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:	Cork City North 15
Name of provider:	Horizons
Address of centre:	Cork
Type of inspection:	Unannounced
Date of inspection:	25 June 2026
Centre ID:	OSV-0005395
Fieldwork ID:	MON-0050766

About the designated centre

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

Cork City North 15 is comprised of three purpose-built bungalows which are located within a secure campus setting adjacent to another designated centre and a day activation centre on the outskirts of Cork city. The designated centre can provide full residential care for up to 17 adult residents. Two bungalows are comprised of six individual bedrooms, kitchen, dining and sitting room, music room, laundry and linen room. Each bungalow also has two shared bathrooms and an additional toilet for residents to use. There is a connecting corridor between two bungalows where a staff office and facilities are located. The third bungalow has been re-structured to create one self-contained apartment styled dwelling to support one resident and the rest of the bungalow can support a maximum of four residents. The centre supports residents with mild, moderate and severe/profound levels of intellectual disability with many residents presenting with additional complex needs and behaviours that challenge. Residents are supported by a staff team that comprises of both nursing and social care staff by day and night.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	12

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
Thursday 25 June 2026	09:30hrs to 17:10hrs	Elaine McKeown	Lead
Thursday 25 June 2026	09:30hrs to 17:10hrs	Louise O'Sullivan	Support

What residents told us and what inspectors observed

This was a focused unannounced inspection to monitor the provider's compliance with the regulations. The Chief Inspector had attached an additional condition of registration to this designated centre following an inspection by inspectors of the Health Information and Quality Authority (HIQA) in September 2023. The provider was to address the issues as outlined in the compliance plan response returned to the Chief Inspector by 31 December 2026. This designated centre was also inspected in November 2024 with improvements observed in some regulations. There were issues also identified during that inspection. While some progress was evident on the day of this inspection, there were ongoing issues with fire safety and further review was required of the supports being provided to residents to ensure all of their assessed needs were being met.

The inspectors met with eight of the current residents at times that best suited their routines. All three houses were visited during the inspection at different times during the day. One resident was walking up to their day service independently when they greeted the inspectors with a hand shake as they were about to visit one of the houses. The resident told the inspectors they were doing well, had recently purchased some items and enjoyed helping with jobs around the campus.

The inspectors were introduced to three residents in the first house. One resident was sitting in a communal room watching a programme before it was time to go to their day service. The resident was encouraged by a staff member to speak about their family and one inspector noted there was a new couch in place since the previous inspection and the resident smiled when this was commented on. This resident was observed to seek out a staff member when it was time for them to leave and the staff member supported the resident to go to their day service. The staff present spoke of plans for the day for three remaining residents which included a trip to the beach as the weather was good on the day of the inspection. The staff also explained terms that one resident used to communicate and this was observed by the inspectors. The inspectors were informed one resident was still sleeping as per their usual morning routine.

In the second house the inspectors were introduced to two residents briefly as they passed the inspectors in the hallway. The inspectors met one of these residents again in the afternoon on a return visit. Staff working in this house spoke of preferences in routines and a shared interest in a major sporting event that was taking place at the time of the inspection. Decorations to mark this event were evident in this house.

The inspectors were advised of a preferred time to visit the third house when a resident had returned from a planned social outing. This resident greeted the inspectors at the door to their home with a staff member supporting them. The resident invited the inspectors into their dining room and chatted about many topics,

including plans for the afternoon, the art work they had completed which was on display around their home and how they liked having so much space. There were no other residents living in this area with the resident who had moved into the designated centre in January 2025. The staff member was observed to be familiar with the resident's preferences and provided clarity to the inspectors when the resident was trying to explain some things that were important to them.

There was a self-contained apartment in the third building which supported one resident. The staff supporting this resident explained the resident was sleeping at the time the inspectors were present and they were unable to meet the resident. The staff member was familiar with the routine both by day and night of this resident and outlined how staff ensured the resident had access to a transport vehicle each morning to engage in a particular activity. This was consistent with information provided by another staff member to the inspectors earlier in the inspection. The importance of regular routine and visiting particular social areas for this resident were explained by both staff to the inspectors.

During the walk around of the designated centre it was evident residents were supported to decorate their own bedrooms with personal possessions. Communal areas were bright and well ventilated. There was evidence of regular cleaning taking place and there was a dedicated staff who attended to these duties each week. Some issues regarding maintenance were identified which included a missing handle from a bathroom window and a small amount of water behind a toilet bowl in the same bathroom in one of the houses. The most recent internal audit of the 10 June 2026 had identified these issues. The person in charge informed the inspectors they had logged the issues with the provider's maintenance department after that audit. However, additional issues with the premises were identified during the inspection which included not all fire doors could operate as intended to ensure effective fire containment measures. An extension panel to a bedroom door in the second house was observed to be opened back and did not have a mechanism that would facilitate it to close in the event of the fire alarm being activated. This has been a re-occurring issue within this designated centre in the previous two inspections and was discussed during the feedback meeting at the end of the inspection. The inspectors acknowledge the person in charge addressed the issue immediately once they noticed it themselves during the walk around of the house with the inspectors.

The next two sections of this report will present 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 service being provided.

Capacity and capability

This was a focused inspection to monitor the provider's progress to attain compliance with the regulations as outlined in the compliance plan response

returned to the Chief Inspector of Social Services after the September 2023 inspection. Following the findings of the September 2023 inspection the Chief Inspector attached an additional condition to the registration of the designated centre. The provider was afforded until 31 December 2026 to come into compliance with the regulations as outlined in the compliance plan. There was evidence that actions had been taken by the provider to seek to address the issues previously identified. However, further review and progress was required to ensure compliance with the specific regulations outlined in the September 2023 compliance plan are attained on or before the 31 December 2026.

The provider was aware of the regulatory requirements to complete an annual report and internal provider led audits every six months. An inspector reviewed the two most recent internal audits of January and June 2026 as well as the annual report for 2025. Ongoing issues relating to staff resources, staff training and fire safety were repeated findings in these reports. Some findings were documented as requiring immediate attention but remained an issue at the time of this inspection.

The person in charge outlined the provider's protocol in place to ensure agency staff who reported for duty in the designated centre were adequately trained and deemed to meet the criteria to work with vulnerable residents. Staff spoken to during the inspection provided the same consistent information that new/ unfamiliar agency staff were required to report at the start of their shift to the manager on duty in the campus before going to any house in the designated centre. The inspectors were informed the person in charge did not complete supervisions with agency staff.

As part of the review during the inspection of the response from the provider to the issues identified in the November 2024 inspection, the inspectors were informed there were no open safeguarding plans or complaints. Updates were provided on protocols in place regarding these regulations which included residents were being supported with protected meal times. In addition, one resident was reviewed by a speech and language therapist with an updated communication plan developed to ensure all staff were aware of the resident's communication style.

Regulation 15: Staffing

The registered provider was aware of the high level of reliance on agency staff to provide support to the residents living in this designated centre. The inspectors were informed this had been identified as a corporate risk by the provider.

Of the actual and planned rotas reviewed there were agency staff on duty on each shift. For example, on 21 June 2026 there were five agency care assistants, an agency nurse and three relief staff supporting the core staff team of eight (comprised of nurses and care assistants) over the 24 hour period. The person in charge outlined that where possible agency staff familiar to the residents would be requested.

The actual rotas demonstrated the ongoing requirements to make changes due to unplanned absences. However, on review of the actual rota for the day of the inspection the actual start times for two staff were not reflective of the staff that were on duty at the start of the inspection. Both staff commenced their shift later in the morning. The inspectors acknowledge this did not impact the minimal staffing levels for the designated centre at that time. The inspectors were informed staff would take time owing to them when additional/sufficient staff resources were on duty but inspectors were not assured this was always accurately reflected on the actual rotas.

There were two whole time equivalent (WTE) activation posts vacant at the time of this inspection and a 0.5 WTE nursing post.

As outlined to the inspectors during the inspection, a number of residents required specific staffing supports which included at least one familiar staff to be on duty to support them. However, the inspectors were informed a resident who required two staff to support them during the day time at weekends did not consistently have this in place. The person in charge outlined how a second staff was being allocated from the staff team/relief staff or agency staff where possible to support the resident such as on 21 June 2026 from 10:00hrs-20:00hrs.

Judgment: Substantially compliant

Regulation 16: Training and staff development

At the time of this inspection the staff team was comprised of 36 members, not all were in full time posts. This included the person in charge who worked full time in the designated centre, a clinical nurse manager, seven nurses, 24 care assistants and three relief care assistants. This was an increase in the staff team since the previous inspection in September 2024 when there was a total of 28 staff members at that time providing support to 13 residents.

- Supervision of the core staff team had been completed during 2025 and had commenced for 2026 by the person in charge. This included some clinical supervision by the clinical nurse manager of the nursing staff. The inspectors were informed this clinical supervision took place at the same time as the person in charge supervision with the nursing staff member.
- The person in charge had a training matrix in place which was reflective of the training completed and scheduled in the coming weeks for the staff team this was subject to regular review.
- All core staff had completed up-to-date training in safeguarding which had been identified as an action from the previous inspection. In addition, all core staff team members and two relief staff had attended training in fire safety. One relief staff who had last worked in the designated centre at the start of May 2026 was required to complete refresher training in fire safety.

- However, there were gaps in some training including mandatory training for the staff team, positive behavioural supports, safety intervention and manual handling. Training in safety intervention and manual handling had recently taken place and further scheduled dates were documented in the matrix reviewed during the inspection.

Judgment: Substantially compliant

Regulation 23: Governance and management

The registered provider had failed to ensure that the designated centre was appropriately resourced in terms of effective management systems to deliver safe, effective and consistent care and support to residents.

The registered provider had made insufficient progress in achieving compliance with the regulations to date. Despite previous regulatory engagement, areas of non-compliance remained, demonstrating that governance arrangements had not resulted in sustained improvements in the quality and safety of the service.

The registered provider had not ensured effective workforce planning or oversight. There were ongoing staffing deficits, resulting in a continued high reliance on agency staff. Arrangements for the supervision and integration of agency staff were ineffective. Agency staff did not routinely receive formal supervision and the inspectors were not assured such staff were attending team meetings, reducing opportunities to communicate best care practices, review residents' changing needs and promote consistent care.

Governance and oversight systems were not sufficiently robust to provide the registered provider with assurance regarding the quality and safety of care. Monitoring systems were underdeveloped and failed to consistently identify, monitor and respond to known risks. The provider was unable to clearly demonstrate that residents' activities, participation and outcomes were routinely monitored and reviewed to ensure they were meaningful, person-centred and in-line with residents' assessed needs and preferences.

The registered provider had failed to ensure that adequate fire containment measures were in place throughout the designated centre. Deficits identified during previous inspections had not been effectively addressed to date, and the provider had not implemented its compliance in full plan to date. The actions taken had not been sufficient to mitigate identified fire safety risks or provide assurance that residents were adequately protected from the risk of harm. This represented a repeated finding across the previous three inspections since May 2023 and demonstrated ineffective governance arrangements to identify, monitor and resolve known risks.

Judgment: Not compliant

Quality and safety

Overall, the inspectors found that the quality and safety of care provided for residents required further review. Not all residents living in this designated centre were in receipt of safe services and support in-line with their their assessed needs. The repeated finding of fire containment measures not being effective in the event of the fire alarm activating had not been adequately addressed by the provider.

On review of residents personal plans there were gaps evident in some of the documentation reviewed. This included the inconsistent documentation of the progression of personal goals. This had also been a previous finding on inspection in this designated centre. Inspectors were informed that one resident was being supported to adhere to a specified fluid restriction but no guidance was documented in the resident's relevant healthcare plan or on the fluid recording sheet being used by staff. The inspectors did not review Regulation 6: Healthcare during this focused inspection and findings relating to the assessed medical needs of residents have been actioned under Regulation 5: Individual assessment and personal plan.

The inspectors were informed by the person in charge that an external advocacy service had visited the designated centre four times since January 2026 to provide support to residents if they wished to engage in the services and meet with them. The focus is to build meaningful relationships with the residents to support them with future needs where required such as in connection with possible de-congregation.

Regulation 17: Premises

The inspectors visited all three buildings during the inspection. However, there were some areas not viewed due to residents sleeping which included the apartment located in one of the houses. The buildings were well ventilated, windows were open in most areas due to the warm weather conditions. There was evidence of regular cleaning taking place including on the day of the inspection from dedicated cleaning staff.

- Actions from the November 2024 inspection were evidenced to have been addressed which included replacement of damaged seating for some residents.
- The inspectors were informed there was an ongoing maintenance planned for the designated centre which included internal painting.

- An internal audit completed on 10 June 2026 had identified an number of maintenance issues which included a missing handle from a bathroom window and water lodging on the floor behind a toilet in one of the houses. These issues remained unresolved and were observed by the inspectors during the walk around. In addition, inspectors also observed damaged seating with the internal material exposed in the room used by staff supporting the resident living in the apartment. Damage was also evident on the wall between the kitchen and dining area in one of the houses.

During the feedback the inspectors also advised the provider that further review of the floor plans was required before submitting the application to renew the registration of this designated centre later in 2026 as it had been identified during the walk around that the positioning of doors on a corridor in one of the houses was not accurately reflected in the floor plans provided to the Chief Inspector.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

The registered provider had not ensured that effective systems were in place to identify, assess, manage and review risks within the designated centre.

The centre's risk management policy required review as it did not provide assurance that identified risks were comprehensively assessed or that control measures implemented were proportionate, effective and subject to ongoing review.

Inspectors found that identified risks had not been effectively managed. For example, the control measures identified to manage fire prevention and fire containment risks were not fully implemented and were ineffective in reducing the identified risk. Consequently, the provider could not demonstrate that the arrangements in place were sufficient to protect residents from the risk of fire.

Inspectors also identified that the provider had failed to adequately assess and manage individual resident risks. One resident had a known medical condition which significantly increased their risk of injury following a fall. However, the associated risk assessment did not identify or adequately assess this increased risk, and therefore did not demonstrate that appropriate control measures had been considered or implemented to mitigate the risk.

In addition, the centre's staffing risk assessment did not provide assurance that the ongoing reliance on agency staff had been adequately assessed or effectively managed. The control measures identified did not demonstrate how continuity, consistency and safe delivery of care would be maintained, nor did they provide assurance that this identified risk was effectively mitigated.

Overall, the provider's risk management arrangements did not provide assurance that risks were consistently identified, appropriately assessed, effectively controlled

and regularly reviewed to ensure the safety and welfare of residents. The inspectors were informed a complete review of the designated centre's risk register and individual risks for resident had been completed during 2025. The most recent review of the centre specific risks had taken place in May 2026. There were a number of risks escalated to senior management at the time of this inspection which included staffing resources and staff training.

Judgment: Not compliant

Regulation 28: Fire precautions

The registered provider had failed to ensure that effective fire safety management systems were in place to protect residents. This is a repeated finding, identified during each of the four inspections of this designated centre since May 2023, demonstrating that the provider had not implemented sustained and effective actions to address known fire safety risks.

In one house, no fire drill had been completed since July 2025. In addition, there was no evidence that a fire drill involving the minimum staffing levels and maximum occupancy had been completed in any of the houses within the previous 12 months. For example, a fire drill undertaken in June 2026 involved two residents and three staff, despite five residents living in that house. Consequently, the provider could not demonstrate that residents could be safely evacuated under the house's full occupancy.

Fire drill records were also incomplete and inconsistent. Records did not consistently document the number of staff involved, the evacuation scenario, the exits used, or the actions to be taken where a resident declined to evacuate. For example, these details were absent from the fire drill completed on 29 March 2025. This limited the provider's ability to evaluate the effectiveness of fire drills and identify learning to improve fire safety.

Daily fire safety checks were not consistently completed or recorded in accordance with the provider's own procedures. The inspectors reviewed a selection of these records and found the required checks had not been documented on 4, 11, 18 and 23 June 2026. As a result, the provider could not demonstrate that essential fire safety systems were routinely monitored.

This was the fourth consecutive inspection since May 2023 where ineffective fire containment measures were identified by inspectors. The inspectors reviewed the management of fire doors throughout the centre as previous inspections had identified issues of concern. During the inspection, an extension panel on a bedroom fire door was observed to be opened back. The panel was not fitted with an automatic closure mechanism upon on activation of the fire alarm, this prevented effective containment measures being in place. The bedroom was empty at the time. Inspectors also found that fire doors and extension panels had been routinely

obstructed/ held open or placed in the opened back position during every inspection of this designated centre since May 2023, demonstrating a persistent failure to implement effective fire safety practices despite repeated regulatory findings.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

The inspectors reviewed sections of personal plans for four residents. Further review of residents personal plans and healthcare management plans was required to ensure all residents were being supported consistently in-line with their assessed needs.

While the expressed wishes of one resident not to engage in the personal planning process was documented and this included goal setting, details of progress for other residents goals were not consistently documented. For example, one resident had progress updates on their short term goals recorded four times during January and February 2026 but no further updates documented since 4 February 2026. The provider had outlined a goal progress tracker had been implemented to support residents and key workers to achieve their individual goals after the November 2024 inspection.

The provider had outlined an action following the November 2024 inspection that a new activities record had been developed. However, on review of a selection of community notes and activities records it was unclear if residents had participated in some activities which they had expressed an interest in attending. This included a resident attending a football match at the start of May 2026. Another resident's community notes reviewed from 31 May 2026 until 24 June 2026 did not refer to any activities that the resident had participated in.

During the inspection the inspectors were informed a resident was on a daily restricted fluid intake. However, on review of this resident's personal plan, their health care management plan for a related healthcare condition did not reflect this. Staff spoken too were asked was there guidance to support the resident during the current hot weather in relation to their fluid consumption. The inspectors were informed there was no additional guidance. On some recording sheets the maximum amount of fluid was documented, on others it was not. The inspectors reviewed the recording sheets of recent daily intakes and there were variances from the maximum recommended of 1000 mls. On the 19 and 23 June 2026 this amount had been exceeded.

Another resident had a medical diagnoses that required a Dexa scan to be repeated in January 2026. This had not been documented as been arranged or completed at the time of this inspection. The vulnerability was also not documented for the resident in their relevant risk assessment regarding falls.

Judgment: Not compliant

Regulation 9: Residents' rights

The provider had ensured some actions from previous inspections had been addressed this included the removal of personal information from communal areas.

However, due to the current vacancies of the two activation posts the staff working in each of the houses were responsible for ensuring each resident was supported to engage in regular meaningful activities. From a review of community notes and activity sheets there were gaps in the information available for the inspectors to review to ensure each resident was being supported in-line with their expressed wishes and interests. The provider had outlined to the Chief Inspector following the September 2023 inspection the role of the activation staff to ensure good oversight and choice being offered to all residents. This included protected time to plan and schedule activities for the week ahead. As previously mentioned in this report agency staff were working on all shifts both day and night in the designated centre which resulted in ongoing changes for the residents. These findings have been actioned under Regulation 5: Individualised assessment and personal plan

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	Not compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Cork City North 15 OSV-0005395

Inspection ID: MON-0050766

Date of inspection: 25/06/2026

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 Provider will recruit to all approved vacancies, including the two vacant Whole Time Equivalent (WTE) Activation Staff posts and the 0.5 WTE Nursing post through targeted recruitment campaigns. • The Person in Charge (PIC) or delegate will review staffing levels and skill mix on an ongoing basis to ensure staffing arrangements are aligned with the assessed needs and support requirements of residents. • The PIC or delegate will monitor staffing vacancies and recruitment progress through monthly workforce planning and governance meetings. • The PIC or delegate will continue to utilise the organisation's relief panel to minimise the use of agency staff and improve continuity of care. • The PIC has implemented an induction arrangement for all agency staff, including orientation to residents' assessed needs, personal plans, safeguarding requirements, risk management procedures, and emergency response arrangements. • The PIC or delegate will ensure agency staff receive ongoing guidance, support and oversight from the Person in Charge and senior staff while working in the designated centre. • The PIC or delegate will include agency staff, where practicable, in team communications, practice updates, and team meetings to promote consistency of care and support. • The PIC or delegate will review residents' individual staffing requirements to ensure support arrangements identified within assessments and personal plans are consistently implemented. • The PIC or delegate will introduce weekly roster reviews by the Person in Charge or delegate to monitor staffing allocations and ensure residents' assessed support needs are met. • The PIC or delegate will strengthen roster management processes to ensure planned and actual rosters accurately reflect staff attendance, shift changes, additional hours worked, and time owed arrangements.	

• The PIC or delegate will complete regular audits of planned and actual rotas to verify staffing levels and identify any discrepancies requiring corrective action.
• The PIC or delegate will monitor agency usage, unplanned absences, and staffing trends through monthly governance meetings and develop targeted actions to reduce reliance on agency staff over time.
• The PIC or delegate will report staffing metrics, recruitment progress, agency utilisation, and roster audit findings through the centre's governance and quality assurance structures to provide ongoing assurance regarding compliance with Regulation 15.

Regulation 16: Training and staff development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:

• Maintain a comprehensive training matrix for all staff, including relief and agency staff where applicable, to ensure training requirements, renewal dates, and scheduled training are effectively monitored.
• Review the training matrix on a monthly basis to identify upcoming training requirements and address any gaps in mandatory and role-specific training.
• Ensure all staff complete mandatory training within required timeframes, including fire safety, safeguarding, manual handling, and any other training identified by organisational policy.
• Facilitate the completion of outstanding training in Positive Behaviour Support, Safety Intervention, and Manual Handling for all staff who require refresher or outstanding training as soon as possible.
• Ensure the relief staff member identified during the inspection completes fire safety refresher training before undertaking further shifts within the designated centre.
• Implement a system of escalation to line management where staff training is approaching expiry or has not been completed within the required timeframe.
• Continue the programme of formal supervision for all staff, ensuring supervision is completed in accordance with organisational policy and documented appropriately.
• Continue the current supervision arrangements for nursing staff to ensure both managerial supervision and clinical supervision requirements are clearly defined, documented, and completed.
• Develop an annual supervision schedule to ensure all staff receive regular support, performance review, and opportunities to discuss their learning and development needs.
• Monitor training compliance and supervision completion rates through monthly management reviews and governance meetings.
• Provide additional training and development opportunities based on residents' assessed needs, identified risks, safeguarding requirements, behavioural support needs, and emerging service priorities.
• Include training compliance, supervision completion, and staff development as standing agenda items at local governance meetings to ensure ongoing oversight and accountability.
• Undertake periodic audits of training and supervision records to ensure records remain accurate, up to date, and provide assurance regarding staff competency.

Regulation 23: Governance and management	Not Compliant

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

Governance and Management Systems
• A governance oversight team has been established to oversee the implementation of this compliance plan and ensure all actions are completed in the timeframe outlined.
• Monthly governance and quality assurance meetings have been implemented to review regulatory compliance, risks, incidents, staffing, resident outcomes, and progress against inspection findings.
• A centre-specific quality and safety database will be introduced to support effective oversight and provide assurance to the Person in Charge, senior management team and Provider.
• Quarterly provider audits will be undertaken, with findings tracked through a formal action management system to ensure completion and sustainability of improvements.
• Progress against all regulatory actions will be reviewed monthly by the senior management team and escalated through organisational governance structures where delays or barriers are identified.

Workforce Planning and Staffing
• A workforce review has been initiated to determine the staffing resources required to meet the assessed needs of residents.
• Active recruitment campaigns are underway to fill vacant positions and reduce the reliance on agency personnel.
• A structured onboarding and induction process has been implemented for all agency staff assigned to the centre.
• Agency staff will receive competency oversight, and access to relevant resident information to support safe and consistent practice.
• Agency staff will be required to attend team meetings where practicable and will be included in service communications to ensure awareness of residents' changing needs, safeguarding requirements, support plans, and best practice guidance.
• The Person in Charge will complete regular reviews of staffing arrangements, continuity of care, and agency utilisation, with reports submitted through governance processes
Quality Assurance, Monitoring and Resident Outcomes
• The Provide will introduce a system to strengthen monitoring of residents' quality of life, participation, goals, and outcomes.
• Residents' personal plans, activity programmes, and assessed support needs will be reviewed to ensure meaningful, person-centred opportunities are available and appropriately recorded.
• Resident participation, community inclusion, goal achievement, health and wellbeing outcomes, incidents, and safeguarding will be monitored monthly.
• The PIC or delegate will complete regular audits of personal plans, activity records, and outcome tracking systems to ensure that services provided are aligned with residents' preferences and assessed needs.
• Findings from audits will be reviewed through governance meetings and corrective actions monitored to completion.

Regulation 17: Premises	Substantially Compliant

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

• Complete all outstanding maintenance issues identified through the internal premises audit conducted on 10 June 2026.
• Replace the missing bathroom window handle identified during the inspection and confirm safe operation of the window.
• Repair the issue resulting in water pooling behind the toilet and undertake an assessment of the surrounding area to ensure there is no associated damage or infection prevention and control risk.
• Repair damaged wall surfaces identified between the kitchen and dining area and complete any necessary redecorating works.
• Remove and replace damaged seating identified in the staff support area of the apartment to ensure all furnishings are safe, suitable, and maintained in good condition.
• Continue with the planned maintenance programme for the designated centre, including internal painting and decoration works across all three houses.
• Implement a schedule of monthly premises inspections by local management to identify and address maintenance issues in a timely manner.
• Strengthen oversight of maintenance requests by reviewing PEMAC submissions monthly.
• Review all actions arising from internal environmental and premises audits to ensure corrective actions are completed within agreed timeframes and are subject to management oversight.
• Ensure that premises-related risks identified through audits, inspections, or staff reports are recorded, monitored, and escalated where required through the centre's governance structures.
• Undertake a comprehensive review of the designated centre floor plans to ensure they accurately reflect the current layout of all buildings, including the positioning of internal doors and circulation areas.
• Engage with the organisation's property and estates function, and where required a suitably qualified professional, to verify the accuracy of floor plans prior to submission as part of the designated centre's registration renewal application.
• Establish a quality assurance check process for all future submissions to the Chief Inspector to ensure supporting documentation, including floor plans, remains accurate and up to date.
• Monitor premises maintenance and environmental audits through local governance meetings, with progress reported to senior management until all actions are completed.

Regulation 26: Risk management procedures	Not Compliant

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

• The PIC will complete a full review and revision of the designated centre's risk management policy to ensure risks are comprehensively identified, assessed, controlled, monitored, and reviewed in accordance with regulatory requirements and organisational policy.

• The PIC will ensure all staff are aware of and understand the organisations Risk Management Policy, how to document risks and the organisations Risk Escalation Pathway.
• The PIC and delegates will undertake a comprehensive review of the centre-specific risk register to ensure all operational, environmental, clinical, safeguarding, staffing, and fire safety risks are accurately identified, assessed, and risk-rated.
• Review all existing risk assessments to ensure control measures are specific, proportionate to the identified risk, and capable of effectively reducing the level of risk.
• Strengthen governance arrangements for risk management through the introduction of monthly risk review meetings involving the Person in Charge and Regional Manager.
• The PIC will ensure all risks identified through audits, incidents, complaints, inspections, and resident reviews are considered for inclusion on the risk register and monitored to resolution.
• The PIC will establish a formal system for monitoring and tracking actions arising from risk assessments to ensure identified control measures are implemented within agreed timeframes.
• The PIC, Regional Manager and senior management will maintain oversight of all escalated risks through organisational governance and risk management structures until satisfactory controls have been implemented and risks reduced to an acceptable level.

Regulation 28: Fire precautions	Not Compliant

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

The following actions will be implemented as a priority:
• A comprehensive review of all fire documentation and risks within the designated centre will be undertaken by the Health and Safety Officer and Person In Charge.
• All outstanding fire safety actions identified during previous inspections and fire risk assessments will be reviewed, prioritised and actioned.
• Any deficiencies in fire containment measures and associated infrastructure will be addressed in accordance with professional fire safety recommendations.
• Progress against fire safety actions will be monitored monthly through governance and risk management meeting and overseen by the governance oversight team.
• The provider will implement enhanced oversight arrangements to ensure fire safety risks are clearly identified, monitored, escalated, and resolved within agreed timeframes.
• Evidence of completed works and verification of compliance will be retained and reviewed by senior management.

Regulation 5: Individual assessment and personal plan	Not Compliant

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

• Complete a review of all residents' personal plans to ensure they accurately reflect each resident's current assessed needs, preferences, goals, health supports, and required interventions.
• Ensure all personal plans are reviewed at least annually and more frequently where there is a significant change in a resident's needs, wishes, health status, or support

requirements.
• Review and strengthen the goal tracking system implemented following the previous inspection to ensure progress towards personal goals is consistently documented, monitored, and reviewed.
• Ensure key workers complete regular documented progress updates on resident goals and identify any barriers to goal achievement.
• Introduce monthly audits of personal plans and goal trackers to ensure progress updates are completed consistently and residents are supported to achieve meaningful outcomes.
• Ensure residents who choose not to engage in aspects of the personal planning process have their preferences respected and documented, while continuing to provide opportunities for participation and review.
• Review activity records, community participation records, and daily notes to ensure residents' engagement in activities is accurately recorded and clearly demonstrates participation in activities aligned with their preferences and personal goals.
• Key workers meeting log and residents' forums provide opportunities for staff to record activities and community participation aligned with residents goals.
• Ensure key workers and shift leaders review activity records regularly to identify any reduction in participation and address barriers to engagement.
• Complete a review of all healthcare management plans to ensure they accurately reflect current clinical recommendations, restrictions, monitoring requirements, and healthcare interventions.
• Immediately review and update the healthcare management plan for the resident on a restricted fluid intake to ensure the prescribed daily fluid restriction is clearly documented and supported by clear guidance for staff.
• Introduce management oversight of fluid monitoring records to ensure prescribed fluid limits are maintained and any variances are promptly identified, reviewed, and addressed.
• Review all residents' healthcare appointments, investigations, and follow-up requirements to ensure recommended assessments and reviews are arranged and completed within prescribed timeframes.
• Immediately review the resident's healthcare management plan relating to the outstanding Dexa scan and ensure appropriate medical follow-up is arranged and documented.
• Ensure all healthcare vulnerabilities, diagnoses, and associated risks are accurately reflected within residents' risk assessments and personal support plans.
• Review all falls risk assessments to ensure underlying medical conditions and factors that may increase the likelihood or impact of injury are appropriately identified and addressed through suitable control measures.
• Completed schedule of regular audits of personal plans, healthcare management plans, activity records, and risk assessments to ensure documentation remains current, accurate, and reflective of residents' needs.
• Discuss personal planning outcomes, healthcare reviews, and goal progression at multidisciplinary reviews and local governance meetings to ensure ongoing oversight and accountability.
• Provide refresher guidance to staff regarding documentation standards, person-centred planning, outcome monitoring, and healthcare record management.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Substantially Compliant	Yellow	27/02/2027
Regulation 15(3)	The registered provider shall ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.	Substantially Compliant	Yellow	27/02/2027
Regulation 15(4)	The person in charge shall ensure that there is a planned and actual staff rota,	Substantially Compliant	Yellow	31/08/2026

	showing staff on duty during the day and night and that it is properly maintained.			
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	27/02/2027
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	27/02/2026
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	27/02/2027
Regulation 26(1)(b)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5,	Substantially Compliant	Yellow	30/11/2026

	includes the following: the measures and actions in place to control the risks identified.			
Regulation 26(1)(e)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: arrangements to ensure that risk control measures are proportional to the risk identified, and that any adverse impact such measures might have on the resident's quality of life have been considered.	Substantially Compliant	Yellow	30/11/2026
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	30/11/2026
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	30/11/2026

Regulation 28(4)(b)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Substantially Compliant	Yellow	31/08/2026
Regulation 05(1)(b)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out subsequently as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.	Not Compliant	Orange	31/10/2026
Regulation 05(6)(d)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall take into account changes in	Not Compliant	Orange	31/10/2026

	circumstances and new developments.			