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:	Killowen House
Name of provider:	St John of God Community Services CLG
Address of centre:	Louth
Type of inspection:	Announced
Date of inspection:	30 June 2026
Centre ID:	OSV-0005671
Fieldwork ID:	MON-0042321

About the designated centre

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

The centre is a two-bedroom bungalow located close to the centre of a large town in Co. Louth. Two residents live in this centre. The centre is spacious and homely and each resident has a large bedroom. The staffing levels in the centre comprise of nursing, social care workers and healthcare assistants. There are two staff members on duty during the day, who provide individualised supports to each resident and one staff member supports residents at night. The person in charge is responsible for three other centres under this registered provider. They are supported in their role by a house manager to ensure effective oversight. Residents do not attend a formal day service, instead they choose activities on a daily or weekly basis that are in line with their personal wishes and goals. A car is provided so that residents can travel to a range of activities they enjoy.

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
Tuesday 30 June 2026	10:15hrs to 18:15hrs	Karena Butler	Lead

What residents told us and what inspectors observed

This announced inspection found that while in the main good practice was observed and residents enjoyed a good quality of life, improvements were required particularly in relation to fire precautions and governance and management. Other improvements required related to training and staff development, premises, medicines management, and to ensure that all areas of the designated centre were included in the floor plans. These points are discussed in detail later in this report.

During the inspection, the inspector met the two residents living in this centre. One resident used alternative communication methods and did not share their views directly with the inspector. Instead they were observed in their home for part of the morning until they went out for the day to Dublin city to go for lunch and the cinema. The second resident had limited verbal communication and briefly shared their views with the inspector answering 'yes' that the staff were nice and that they were happy living in the centre. The inspector had the opportunity to spend some time with them in the morning and early evening. During the day they went to Belfast and another town. They went shopping and had their lunch out. They said they had a nice day when they returned.

Residents were supported to have a meaningful day in line with their interests. For example, they enjoyed going for drives to different towns, going to the pub for a pint or watching matches.

Both residents appeared very relaxed and content in their home and moved around freely. They also appeared comfortable in the presence of their supporting staff. For example, a resident was observed smiling at their support staff when they were chatting.

In addition to the person in charge, the inspector had the opportunity to speak with the two staff members on duty. Despite being new in the role, the person in charge, along with the staff members, demonstrated that they were familiar with the residents' support needs and likes. Staff were observed to interact with residents in a relaxed and respectful manner. For example, a staff member was observed to offer a resident choices on each occasion a choice was available.

The provider had arranged for staff to have training in human rights. One staff member explained how they had put that training into everyday practice. They felt that in the past that while they did provide residents with choice in their everyday life, they may not have thought of including them in all matters that may affect them. They gave an example that in the past they may have made small choices on behalf of the residents based on known preferences. The staff member explained that they now provided the residents with available options for them to make informed decisions.

The inspector spoke with a family representative over the phone. Feedback received from this person indicated that they were very satisfied with the service provided to their relative. They felt their family member was 'safe' and that 'all their needs were met'. They said that they felt welcome to visit the house. They also said that had 'no concerns whatsoever' and 'would definitely feel comfortable raising a concern' if necessary. They said that communication with the staff team was good and that they treat their family member with respect.

There was an accessible back garden. While the house was tidy and had adequate space for the residents the inspector found that certain areas had not been effectively cleaned, as detailed later in the report.

At the time of this inspection there were no visiting restrictions in place and there were no volunteers used. No complaints had been recorded in 2025 or 2026 to the time of this inspection.

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

Capacity and capability

This inspection was announced and was undertaken as part of the provider's application to renew the registration of the centre as well as part of ongoing monitoring with compliance with the S.I. No. 367/2013 - Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (the regulations).

This inspection identified areas for improvement in relation to staff training and governance and management.

While there were many adequate governance and management arrangements in place, such as the completion of provider-led unannounced visits to the centre, several areas required enhanced oversight. For instance, ensuring agreed actions from compliance plans were completed.

Staffing levels were appropriate to meet the residents' needs. While the staff team were found to have access to a suite of training in order to carry out their roles, oversight of training required some improvement particularly in relation to refresher training.

The provider had ensured that the centre was adequately insured against risks to residents.

Additionally, there was a statement of purpose in place that was reviewed and updated on a regular basis as required by the regulations. However, the provider had not ensured that a relaxation shed in the back garden was included in the statement of purpose and floor plans which was not in line with Condition 1 of their registration.

Registration Regulation 8 (1)

The registered provider is required to notify the Chief Inspector of any changes or additions to their floor plans in line with the requirements of the regulations.

The registered provider had not included a relaxation shed, located in the back garden, in the layout of the designated centre. As this shed was used by a resident, it was a requirement of the centre's registration that it be included in the floor plans and the statement of purpose.

Judgment: Substantially compliant

Regulation 15: Staffing

This inspection demonstrated that there were sufficient staffing levels in place with staff who had the appropriate skills and experience to meet the assessed needs of the residents.

The inspector reviewed a sample of rosters across a four-month period from March to June 2026. There was a planned and actual roster in place. The centre had a full complement of staff which facilitated continuity of care to the residents. There were sufficient staff available to meet the assessed needs of residents.

While full staff personnel files were not reviewed, the inspector reviewed a sample of two core staff members' and two relief staff members' Garda vetting disclosures. Three of the Garda vetting disclosures were completed within the last three years and while one relief staff member had received Garda vetting, they were due to re-apply for vetting which the person in charge said they would follow up on. This demonstrated that the provider had arrangements for safe recruitment practices in line with best practice and the requirements of schedule 2 of the regulations.

Judgment: Compliant

Regulation 16: Training and staff development

There were mechanisms in place to monitor staff training needs and to ensure that adequate training levels were maintained. Staff received training in areas determined by the provider to be mandatory, such as safeguarding and fire safety. While refresher training was available, there were some deficits in the provision of refresher training within the time frame set out by the provider.

The inspector reviewed the certification of four training courses for all the staff team, as well as the training oversight documents for the core staff. This review demonstrated to the inspector that staff members had each received training in these key areas as well as additional training specific to residents' assessed needs.

Examples of the training staff had completed included:

- safeguarding vulnerable adults
- Children First
- basic life support
- training related to positive behavioural support
- medication management
- epilepsy management
- training related to eating, drinking and swallow
- fire safety.

While the inspector found that one particular staff member was trained in safeguarding vulnerable adults from abuse, they had a gap of nearly one year from the time one training had expired before they completed any further training. Therefore, improvements were required to the oversight of staff training to ensure staff always remained in-date with their training and that they are provided with all relevant information to ensure they have the appropriate knowledge to support and safeguard the residents.

Additionally, the inspector found that some staff required refresher training in training related to infection prevention and control (IPC), for example hand hygiene, standard and transmission based precautions, and cough etiquette and respiratory hygiene, as the time since last completion was outside of the provider's own time frames. In addition, it was not evident if two core staff had completed standard and transmission based precautions.

Staff had received additional training to support residents. For example, staff had received training in human rights. Further details on this have been included in the 'what residents told us and what inspectors observed' section of the report.

Judgment: Substantially compliant

Regulation 22: Insurance

As per the requirements of the regulations, the provider had ensured that the centre was adequately insured against risks to residents and evidence of the insurance was submitted to the Chief Inspector.

Judgment: Compliant

Regulation 23: Governance and management

The inspector found that the governance and management arrangements were not always effective in ensuring the service was consistently and accurately monitored.

The role of the person in charge had seen frequent turnover in recent years and a new person in charge had recently commenced the role and was responsible for three designated centres.

The provider failed to fully implement the compliance plan from the previous inspection that had occurred in October 2025. For instance, the provider had committed to update residents' personal belonging inventories. This had not occurred. The inspector saw records that had not been updated since November 2024. Inaccurate or incomplete records posed a risk that residents' belongings could not be thoroughly safeguarded in the absence of a robust oversight record.

While the majority of audits were being completed as prescribed, some local monthly or periodic audits had not taken place as prescribed by the provider or there had been a delay in when they were completed. For example, a finance audit although completed was late being conducted. The inspector found inaccuracies in several finance audits, as shown to the person in charge on the day. This meant that the provider's oversight was not consistently ensuring that residents' finances were accurately monitored.

In May 2026 there was no evidence that two required hygiene audits and one fire safety audit had been completed as required. Improvement was required to ensure that internal monitoring systems were carried out in accordance with the provider’s scheduled time frames. In addition, it was not always evident if all identified actions in audits had been addressed as those sections of the audits were not always consistently completed.

Additionally, further attention was required to ensure that local audits comprehensively reviewed quality and safety risks, as not all the actions found on this inspection were identified by the provider. For example, the deficits in fire safety had not been identified though the provider's own audits and reviews.

The provider had carried out an annual review of the quality and safety of the centre which included positive feedback from family consultation. However, the review contained some inaccuracies. For instance, it stated that the centre had received full compliance during the last inspection which was inaccurate information. Additionally, It stated that there had been one safeguarding incident reported when

two safeguarding incidents had occurred in this period. The provider needed to ensure the annual review was accurate to properly understand the centre's performance and address any recurring risks.

Overall, while the inspector did not identify any immediate negative outcomes for the residents, the cumulative findings in not identifying fire safety risks, not following up on all identified actions, and some inaccuracies in reviews demonstrated that improvement was required to the robustness of the governance systems to ensure a safe and effective service.

Judgment: Not compliant

Regulation 3: Statement of purpose

The provider prepared a statement of purpose which was up to date and described the service provided. While some minor amendments were required to ensure it contained all of the information as required by the regulations and that the information was clear, this was amended on this inspection.

While the inspection identified that a shed used by a resident was not included as part of the registered areas of the designated centre, this was addressed under Registration Regulation 8: Applications by registered providers for the variation or removal of conditions of registration.

Judgment: Compliant

Quality and safety

The inspection found that residents were receiving a good service that met their needs. However, improvements were required to fire precautions and some improvements were required to aspects of the premises, and medicines management.

While the provider had ensured there were many appropriate firefighting and detection systems in place in the case of an emergency, several improvements were noted as being required. For example, the fire alarm coverage did not meet requirements.

For the most part the premises was found to be suitable for the needs of the residents; however, some minor improvements were required to ensure the house

was thoroughly clean, could be effectively cleaned, and was in a good state of repair. For example, some mildew was observed in a resident's bedroom.

While there were arrangements in place regarding medicines management, such as medicines were found to be appropriately stored in a locked cabinet, some minor improvements were required to the medicines stock intake form to ensure all applicable checks were completed.

Appropriate healthcare support was provided to the residents, and they had access to applicable healthcare professionals as required, such as a general practitioner (GP).

The provider had ensured that there were suitable arrangements in place to safeguard residents. For instance, a staff spoken with was able to explain possible warning signs of abuse and how to respond should they observe those signs.

Residents were found to have access to their own money and were supported to engage in activities that interested them.

In addition, there was a residents' guide that contained the required information as set out in the regulations.

Regulation 12: Personal possessions

The inspector found that residents were supported to hold ownership of their own finances, and support was provided was in line with residents' assessed needs and preferences. For example, residents had bank accounts and other financial accounts in their own name. The staff team completed a daily check of their cash expenses and quarterly finance audits and bank statement reconciliation were completed. Although some minor improvements were required in the auditing of aspects of residents' finances this has been addressed under Regulation 23: Governance and Management.

Residents were supported to spend their money as they wished. For example, a staff member communicated that one resident enjoyed buying new scarves, and staff facilitated regular purchases. Another resident loved to buy a drink and a paper at the local shop each day and this was facilitated.

Judgment: Compliant

Regulation 13: General welfare and development

Residents had access to opportunities for leisure and recreation. Residents engaged in activities in their home and community.

Residents had individualised interests and they planned their days according to their preferences. From a review of the residents' files over a two week period in June 2026, the inspector found that residents engaged in activities ranging from shopping, walks, trips to many different towns or cities, lunch out, trips to beaches, attending the cinema, and attending sporting matches.

The inspector observed some evidence that staff members were in the process of trying to come up with new ideas for the residents to trial sampling different activities and visiting different locations.

Residents were supported to set and achieve personal goals in order to enhance their quality of life. For example, some residents goals were to attend a concert, go on an overnight in a specific hotel, and go on specific tours.

Judgment: Compliant

Regulation 17: Premises

The layout and design of the premises was appropriate to meet residents' needs. While the premises was tidy and generally in a good state of repair, there were some cleaning and cosmetic issues that needed to be addressed.

Mildew was observed on the bottom of the doors in a resident's bedroom.

There were some maintenance and housekeeping issues identified, such as the front of one garden shed was broken. There were some worn surfaces which would prevent effective cleaning, such as the bathroom plug hole. In addition, the inspector identified issues with the cleanliness of some of the soft furnishings internally and in the relaxation shed in the garden, as discussed with the person in charge on the day.

More thorough cleaning was required to some areas in the house as the inspector observed some limescale build up, dirt or residue in different areas, for instance the main shower, a resident's toilet, a foot spa, and the kitchen vent. A resident's mobility aid was also observed to require cleaning; however, this equipment was not included on the periodic cleaning checklist. While the mobility aid was cleaned prior to the end of this inspection, the cleaning of this equipment had yet to be added to the formal cleaning checklist.

There was guidance in place for equipment used to clean the centre and how it was to be stored. The inspector found the equipment was not stored in line with this guidance and some pooled water and debris were observed in some cleaning buckets. This could put the residents at risk.

On review of other arrangements in place to meet the requirements of this regulation, the inspector found each resident had their own bedroom, which was individually decorated. For example, personal pictures were displayed.

The back garden had a swing bench, potted plants, and a table and chairs for use in good weather.

Judgment: Substantially compliant

Regulation 20: Information for residents

There was a residents' guide that contained the required information as set out in the regulations. For example, it explained to residents how to access inspection reports, and what the arrangements for visiting were to the centre. While some minor amendments were required to ensure it contained all of the information as required by the regulations and that the information was clear, this was amended on this inspection.

Judgment: Compliant

Regulation 28: Fire precautions

The provider had not ensured that all fire safety systems met the required standards, particularly regarding alarm coverage and attic detection.

The inspector found that there were many adequate fire safety management systems in place. For example, there was firefighting equipment and internal emergency lighting was installed and regularly serviced, and residents had personal emergency evacuation plans (PEEP) to guide staff as to their evacuation supports required. However, a number of improvements were required regarding the alarm coverage, evacuation, emergency lighting, and fire containment measures.

Regarding detection and alert measures, while there was a fire detection alarm in place, the inspector queried the coverage of the fire alarm system and additional assurances were sought. It was then communicated to the inspector by a senior manager that the fire alarm coverage did not meet the all requirements and the provider could not evidence if there was attic detection in place. They communicated to the inspector that they were aware the system required enhancement to bring it to a suitable level of cover. They confirmed that a business case was being brought to allow for the improvements to be made but no set date could be provided for when the works would commence.

The inspector found that the relaxation shed in the back garden had a battery-operated smoke detector; however, there was no evidence to suggest that a fire

professional had reviewed the fire precautions for the shed to ensure it met requirements due to the proximity from the house.

While there were fire containment doors fitted with self-closing devices, cold smoke seals and heat protection strips, a review of fire doors found that the self-closing device on one resident's bedroom door was not functional, and there was a gap between the door and frame of the utility to kitchen door, which compromised the effectiveness of the fire containment measures.

The inspector found that three external emergency lights were not functioning. The person in charge arranged for this to be reviewed on the day with two of the lights fixed during the inspection and the third was due to be fixed the day after this inspection.

Based on a review of four fire practice drills completed during 2025 and 2026, the provider had ensured regular fire drills were taking place which included ones with minimum staff levels and using alternative evacuation routes. However, an evacuation drill had not been undertaken during hours of darkness as required to ensure that staff could safely evacuate the residents during darkness.

Additionally, the inspector found that there were gaps in some of the documentation of the fire safety checks the staff team completed.

Overall, while there were fire precautions in place, a number of areas required further oversight or enhancement to ensure that the arrangements in place would sufficiently protect residents from the risk of fire in their home.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

The inspector found that, for the most part, there were suitable arrangements in place regarding the ordering, receipt and storage of medicines which ensured residents received their prescribed medications correctly. However, some improvements were required to how medications were received into the centre.

While staff reviewed and signed in medication upon receipt from the pharmacy, the process did not involve a formal check that all required medication was actually received and pharmacy labels were not checked against the residents' prescription documents. This omission increased the risk of medication errors going undetected.

The inspector found that out-of-date or no longer required medications were not segregated appropriately from current stock as required by the regulations until they could be returned to the pharmacy for disposal. When this was brought to the person in charge's attention, they arranged for a system to be put in place to allow for segregation of medicines to be returned.

There were audits in place to monitor medicine management. The provider had introduced guidance to help staff identify medicines during stock intake. However, some of the photographs provided were unclear and lacked written descriptions, which could limit their effectiveness.

The inspector observed medicines had pharmacy labels attached as required to support in medication administration. In addition, the date of opening certain medicines was recorded as required to ensure that they could be disposed of once opened past a certain time frame.

There was a weekly medicines balance sheet completed for the stock control for medications to ensure medication was being administered as prescribed and facilitate the identification of any potential medication errors. The inspector completed a count of one medication and found the amount accurately matched that of the stock balance count.

Judgment: Substantially compliant

Regulation 6: Health care

The inspector found that the health needs of the residents had been appropriately assessed, and appropriate healthcare was made available to both residents.

From a review of a sample of both residents' healthcare information, there were care plans in place for any identified assessed needs. For example, there was an epilepsy plan and associated epilepsy emergency medication protocol, and an eating, drinking, and swallowing plans in place for residents that required support in that area.

There was evidence that residents had access to health and social care professionals and were supported in attending appointments with GPs when required. For example, residents had access to a dentist, psychiatrist, and a chiropodist. Additionally, residents were supported to avail of vaccines and national screening tests as appropriate.

At the time of the inspection, the residents were in good health, and efforts were being made to ensure that they maintained in the best possible health.

Judgment: Compliant

Regulation 8: Protection

The inspector reviewed the safeguarding arrangements in place and found that residents were protected from the risk of abuse.

Staff were found to be suitably trained to recognise and escalate any safeguarding concerns. There was a reporting system in place with a designated safeguarding officer (DO) nominated for the organisation and the identification of the DO was displayed in the kitchen.

There were no reported safeguarding concerns in the centre in 2026 to the time of this inspection. A staff member spoken with was familiar with the steps to take should a safeguarding concern arise including a witnessed peer-to-peer incident or an unwitnessed disclosure. For example, in the case of an unwitnessed disclosure, the staff member explained that they would gather the facts, that they would not promise confidentiality, would not ask leading questions, and would report the potential safeguarding incident.

From a review of both residents' files, the inspector found that there were intimate care plans in place that provided clear guidance to staff as to supports residents required.

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	
Registration Regulation 8 (1)	Substantially compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Compliant
Quality and safety	
Regulation 12: Personal possessions	Compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 20: Information for residents	Compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Killowen House OSV-0005671

Inspection ID: MON-0042321

Date of inspection: 30/06/2026

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
Registration Regulation 8 (1)	Substantially Compliant
Outline how you are going to come into compliance with Registration Regulation 8 (1): An application to vary will be submitted to include the relaxation shed as part of the foot print of the designated centre.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: All staff have completed the 5 mandatory IPC trainings on HSELand. 1 Staff member that required safeguarding update has now completed same. PIC has added subheadings to training matrix to include 5 mandatory IPC trainings. PIC will continue to maintain training matrix to predict future requirements.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: Residents' personal belongings inventory has been completed to reflect purchase in 2025 and 2026. Fire and Hygiene audits were completed on the 6/07/2026. All identified actions are being addressed. Hard copies of each audit are available in the designated centre for review when necessary.	

On receipt of future audits PIC will upload any actions onto the Quality Enhancement Plan to be discussed with PPIM during the Designated Centre meeting to establish appropriate time frame for completion.

Annual Review for 2026 will reflect accurate information from the Designated Centre.

Regulation 17: Premises	Substantially Compliant

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

Mold was cleaned and treated in identified areas in the Designated Centre.

An Air Quality risk assessment was completed to ensure staff are aware of the importance of reporting mold if discovered and the correct method of cleaning mold.

PIC added section regarding mold to the Hygiene Audit.

The Broken shed door is being repaired

A more robust cleaning schedule has been developed to incorporate all identified findings in the report.

Regulation 28: Fire precautions	Not Compliant

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

A Fire professional will be engaged to review the fire alarm system and coverage.

Three external emergency lights have been fixed

Fire door self-closing device was mended on 30.06.26. The gaps between the fire doors and frames has been repaired.

All staff informed of the importance of checking daily the fire safety documentation.

The PIC will review fire safety documentation weekly to ensure there are no gaps in the fire safety documentation going forward.

A nighttime fire evacuation drill will take place in darkness.

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:

On receipt of medication staff check medication in line with residents Kardex.
Staff use stock control sheets to maintain safe amounts of stock to ensure there is the

correct amount of medication available.

Staff check blister packs of medication against residents Kardex.

A separate box was put in place for any out-of-date medications or other medications that need to be returned to the pharmacy. This box is kept separate from resident's medications in a safe location.

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
Registration Regulation 8(1)	A registered provider who wishes to apply under section 52 of the Act for the variation or removal of any condition of registration attached by the chief inspector under section 50 of the Act must make an application in the form determined by the chief inspector.	Substantially Compliant	Yellow	04/08/2026
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	04/08/2026
Regulation 17(1)(b)	The registered provider shall ensure the	Substantially Compliant	Yellow	28/07/2026

	premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.			
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Substantially Compliant	Yellow	28/07/2026
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	28/07/2026
Regulation 28(2)(c)	The registered provider shall provide adequate means of escape, including emergency lighting.	Substantially Compliant	Yellow	01/07/2026
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	11/09/2026
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where necessary in the	Substantially Compliant	Yellow	29/09/2026

	event of fire, all persons in the designated centre and bringing them to safe locations.			
Regulation 29(4)(b)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine which is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.	Substantially Compliant	Yellow	01/07/2026