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:	Cuan Mhic Giolla Bhride
Name of provider:	Inspire Wellbeing CLG
Address of centre:	Louth
Type of inspection:	Unannounced
Date of inspection:	29 January 2026
Centre ID:	OSV-0005559
Fieldwork ID:	MON-0049314

About the designated centre

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

This service provides full-time residential care and support for two adults with disabilities. The centre consists of a modern, two storey house situated in a peaceful, scenic and rural setting in Co. Louth. It is within driving distance to a nearby city and a number of large urban towns. There are good sized grounds and well maintained gardens surrounding the centre and ample space provided for private car parking. The ground floor of the property is essentially divided into two separate living spaces for the residents who live on the ground floor of the property. The residents have their own bedroom and bathroom. The residents share the use of a communal kitchen with a breakfast bar, a dining room and separate laundry facility. Upstairs there is one staff sleepover room, a staff room and an office. There is a full time person in charge employed in the centre. The centre is staffed on a 24/7 basis by nursing staff or a team leader. There are a team of support staff who work during the day and at night. Part of the service provided includes as required access to general practitioner (GP) services, allied health professionals. Residents do not attend formal day services but instead are supported by staff to choose how they want to spend their day and what social/learning activities to engage in.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	2

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Thursday 29 January 2026	10:40hrs to 19:40hrs	Anna Doyle	Lead

What residents told us and what inspectors observed

This inspection was unannounced and was carried out to ensure compliance with the regulations. This centre was registered to support two residents.

Over the course of the inspection, the inspector met with the residents living in the centre for a short time, spoke to three staff members two of whom were team leaders. The person in charge was on planned leave on the day of the inspection. The team leaders facilitated the inspection in the absence of the person in charge. The inspector reviewed documents pertaining to the governance and management of the centre and the care and support provided to the residents and observed some practices. Some documents not available in the centre on the day of the inspection, were submitted post inspection to ensure compliance with the regulations.

Overall, the inspector found that while the residents appeared happy living in their home and were being supported by a staff team who knew the residents well, improvements were required in some of the regulations. In particular, personal plans relating to the residents healthcare needs. Other improvements were required in the oversight of training, staff, personal plans and risk management. As a result of these findings the inspector found that improvements were required also in Regulation 23: Governance and management.

The property is a detached house, situated on a large site in the countryside. The ground floor of the property is essentially divided into two separate living spaces for the residents who live on the ground floor of the property. The residents had their own bedroom and bathroom. One resident had a bespoke living environment that was tailored around the residents' needs. The living area comprised of a changing room, a large bedroom and a shower room. The resident preferred to live in a minimal environment, meaning they did not like clutter or certain items in their living environment. They also liked to have things a certain way in their environment. For example; at the time of the inspection, the resident liked all doors to be kept closed and it would cause the resident some anxiety if staff did not follow this. The inspector observed the staff ensuring that this was completed when the inspector was conducting a walk around of the living environment.

While this resident could choose to access other areas of the centre should they wish, they invariably spent most of their time in these spaces in line with their expressed wishes. The bespoke living area had soft padding on the walls to prevent the resident injuring themselves. The inspector noted on the fire safety risk assessment that this was not referenced in the document to provide assurances that the material used was in compliance with fire safety regulations. The provider was requested to submit assurances after the inspection confirming this.

There was also a communal kitchen with a breakfast bar, a dining room and separate utility room where residents can launder their clothes if they wished. One

of the staff informed the inspector that one of the residents liked to help with their laundry some days. This resident also liked to help out with preparing some meals and did some cleaning around their home. There was also a sitting room where one resident chose to spend a lot of time on their computer and the resident had a large office desk to ensure that they were comfortable when they were on their computer.

Upstairs there was one staff sleepover room, a staff room and an office.There was plenty of outdoor space to park cars and for residents to enjoy outdoor activities should they wish to. One resident liked to go for short walks around the outdoor space.

The centre was generally clean however, repair works were required in some areas For example; a press in the utility room needed to be replaced. A list of the improvements required are outlined under Regulation 17: Premises of this report.

The inspector met both of the residents on the day of the inspection, and both residents engaged with the inspector with staff support. Both residents looked well care for and appeared happy and content in the presence of staff. They had access to meaningful activities in line with their preferences and wishes. One resident had decided over the last number of months to only partake in certain activities. This included a sensory walk each day. The other resident had a schedule of activities that they kept in an easy-to-read folder. This schedule showed pictures of activities the resident liked to engage in. Every Thursday, for example, the resident went swimming and the resident was observed using the communication sign with staff indicating that they were due to go swimming the day of the inspection. The resident also liked to go shopping, out for lunch and every Sunday they went out for dinner.

Residents had communication plans in place that detailed how they communicated their needs and emotions. Both residents had previously been assessed by a speech and language therapist with recommendations to assist their communication skills further. For example; one of the resident's was learning some new signs. A staff member spoken with demonstrated that they knew the different sounds or words used by the resident and what the resident was trying to communicate by using these signs and words. The inspector noted however, that some improvements were needed to these plans this will be discussed further later in the report under Regulation 5: Personal plans.

The inspector also observed from personal plans and from talking to staff that residents were supported to keep in touch with family. One resident video called their family member every week and the other resident regularly made phone calls to their family and went home for breaks to family members throughout the year.

Notwithstanding that the residents appeared happy in the centre at the time of the inspection, and got to choose activities they liked in line with their preferences, improvements were required in a number of regulations.

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

Overall, the inspector found the centre was adequately resourced. However, improvements were required in a number of regulations which indicated that some improvements were required in the governance and management arrangements in the centre as these improvements had not been picked up in the providers own audits and reviews. Areas of improvement included staffing, training records, personal plans, risk management and healthcare.

There was a planned and actual rota kept in the centre. On review there was a consistent staff team working in the centre which included agency staff. However, the skill mix in the centre needed to be reviewed, to assure that all staff had the necessary knowledge and skills to support one resident with their healthcare needs.

The staff training records provided to the inspector on the day of the inspection, did not provide assurances that all staff had completed refresher training in the centre. This required review.

Regulation 15: Staffing

The staff skill mix included team leaders, support workers, social care workers and one nurse. At the time of the inspection, there was also one full time staff nurse post vacant. The team leaders and nurse worked on a sleepover basis meaning there was always one of them rostered on duty 24/7. The team leaders and the nurse directed and supervised the care and support being provided each day. However, as discussed under governance and management there remained a vacant staff nurse position that could not be filled by agency staff due to availability issues. There had been no review of this issue to provide assurances that the team leaders (who were now the persons responsible at night and during the day) had all of the skills and knowledge to monitor and provide support to the residents at all times particularly in relation to healthcare needs. While both team leaders demonstrated a good knowledge of the resident's needs on the day of the inspection, there were deficits in some of the healthcare plans as discussed under Regulation 6: Healthcare to guide practice and ensure consistency of care to the residents.

The staff numbers consisted of five staff during the day, three waking night staff and a sleepover staff. The inspector reviewed a sample of rotas in October and November and December 2025 and found that those staffing levels were

maintained. There were some vacancies in the centre which the registered provider was recruiting for at the time of the inspection. A number of consistent agency staff were employed in this instance which assured a consistency of care for the residents. The nurse for example, was employed from an agency and had been working on a full time basis in the centre for a number of years.

A team leader or nurse was assigned to work each day to supervise the care and support provided.

Staff personnel files were not reviewed as part of this inspection, however the inspector reviewed the Garda Vetting records for all staff and found that there were no concerns noted. The registered provider had also records to demonstrate that all agency staff had been Garda Vetted.

Overall, the inspector found that the staffing levels in the centre were maintained to assure a safe service to the residents, however as discussed under the governance and management, the registered provider need to conduct a review to ensure that the skill mix in the centre was appropriate to meet the needs of the residents.

Judgment: Substantially compliant

Regulation 16: Training and staff development

The inspector reviewed a sample of training records maintained on the registered providers training database. This system required review, as the records were not up to date, which meant that the team leader or person in charge could not be fully assured that all staff had their training completed or updated because of this. For example; a number of staff training records indicated that they were not compliant on the database (meaning they had either not completed it or their refresher training had not been completed in a timely manner). However, a team leader was able to show the inspector a sample of certificates to demonstrate that staff had completed some of this training. Notwithstanding, this database required improvements. A sample of the training recorded that staff had completed included:

- Antimicrobial Resistance and Infection Control (AMRIC) - Basics of Infection & Prevention Control
- AMRIC Hand Hygiene
- Safeguarding of Vulnerable Persons
- Fire Safety
- Epilepsy Awareness
- First Aid Responders
- Positive Behaviour Support
- Percutaneous Endoscopic Gastrostomy Feed
- Medicine Management
- Autism

- Crisis Prevention Intervention (CPI).

The person in charge also maintained a log for agency staff employed indicating the mandatory training they had completed. This included for example, safeguarding vulnerable adults and fire safety.

The staff spoken with stated they felt supported in their role and supervision meetings were scheduled with staff to discuss any concerns they may have. A sample of records viewed indicated that staff had not raised any concerns about the quality of care provided and that all training for example, was up to date. Where new staff were employed the registered provider also had an induction pack that staff had to complete to ensure they were familiar with policies and procedures and practices in the centre.

Staff meetings were also held every month and a sample of the minutes viewed showed that topics discussed included risk management, safeguarding, staff training and the resident's care and support needs.

Overall, the inspector found that the training records available in the centre on the day of the inspection could not demonstrate that all staff had completed refresher training as required. This required review.

Judgment: Substantially compliant

Regulation 23: Governance and management

There was a clearly defined management structure in the centre. The person in charge was employed on full time basis Monday to Friday. A team leader or nurse was also assigned on a 24 hour basis to assure effective oversight of the care and support of the residents.

The centre was being audited and reviewed as required under the regulations. On the day of the inspection for example, the registered provider had organised an unannounced six-monthly review of the quality and safety of care. The auditor was reviewing for example, compliance with regulation 28: Fire Safety. The last unannounced six-monthly review had been completed in July 2025, this included feedback from a family member who stated that they were very happy with the supports provided in the centre. Actions had been developed from this review to assure compliance with the regulations. For example, in relation to fire safety, magnetic locks were to be fixed on a fire door. The inspector observed that the auditor in the centre on the day of the inspection was following up on this by conducting a review of fire doors in the centre.

An annual review had been completed for the period between February 2024 and February 2025. Actions had also been developed from this which had been completed. The next annual review was due to take place after the inspection in February 2026. Other audits and checks were completed in the centre by the person

in charge, team leaders or staff. For example, a financial audit had been completed in January 2025.

However, as evidenced on this inspection some improvements were required in a number of regulations which were not picked up on in audits or checks conducted by the registered provider. As well as this, at the time of the inspection, a full time nurse vacancy post had not filled, and while the staffing arrangements were being reviewed at MDT meetings, there had not risk assessment completed or full review of the non-nursing staffs skills, expertise and competence as a way of assuring that they could support all of the residents' healthcare needs.

Judgment: Substantially compliant

Quality and safety

Overall, the residents appeared content and happy in the presence of staff and the centre was adequately resourced to provide person-centred care to the residents in terms of the number of staff employed. However, significant improvements were required under healthcare and some improvements were required under risk management, personal plans and the premises.

An assessment of need had been conducted and supporting care plans had been developed for most of the residents' assessed needs. However, some of these plans required review to ensure that recommendations from allied health professionals were included in plans to guide practice.

Residents were supported with their health and emotional needs and had access to allied health professionals where required prior to this inspection. However, there were a number of deficits in the records maintained for residents' healthcare needs which required review. At the time of the inspection, one resident also did not have access to two allied health professionals which was an assessed need for this resident.

The premises were spacious, and designed to meet the needs of the residents. However, at the time of the inspection a number of upgrades were required to the property.

There were systems in place to manage and mitigate risk and keep residents safe in the centre. However, improvements were needed in some of the risk assessments.

The residents were being supported with their general welfare and development and to maintain links with family members.

The residents were being assisted and supported to communicate in line with their needs and the inspector found some good examples showing how residents were being supported with their communication needs.

Regulation 10: Communication

The residents were being assisted and supported to communicate in line with their needs. Residents communicated using some verbal and non-verbal cues and some of them used signs to communicate. The inspector found some good examples of how residents were being supported with their communication needs. One resident was learning new signs and staff were in the process of completing training on these signs. The resident was observed using the communication sign for swimming, with staff indicating that they were due to go swimming the day of the inspection and staff recognised this sign and were able to assure the resident then that they were going swimming later in the day.

Both residents had been reviewed by a speech and language therapist in relation to their communication needs. Communication passports were also in place detailing the residents likes and dislikes, what the residents were communicating when they were using some non-verbal cues, and an explanation of the meaning of some words that residents used to communicate. A staff member who spoke to the inspector was very aware of the communication needs of one resident.

Some improvements were required to the communication plans in place to assure that they were effectively reviewed. However, this is discussed under Regulation 5: Personal plans.

Residents had access to the Internet, and could keep in touch with family through video calls.

Judgment: Compliant

Regulation 13: General welfare and development

The inspector found that residents were supported to avail of activities in line with their personal preferences. At the time of this inspection one resident did not want to engage in certain activities that they had previously enjoyed. This was related to the residents' wellbeing at the time of the inspection. However, the staff team were still offering activities to the resident on a daily basis. For example, the resident liked to complete a sensory walk most days.

The other resident was engaged in a number of activities and showed the inspector a specific routine that they liked to adhere to each week. For example; on the day of

the inspection the resident was going swimming other days the resident went out for dinner or liked to do the weekly grocery shopping with staff.

Both residents were supported to keep in touch with their family and had regular contact with their families. One of the residents went home to visit family members throughout the year and the other resident had weekly video calls with their family member.

Judgment: Compliant

Regulation 17: Premises

The property was spacious and provided for the assessed needs of one resident who required a bespoke living arrangement. In general the centre was kept in good state of repair, however at the time of the inspection there were some repair works that had been reported to the personnel responsible for carrying out these repairs, that had not been completed.

These included:

- a press in the utility room, which needed the two doors to be replaced or repaired
- the flooring in the sitting room needed to be replaced or repaired
- one of the walls in the centre needed to be repaired.

The registered provider had systems in place to maintain equipment in the centre. For example, from a sample of records viewed the boiler had been serviced in August 2025 and an annual assessment had been conducted on the quality of water in the centre.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

The registered provider had systems in place to manage risk. This included risk assessments covering the risks in this centre. However, the inspector found that improvements were required to some of these assessments to ensure there is an effective system in place for assessing and managing risk.

There was a fire risk assessment in place detailing the control measures in place to prevent a risk of fire in the centre. The inspector observed that this required more detail to assure compliance with some materials used in the centre to assure that they met fire safety standards. For example, there was sensory padding on some walls in the bespoke living area for one resident and the fire risk assessment did not

mention this. Following the inspection, the registered provider submitted a fire safety assessment that had been conducted in March 2025 which outlined no concerns with fire safety standards. This provided assurances, however the risk assessment needed to be updated to reflect this.

The risk assessment in place for infection prevention and control for the centre was not detailed. For example, there was no control measures or plans in place to guide standard infection prevention and control techniques required in this centre. This is also discussed under Regulation 6: Healthcare.

Improvements were also required in the individual risk assessments for some residents, for example, according to the risk assessments they were to be reviewed every 6 months, however. The inspector also found that a risk assessment in place for one resident who engaged in self-injurious behaviour did not have all the control measures outlined in the risk assessment. For example; if the resident hit their head off a hard surface, then it did not detail that the residents vital signs should be monitored. Notwithstanding, staff were able to demonstrate that this was completed in other records shown to the inspector.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Each resident had an assessment of need conducted which had been reviewed on a yearly basis. Residents care and support was being reviewed on a regular basis by allied health professionals. One resident who had complex sensory needs had regular reviews conducted by allied health professionals and doctors involved in their care.

Personal plans had been developed for most of the residents needs. However, as discussed under regulation 6, improvements were required to some of healthcare plans.

Where required residents had behaviour support plans in place to guide staff on the approaches to be used to support the residents. In August 2025 one resident had a specific sensory assessment completed that had outlined some recommendations and approaches that might benefit the resident. However, these approaches had not been included in the residents behaviour support plan which had been last updated in July 2025. This required review to ensure a consistent approach with the resident.

Notwithstanding the positive observations made in relation to supporting residents with their communication needs as discussed under regulation 10 Communication, the interventions agreed by a speech and language therapist, needed to be comprehensively recorded on a communication plan for the resident. This would enable a review of the interventions to assess the effectiveness of those interventions for the resident.

Judgment: Substantially compliant

Regulation 6: Health care

The inspector reviewed a sample of residents' personal plans regarding healthcare needs and cross-checked these plans with observations regarding how these plans were implemented in practice. The inspector found that a number of improvements were required in this area to guide practice for staff as there were significant deficiencies in documentation which could pose a risk to the resident or impact on the quality of care provided. Some healthcare plans required more detail to guide practice.

These included:

- an epilepsy management plan did not provide an explanation of the residents' seizure types. Monitoring documents recording incidents of when a seizure occurred also did not describe the type of seizure directly observed by staff
- a plan for the Percutaneous endoscopic gastrostomy (PEG) feeds did not detail all of the care provided. Although staff were very clear about the management of this. The policy in place did not guide practice either
- infection prevention and control plans were not in place to clearly outline the type of precautions required. For example, standard precautions or transmission-based precautions (contact, droplet or airborne) and plans were not fully developed to ensure that all relevant staff were made aware of these for the residents concerned
- There was no comprehensive pain management plan in place for one resident to guide practice for staff. For example, the resident was prescribed a number of pain medicines to manage pain and there was no plan to indicate in what circumstances these should or should not be administered.
- one resident had a feed, eating and drinking plan in place that required their weight to be checked on a monthly basis. This was to ensure that the resident maintained an appropriate weight. However, there was no scales in place at the time of this inspection in order to implement this intervention. The inspector was informed that this had been ordered.

There were also some deficits in monitoring certain healthcare interventions. For example; one resident had a bowel management plan that required detailed interventions that needed to be monitored each day by staff. These were recorded on a computerised recording system which did not always give a clear picture of these interventions and therefore made it difficult to review the effectiveness of care. This required review.

The inspector found from reviewing residents personal plans that they had access to a number of allied health professionals, which included:

- Occupational Therapist

- Speech and Language Therapist
- Positive Behaviour Support Specialist
- Psychiatrist
- Dietician
- General Practitioner (GP)
- Chiropody
- Dental services
- Ophthalmology.

At the time of the inspection one resident did not have access to a dietician or a speech and language therapist. While, the registered provider was in the process of trying to source another dietician and speech and language therapist, this required attention to ensure that this was completed in a timely manner for this resident.

Overall, while the inspector found that for the most part, residents healthcare needs were being met, several gaps were noted in the documentation in the residents plans. These cumulative findings resulted in significant improvements being required.

Judgment: Not compliant

Regulation 8: Protection

All staff had been provided with training in safeguarding adults. Staff spoken with were aware of the procedures to follow in the event of an incident of abuse occurring in the centre.

Prior to this inspection, the registered provider had notified the Chief Inspector of Social Services, of incidences of allegations of abuse reported in the centre. The inspector found that registered provider had notified the appropriate authorities, had conducted an investigation into those allegations and had taken measures to ensure the safety of the residents when these allegations were reported.

At the time of this inspection, there were no complaints on the quality and safety of care provided. The staff who met with the inspector was aware of the different types of abuse and the reporting procedures in place should an incident occur. The team leaders and the staff informed the inspector that they had no concerns about the quality and safety of care provided.

The resident also had an intimate care plan in place which outlined their personal preferences in relation to supports provided.

Judgment: Compliant

Regulation 9: Residents' rights

The inspector found some examples of where the resident's rights were considered in the centre. For example, a list of all the things the resident liked and disliked were included in the resident's personal plan.

Each resident could exercises choice and control in their daily life in accordance with their preferences.

The communication needs of residents were respected and the staff team were undertaking training to enhance the residents skills to communicate their choices.

Staff were observed treating residents with dignity and respecting the residents individual preferences on the day of the inspection.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Not compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Cuan Mhic Giolla Bhride OSV-0005559

Inspection ID: MON-0049314

Date of inspection: 29/01/2026

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: 1. The PIC will review the skills set and knowledge base of the Team Leaders and Agency Nursing staff with the MDT, to assure that staff continue to have the knowledge and skills to support the residents in the centre with their healthcare needs by next MDT on 23/04/2026 2. PIC will continue to ensure as best practice that all staff have the adequate training to meet the needs of both residents. 3. The Provider continues to undertake rolling recruitment to fill the currently vacant nursing roles on a permanent basis;	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: 1. The PIC and the Provider's Organisational Development team have corrected inaccuracies in the current training matrix records, by 09/03/2026. 2. The Provider is reviewing the current learning management system (LMS) to transfer of all training records to this system to improve the accuracy of compliance reports. The LMS platform's compliance reports will replace the current 'matrix'. Project completion date: 01/09/26.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management:	

1. PIC will continue to ensure as best practice that all staff have the adequate training to meet the needs of both residents.
2. The Provider is undertaking a review of quality monitoring processes to address gaps in the identification of improvements found at inspection. Review will be completed by 01/04/26.
3. The PIC will review the skills set and knowledge base of the Team Leaders and Agency Nursing staff with the MDT, to assure that staff continue to have the knowledge and skills to support the residents in the centre with their healthcare needs by next MDT on 23/04/2026
4. The Provider continues to undertake rolling recruitment to fill the currently vacant nursing roles on a permanent basis;

Regulation 17: Premises	Substantially Compliant

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

The PIC has arranged for the outstanding maintenance issues to be addressed by
- Replacement flooring in the living room – will be completed by 16/03/2026
- Replacement doors in the utility room press – will be completed by 16/03/2026
- Repair the damaged area of wall in the downstairs – Completed 06/03/2026

Regulation 26: Risk management procedures	Substantially Compliant

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

1. The PIC has engaged the external Fire Management provider to carry out a new fire risk assessment 18/03/2026, to explicitly include a review of the wall padding in areas of house.
2. The PIC reviewed the Risk Assessment on 06/03/2026, and updated IPC control measures and guidance.
3. The PIC reviewed Individual Risk Assessments on 06/03/2026 to bring them up to date and improve accuracy. Risk Assessment reviews will continue no less than 6 monthly.

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:

1. Reg 5(6)(c) The PIC reviewed and updated Behaviour Support Plan on 09/03/2026 to fully reflect the most up to date strategies, and approaches from the Sensory Assessment.
2. Reg 5(6)(d) The PIC has reviewed and updated the Communication Plan on 09/03/2026 to fully reflect the new interventions agreed with the SALT and the MDT.

Regulation 6: Health care	Not Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
Reg 6(1) Healthcare plans for both Residents have been reviewed and updated where required by the PIC on 09/03/2026, with protocols in relation to their prescribed PRN pain medication for each health condition.
1. The PIC has reviewed & updated the Seizure Management Plan and Monitoring Records on 06/03/2026, to include the type of seizure activity for each Resident These have been shared for MDT review on 23/4/26.
2. The policies covering PEG's will be reviewed by the Provider by 31/03/2026 to ensure it guides practice in this area. The PIC has reviewed the care plan on 6/3/26 to reflects all the care provided. These have been shared for MDT review on 23/4/26.
3. The PIC has created an infection control guidance on 06/02/2026 for the management of cross contamination risks (re PEG Care and Incontinence care). Items for eye and PEG care are kept separate to items for incontinence care.
4. The PIC has combined existing pain medication protocols into a pain management plan. These have been shared for MDT review on 23/4/26.
5. Weighing scales are in place, and weight will continue to be recorded monthly for the one Resident where this is required in their plan.
6. The access for Team Leader's to the records / reports on the Provider's client record management system (Iplanit) has been reviewed by the PIC on 06/03/2026, and revised to ensure they are all able to access the right sections and provide oversight of completions and record management.

Reg 6(2)(d) The PIC continues to source Dietician and Speech and Language Therapist support for one resident and progress is reviewed monthly with the Assistant Director, by 31/08/2026.

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	23/04/2026
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	01/09/2026
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre	Substantially Compliant	Yellow	16/03/2026

	are of sound construction and kept in a good state of repair externally and internally.			
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.	Substantially Compliant	Yellow	23/04/2026
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.	Substantially Compliant	Yellow	18/04/2026
Regulation 05(6)(c)	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 assess the effectiveness of the plan.	Substantially Compliant	Yellow	09/03/2026

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 circumstances and new developments.	Substantially Compliant	Yellow	09/03/2026
Regulation 06(1)	The registered provider shall provide appropriate health care for each resident, having regard to that resident's personal plan.	Not Compliant	Orange	31/03/2026
Regulation 06(2)(d)	The person in charge shall ensure that when a resident requires services provided by allied health professionals, access to such services is provided by the registered provider or by arrangement with the Executive.	Substantially Compliant	Yellow	31/08/2026