measures outlined in these risk assessments were in place and also effective in mitigating the risk outlined. For example, the inspector observed the following control measures in place, nurse oversight of the care plan, non-nursing staff trained in catheter care and, written guidance on when to escalate to the residents doctor.

The inspector met with one of the front line staff on duty and discussed some of the key risks in the centre. The staff member showed a strong knowledge of risk in the centre and, for example, was aware of key control measures in place to support a resident's catheter care.

In summary, risk assessments guided and supported the staff team to ensure as much as possible that key risks were mitigated in the centre.

Judgment: Compliant

Regulation 28: Fire precautions

The provider had adequate fire fighting systems in place including fire detection and alarm systems, fire doors, fire extinguishers, emergency lighting and fire signage. However, not all daily and weekly fire safety checks were being completed by staff as required.

In reviewing the fire safety checks completed by the front line staff team the inspector observed some gaps in the documentation. The inspector observed gaps in the checks relating to the fire alarm panel, fire exit checks and emergency lighting checks. These checks were a mix of both daily and weekly checks. The inspector observed that this had been discussed at the June team meeting by the person in charge.

The inspector reviewed the centres fire folder and observed the following:

- fire extinguishers and fire blankets were last serviced in February 2026
- fire door were last inspected in June 2026 and all fire doors were linked to the centre's fire alarm
- the house alarm was last serviced in December 2025
- the centres emergency lighting had an annual service in October 2025 as well as quarterly checks
- fire drills were conducted in line with the providers policy including night time fire drills

The inspector observed that each resident had their own personal emergency evacuation plan. Each of the plans was individual to the resident and offered guidance on supports needed to safely evacuate and night time as well as during the day.

In the main the providers fire safety systems were in place, however, due to the gaps in staff checks observed by the inspector, the provider could not assure themselves that all safety measures were adequately in place at all times.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

The provider had comprehensive care plans in place for all residents living in the centre. Care plans were subject to regular review from nursing staff, non-nursing staff and centre management. Care plans provided guidance and support to staff in meeting the assessed needs of the residents.

On the day of this inspection the inspector observed residents had care plans in place in areas such as:

- communication
- mobilising
- feeding, eating, drinking and swallowing
- intimate care
- specific medical conditions
- diabetes

Plans reviewed by the inspector contained clear guidance for the staff in meeting the assessed needs of the residents. For example, one resident a care plan in place to manage diabetes. The inspector observed that the plan was last reviewed in July 2026. The plan informed the staff team on the dietary requirements for the resident, regular exercise including weekly physiotherapy. On the day of this inspection the provider's physiotherapist was in the centre supporting the resident. The plan also guided staff on important observations in vision and infections that would indicate the resident requires additional medical supports.

The inspector reviewed another residents intimate care plan. The plan was last reviewed in May 2026. The plan guided staff on key resident preferences in terms of showering, dressing, undressing, oral care, hair and nail care. The plan also offered guidance on how to maintain the residents skin integrity as they had mobility issues. In talking with the resident the inspector was told that since moving to the centre the residents skin has never been as good.

In summary, the inspector found that care plans offered strong guidance to staff in the areas of day-to-day care as well as in supporting residents with specific health care needs.

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	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 12: Personal possessions	Not compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Compliant

Compliance Plan for Meath Westmeath Centre 2 OSV-0003958

Inspection ID: MON-0050972

Date of inspection: 22/07/2026

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	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • The Person in Charge and Person Participating in Management (PPIM) have undertaken a comprehensive review of staffing arrangements to ensure that staffing levels, skill mix and deployment are aligned with the assessed needs of residents and the Statement of Purpose. Following a successful recruitment campaign, the Centre now has a full complement of staff in place, ensuring the service is resourced in accordance with funded staffing hours as per roster. • The Provider has completed a business case to the funder for additional funding for staffing resources for 3 staff across day and evening hours over 7 days.	
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 Person in Charge has scheduled Diabetes training for all staff in the Centre through the internal Training to be completed by 07/09/2026. • The Person in Charge reviews staff training matrix quarterly or as the need arises to ensure that all mandatory and resident support specific training appropriate to their role is undertaken.	

Regulation 23: Governance and management	Substantially Compliant

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

• The Person in Charge (PIC) and the Person Participating in Management (PPIM) have completed a comprehensive review of the findings identified within this report. A quality improvement action plan has been developed to address the areas requiring improvement and to support sustained regulatory compliance.

• The PPIM has completed a review of the Centre's transport provision. As part of this review, approval has been sought to replace the current wheelchair-accessible vehicle with a vehicle capable of transporting two wheelchair users simultaneously, thereby enhancing residents' opportunities for community participation and access to appointments. In addition, a second vehicle has been purchased to support residents who do not require wheelchair-accessible transport. These measures increase the flexibility and availability of transport resources within the Centre and ensure residents can access community-based activities in line with their assessed needs, preferences and individual support plans. Ongoing oversight of transport arrangements will form part of the Centre’s governance and quality assurance processes to ensure resources remain effective and responsive to residents' needs.

• The PPIM has established a schedule of quarterly governance and oversight reviews of the designated Centre. These reviews will monitor the effectiveness of audits, assess progress against identified actions, and ensure that all actions are progressed and completed within the agreed timeframes. Where delays arise, these will be appropriately escalated, the rationale documented, and revised completion dates agreed, monitored, and reviewed through the Centre’s governance systems.

• Weekly residents' meetings take place within the designated centre to support residents in expressing their views and participating in decisions relating to their home and daily lives. The Person in Charge oversees and monitors this process to ensure residents are actively involved in decision-making.

• The actions outlined below have been identified to address the findings of this report and will be implemented, monitored, and reviewed in accordance with the relevant regulations and the provider's quality assurance and governance framework to ensure continuous improvement in the quality and safety of services provided to residents.

• The PPIM has completed a review of the Centre's transport provision. As part of this review, approval has been sought to replace the current wheelchair-accessible vehicle with a vehicle capable of transporting two wheelchair users simultaneously, thereby enhancing residents' opportunities for community participation and access to appointments. In addition, a second vehicle has been purchased to support residents who do not require wheelchair-accessible transport. These measures increase the flexibility and availability of transport resources within the Centre and ensure residents can access community-based activities in line with their assessed needs, preferences and individual support plans. Ongoing oversight of transport arrangements will form part of the Centre’s governance and quality assurance processes to ensure resources remain effective and responsive to residents' needs.

• Residents’ finances are appropriately managed and audited to ensure that residents’

funds are safeguarded. However, despite ongoing efforts, there have been difficulties in opening individual bank accounts for each resident. The Person in Charge has engaged with the independent advocate to support residents in opening personal bank accounts, enabling greater independence and easier access to their finances. Ongoing engagement with financial institutions will continue to progress with the opening of individual accounts.

• A risk assessment has been developed to address the risk associated with residents who currently use Patient Private Property Accounts (PPPA) and may not have immediate access to their personal funds. The risk assessment outlines the existing control measures in place to safeguard residents' finances and details additional controls to be implemented by the Person in Charge to further mitigate identified risks.
• The registered provider is also exploring alternative methods for residents to access their personal funds, including the introduction of a debit card that can be topped up as required and used for ATM withdrawals and online purchases. This option aims to promote greater autonomy and timely access to personal finances while maintaining appropriate financial safeguards.
• A scope of works required to address the damaged and scratched flooring within the hallway and sitting room has been forwarded to the funder for resource approval.
• Works to improve accessibility for a resident to access the en-suite of their bedroom have been agreed
• The Person in Charge has enhanced monitoring arrangements through increased auditing of fire safety records and regular review of completed checks.
• Any omissions identified will be addressed promptly with staff and at team meetings to ensure that all fire safety checks are consistently completed and accurately recorded.
• These measures will support ongoing compliance with fire safety procedures and provide assurance that fire safety systems within the designated centre are effectively monitored and maintained.

Regulation 12: Personal possessions	Not Compliant

Outline how you are going to come into compliance with Regulation 12: Personal possessions:
• Residents' finances are appropriately managed and audited to ensure that residents' funds are safeguarded. However, despite ongoing efforts, there have been difficulties in opening individual bank accounts for each resident. The Person in Charge has engaged with the independent advocate to support residents in opening personal bank accounts, enabling greater independence and easier access to their finances. Ongoing engagement with financial institutions will continue to progress with the opening of individual accounts.

• A risk assessment has been developed to address the risk associated with residents

who currently use Patient Private Property Accounts (PPPA) and may not have immediate access to their personal funds. The risk assessment outlines the existing control measures in place to safeguard residents' finances and details additional controls to be implemented by the Person in Charge to further mitigate identified risks.
• The registered provider is also exploring alternative methods for residents to access their personal funds, including the introduction of a debit card that can be topped up as required and used for ATM withdrawals and online purchases. This option aims to promote greater autonomy and timely access to personal finances while maintaining appropriate financial safeguards.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
The Registered Provider and Person Participating in Management (PPIM) have completed a comprehensive review of all outstanding maintenance issues identified within the report to ensure environmental risks are appropriately assessed, prioritized, and addressed, thereby safeguarding residents' rights, wellbeing, and safety.
• A scope of works required to address the damaged and scratched flooring within the hallway and sitting room has been forwarded to the funder for resource approval.
• Works to improve accessibility for a resident to access the en-suite of their bedroom have been agreed.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• The Person in Charge has enhanced monitoring arrangements through increased auditing of fire safety records and regular review of completed checks. Any omissions identified will be addressed promptly with staff and at team meetings to ensure that all fire safety checks are consistently completed and accurately recorded.
• These measures will support ongoing compliance with fire safety procedures and provide assurance that fire safety systems within the designated centre are effectively monitored and maintained.

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 12(1)	The person in charge shall ensure that, as far as reasonably practicable, each resident has access to and retains control of personal property and possessions and, where necessary, support is provided to manage their financial affairs.	Not Compliant	Orange	27/08/2027
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	31/01/2027
Regulation 16(1)(a)	The person in charge shall	Substantially Compliant	Yellow	30/09/2026

	ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.			
Regulation 17(1)(a)	The registered provider shall ensure the premises of the designated centre are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.	Substantially Compliant	Yellow	31/01/2027
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.	Substantially Compliant	Yellow	31/01/2027
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.	Substantially Compliant	Yellow	31/01/2027
Regulation 23(1)(c)	The registered provider shall ensure that management	Substantially Compliant	Yellow	31/08/2026

	systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.			
Regulation 28(2)(b)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Substantially Compliant	Yellow	31/08/2026