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:	Blackwater Lodge
Name of provider:	Dundas Unlimited Company
Address of centre:	Meath
Type of inspection:	Unannounced
Date of inspection:	11 August 2026
Centre ID:	OSV-0005889
Fieldwork ID:	MON-0047037

About the designated centre

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

This service provides residential care and support to adults with disabilities. The centre can accommodate up to five residents and is situated in a large town in County Meath. The house comprises a large two-storey dwelling with its own private gardens. There are adequate private and on-street parking facilities. Accommodation includes five bedrooms, three of which are en-suite, two communal bathrooms, a kitchen cum dining room, a utility room, a sun room, an office and a living room. The centre is staffed with person in charge, two team leaders, a social care worker and a team of direct support workers. Where or if required, community nursing support can also be provided for.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	5

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Tuesday 11 August 2026	10:00hrs to 18:30hrs	Karena Butler	Lead

What residents told us and what inspectors observed

Overall, on this unannounced inspection, the inspector found a caring staff team delivering good quality care to the residents. However, the inspector identified that several areas of governance oversight required improvement, particularly in relation to making sure required audits are completed. While residents received good care, there were gaps in cleaning practices, and additional staffing was identified as required to help reduce safeguarding incidents and their impact on the residents. These points are discussed in detail later in this report.

The inspector had the opportunity to meet and observe the five residents who were living in the centre. At the time of this inspection, there were no vacancies. On the day of this inspection, three residents attended day service programmes. Afterwards, their activities ranged from out for lunch, watching a movie in the house, going out shopping or completing artwork. The other two residents, who had not attended a day service, individually went out with support staff. One went personal shopping, while the other completed recycling followed by looking around antique shops.

All five residents said they liked living in the centre and that the staff were nice. One resident said they felt safe living in the centre and would tell a staff member if they were worried or concerned. They confirmed they were offered choices regarding their meals and daily activities.

Residents appeared content and comfortable in the centre. Interactions between staff and residents were seen to be relaxed and jovial. For example, the inspector heard a resident and a staff member laughing several times together in another room. Later the resident explained that the staff member had been making jokes. For example, the staff member had asked the resident to tie the staff member's shoelace as they were pretending they were too lazy to do it.

The inspector had the opportunity to speak with the person in charge as well as the team leader and staff member on duty. They appeared knowledgeable regarding the residents' support needs and preferences when speaking with the inspector. No volunteers were used in this centre.

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 explained that they were more conscious to support residents in making meaningful decisions and not to make choices on their behalf based on known preferences.

The inspector had the opportunity to speak with one resident's family representative on the phone on the day of this inspection and feedback received was very positive. The family representative communicated that staff were 'kind and approachable'. They felt that the interactions between staff and their family member were

'genuinely caring'. They said that staff were meeting their family member's needs and responsive to any changing needs. They felt welcome to visit the centre. They felt that their family member got on well with their housemates and they felt their family member was safe living in the centre. They added that if they were to have a concern they would feel comfortable raising it with staff or management.

The premises was found to be tidy. However, some additional cleaning was required. Each resident had their own bedroom which was decorated in line with their preferences. For example, one resident liked money boxes. They collected various ones and had them neatly displayed in their room.

There was a front and back garden that were accessible to the residents. There were potted plants and flowers displayed both in the front and back garden which helped make the house look more appealing and homely. Garden seating was also available for use in times of good weather. The residents were supported to have a pet rabbit, and this was housed in the back garden. One resident proudly showed the inspector the rabbit.

At the time of this inspection, there had been one complaint received in the last 12 months, and while the person in charge confirmed it was dealt with appropriately, not all documentation was available. This was addressed under Regulation 23: Governance and management.

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 unannounced inspection was undertaken as part of ongoing monitoring of 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 centre was last inspected in November 2024.

While there was evidence of regular quality assurance audits taking place, the provider's governance and management arrangements were found to require several improvements to ensure appropriate oversight of the quality and safety of the service. However, the inspector found that the person in charge was operating the service in a manner which ensured delivery of care was meeting the residents' needs.

There were adequate staffing levels in place to support the assessed needs of the residents. The inspector also found that there was a programme of training and refresher training in place for all staff.

Regulation 14: Persons in charge

The registered provider had appointed a full-time, suitably qualified person in charge to the centre.

They were supported in this centre by two team leaders to support the person in charge to maintain appropriate oversight and support.

The person in charge was familiar with the residents' needs and could outline their individual health and social care needs on the day of the inspection.

They were also found to be aware of their legal remit in line with the regulations, such as to notify the Chief Inspector of Social Services (the Chief Inspector) when adverse incidents occurred in the centre. They were also found to be very responsive to the inspection process.

A staff member spoken with communicated that the person in charge was very good at their job and approachable.

Judgment: Compliant

Regulation 15: Staffing

The registered provider ensured that the number and skill-mix of staff was appropriate to meet the routine and assessed needs of the residents.

While a 0.5 whole-time equivalent (WTE) staff vacancy post was required, the provider was actively recruiting to fill the position. The person in charge successfully managed this vacancy using two consistent relief staff members to facilitate continuity of care for the residents.

A review of the rosters from May to August 2026 demonstrated that a core, familiar staff team was in place, which ensured continuity of care. Additionally, the planned and actual rosters reviewed accurately reflected the staffing arrangements in the centre, including the full names of staff on duty during both day and night shifts.

On the day of inspection, there were sufficient staff available to support residents in attending day services and engaging in individual community-based activities.

The inspector found that residents' daily health and social care needs were being met by the current staffing levels. While a requirement for additional staffing had been identified as a specific measure to mitigate periodic safeguarding incidents, the inspector found that the baseline staffing was sufficient for the general operation of the centre and the delivery of routine care. The specific impact of the outstanding additional staffing hours is discussed under Regulation 8: Protection.

Throughout the inspection residents were observed to be very comfortable in the presence of staff and they were complimentary of the staff team saying that they were nice.

Full staff personnel files were not reviewed at this inspection. However, the inspector reviewed a sample of the Garda vetting certificates for the two staff members on duty and their police clearance certification where applicable. Both Garda vetting certifications were completed within the last three years as per best practice and demonstrated that the provider has arrangements for safe recruitment practices.

Judgment: Compliant

Regulation 16: Training and staff development

There were adequate systems in place for the training and development of the staff team.

The inspector reviewed the training oversight records for all staff and a sample of certification for three different training courses for the two staff members on duty. This review demonstrated that staff had completed a range of training courses, ensuring they possessed the necessary knowledge and skills to effectively support residents. This included mandatory training in critical areas such as fire safety, safeguarding vulnerable adults, medication management, and training related to positive behaviour support.

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.

From speaking with one staff member, they confirmed that they received formal supervision four times a year and that was an opportunity for them to raise concerns should they have any. The inspector's review of the supervision records for the two staff members on duty confirmed the same.

Judgment: Compliant

Regulation 23: Governance and management

The provider's governance systems had not always ensured the service was consistently monitored, or effectively overseen. Improvements specifically related to ensuring guidance documents for staff contained relevant and accurate information, that required audits were completed and in a timely manner as well as ensuring all identified actions were completed.

While there were arrangements for unannounced visits to be carried out on the provider's behalf every six months and the most recent one was shown to the inspector which took place in March 2026; however, none took place in 2025 as required by the regulations. This was a significant gap in oversight at provider level and it also failed to meet the requirement of the stated regulation.

Additionally, while the person in charge had completed an initial finance review following identified safeguarding concerns, the provider had failed to honour a formal written commitment to the office of the Chief Inspector to conduct a subsequent, specific review of residents' finances in September 2025. This review was not undertaken until February 2026, representing a five-month delay. This oversight fell outside provider's own confirmed time frame and was a breach of their agreed governance and internal control frameworks.

The provider had carried out an annual review of the quality and safety of the centre which included positive resident and family representative consultation. However, while the annual review was completed in January 2026, it was not made available in the centre until April 2026. Therefore, any actions that arose from this review were unable to be progressed in the absence of the relevant information. This had the potential to affect the effectiveness and consistency of the service being provided to the residents. Additionally, the annual review failed to identify the two required missing provider-conducted audits for the year reviewed, which called into question the robustness of the provider's self-monitoring.

From a review of two residents' care plans the inspector observed gaps in information that had not been identified through the provider's own audits and reviews. Improvements were needed for the oversight of documents so that they provided accurate information to ensure residents were provided with consistent and applicable care supports. The inspector identified a number of gaps in information around health monitoring and hospital passports. For example, from a sample of two hospital passports reviewed they both contained some inaccurate information and one of the passports did not contain all relevant information. For example, it did not mention two specific important health conditions the resident was diagnosed with and when the document asked if the resident required support with eating, it stated non-applicable despite the resident having speech and language therapy recommendations regarding their food. Therefore, the inspector was not assured that information governance arrangements were robust.

Furthermore, the provider's oversight of documentation was insufficient to ensure a complete record of the complaints process was maintained, as required for effective

monitoring. Evidence indicated that the person in charge and the provider had followed up on the complaint and had taken the appropriate steps to review and resolve the complaint. However, they failed to keep a formal response made to the complainant and the advice to the complainant of their right to appeal the decision should they not be satisfied. Although other applicable records were maintained, the provider must ensure that all applicable information and decisions are formally documented moving forward. This improvement is necessary to provide clear evidence of the decision-making process, demonstrate accountability, track whether correct procedures were followed, and allow for effective monitoring.

The lack of robust oversight created an unnecessary risk to the safety and consistency of the service provided to the residents.

Judgment: Not compliant

Quality and safety

The inspector found that the quality and safety of care provided for residents was of a good standard. The centre was presented as a comfortable home and the staff team provided person-centred care to the residents. The inspector found that some improvements required regulations related to protection and the premises.

There were arrangements in place to recognise and respond to any potential safeguarding risks to residents, for example staff had received training in safeguarding vulnerable adults. However, additional staffing had been identified as required to minimise safeguarding risks and had not yet been provided.

While the centre was found to be tidy and homely, some additional cleaning was required to ensure it was always hygienically kept.

Residents were supported to have the best possible health and were found to have access to appropriate health and social care professionals as required, for example a psychologist.

An assessment of need was completed for residents, and a support plan was in place for any identified needs. This included positive behavioural support plans as required.

The inspector reviewed the fire management arrangements and found the provider ensured that adequate fire precautions were in place. For example, appropriate fire detection and alert systems and firefighting equipment were available and maintained.

Regulation 17: Premises

The inspector completed a walk around of the premises and found that there was adequate communal and private space for residents. The centre had been decorated to ensure it was homely in presentation, and it was found to be tidy. However, improvements were required to the thoroughness of some of the cleaning and to ensure all surfaces could be effectively cleaned.

Each resident had their own bedroom, which was decorated to reflect their individual tastes.

The centre was found to meet the requirements of Schedule 6 of the regulations. For example, the residents had access to cooking and laundry facilities.

Areas found to require cleaning or amended to ensure they could be effectively cleaned included:

- mildew was found on several soft toys belonging to one resident and on the windowsill in their room as well as in several en-suite bathrooms
- from a sample of pillows viewed, no pillow protectors were fitted, and some pillows were found to have staining, and one mattress had no protector fitted and the mattress has some light staining on it
- the radiator in the main bathroom was rusty in some areas
- there was staining observed on the sitting room blinds
- some minor limescale build-up was observed around some bathroom taps and in one toilet, which would make it difficult to ensure they could be effectively cleaned.

Overall, while the premises was in a good state of repair and tidiness, additional cleaning was required to ensure residents were protected from the risk of healthcare-related illness. Additionally, those issues detracted from the otherwise homely environment.

Judgment: Substantially compliant

Regulation 28: Fire precautions

There were effective fire safety management systems in place in the centre. The inspector observed fire fighting equipment, detection systems, and emergency lighting all in working order around the centre and they were serviced as required.

There were fire containment doors in place that were fitted with self-closing devices, fire seal strips and cold smoke seals. Each door was tested and all were found to close effectively, which demonstrated that they would facilitate protecting residents from the spread of smoke and fire. While the hot press leading onto an escape route

did not have a fire containment door fitted, when this was brought to the attention of the management on the day, it was confirmed that a fire containment door was ordered and would be fitted to the press the next day. Management arranged for photographic evidence to be submitted to the office of the Chief Inspector, that a fire containment door was fitted.

A review of a sample of eight practice fire evacuation drills showed that staff and residents were completing them periodically to ensure they were familiar with how to safely evacuate in the event of an emergency. Drills included one during hours of darkness, some with minimum staffing levels and maximum residents participating, and drills undertaken used alternative evacuation routes to ensure that residents could be evacuated from all areas of the house and under different conditions.

Additionally, each resident had a PEEP in place which guided staff on the support they required if an evacuation was necessary.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The provider had ensured that assessments of residents' health and social care needs had been completed and care plans developed for any identified needs. These assessments, along with residents' support plans, were under periodic review and demonstrated that multidisciplinary professionals were involved in the development of care being provided.

For example, from a review of aspects of two residents' files, the inspector found that there were support plans in place for identified needs, such as eating, drinking and swallow plans, and plans for high blood pressure. The information contained guided staff as to what supports were required.

While two care plans required updating to ensure all applicable information was contained, from speaking with a staff member, residents' support needs were known. The person in charge updated the information on the day. Therefore, this was discussed and addressed under Regulation 23: Governance and Management. The inspector found that care and support was provided in line with residents' care needs.

Judgment: Compliant

Regulation 6: Health care

The service had implemented a proactive model of care that was centred on the needs of the individuals. The health and wellbeing of each individual was promoted

and supported and each individual had access to a range of health and social care professionals to support to support them in experiencing a good quality of life.

Residents were supported to attend appointments with health and social care professionals as required. For example, a general practitioner (GP), chiropodist, a speech and language therapist, and a dentist.

From a review of two residents' files, the inspector found they were also supported to avail of national screening tests as well as vaccination programmes were required or applicable.

Judgment: Compliant

Regulation 7: Positive behavioural support

The inspector found there were appropriate arrangements in place to support residents' positive behaviour support needs. Where required, residents had access to members of the multidisciplinary team to support them to manage behaviour positively. For example, access to psychiatry and psychology.

Where necessary, residents received specialist support from a behaviour specialist to understand and alleviate the cause of any behaviours that may put them or others at risk.

Where applicable residents had behaviour support plans in place. From a review of two residents' files, the plans were found to be detailed and person-centred. They gave information regarding how to communicate with the person, listed possible triggers and how to support them during periods of escalation.

Judgment: Compliant

Regulation 8: Protection

There were arrangements in place to protect residents from the risk of abuse. For example, it was found that any safeguarding concerns were reported to the relevant statutory agencies and a safeguarding plan was implemented to mitigate the chances of recurrence. However, the provider had not promptly addressed identified staffing needs to mitigate known peer-to-peer risks.

There were a number of occasions whereby the behaviours of one resident was negatively impacting on others living in the centre. The person in charge had identified in May 2026, that additional staffing was required for the centre to better support one resident's needs and reduce the likelihood of incidents. However, there was a delay progressing the application to the external funder for additional staffing

which was only submitted just prior to this inspection. At the time of this inspection, no additional staffing had been provided to this centre. From speaking with a staff member, they confirmed that a high level of supervision was required to ensure incidents did not occur or to de-escalate any developing negative situations in a timely manner. The current arrangements meant at times that staffing attention could be diverted away from improving quality of life due to supervision requirements.

On review of other arrangements in place to meet the requirements of this regulation, the inspector observed that the registered provider had a policy in place to safeguard the residents, which included the procedures staff should follow in the event of an allegation of abuse being reported or observed. All staff had been provided with training in safeguarding vulnerable adults.

A staff member spoken with was aware of the different types of abuse and informed the inspector about the actions they would take if they observed an abusive interaction occurring or if a disclosure was made.

Two staff members spoken with could confirm who the designated safeguarding officer (DO) for the organisation was and the identity of the DO was displayed in the hall.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Substantially compliant

Compliance Plan for Blackwater Lodge OSV-0005889

Inspection ID: MON-0047037

Date of inspection: 11/Aug/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 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
A governance schedule is now in place to provide oversight of all statutory and organisational audits and reviews required within the designated centre. In addition, a new auditing system has been implemented from 02 September onwards resulting in the centre having a clear dashboard of pending/complete and outstanding audits. This will better identify the audit/review required, the person responsible, the required completion date and confirmation that identified actions have been completed. This will be routinely reviewed by the assistant director to ensure required audits and reviews are completed within the appropriate timeframes.
The registered provider will ensure that unannounced provider visits are undertaken at least once every six months in accordance with Regulation 23(2)(a). Provider-level oversight arrangements have been implemented to monitor the scheduling and completion of these visits. Current status of provider led audit completion is a standing agenda item during weekly DOS/COO meetings.
The registered provider will ensure that annual reviews of the quality and safety of care and support are made available to the designated centre promptly following completion. Actions arising from annual reviews, six-monthly provider visits and other governance audits are actively tracked, with responsible persons and completion dates identified.
Following the inspection, a review of residents' hospital passports was undertaken. Hospital passports have been updated to ensure that relevant health conditions, support needs and recommendations are accurately reflected. Hospital passports will continue to be reviewed as part of the centre's ongoing documentation oversight arrangements to ensure information remains current and accurate.
Complaints documentation has been reviewed by the PIC and Assistant Director to ensure that a complete record of all open and closed complaints is maintained. This has included documenting the response/outcome communicated to the complainant and evidence that the complainant has been informed of the applicable review or appeal

process.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises: Following the inspection, the environmental issues identified have been reviewed and remedial actions commenced. The mildew identified on the resident's soft toys has been removed and the affected items have been cleaned. The radiator identified as rusted in the main bathroom has been reported to the maintenance department for replacement. This action will be completed on or before 18/09/2026, a request for new blinds in the sitting room has also been escalated to the maintenance team, this is also due for completion on or before 18/09/2026.

The remaining environmental areas identified during inspection have been addressed, including ensuring appropriate pillow and mattress protectors are in place, addressing staining where required and removing identified limescale.

The centre's environmental oversight arrangements have been reviewed to ensure that bedrooms, bathrooms, soft furnishings, bedding, mattresses and other environmental areas are routinely monitored. Any issues that prevent surfaces or furnishings from being effectively cleaned will be identified and escalated for remedial action.

Following completion of the outstanding works, an environmental review will be undertaken to verify that all actions identified during the inspection have been addressed.

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection: Following the identification of additional staffing requirements to mitigate peer-to-peer safeguarding risks within the designated centre, additional staffing resources have now been put in place. An additional 12 hours of 1:1 staffing support has been approved to support the identified resident's assessed needs and to reduce the likelihood and impact of peer-to-peer safeguarding incidents. The additional staffing hours will be incorporated into the centre's staffing arrangements and deployed in accordance with the resident's assessed needs, identified risks and safeguarding arrangements. The statement of purpose has been updated to reflect the increased staffing supports.

Relevant safeguarding plans, risk assessments and support plans have been reviewed to reflect the additional staffing resource and to ensure that staff have clear guidance regarding proactive supervision, early intervention and de-escalation strategies.

The effectiveness of the additional 1:1 staffing will be monitored through ongoing review of safeguarding and peer-to-peer incidents. Incident frequency, patterns, triggers and outcomes will be reviewed to determine whether the additional staffing is reducing the frequency and/or impact of incidents.

The Person in Charge will continue to monitor safeguarding arrangements through the centre's governance systems. Where incident review indicates that existing measures are not sufficiently mitigating the identified risks, this will be escalated through the appropriate management and safeguarding structures for further review.

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 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Substantially Compliant	Yellow	18/Sep/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	5/Oct/2026
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more	Not Compliant	Orange	5/Oct/2026

	frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.			
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Substantially Compliant	Yellow	4/Sep/2026