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:	The Court - Kingsriver
Name of provider:	Kingsriver Community Holdings Company Limited by Guarantee
Address of centre:	Kilkenny
Type of inspection:	Unannounced
Date of inspection:	25 May 2026
Centre ID:	OSV-0007915
Fieldwork ID:	MON-0050418

About the designated centre

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

The Court - Kingsriver is a designated centre operated by Kingsriver Community Holdings CLG. The designated centre provides a community residential service for up to seven adults with a disability. The centre comprises of three houses within a close proximity to each other in an urban area in County Kilkenny. Each house comprises of a sitting room, dining area, kitchen, bathrooms and individual resident bedrooms. The designated centre is staffed by a team leader, social care workers and health care assistants. The staff team are supported by a person in charge.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	6

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
Monday 25 May 2026	09:40hrs to 19:20hrs	Lisa Walsh	Lead
Monday 25 May 2026	09:40hrs to 19:20hrs	Linda Dowling	Support

What residents told us and what inspectors observed

This was an unannounced risk inspection, conducted to assess the provider's regulatory compliance in relation to the care and welfare of residents living in the centre. It was completed by two inspectors over the course of one day. The inspection was also completed to follow up on unsolicited information of concern submitted to the Chief Inspector of Social Services which raised concerns about the provider's governance and management arrangements and possible impact on the quality and safety of care provided. While one resident in one premises spoke positively about living in the centre there were high levels of non-compliance with the regulations reviewed on the day of inspection. Significant gaps in oversight were identified which impacted on the governance systems and the quality and safety of care provided to residents.

On arrival to the centre, inspectors were greeted by one resident and one staff member. The resident had just been supported to get up for the day and sat with the inspectors and chatted with them. This resident had only recently moved to the centre, they spoke about their family, things they enjoyed doing and how they worked two days per week. The resident then ate their breakfast and spent the morning sitting at the dining room table doing word puzzles which they said they enjoyed. The resident explained that this was their morning off and they wanted to relax. Inspectors were not however, assured that the design and lay out of the centre would meet their needs. They required mobility aids when mobilising and one-to-one supervision at all times. Their bedroom was located on the first floor, when inspectors asked if they wanted to show them their bedroom they declined and said the inspectors could go upstairs and look at it with staff.

Inspectors were informed that the person in charge and team leader were based in a separate office not located within the centre. Staff stated that they attended the centre, however, they were not part of or reflected on the rosters for the centre and staff were not always aware of where they were.

The other staff member on duty had gone to drop one resident out to their day service and another resident had gone along for the drive. They both returned to the centre after a short period, the resident was observed to move around their house with ease and they interacted with the two inspectors, it was difficult at all times to understand their communication attempts although given time and support from staff they were able to communicate their needs and wishes. The resident no longer attended a day service and was supported by staff to engage in activities. On the day of inspection, the resident engaged in limited activities. They went for short walks around their housing estate and out for a drive with staff. Inspectors were informed that they rose very early each day and went for a nap at lunchtime for two hours every day. They then went to bed by 17:00 each day.

Inspectors identified concerns in relation to compatibility issues between some residents, with one resident telling inspectors they 'did not like' another resident. There had also been several incidents notified to the Chief Inspector which occurred between residents which showed further compatibility issues. Staff informed inspectors that two residents required constant supervision when they were together in the same room, however there were no clear plans or risk assessments in place to guide staff practice.

The resident who attended day service returned to the centre in the late afternoon. Inspectors briefly chatted with them. They said they enjoyed the day service and living in the centre. They watched television briefly and then went out with staff. They had requested to go swimming, packed their bag and headed out. On return to the centre they said they couldn't go in for a swim as the pool was not open to the public.

A resident living in the centre had been absent from the centre for several weeks. While there were risk assessments and plans in place to manage this, they were ineffective and had not been updated to reflect the current arrangements in place.

The centre comprises of three properties and was registered to accommodate a maximum of seven residents, with one vacancy on the day of inspection. The first property was a modern two-story house located in a large estate close to the centre of Kilkenny, which had four residents' bedrooms. Communal space consisted of a bright open plan kitchen/dining area and a sitting room. For the most part, the property was well maintained and provided a homely atmosphere, although painting was required in a number of areas of the home including the sitting room where the walls were marked and stained in several areas. The management of heat and ventilation also required review with the centre being uncomfortably hot on the day of inspection. One resident had two fans in their bedroom when inspectors arrived, however this rooms was still very hot. In the late afternoon, additional fans arrived to the centre. However, it remained very hot in the centre and the fans had little impact.

The second property was home to one resident, another two-story house close to local amenities. This house was personalised to the resident’s taste, and they enjoyed showing the inspectors around their home. It was seen to be clean, tidy and well-maintained. The door from the sitting room to the dining room had no fire seals and no fire door closers which would mean that it would not automatically close in the event of a fire. After showing the inspectors around their home, the resident had a cup of tea with them and chatted about their life living in the centre, things they enjoyed doing, their health and the staff that worked with them. They said they were very happy living in the centre and had been there for many years. They were highly complimentary about the staff that worked with them also.

The third property was also single occupancy although on the day of inspection the resident requested the inspectors not visit them. The documentation from this property was made available at another location for the inspectors to review.

Inspectors observed the dining experience for residents at dinner time. In one house there were two different mealtimes to accommodate one resident going to bed early each day. Both of these dining experiences varied greatly. For one sitting residents' meals were freshly prepared and cooked with a nutritious and appetising looking and smelling meal of fresh vegetables and meat. For the other sitting the majority of the meal was defrosted and microwaved. Inspectors were informed that a large portion of beef was cooked and then portioned into four or five meals and then frozen. Potatoes had also been batched cooked in advance. These were then heated and served to the resident also with some frozen vegetables that had been prepared. Inspectors heard the resident clearly request chicken for dinner, although a beef dinner was already prepared and defrosted for their meal.

The next two sections of the report present the findings of this inspection in relation to the governance and management arrangements in place in the centre, and how these arrangements impacted on the quality and safety of the service being.

Capacity and capability

Overall, findings of this inspection were that the provider failed to put effective management systems in place to ensure that the service provided was safe and that appropriate plans were in place to manage risk within the centre. Some incidents had occurred and these had not been recognised as a safeguarding concern.

Resources such as the consistent presence of the local management team required review to ensure there was effective oversight. A review was also required of staffing resources to ensure that residents who required specific support needs were met.

The systems for oversight, monitoring and auditing were not identifying areas of improvement and were ineffective. It had been almost a year since the provider's last six-monthly audit had been completed.

Unsolicited information had been received for the centre by the Chief Inspector, following which the provider completed an internal audit and identified some areas that required action. However, this audit did not incorporate all premises that comprise the centre and several actions remained outstanding past their due date for completion. Inspectors were not assured that plans in place would bring the service back into compliance in a systematic manner. In addition, the audit was not effective in identifying all of the key areas of concern that were highlighted on this inspection.

Regulation 15: Staffing

The inspectors reviewed the staffing arrangements in place in the centre. This included speaking with staff members and a member of the management team, reviewing rosters and making observations across the day of inspection.

The inspectors had the opportunity to meet with six staff members over the course of the day, five in the larger house and one in the other smaller home. Staff spoken with were found to be kind, respectful and well known to the residents. They were also familiar with residents' needs.

The centre was staffed with a person in charge, team leader, social care workers and healthcare assistants. On the day of inspection, there was one social care worker vacancy. The centre currently does not utilise agency staff and manages to cover gaps on the roster created from planned and unplanned leave by core staff working additional hours or using the provider's relief staffing panel. Staff spoken with reported staff shortages previously but noted that this had started to improve.

In the small house, an all female staff team was required and facilitated to meet the resident's needs. In the larger house, a resident also required female staff to meet their needs. The inspectors were informed that the person in charge and team leader had been moving staff between the houses to ensure that this was facilitated where possible for the last two months. While there were female staff working during the day, this was not always in place at night. Inspectors were informed that as the resident was in bed they did not require this support then. However, there had been incidents during the night where they required assistance from female staff and this was not always possible. Management present informed the inspectors that staff could phone the on-call management team for support on these occasions to attend the centre, this was however, ineffective and did not meet the assessed needs of the resident.

Inspectors were also informed that a full and complete planned roster was not available in the centre for residents to know who was supporting them each day. Staff were individually given their roster and would then put this together to know who was working.

Judgment: Not compliant

Regulation 16: Training and staff development

The inspectors asked to review the training matrix in place that provided an account of all staff training within the centre. On review of this document it was found that there were some gaps in the records of staff training across areas of care and support. Inspectors were informed that this may not be the most up-to-date record in place.

Due to the gaps in the matrix system, inspectors and the provider could not be assured that staff had completed or attended some mandatory training. For

example, three staff were due to complete training in first aid previous to the inspection. However, it was not clear if they had attended from records provided. Additionally, five other staff had not completed this mandatory training and were not scheduled to attend this training until November 2026. Three staff who had no first aid training also lone worked with residents.

Six out of seven staff had not completed mandatory training on administration of specific epilepsy rescue medication, some residents living in the centre required this support. Staff were not scheduled to complete this training until August 2026.

Gaps were also identified in positive behaviour training, with two staff who had not completed this. One staff was lone working with a resident and the other staff worked in a house that had several incidents occurring.

Judgment: Not compliant

Regulation 23: Governance and management

Overall, the inspectors found that the provider had failed to effectively implement monitoring tools and management systems to ensure that the service was effectively managed and that residents were being provided with a safe and quality service. Inspectors noted a high number of concerns in relation to risk management in the designated centre throughout the inspection day.

Before the inspection, the provider had informed the inspectors that following receipt of unsolicited information they had completed an internal audit of their governance and management systems. However, when inspectors arrived at The Court- Kingsriver they were informed that the audit had been completed for only one of the three houses which form this centre. The inspectors requested a copy of this audit, however this was not received by inspectors to review despite asking for it. Inspectors were provided only with the action tracker from this audit. This audit by the provider identified some areas of non-compliance with staffing, governance and management, training and staff development, complaints and risk management. There was an action plan in place with all actions to be completed between the 11 and 15 May 2026. However, on the day of inspection 11 of the 48 actions had not been completed. This included six high risk red rated actions for risk management. There was no clarity provided on the progress of these outstanding actions and when they would be completed.

The provider had not completed as required by the regulation a six-monthly unannounced audit since June 2025, with only two six-monthly audits having been completed since December 2024. Without this audit being completed, inspectors were not assured that the provider was fully aware of the safety and quality of care and support being provided in the centre. It also meant that in the absence of this report there had been no plans in place to address any concerns in the centre.

Inspectors requested a copy of the 2025 annual review of the quality and safety of care and support in the centre. They were provided with an annual review which had no clear date on it to demonstrate what year was in review. Inspectors queried if this was for 2025 as actions listed were to be completed in 2025, management present confirmed that it was. However, on a further review of documentation, inspectors found another annual review which was for 2025; the previous one provided was for 2024. This review was ineffective in capturing and actioning key areas of concern in the centre and had found the centre to be fully compliant with the regulations.

Other audits completed locally, such as the infection control, fire safety or medicines management did not identify actions that were required and had no associated action plan. For example, weekly checks in relation to fire doors were completed and noted that there were no issues with fire doors. However, inspectors observed fire doors that were not closing properly. Infection control audits were being completed and had identified some actions were required; however these had not been completed and being found as repeat issues on several audits with no actions taken. In addition, there was no evidence that these audits had been reviewed by the person in charge.

There was an electronic system in place to report maintenance issues within the centre. The inspectors were informed that the need for painting in some areas of the centre had been identified, however the person in charge could not see the progress of the action being taken for these and could only see when an issue was resolved.

Inspectors found limited evidence that the person in charge was present in the centre to provide effective day-to-day oversight. This impacted on governance and management systems which were not effective and impacted the safety and quality of care provided to residents. On reviewing the staff rosters there was no evidence that the person in charge was present or where they were on a given day. Inspectors were informed that the person in charge would use the visitors sign-in book to demonstrate their attendance to the centre. Inspectors reviewed the visitors log and saw that the team leader generally attended the centre once a week and sometimes more frequently for a brief amount of time. The person in charge was recorded as attending the centre less frequently than this and for short periods of time. Staff spoken with reported having little support in the centre, however, said in recent weeks this had started to improve and more supervisions were being provided.

Inspectors reviewed staff meeting records which were available. While records were being maintained these were ineffective in keeping staff informed and ensuring required actions were completed. For example, a new resident had moved into the centre in March 2026, however there was no evidence that this was discussed at team meetings to ensure that all staff were aware of the resident's needs. While audits were a standing agenda item, these were not discussed and not applicable was written next to this topic. There was also no evidence that incidents were being

discussed either. This meant that there were no actions in place and no shared learning from incidents to ensure residents' needs were being met.

On a review of rosters it was identified that some staff were working an excessive amount of hours each month. Some staff were working a considerable amount of time without sufficient breaks in between. For example, a staff had worked 10 waking night shifts in a row across two houses. The inspectors identified several examples of staff working more than 190 hours in the month, with one staff recorded as working 256 hours. As well as impacting staff welfare this posed a risk to the service being provided to residents.

Judgment: Not compliant

Quality and safety

Overall, the inspection findings identified substantial concerns and failings regarding the centre's risk management processes. While residents' care and support was provided by a consistent staff team who were familiar with their needs this was in the absence of robust and safe oversight mechanisms. Overall the inspectors found that significant improvement was required to areas of care and support for residents, including in the areas of premises, safeguarding and protection, fire safety and medicines and pharmaceutical services.

The inspectors reviewed a number of key areas to determine if the care and support provided to residents was safe and effective. These included meeting residents and staff, a review of safeguarding plans, risk documentation, fire safety documentation, and documentation in relation to medicines.

Regulation 17: Premises

This designated centre comprises three locations, one a large newly built two storey premises in a housing estate near Kilkenny town. Another was a small two-storey house set in a residential housing estate also. The two premises were about 10 minutes' drive apart. Inspectors did not get an opportunity to view the third house as the resident requested, they not visit.

Both houses visited were homely and decorated to a high standard. While one was designed and laid out to meet the number and needs of residents another was not. This reflected a new resident who had moved into the centre the inspectors were not assured that it would safely meet their needs. The resident required the use of a mobility aid when walking and their bedroom was located on the first floor as there were no alternative bedrooms available to them. There was toilet on the ground

floor that the resident used during the day when they were downstairs. However, this toilet was also used as an en-suite for another resident. The resident who needed mobility support required one-to-one supervision and assistance from staff at all times. However, on review of documentation inspectors noted that the resident had used the stairs unaided on one occasion which posed a risk of falls. Inspectors were informed that the provider was aware that this premises was not suitable to the resident and they stated this was a temporary placement while they were seeking more appropriate accommodation for the resident. The resident had lived there for a couple of months; however, inspectors observed that their bedroom was not personalised to their taste, and the storage of some items required a review to ensure it provided a homely space for them to relax in.

For the most part, the property was well maintained although painting was required in several areas of the home including the sitting room where the walls were marked and stained in several areas.

The management of heat and ventilation required review. While the inspectors acknowledge it was a hot summer day, it was very hot within the centre which made it very uncomfortable. Some of the residents' bedrooms and the staff office, which also stored medicines, were recording temperatures of 31.6 degrees in the late afternoon. One resident had two fans on in their bedroom when inspectors arrived at the centre that morning and that room was recording 28.7 degrees.

The storage practices of toiletries placed residents at risk of cross-contamination and healthcare associated infections. There were multiple bottles of toiletries in the shared bathrooms. Staff could not identify who the toiletries were belonging to.

Judgment: Not compliant

Regulation 26: Risk management procedures

A high number of concerns in relation to risk management were found in the designated centre throughout the inspection day.

Risk management documentation and assessments required review. It was unclear when risk assessments in place had been reviewed by management and / or updated, there appeared to be two different systems in operation and in some cases it was difficult to locate the residents individual risk assessments. This did not provide an assurance that guidance was available for staff to follow.

The provider and person in charge were, in part, identifying safety issues and putting risk assessments and control measures in place. However, not all potential serious risks had been identified. For example, when circumstances around a resident's absence from the centre changed, additional or amended control measures were not reflected on the risk assessment. This did not as a result provide

full detail of the current risk nor detail of control measures in place that were reflective of the impact on the resident due to their continued absence

Centre risk assessments were not found to be centre specific, for example, a risk assessment for safeguarding outlined the provider policies and procedures but did not identify the current safeguarding risks within the centre or offer guidance to staff on how to manage these risks.

The inspectors found that risk ratings were not revised following the implementation of control measures. This meant that it was not clearly documented whether the risk had been reduced or mitigated following the implementation of control measures and whether these were effective.

On review of the provider's incident and accident system, gaps were noted in the recording and review of incidents happening in the centre. For example, a significant incident that happened three days before the inspection had not yet been recorded in full. The inspectors observed that when incidents were being recorded they lacked detailed relating to actions, learning and trending. This did not provide assurance that they were being reviewed.

Judgment: Not compliant

Regulation 28: Fire precautions

Inspectors completed a walkthrough of two of the houses which comprise the designated centre and carried out a manual check on all fire doors. Inspectors found that in three residents' bedrooms and a store room the fire doors were not fully closing when manually released.

Inspectors also found that two doors in two different houses had no fire seals and no self-closing mechanism so did not automatically close when the fire alarm sounded. This posed a risk to fire containment.

The registered provider had taken some precautions against the risk of fire in the designated centre with suitable fire-fighting equipment. However, there had been a two-month delay on completing annual testing of the fire-fighting equipment in place by a competent person.

Inspectors reviewed fire drills completed in the centre and found that while the person in charge was ensuring regular fire drills were occurring in the centre, no fire drill had been completed which demonstrated a night-time scenario with the minimum number of staff to ensure that residents could be safely evacuated since the new resident had moved into the centre.

Residents had personal emergency evacuation plans (PEEP's) in place; however, for the new resident the PEEP was incomplete and there was no evidence of evacuation

guidance in place for the designated centre. The resident also required mobility assistance and was residing on the first floor.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

Inspectors reviewed medication management systems in the centre. Overall it was found that a number of improvements were required to ensure safe practice at all times. This was seen in the following areas:

- Residents did not have a clearly prescribed KARDEX or prescription in place to identify their regular and 'as required' (PRN) medicines.
- On review of the administration records, some regular medications were unclear on the time to administer. For example, one resident's documentation suggested it was to be administered on three occasions throughout the day although a line was drawn through one of the times. It was unclear who made this amendment to the documentation or when this change had happened.
- Staff had no guidance on the administration of PRN medicines. The providers policy states that 'each PRN much have a clear individualised PRN protocol, on the day of inspection no PRN had a supporting protocol in place.
- One resident was prescribed medicines to manage their anxiety in regular and PRN form. There was no guidance in place to identify how they can both be safely administered. For example, minimum timeframe between each dose and maximum safe daily dose was not documented.
- On the day of inspection the temperature of the room where the medicines were stored was a concerning 31.6 degrees, this required review.
- On review of training records six out of seven staff members remained outstanding on the administration of emergency rescue medication, there was no scheduled date for this training to be completed.

Judgment: Not compliant

Regulation 8: Protection

The provider had failed to recognise and respond to significant safeguarding concerns within the designated centre. The provider had an up-to-date safeguarding policy that reflected current national guidance. While this policy provided directions to staff on how to identify, report, and respond to safeguarding concerns and staff had been in receipt of training, practice in the centre was not reflective of the guidance within the policy nor staff knowledge.

Inspectors were not assured that the staff team or the person in charge had recognised or reported all safeguarding concerns. From review of incident and accident records, some incidents had not been identified as safeguarding concerns and had subsequently not been reported to the relevant authorities in line with national policy. This also meant that there were no safeguarding plans in place following serious incidents.

The inspectors reviewed the documentation available in relation to the most recent admission to the centre and found a full assessment of needs had not been completed, as a result the resident was not adequately protected with the required supports in place when they moved in. For example, the resident had mobility difficulties and was assigned an upstairs bedroom, the shower and toileting facilities available to the resident posed a falls risk as they they were not in line with the resident's requirements.

The provider had not completed compatibility assessments prior to the new admission coming into the centre or following peer to peer safeguarding concerns in the centre. On arrival to the centre the inspectors met with a resident who clearly stated they did not like one of the other residents in the house.

On review of safeguarding plans the information differed from current practice, for example, one safeguarding plan outlined that a resident no longer went on overnight home visits and was at risk of potential safeguarding incidents should they stay overnight, however, their risk assessment and daily notes stated they were going on regular overnight visits without appropriate safeguards in place.

There had been a number of negative peer-to-peer incidents in the centre and inspectors were informed this risk was managed well through supervision of the residents although no risk assessment or safeguarding plan was available to guide staff in how and when supervision was required.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 8: Protection	Not compliant

Compliance Plan for The Court - Kingsriver OSV-0007915

Inspection ID: MON-0050418

Date of inspection: 25/05/2026

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	Not Compliant

Outline how you are going to come into compliance with Regulation 15: Staffing:
• The registered provider has completed a comprehensive review of staffing arrangements within the designated Centre to ensure that residents' assessed staffing requirements are consistently met.
• A Local Operating Procedure – Rostering, Workforce Planning and Shift Approval has been implemented to strengthen roster planning, workforce management, contingency arrangements and provider oversight. The procedure is supported by Appendix A – Site-Specific Rostering Requirements, which sets out the staffing requirements for each designated Centre. These requirements must be reflected in both the planned and actual roster and are verified daily by the Person in Charge/Deputy Manager.
• For The Court, the Site-Specific Rostering Requirements identify the staffing arrangements for both locations, including the gender-specific staffing arrangements required to ensure residents' assessed staffing requirements are consistently met.
• The Person in Charge prepares, reviews and publishes all planned rosters based on residents' current assessed staffing requirements, personal plans and risk assessments.
• Planned rosters are reviewed prior to publication to ensure that residents' specific staffing requirements, including identified gender-specific staffing requirements, are met.
• Daily verification of the actual roster is completed by the Person in Charge/Deputy Manager to confirm that staffing levels, skill mix and residents' assessed staffing requirements continue to be maintained throughout the roster period.
• Where any staffing variance arises, contingency and escalation arrangements are implemented immediately to ensure continuity of care and that residents' assessed staffing requirements continue to be met.
• Provider oversight has been strengthened through daily roster verification, monthly reconciliation of planned and actual rosters, monthly roster audits and ongoing governance oversight to ensure sustained compliance with Regulation 15.

Regulation 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
A Community Practitioner Programme led out by Innovation & Experience Manager commenced on 15 June 2026 to strengthen clinical governance, provide enhanced support to Persons in Charge and frontline teams, improve quality monitoring and promote consistent implementation of best practice across services.
• Training Matrix was updated with final draft being sent to PIC by 17.07.2026 for oversight
• All staff are trained in Epilepsy Buccal will be trained by 10 July 2026.
• One staff, a Community Practitioner has trained as a First Aid Instructor, and will plan first aid trainings across the service. The staff in the designated will be trained by 31.07.2026
• Four people are now trained CPI Safety Techniques Instructors and have scheduled trainings across the service, all staff in the designated centre will be trained before 31.07.2026
• A dedicated training email inbox was created 07.07.2026 to centralise certification records and provide authorised personnel with shared access to update the training matrix.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
Enhanced Executive Management Team oversight has been introduced, supported by themed governance meetings focusing on key areas of regulatory compliance, including governance and management, safeguarding, risk management, medication management, staffing, restrictive practices and person-centred care.
• At local level, Quality and Safety meetings are held within each designated centre. The outcomes and actions from these meetings feed into the organisation's Quality and Safety Committee, which reports directly to the Board of Directors. This structure ensures that quality and safety matters are escalated appropriately and that the Board maintains oversight of regulatory compliance and service quality across all designated centres.
• A Senior Operations Manager has been appointed and will commence on 10 August 2026, providing additional operational leadership, oversight and support across all designated centres.
• A Quality Enhancement Plan has been introduced across all designated centres to strengthen provider assurance, monitor regulatory compliance, track improvement actions and provide evidence of sustained compliance through enhanced executive oversight.
• A standardised, colour-coded documentation and governance filing system has been

introduced into the designated centres to improve accessibility, consistency and oversight of regulatory documentation
• Centre-specific governance arrangements for The Court include the appointment of a full-time supernumerary Person in Charge, appointment of a full-time supernumerary Deputy Manager, increased provider monitoring visits, review of the centre risk register, review of resident care and support documentation, review of staffing arrangements and enhanced local action tracking.
• The Registered Provider is progressing an application to vary the registration of the centre to reduce its footprint, in order to reduce management span of control and further strengthen oversight; this application is due to be submitted to the Chief Inspector by 10 July 2026.
• A quality and compliance officer was appointed on 23.03.2026 to assess quality and compliance for the service.
• A health and wellbeing lead/RNID was appointed on 12.05.2026 to oversee personal development, health and well-being of people supported.
• Innovation & Communication Manager developed guidance and updated minute template on Team Meetings, same sent to Person in Charge on 26.05.2026.
• PIC will use new guidance and template at June team meetings and Quality & Compliance Officer will review quality and sign off same by 10.07.2026
• PIC will add schedule of team meetings to year end in team meeting folder and inform all staff by 12.06.2026
• Analysis and learning about incidents, accidents will be shared at monthly team meetings, will be reported to the quality and safety committee monthly who will report to the Board subcommittee on Quality and Safety on a quarterly basis.
• The Quality & Compliance Officer will complete six-monthly unannounced audit in the designated before the 25.07.2026
• The Quality & Compliance Officer developed a schedule on 29.06.2026 in regards to six-monthly and annual reviews to be completed on behalf of the provider.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• In relation to ventilation, the system at one location has been serviced and is operating within required parameters. As a highly energy-efficient A-rated property, the Provider has focused on operational management measures to maintain resident comfort during periods of elevated external temperatures. These measures include promoting hydration and providing mobile cooling units when required.
• Painting has been scheduled and will be completed by 14.08.2026
• New chair lift has been sourced and will be installed by 31.08.2026

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
• An external review of the organisation's Risk Management Policy and Framework has been commissioned to ensure the policy is robust, aligned with regulatory requirements and reflective of best practice. The revised Risk Management Policy and associated management training will be completed on or before 10 September 2026. The findings and recommendations from this review will be implemented across all designated centres.
• All managers completed risk management training on 26.05.2026
• A review of all centre risk assessments will be completed by 31.07.2026. All staff will be required to read and sign updated risk assessments by 31.08.2026.
• Risk assessments will be a standing item on each team meeting

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• An external fire safety review has been completed and the report has been received. The findings and recommendations from this review will inform the fire safety action plan for the designated centre. Implementation of fire safety actions will be monitored through the organisation's Health and Safety Committee and through provider-level governance arrangements.
• PEEP's were reviewed and signed off by PIC on 01 July 2026
• Fire evacuations were completed on 07 July 2026 including a night-time scenario

Regulation 29: Medicines and pharmaceutical services	Not Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
• An independent external review of the organisation's Medication Management Framework has been completed. A revised Medication Management Framework has been developed, with implementation commencing on 6 August 2026. A comprehensive training programme will be delivered to all relevant staff by 31 October 2026.
• A new pharmacy provider has been engaged to support medication management across the service. The pharmacy will complete monthly Kardex reviews and six-monthly

medication reviews for every resident. These arrangements will strengthen medication oversight, support safe prescribing and administration, and provide additional clinical assurance at centre and provider level.
• The revised Medication Management Framework includes guidance on the safe storage of medications during periods of elevated temperatures. This guidance addresses appropriate storage conditions, temperature monitoring, and practical measures to maintain medication efficacy and safety in line with manufacturer recommendations and best practice.
• All PRN protocol are being reviewed and updated by Health & Wellbeing Lead by 16.07.2026
• All staff are trained in Epilepsy Buccal, with final new staff completing their training on 10.07.2026

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
• The Registered Provider acknowledges the requirement to protect residents from abuse and to ensure safeguarding concerns are identified, reported, investigated and managed appropriately. Safeguarding arrangements have been reviewed, and staff will receive continued safeguarding guidance and training. Safeguarding concerns will be monitored through centre and provider-level governance arrangements.
• All members of the management team will complete Designated Officer training by 30 September 2026. A dedicated safeguarding training day for the management team will be scheduled to support this.
• The Registered Provider has requested that the CHO5 Safeguarding Team undertake a review of all safeguarding arrangements within the service and meet with the Provider to offer additional guidance and support in strengthening safeguarding practice.
• A full review of the new admission to the centre will be completed by 17.07.2026

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.	Not Compliant	Orange	07/07/2026
Regulation 15(4)	The person in charge shall ensure that there is a planned and actual staff rota, showing staff on duty during the day and night and that it is properly maintained.	Substantially Compliant	Yellow	07/07/2026
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training,	Not Compliant	Orange	31/07/2026

	as part of a continuous professional development programme.			
Regulation 17(1)(a)	The registered provider shall ensure the premises of the designated centre are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.	Not Compliant	Orange	31/08/2026
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Substantially Compliant	Yellow	31/08/2026
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Substantially Compliant	Yellow	14/08/2026
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Not Compliant	Orange	31/08/2026
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in	Not Compliant	Orange	31/07/2026

	accordance with the statement of purpose.			
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	10/08/2026
Regulation 23(1)(d)	The registered provider shall ensure that there is an annual review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards.	Substantially Compliant	Yellow	31/12/2026
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 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	Not Compliant	Orange	25/07/2026

	put a plan in place to address any concerns regarding the standard of care and support.			
Regulation 23(3)(a)	The registered provider shall ensure that effective arrangements are in place to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.	Substantially Compliant	Yellow	31/07/2026
Regulation 23(3)(b)	The registered provider shall ensure that effective arrangements are in place to facilitate staff to raise concerns about the quality and safety of the care and support provided to residents.	Not Compliant	Orange	31/07/2026
Regulation 26(1)(d)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: arrangements for the identification, recording and	Not Compliant	Orange	10/09/2026

	investigation of, and learning from, serious incidents or adverse events involving residents.			
Regulation 26(1)(e)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: arrangements to ensure that risk control measures are proportional to the risk identified, and that any adverse impact such measures might have on the resident's quality of life have been considered.	Not Compliant	Orange	10/09/2026
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Not Compliant	Orange	31/08/2026
Regulation 28(1)	The registered provider shall ensure that effective fire safety management systems are in place.	Not Compliant	Orange	07/07/2026
Regulation 28(2)(b)(iii)	The registered provider shall	Substantially Compliant	Yellow	31/07/2026

	make adequate arrangements for testing fire equipment.			
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	31/07/2026
Regulation 28(4)(b)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Not Compliant	Orange	07/07/2026
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.	Not Compliant	Orange	06/08/2026

Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	31/07/2026
Regulation 08(7)	The person in charge shall ensure that all staff receive appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse.	Not Compliant	Orange	30/09/2026