



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

Issued by the Chief Inspector

Name of designated centre:	Creg Services
Name of provider:	Corlann
Address of centre:	Galway
Type of inspection:	Unannounced
Date of inspection:	07 July 2026
Centre ID:	OSV-0005007
Fieldwork ID:	MON-0049156

About the designated centre

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

Creg services provides a residential service to four adults. Residents of this service require a high level of support from staff in the context of their assessed needs. Residents may also have medical needs and a combination of nurses, social care workers and care assistants work in this centre. The centre is located on the outskirts of a city where public transport links such as trains, taxis and buses are available. The centre also provides transport for residents to access their local community. Each resident has their own bedroom and an appropriate number of shared bathrooms are available for residents to use. A social model of care is offered to residents in this centre, some residents are receiving an integrated type service with both day and residential supports, provided in the designated centre; other residents attend separate off-site day services. One staff member supports residents during night time hours and three staff members support residents during the day. The day to day management of the centre is assigned to the person in charge.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	4
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How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Tuesday 7 July 2026	09:20hrs to 16:00hrs	Mary Costelloe	Lead

What residents told us and what inspectors observed

This was an unannounced inspection carried out to monitor compliance with the regulations and conditions of registration. The purpose of this inspection was to review actions taken by the provider, as outlined in their compliance plan to address areas of non compliance with the regulations. The registration of the designated centre was renewed in December 2025 with a non-standard condition attached to the registration. This condition required the provider to address the regulatory non compliance's as outlined in the plan dated 09/07/2025 to the satisfaction of the Office of the Chief Inspector no later than 30/06/2026.

The findings from this inspection showed that the provider had failed to address the non compliance's identified at the previous inspection and had failed to implement the compliance plan submitted to the Chief Inspector. The provider was operating the centre in breach of condition 4 of its registration. There continued to be non compliance's in governance and management, premises, safeguarding, fire safety management, and risk management. Further non-compliance's were identified in relation to resources available to the person in charge to maintain effective oversight of the service and regarding the non submission of statutory notifications required to be made to the Chief Inspector. Improvements were also required to aspects of staff training and care planning documentation.

Creg Services consists of one house located in rural residential area and close to a number of towns and villages. The inspection was facilitated by the person in charge and team leader. On the day of inspection, there were four residents being accommodated in the centre. Two residents normally attended a service programme while two residents were supported by staff with an integrated day programme from the house. The inspector met with two residents and spoke with two staff who were on duty. Residents living in the centre had complex and high support needs including requiring supports with all activities of daily living, with managing behaviours, communication, eating, drinking and swallowing difficulties and in managing specific health care conditions.

Due to communication needs of residents, they were unable to tell the inspector their views about the care and support they received; however, they appeared comfortable and content in their environment and with the staff supporting them. The inspector noted positive interactions between residents and staff, with residents engaging in their surroundings and displaying signs of enjoyment throughout the day. There was consistent and stable staffing arrangements in place. Staff spoken with had worked in the centre over a sustained time period and demonstrated a good knowledge and understanding of residents' individual communication styles, needs, preferences and interests. They were seen to respond appropriately to non-verbal cues, gestures and prompts, ensuring that residents preferences and wishes were interpreted and respected.

On the day of inspection, two residents had left to attend their regular day service programme and two residents remained in the house. Residents who remained in the house went about their own routines, and were supported by staff with personal care and breakfasts. Later in the morning, residents were supported by staff to go for a drive and had plans to have lunch out, however, due to issues with the transport vehicle they returned to the centre after a short period of time. Staff informed the inspector that the vehicle needed to be checked at the garage. The inspector noted residents spending some time outside with staff and one resident enjoyed spending time in the ball pool and in the sensory room, another resident relaxed in their bedroom and both residents were supported to have their lunch in the centre. Staff spoken with were knowledgeable regarding the individual nutritional needs and recommendations from the speech and language therapist. Staff told the inspector how residents enjoyed eating out in local restaurants and hotels and would regularly have lunch out two to three days a week. Staff advised that another transport vehicle would be available in the afternoon and they planned to ensure that residents got out in the evening time. Staff reported that both residents got out and about to partake in their preferred activities in the community on a daily basis.

Staff spoken with outlined that residents continued to enjoy a variety of activities and outings including attending the cinema, attending discos and social evenings, going for walks in the city and nearby towns. One resident enjoyed attending weekly Jacuzzi and horse riding sessions. Staff also spoke of plans in place for some residents to attend Able fest music and arts festival later in July and other local arts festival events during the summer months. They outlined how some residents had recently enjoyed attending 'Momentum' music festival, a trip to Mondello Park and an overnight stay away in a hotel in Athlone. Residents also enjoyed spending time in the house partaking in arts and crafts activities, baking activities, spending time in the ball pool and sensory room and having hand and foot massages. Some residents enjoyed watching action movies, listening to music, watching GAA matches and horse racing on television. Another resident enjoyed watching the Disney channel and spending time using their iPad which they now could stream onto the larger screen of the television. Staff also supported residents to remain in contact with family members and supported one resident to visit family on a weekly basis. They supported another resident who liked to visit and spend time at a family grave and another resident who liked to visit the church and light a candle.

The designated centre comprises of a single storey detached house set on its own grounds in a rural area but close to a village and near by city. Three residents had their own bedrooms and one resident had their own apartment. There was one accessible shower and bathroom room which was shared by three residents. There was a variety of communal day spaces provided including a sitting room, dining room, sensory room and lounge seating area off the kitchen. Residents had access to a large garden area at the rear of the house. While some bedrooms had been repainted and flooring to the main bathroom had been replaced, other improvements works required to the premises and garden area had not been addressed. The provider had failed to implement the actions as outlined in the compliance plan submitted following the last inspection which had included reconfiguration to the internal layout of the building to provide a separate suite for

one resident as recommended in the safeguarding plan. Staff spoken with advised that they continued to supervise residents closely to manage identified safeguarding concerns and to reduce the risk of incidents occurring. As a result the safeguarding arrangements remained reliant on continuous staff supervision rather than the implementation of the agreed environmental controls.

Other planned improvements to pathways to the garden area to improve accessibility, plans to provide a sensory garden and safe enclosed garden area for a resident had not been completed. The kitchen was found to be in need of refurbishment and upgrading, with many of the wooden surfaces noted to be worn, damaged and ill-fitting. The wooden strips used at wall floor junctions were also found to be worn and defective in some areas. The walls to some rooms including the sensory and dining rooms were damaged and in need of repainting. The rear garden area was poorly maintained with many areas not safely accessible to residents.

The next two sections of the report outline the findings of this inspection in relation to the governance and management arrangements in place in the centre and how these arrangements impacted on the quality and safety of the residents lives.

Capacity and capability

The findings from this inspection showed that the provider had failed to address the non compliance's identified at the previous inspection and had failed to implement the compliance plan submitted to the Chief Inspector within the agreed time frames. The provider was operating the centre in breach of condition 4 of its registration. There continued to be non compliance's in governance and management, premises, safeguarding, fire safety management, and risk management. Further non compliance's were identified in relation to notifications, as the provider had not ensured that all required statutory notifications were submitted to the Chief Inspector. Further improvements were also required to aspects of staff training and to care planning documentation.

The provider had appointed a new full-time person in charge in September 2025, however, the inspector was not assured that adequate resources were in place for the person in charge to maintain effective governance and operational oversight of the centre. The inspector was informed that there had been other changes to management arrangements in the centre but the Chief inspector had not been notified of these changes. The provider had also recently appointed a team leader in June 2026.

The inspector was not assured that the provider had effective governance systems in place to monitor service quality, identify areas requiring improvement and ensure that necessary actions were implemented and reviewed. The annual review of the quality and safety of the service was not available in the centre, the staff team or

the the recently appointed team leader had not had the opportunity to review its findings or associated actions. While the inspector was informed that six-monthly provider-led reviews had been completed, no reports had been issued following these reviews and no actions plans had been developed to address identified findings or drive quality improvements. Monthly in house reviews of infection, prevention and control which included reviews of the premises had not identified a number of issues observed by the inspector during the inspection. Recent audits findings reviewed indicated 100% compliance in these areas which was not consistent with the inspection findings.

There were deficiencies in the providers systems for identifying and reporting notifiable incidents and events to the Chief Inspector in line with regulatory requirements.

Regulation 14: Persons in charge

The provider had not ensured that the person in charge can provide effective governance, operational management and administration of the centre. The person in charge was responsible for two designated centres (consisting of three houses) and also had other managerial responsibilities in the organisation as a service coordinator for five residential services and seven day services. While the person in charge advised that they maintained regular telephone contact with the team leader and visited the centre for one to two hours weekly, this limited their capacity to maintain effective oversight of the day-to-day operation of the service and to ensure ongoing monitoring of the quality and safety of care provided. In light of the significant number of non-compliance's identified during this inspection, the inspector was not assured that the person in charge had sufficient capacity to provide effective oversight, monitor regulatory compliance and ensure that identified risks and required improvements were addressed in a timely manner.

Judgment: Not compliant

Regulation 15: Staffing

The staffing levels at the time of inspection met the support needs of residents. The rosters reviewed for the 28 June to 11 July 2026 showed consistent and stable staffing arrangements. There were normally three staff on duty during the day with one staff member on active duty at night-time. There was an additional housekeeping staff member on duty three days a week. There was a full compliment of staff at the time of inspection.

Judgment: Compliant

Regulation 16: Training and staff development

Improvements were still required to aspects of staff training. The recently appointed team leader advised the inspector that they were in the process of reviewing training needs and identifying gaps in training requirements. They had identified that the current training matrix was not accurate and did not reflect all training completed. A number of staff required refresher training in areas such as safeguarding, manual handling and fire safety. Some staff had been scheduled to attend refresher training while others had yet to be scheduled.

Judgment: Substantially compliant

Regulation 23: Governance and management

The provider had not ensured that the governance and management arrangements in place were effective in ensuring that the service was safe, consistently monitored or compliant with the regulations.

The provider was operating in breach of a condition 4 of its registration (Notwithstanding the requirements placed on the registered provider to comply with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, the registered provider shall take all necessary action to comply with Regulation 17: Premises, Regulation 8: Protection

To the satisfaction of the office of the Chief Inspector no later than 30/06/2026).

The provider had failed to implement the compliance plan submitted following the previous inspection and a number of repeated and significant non-compliance's were identified during this inspection. Non compliance's were identified in relation to Regulation 23: Governance and management, Regulation 14: Persons in charge, Regulation 31: Notification of incidents, Regulation 17: Premises, Regulation 26: Risk management procedures, Regulation 28: Fire precautions and Regulation 8: Protection.

The inspector was not assured that the person in charge, who was responsible for two designated centres and held additional management responsibilities, had sufficient capacity to provide effective oversight of the service given the significant number of non-compliance's identified during this inspection.

Quality assurance systems were ineffective in identifying deficits, with annual and six monthly reviews not driving improvements and in-house audits reporting full compliance despite significant issues being identified on inspection.

Records reviewed by the inspector demonstrated that regular staff meetings had not been maintained. Aside from one recent staff meeting held in May 2026, no other meeting minutes were available since September 2025. This limited the providers assurance that effective communication, oversight and governance arrangements were in place in the centre. Therefore, the provider could not demonstrate that information was consistently communicated or that staff had opportunities to raise concerns and contribute to service improvement.

Furthermore, systems for the notification of incidents, restrictive practices and changes to the management arrangements were not in line with regulatory requirements further demonstrating ineffective governance and oversight of the centre.

Judgment: Not compliant

Regulation 31: Notification of incidents

The provider had not ensured compliance with the regulatory requirements for the notification of incidents and events to the Chief Inspector. A safeguarding incident which occurred in May 2026 had not been reported as required. The quarterly notifications submitted in relation to restrictive practices were also found to be inaccurate and did not accurately reflect the number or type of restrictions in use within the centre. The inspector noted that there were several physical and environmental restrictive practices in use that had not been notified.

Judgment: Not compliant

Quality and safety

Overall, residents received a good standard of care and support from a stable and experienced team who were familiar with their individual needs and preferences. Throughout the inspection, staff demonstrated a good knowledge of residents and interacted with them in a respectful and person-centered manner. Residents were supported to access their local community on a regular basis and participated in a range of activities in line with their interests and preferences. Residents health care needs were appropriately identified and they had access to relevant health care professionals when required.

However, the lack of effective governance, management and oversight combined with ineffective quality assurance systems meant that areas requiring improvement had not been addressed in a timely manner. The provider had identified the need to reconfigure the premises to create a separate suite for one resident in line with

recommendations arising from safeguarding concerns. This was intended to enhance residents' quality of life and reduce identified safeguarding risks, however, the planned works had not progressed in line with the compliance plan submitted. In addition, improvements were still required in relation to maintenance of the house and gardens. There were also continued deficits identified in relation to fire safety documentation and risk management processes. The lack of timely action to address identified risks had the potential to impact on the safety and quality of the support provided to residents.

Improvements were required to ensure that care and support plans maintained on the computerised documentation system accurately reflected residents' assessed needs. There was no comprehensive assessment of each resident's health, personal and social care needs available. The team leader did outline residents' individual care and support needs and there were corresponding assessments, as well as, care and support plans recorded for those needs. However, a number of support plans required review and updating to ensure that they provided clear, current guidance to staff and reflected changes in residents' needs and the supports required.

Regulation 17: Premises

Improvement works were still required to the premises to ensure it met the assessed needs of residents and was maintained in a good state of repair externally and internally. This was a repeat non-compliance and the provider had not addressed the issues as outlined in the compliance plan submitted following the last inspection. The provider had identified the need to reconfigure the premises to create a separate suite for one resident in line with recommendations arising from safeguarding concerns. At the time of this inspection, there was still no time-bound plan in place for the completion of works.

Other planned improvements to pathways to the garden area to improve accessibility, plans to provide a sensory garden and safe enclosed garden area for a resident had not been completed. The outdoor garden furniture, raised garden beds and a swing seat were inaccessible to residents due to the lack of maintenance of the garden areas.

The kitchen was found to be in need of refurbishment and upgrading, with many of the wooden surfaces noted to be worn, damaged and ill-fitting. The wooden strips used at wall-floor junctions were also found to be worn and defective in some areas. The walls to some rooms including the sensory and dining rooms were damaged and in need of repainting.

Judgment: Not compliant

Regulation 26: Risk management procedures

The providers systems for identifying, assessing and managing risks in the centre still required improvement. The risk register reviewed was not reflective of risk in the centre. The person in charge identified safeguarding as one of the highest risks within the service, however, this was recorded as low risk on the risk register. There was no specific safeguarding risk assessment available to guide the management of identified safeguarding concerns and ensure appropriate controls were implemented and reviewed.

The personal emergency evacuation plans (PEEPS) did not provide sufficient guidance to staff regarding the individual support needs of residents in the event of a fire or other emergency which meant that staff did not have adequate information to support effective emergency responses.

Judgment: Not compliant

Regulation 28: Fire precautions

Improvements were still required in relation to fire safety arrangements, this is a repeat non compliance from the previous inspection. While fire drills had taken place, the fire drill records reviewed did not provide sufficient detail to demonstrate that residents could be evacuated safely in the event of fire. The records did not adequately capture key information or identify any learning or corrective actions identified from the drills. As previously outlined under Regulation 26 : Risk management procedures, PEEP's were not adequate and did not provide sufficient detail to guide staff on the individual support needs of residents during an emergency evacuation. This together with the insufficient detail recorded in the drill documentation meant that the inspector was not assured that the provider had effective systems in place to support the safe evacuation of residents in the event of fire particularly at night-time when there was one staff on duty.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

The person in charge had not ensured that a comprehensive assessment of the health, personal and social care needs of the residents was carried out. While care plans were in place for issues as outlined by the team leader and staff were observed to have a good knowledge of residents needs, they were not underpinned by a comprehensive assessment of need for each resident.

A number of key documents and support plans required review and updating to ensure that they provided clear, current guidance to staff and reflected changes in residents needs and the supports required. For example, 'things you need to know about me' document, nutritional care management plan and epilepsy care plan were not up to date and did not accurately reflect the current needs of the resident.

Judgment: Substantially compliant

Regulation 8: Protection

At the time of inspection, there were still peer to peer safeguarding concerns in place. The designated officer had visited the centre, met with staff and had updated the safeguarding plan in place. They had identified ongoing safeguarding risks and described the environment as not entirely suitable.

The provider had previously identified the need to reconfigure the premises to create a separate suite for one resident in line with recommendations arising from safeguarding concerns. At the time of this inspection, there was still no time bound plan in place for the completion of works. In the interim, safeguarding risks continued to be managed through staff supervision rather than through planned environmental measures. Staff spoken with advised that constant supervision of residents at risk can be challenging. While staff demonstrated the importance of supervision in managing safeguarding concerns, reliance on ongoing staff observation was not considered a sustainable long-term measure.

Two recent safeguarding incidents had occurred in the centre, however, only one of these incidents had been notified to the Chief Inspector as required.

Judgment: Not 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	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Not compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 8: Protection	Not compliant

Compliance Plan for Creg Services OSV-0005007

Inspection ID: MON-0049156

Date of inspection: 07/07/2026

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 14: Persons in charge	Not Compliant
Outline how you are going to come into compliance with Regulation 14: Persons in charge: • In order to ensure compliance with Regulation 14 the Provider has reviewed the responsibility and workload of the current person in charge and is reducing the number of designated centre's under the current Person in Charge responsibility from three houses to one. Therefore, the person in charge will then have responsibility for the governance and oversight and administration of Creg Services. • This change will ensure the Person in Charge has increased capacity to provide effective oversight, oversee day-to-day operations and have increased presence in the centre in order to monitor regulatory compliance and ensure that identified risks and required improvements are addressed in a timely manner.	
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 reviewed and updated the training matrix for the centre to reflect all training undertaken by staff. • Staff scheduled for training by the Person in Charge on the 13th July 2026 completed the refresher training as scheduled, with all remaining staff requiring refresher training being booked and scheduled for completion by the 21st October 2026.	

Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • In Accordance with Regulation 23(1)(d) the provider has reviewed the compliance plan previously submitted, and has communicated to the Authority the rationale why the original plan has not been progressed. This explanation includes a commitment to a relocation of the current Designated Centre to a new premises that will ensure the provider is operating within condition 4 of its registration. In the interim safeguarding will continue to be monitored through ongoing review of safeguarding plans, enhanced supervision, and monthly Management meetings for Monitoring of Safeguarding and also through the consideration of potential alternative accommodation options that may arise within the wider service. • In Accordance with Regulation 23(1)(C) the provider is in the process of ensuring that the current Person in Charge will have responsibility for the governance and oversight of Creg Services only. This will ensure they will work, have capacity and time to have an enhanced presence within the Designated Centre. • In Accordance with 23(2)(a) the last six monthly provider Audit has now been completed for the Designated Centre and a schedule of the Actions is actively being worked on by the PIC and Team Leader. The Person in Charge and Team Leader will also carry out spot checks on completed safety audits to ensure that audits are completed as scheduled and are accurate. Any identified actions or gaps will be addressed promptly. The Team Leader has also recently completed the providers newly developed Leadership and Development Programme, which provides direction on meaningful auditing and using Audits to drive quality improvement. Additionally, a further Quality and Compliance Officer has been appointed by the provider to ensure enhanced oversight of responsibility to meet regulatory requirements including the timely completion of Six Monthly Provider Audits. This role will provide leadership support and development for the Designated Centre's Team Manager, going forward. • In Accordance with Regulation 23(3) (b), the Team Leader has a schedule of Team meetings in place that will further provide the opportunity for staff to raise any concerns about the quality and safety of the care and support provided to the people supported.	
Regulation 31: Notification of incidents	Not Compliant
Outline how you are going to come into compliance with Regulation 31: Notification of incidents: • In Accordance with Regulation 31, The Person in Charge will ensure that any safeguarding concern is notified to the Chief Inspector via the provider portal in the timeline required. The ongoing monitoring of the interim safeguarding plan will support the prompt notification of incidents. • The restriction that had not previously been identified or notified to the Chief Inspector	

through the quarterly notification process will be included in the Q2 2026 notification in respect of the Designated Centre by the Person in Charge.

Regulation 17: Premises

Not Compliant

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

- In Accordance with Regulation 17, The Provider has reviewed the compliance plan previously committed to, and has communicated to the Authority the rationale why the original plan has not been progressed. The explanation includes a commitment to a relocation of the current Designated Centre to new premises by the end of the current lease agreement in 2030. The Provider will also ensure to update the Authority of all progress with this plan through the Person in Charge, every 6 months.
- The Person in Charge has arranged for remedial works required to the flooring and kitchen areas, as well as the update to painting in the other areas of the house to be completed.

Regulation 26: Risk management procedures

Not Compliant

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

- In Accordance with Regulation 26, The Person in Charge and Multi D Team have reviewed the Risk Register for the designated centre to include the risk rating and has amended the same to ensure the highest risk within the Designated Centre is highlighted together with the controls implemented. Safeguarding Risk Assessment have also been completed in collaboration with the Multi D Team to ensure appropriate controls are implemented and reviewed.
- The individual PEEP of each person supported by the designated centre has been reviewed by the PIC, MDT and frontline staff to ensure clarity regarding each individuals support needs, in the event of an emergency.

Regulation 28: Fire precautions

Not Compliant

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

- In Accordance with Regulation 28, the individual PEEP for each person supported by the designated centre has been reviewed by the PIC, MDT and frontline staff to ensure clarity regarding each individuals support needs, in the event of an emergency.
- The Person in Charge organized a fire training session with all staff working in the Designated Centre regarding the completion of Fire Drills that took place on the 13/07/2026. This session further addressed the level of information required to be recorded, and how this information is progressed to lead to improvements in the quality of service delivered.

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: • In Accordance with Regulation 5, The Person in Charge and Team Leader conducted a comprehensive overview of each individuals support needs and supporting documents. This review included each residents " Things You Need to Know about Me" booklet, nutritional management care plan and epilepsy care plan to ensure they provide an accurate reflection of current needs. • The provider is reviewing its Assessment of Need documentation to ensure that a comprehensive documentation is in place to inform on the needs of the person.	
Regulation 8: Protection	Not Compliant
Outline how you are going to come into compliance with Regulation 8: Protection: • In Accordance with Regulation 8, The Provider has reviewed the compliance plan previously submitted, and has communicated to the Authority the rationale why the original plan has not been progressed. The explanation includes a commitment to a relocation of current Designated Centre to new premises that will ensure the provider is operating within condition 4 of its registration and ensuring there are supports through planned environmental measures. • The ongoing monitoring of the interim Safeguarding plan by the Person in Charge, Staff Team, Multi-Disciplinary Team and Designated Officer, will support the prompt notification of incidents.	

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	30/10/2026
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	21/10/2026
Regulation 17(1)(a)	The registered provider shall ensure the premises of the	Not Compliant	Orange	31/07/2030

	designated centre are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.			
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Not Compliant	Orange	30/11/2026
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	30/10/2026
Regulation 23(1)(d)	The registered provider shall ensure that there is an annual review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards.	Not Compliant	Orange	08/07/2026
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered	Not Compliant	Orange	30/11/2026

	provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.			
Regulation 23(3)(b)	The registered provider shall ensure that effective arrangements are in place to facilitate staff to raise concerns about the quality and safety of the care and support provided to residents.	Not Compliant	Orange	31/07/2026
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Not Compliant	Orange	13/07/2026

Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.	Not Compliant	Orange	13/07/2026
Regulation 31(1)(f)	The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: any allegation, suspected or confirmed, of abuse of any resident.	Not Compliant	Orange	31/07/2026
Regulation 31(3)(a)	The person in charge shall ensure that a written report is provided to the chief inspector at the end of each quarter of each calendar year in relation to and of the following incidents occurring in the designated centre: any occasion on which a restrictive procedure including physical, chemical or environmental restraint was used.	Not Compliant	Orange	31/07/2026
Regulation 05(1)(b)	The person in charge shall	Substantially Compliant	Yellow	08/07/2026

	ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out subsequently as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.			
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	30/07/2026