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:	Towlaght House
Name of provider:	Embrace Community Services Ltd
Address of centre:	Meath
Type of inspection:	Unannounced
Date of inspection:	04 August 2026
Centre ID:	OSV-0007996
Fieldwork ID:	MON-0050363

About the designated centre

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

Towlaght House can provide a full-time residential service for five adults who present with intellectual disabilities, autistic spectrum disorder, and or acquired brain injuries. The house is situated within walking distance of a village in Co. Meath. Residents can easily access local amenities. There are five individual bedrooms, one downstairs, wheelchair-friendly bedroom, and one wheelchair-accessible bathroom. On the first floor, there are four bedrooms, all of which have their own en-suite. Residents are supported on a 24-hour basis by team leaders and direct support workers..

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 4 August 2026	10:35hrs to 17:43hrs	Karena Butler	Lead
Tuesday 4 August 2026	10:35hrs to 17:43hrs	Sarah Mockler	Support

What residents told us and what inspectors observed

This unannounced inspection found that significant improvements were required in relation to keeping residents safe in the centre. Key regulations in relation to protection and risk management failed to meet the requirements of the regulations. This was impacting on the level of safe care available in the centre. In addition, staffing, training and overall governance and management required significant improvements.

Due to the level of risk, the inspectors issued an immediate action to the provider on the day of inspection. This is discussed further under Regulation 26: Risk Management.

The designated centre had capacity to accommodate five residents. There were no vacancies on the day of inspection.

During the inspection, the inspectors met the five residents living in this centre. Some residents used alternative communication methods and did not share their views directly with the inspectors. Instead, they were observed in their home for part of the day. Although some residents expressed that they were happy with aspects of care and support, such as choices offered and food and activities. Some residents expressed that they were not happy living in the centre. For example, two residents stated that one of their peers in the home could be very loud and that they did not like the noise.

Residents were observed moving freely around their homes, spending time in the kitchen, sitting room, and bedrooms.

On the day of this inspection, three residents went out to nearby towns as one resident wanted to get their phone fixed. Afterwards they went for lunch. Upon their return home they informed an inspector that they had a nice day. The fourth resident spent most of their day in their room and went out for a walk with a staff member in the afternoon. The fifth resident had music therapy and later went for a walk. In general, while some residents enjoyed outings, this was not always the case for everyone. Others spent long periods in the house or their bedroom with fewer opportunities for meaningful activity or social support.

The inspectors observed residents getting ready for the day, some residents leaving the centre, residents being supported with meals, snacks and drinks and residents relaxing in their bedroom. Some residents were observed to interact with each other and for the most part they seemed comfortable in each others presence.

In the afternoon the inspectors heard loud vocalisations, shouting and banging coming from a resident's bedroom on two separate occasions. Staff were heard to go and support the resident at this time. On one of these occasions the inspectors

heard another resident, who was downstairs, call their peer's name in a distressed manner when the loud noises were occurring.

The residents appeared comfortable in the presence of their supporting staff. For example, one resident was observed to reach out and hold a staff member's hand. However, the inspectors found that there was a lack of consistent staffing, which meant that residents were often supported by staff who were not as familiar with their specific communication styles or healthcare needs.

In addition to the person in charge, one inspector had the opportunity to speak with three of the five staff members on duty. The person in charge had recently joined the organisation within weeks of this inspection. While one staff member demonstrated that they were familiar with the residents' support needs and communication styles, another staff member required some improved knowledge. This was addressed under Regulation 16: Training and Development. Staff were observed to interact with residents in a relaxed and respectful manner. For example, a staff member was observed giving a fist bump to a resident.

One inspector spoke on the phone with two family representatives. Although there was positive feedback received, one family representative did express that they would prefer it if their family member had more regular staff company and if they were encouraged to leave their room more. They did express that the the staff team were 'kind', that they 'do their best' and that they 'try to meet their family member's needs 'as much as they can'. They said that they felt very welcome to visit the house.

The house was split over three floors and it was observed to be tidy and in a good state of repair. There was an accessible front and back garden. The inspectors completed a walk around of all parts of the home. On the walk around the inspectors noted that a number of residents locked their bedroom door. The residents opened the doors to let the inspectors into their room. Four residents had en suite bedrooms and one resident had access to a bathroom across from their bedroom. One resident like to accumulate lots of items and had these in a large but neatly kept pile in the middle of the room.

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

Overall, the findings of the inspection indicated that the governance and management systems within the centre were not effective in ensuring a safe service was provided at all times. There were significant gaps in oversight around the management of safeguarding and risk. Staffing arrangements within the centre did

not provide consistent care due to the level of agency staff employed. In addition, staffing numbers employed on a day-to-day basis were not always in line with the assessed needs of residents. This was impacting on the lived experience of residents within the centre.

While core staff were found to have access to training to carry out their roles, one necessary training was not undertaken, and refresher training was required for some staff in several courses. There was no evidence available to demonstrate whether agency staff had completed required training and improvements were required to staff knowledge to ensure that training could be effectively implemented in practice.

Regulation 15: Staffing

Overall, it was found that the staffing arrangements in place were not sufficient to meet the needs of the residents at all times. The inspectors found that there was an over reliance on agency staff in this centre and there were some occasions when some required shifts could not be filled.

At the time of inspection there were five whole time equivalent vacancies in the centre. It was confirmed that the provider was actively recruiting and four candidates had been identified to fill those vacancies. However, in the interim, there was a considerable reliance on agency staff to cover these positions. For example, over the course of four weeks, 38 shifts were covered by 15 different agency staff. Review of an additional week showed that a further five different agency staff were used, representing a total of 20 different agency staff were utilised over a five-week period. This put residents at increased risk of not receiving continuity of care and the provider was failing to provide a stable environment for the residents. For example, on review of behaviour support plans it indicated that unfamiliar staff were a setting event in relation to a behaviour of concern that put a resident at significant risk. There had been four occurrences of this behaviour in the preceding months that had occurred.

An inspector requested to review rosters from April to August 2026; however, nearly two months of rosters could not be located. Therefore, there were no up-to-date records readily available in relation to the staff that had worked in the centre. On the rosters that could be reviewed, the inspector found that over a four-week sample period, 12 shifts were left unfilled. On two of those days staffing levels dropped from five staff during the day to three staff. This demonstrated that required staffing levels were not in place in line with residents assessed needs.

Sustained attention to recruitment and staffing contingency plans was required to ensure that residents were supported by a consistent and familiar staff team.

On occasion, agency staff were recorded on the roster without their full names and on several occasions, it was recorded on the roster that agency staff filled vacant shifts without any name recorded for those who completed the shift. This meant

that the provider could not accurately verify who had worked in the centre on those dates.

Judgment: Not compliant

Regulation 16: Training and staff development

The inspectors found that core staff had access to various training courses to meet residents' assessed needs. However, one key training identified by the provider necessary to support a resident was not completed, despite this being identified by the provider as mandatory to safely support that resident. Refresher training was required for several training courses, and the provider could not produce evidence to confirm if agency staff employed in the centre had undertaken required training. Furthermore, an inspector identified gaps in staff knowledge as to supports residents may require.

One inspector reviewed the training oversight document for the core staff. The inspector requested records for the agency staff; however, they were not available in the centre. Therefore, the inspector could not be assured by the oversight of training in the centre and could not verify if agency staff had the required training which could put residents at risk of inconsistent or ineffective care practices.

The review demonstrated to the inspector that core staff members had received training key areas as well as additional training specific to residents' assessed needs, such as positive behavioural support. However, there was no evidence that staff members completed trauma-informed training as deemed a necessary control measure by the provider to effectively support a resident. The inspector found that the oversight document contained no record of completion for one staff member in relation to epilepsy management, which was necessary in supporting a resident.

The inspector also found that refresher training was required in several areas, for example:

- safeguarding vulnerable adults for one staff member
- diabetes awareness for one staff member
- first aid for one staff member
- fire safety for two staff members
- hand hygiene for one staff member
- manual handling online course for three staff members.

Additionally, while core staff had completed required training courses, an inspector found that in some cases this training was not always effectively embedded into practice. When spoken with, one staff member was unable to demonstrate sufficient knowledge in certain high-risk areas. For instance, the staff member was unclear on the timeframe for administration of emergency epilepsy medication or how to support individuals who may experience periods of hyperglycemia (high blood

sugar). These knowledge gaps, combined with the lack of training records for agency staff, demonstrated that arrangements to develop and supervise staff were not fully effective.

Furthermore, while supervision was due to occur six times a year, this was not occurring in line with the provider's guidance. Despite requests to review them, supervision records were not available on the day of this inspection. Therefore, the inspector could not determine if supervision was occurring or if it was meaningful for staff.

Judgment: Not compliant

Regulation 23: Governance and management

Taking into account the cumulative findings of this inspection, the governance and management arrangements were not effective in ensuring the service provided to the residents living in this centre were consistently safe, appropriate to their assessed needs or effectively monitored.

The person in charge had recently been appointed and had commenced their role only weeks prior to the inspection and assistant director of service commenced a few months prior. The inspection was facilitated by the person in charge and it was evident that they were committed to providing a good-quality service. However, there had been significant gaps in oversight and monitoring of the service which had resulted in a number of practices that were putting the residents at risk.

Improvement was required to ensure that internal monitoring systems comprehensively reviewed quality and safety risks, as not all the actions found on this inspection were identified by the provider and to ensure that they were carried out in accordance with the requirements of the regulations. For example, the safeguarding risks found on this inspection had not been identified though the provider's own audits and reviews.

A review of previous governance reports also showed that some actions were not completed by the time of this inspection, such as replacing the attic hatch with one that was fire resistant. The inspector found it was not always evident if all identified actions in audits had been addressed as those sections of the audits were not always consistently completed.

There was no evidence that the provider had carried out unannounced audits as required by the regulations, as they were not available for review. While there was an annual review completed that spanned from June 2024 to June 2025, it could not be determined if the most recent annual review had been completed, as on the day of this inspection it was not available on-site and management were unsure whether it had been completed. Additionally, from a review of 2026 audits, one inspector

found that five local monthly audits had not taken place as prescribed by the provider.

The inspector also found that some monthly audits were being completed under the previous manager's log-in which meant that there was no clear accountability for who had actually conducted those checks.

A review of team meetings from January 2026 revealed that two sets of minutes referred to a different centre and to residents who lived in a service that was previously managed by the former person in charge. Despite this, staff had signed these records to indicate they had read and understood them, and the error had not been identified by the provider's oversight processes. This meant that staff were signing off on information that was irrelevant to the residents they were currently supporting, highlighting a failure in the oversight of team communications.

Another inspector found that a resident's information contained conflicting information regarding their swallow plan. Therefore, the inspector was not assured that information governance arrangements were robust. Improvements were needed so that documents provided accurate information to ensure residents were provided with consistent and applicable care supports particularly when there was a high usage of temporary staff working in the centre.

Furthermore, while the provider submitted most notifications as required, they had failed to notify the Chief Inspector of Social Services (the Chief Inspector) of an incident that required notification within three days and when a person participating in management (PPIM) ended their employment with the provider. The PPIM ceased their role in August 2025 and the provider was due to notify the Chief Inspector within a 28-day time frame of the PPIM ceasing their employment. Therefore, improvement was required so that the systems in place would always ensure the provider would fulfil their regulatory responsibilities.

Judgment: Not compliant

Quality and safety

The quality and safety of care did not meet the requirements of the regulations and was not effective in ensuring that the residents living in this service were in receipt of a safe service at all times. Improvements were required to protection, risk management, and some improvements were required to aspects of fire precautions.

On review of the systems in place around safeguarding and risk management there a number of areas that required improvement. In relation to safeguarding, the identification, investigation and reporting of safeguarding incidents was not in line with national policy. Additionally a number of improvements in risk management

were required to ensure that incidents were recorded, trending and appropriate learning and control measures implemented.

The inspectors found that while some residents were afforded opportunities to engage in the community, two residents had limited opportunities.

While the provider had ensured there were many appropriate fire precautions in place, some areas for improvements were identified. For example, it was not evident if residents had been supported to practice an evacuation drill using alternative evacuation routes.

Regulation 13: General welfare and development

The provider failed to ensure that all residents were supported to participate in activities in accordance with their interests and capacities. While three residents had regular access to opportunities for leisure and recreation, based on the information presented to the inspectors it was not evident for the other two residents if they had regular access to opportunities for leisure and recreation.

From a review of two residents' daily record logs for one month, from speaking with staff members on duty, and a family representative, the inspectors found there was limited evidence to suggest that two residents had regular access to the community or engaged in activities of their interest. In the case of one resident, while it was their choice to spend long periods of time in their room, it was not always evident what options were being offered to the resident to encourage them from their room or whether staff spent much quality time with them. The lack of proactive engagement meant that those residents were at risk of social or community isolation, which could potentially impact their overall well-being.

Judgment: Not compliant

Regulation 26: Risk management procedures

Overall, the inspectors were not assured that adequate risk management systems were in place in the centre or that the residents were kept safe at all times.

As previously stated, under this regulation the provider was required to address an immediate risk that was identified on the day on the inspection. The manner in which the provider responded to the risk did provide assurance that the risk was adequately addressed. The immediate action was provided in relation to residents locking their bedroom doors. The inspectors observed three residents opened their bedroom doors on the day of inspection with keys. On review of daily notes for one of these residents over a two-week period it had stated the resident was inside their room with the door locked. This included at night when the resident was sleeping.

One inspector asked the staff in relation to the system in place to open the residents' doors in an event of an emergency. The staff could only locate the keys to some residents' bedrooms. The majority of keys were located on a bunch of keys and were not easily identifiable or accessible. Some other residents' keys were due stored in a separate location; however, on the day of this inspection they weren't present in the centre when an inspector requested to see them. There was no system in place for staff to access some residents' rooms, once locked, if they required to do so. The inspectors issued an immediate action whereby the provider had to have a system in place to access all residents' bedrooms. This significant risk had not been identified by the provider despite there being a significant incidents in relation to this. For example, on review of an incident in December 2025, one resident was distressed in their room and threatened self-harm. The resident refused access to staff to the room and the door was locked. The resident allowed staff access to the room after 20 minutes whereby it was observed that they had gained access to a metal pipe. Despite this incident occurring, there were limited effective actions in place in relation to access to residents' bedrooms at all times.

In addition, on review of incidents from January 2026, an inspector read five incidents involving two separate residents whereby they had left the centre without the direct support of staff. Although for four of the incidents the residents were being observed by staff and encouraged to return to the centre, on one occasion a resident went out of staff sight for a period of time. The inspector reviewed the risk assessments in place for both residents. One resident had a control measure of ensuring the front gate was locked. This was not in place on the day of inspection, as when the inspectors entered the centre the gate was open. Discussions with the management team indicated that the gate was usually left open and they were considering reducing this restrictive practice. However, the lack of incident trending in relation to the above incidents meant that that the effectiveness of control measures was not considered accordingly. This was putting residents at risk.

Other control measures listed in risk assessments, such as having spare keys and specific training were not in place on the day of inspection.

The inspectors were also not assured that all incidents were being recorded in line with good risk management processes and the requirements of the provider's policy. As described under Regulation 8: Protection, one resident engaged in loud vocalisations and banging objects when they were distressed. These incidents were not being recorded on incident forms. Therefore, there was no system in place to track, trend and identify learning from these incidents and inform relevant control measures to mitigate this risk.

Judgment: Not compliant

Regulation 28: Fire precautions

There were systems in place for fire safety management, including a fire alarm system and emergency lighting. However, some improvements were required related to fire evacuation, firefighting equipment, and information provided to staff to ensure residents could be appropriately supported during an emergency.

While there was firefighting equipment available in the centre and it was serviced as required, there was none available on the top floor. This meant that staff may not have timely access to firefighting equipment in the case on an emergency on that floor.

There were personal emergency evacuation plans (PEEP) in place for residents which outlined the support they required to safely evacuate in the event of a fire. However, they were limited in the information provided, found to lack certain applicable information, and contained some conflicting information. For example, one resident was prescribed medication for sleeping yet this was not referred to in their PEEP. One resident's PEEP said they required support from one staff member to evacuate; however, their associated guidance document for their fire evacuation aid stated two staff members were required. While this information was known to a staff member spoken with, due to the high usage of agency staffing in the centre, inaccurate guidance posed a risk to the resident's safe evacuation if required.

A review of five fire practice drill records confirmed that fire drills were taking place periodically. The review indicated that staff could safely evacuate the residents in the event of an emergency, including during hours of darkness. However, the inspector noted the records of the fire drills did not confirm whether alternative evacuation routes had been tested to ensure the residents could safely exit the building if a primary route was blocked.

External servicing was taking place as required for the fire alarm emergency lighting and containment systems. However, an inspector found that one emergency light had failed a specific test on two separate quarterly testing. There was no evidence to suggest that it was repaired and this information was not known to management. Therefore, more robust oversight was required to ensure that identified issues are addressed in a timely manner and don't pose a risk to safe evacuation for residents in the case of an emergency.

Overall, while there were many appropriate fire safety precaution systems in place, further improvements were required to different aspects of the systems to ensure they were robust and would appropriately ensure the safety of the residents.

Judgment: Substantially compliant

Regulation 8: Protection

Overall, the inspection findings indicated that safeguarding measures in the centre were not proving effective and a number of improvements were required to ensure that residents were safe at all times.

As previously stated, the inspectors heard a resident become upset and heard loud vocalisations and banging coming from the resident's bedroom on two occasions across the inspection day. During one of these incidents the inspectors heard the resident's peer call their name and their peer sounded distressed at hearing the noise. Some residents expressed to one inspector that they did not like the noise in the home when their peer became upset. However, the provider had failed to record any of these incidents or review these incidents from a safeguarding perspective. Therefore there had been no investigation, reporting or action taken in relation to these incidents in line with national policy and the requirements of regulation. From a review of residents' daily notes there had been four occasions were loud shouting and banging that occurred in July 2026, with no corresponding incident reports, or review from a safeguarding perspective.

In addition, on review of the incidents, there had been a serious incident in the home whereby a staff member had to leave the centre with another resident to ensure their safety. Again this incident had not been reviewed from a safeguarding perspective, it had not been investigated, reported or any measures taken as required. Overall, this was very poor practice in relation to identifying safeguarding concerns within the centre.

Additionally, an inspector asked to review the investigation and corresponding documentation in relation to a safeguarding concern that had been reported into the Chief Inspector in March 2026. In the centre there was no available documentary evidence that it had been reported into the National Safeguarding Office, there was no evidence available in the centre that it had been investigated and there was no available documentary evidence to demonstrate that safeguarding plans where in place.

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 13: General welfare and development	Not compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 8: Protection	Not compliant

Compliance Plan for Towlaght House OSV-0007996

Inspection ID: MON-0050363

Date of inspection: 4/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 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • The Person in Charge (PIC) will work with the approved agency provider(s) to establish a consistent cohort of agency staff for the designated centre. This will promote continuity of care and reduce the number of unfamiliar staff supporting residents during the recruitment and onboarding period. Due Date: 11th August 2026 - Completed • Recruitment and onboarding activity will continue against all approved vacancies, with the objective of filling vacancies in line with the staffing arrangements set out in the Statement of Purpose and reducing reliance on agency staffing and unfilled rostered shifts. – 2.5 FTE currently onboarding. Due Date: 15th October 2026 • All staff rosters will be maintained at the designated centre and will clearly identify the full name of each staff member, including agency staff, working within the centre. Due Date: 11th August 2026 - Completed • All staff rosters, including agency staff rosters, will be always retained on-site and/or on the centre's electronic system and will be readily available for review by inspectors. Any gap in roster availability will be immediately investigated and addressed by the PIC. Due Date: 11th August 2026 - Completed • The PIC and Assistant Director of Services (ADOS) will review and update the Centre Staffing Contingency Plan to clearly set out the arrangements for responding to staffing shortages and unplanned absences. Identified staffing risks and associated controls will be reflected within the Centre Specific Risk Register and monitored through the centre's governance arrangements. Due Date: 11th August 2026 - Completed • A standardised agency induction checklist will be implemented and maintained within the centre's SharePoint and local records. Agency staff will complete the required centre-specific induction prior to working independently within the designated centre. This will include familiarisation with residents' care and support plans, relevant risk assessments, safeguarding arrangements and emergency procedures. Due Date: 11th August 2026 - Completed	

• Agency utilisation, staffing vacancies, unfilled shifts and recruitment progress will be reviewed through monthly local governance meetings. Any identified staffing risks or concerns regarding the centre's ability to meet residents' assessed needs will be escalated through the organisational governance framework for appropriate action and oversight.
Due Date: 11th August 2026 - Completed
• The ADOS will independently verify completion and implementation of the above actions, including review of supporting evidence at centre level. The ADOS will confirm that the staffing arrangements, contingency planning, agency induction records and governance oversight are operating as described and will escalate any outstanding actions through the organisational governance framework.
Due Date: 31st August 2026 - Completed on-going

Regulation 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
• Education, coaching, competency-based assessment and on-the-floor mentoring will be provided to core Team Members to ensure they are familiar with and can appropriately implement each resident's care plans, risk assessments, Positive Behaviour Support Plans, safeguarding arrangements and other resident-specific protocols. Where gaps in knowledge or competency are identified, additional training, coaching and mentoring will be provided, followed by reassessment where appropriate.

Due Date: 31st August 2026 - completed
• The Person in Charge (PIC)/ Community Nurse will complete competency assessments in epilepsy management and the administration of PRN medication with all relevant Team Members in the designated centre, in accordance with residents' individual protocols. Where a Team Member does not demonstrate the required level of competency, individual mentoring and support will be provided and competency reassessed before the Team Member undertakes the relevant activity independently.

Due Date: 15th September 2026
• Management will undertake practice observations, spot checks and supervision sessions to provide assurance that residents' care plans, risk assessments, behaviour support plans and associated protocols are understood and consistently implemented in practice. Where gaps are identified, appropriate coaching, mentoring or additional training will be provided and the required improvement followed up.

Due Date: 11th August 2026 Implemented on-going
• All required staff supervision records will be maintained within the designated centre and made available for review. The PIC will review the current supervision schedule and

ensure that any outstanding supervision is identified and completed.

Due Date: 11th August 2026 - Completed
• The Assistant Director of Services (ADOS), in conjunction with the Director of Operations, will review training assurance arrangements with the approved agency provider to ensure that agency staff assigned to the centre have completed the mandatory and resident-specific training required under the agreed Service Level Agreement. Any identified gaps or non-compliance will be formally addressed with the agency provider.

Due Date: 31st August 2026 – Ongoing
• The PIC will maintain oversight of the centre's training matrix, competency records and identified training gaps, with training compliance and outstanding actions reviewed through the centre's governance arrangements. Any training or competency deficit that may impact the safe delivery of care will be escalated to the ADOS.

Due Date: 31st August 2026 Implemented and Ongoing
• The PIC will ensure that all training gaps identified during the inspection are addressed, including outstanding or refresher training in trauma-informed care, safeguarding vulnerable adults, diabetes awareness, first aid, fire safety, hand hygiene and manual handling. Completion will be recorded on the centre training matrix, and any outstanding training will be tracked to completion.
Due Date: 31st August 2026

• The ADOS will verify the completion and effective implementation of the above actions through review of the training matrix, competency assessments, supervision records, agency training assurance and a sample of supporting evidence. The ADOS will also seek assurance that learning is being translated into practice through centre-level oversight and will escalate any outstanding actions through the organisational governance framework.
•
Due Date: 31st August 2026 - Completed and ongoing

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
• The Person in Charge (PIC) updated the medication protocols, care plans and associated documentation identified during the inspection to ensure that records accurately reflect residents' assessed needs and prescribed healthcare arrangements. These actions were completed on the day of inspection.

Due Date: 11th August 2026 - Completed
• The Assistant Director of Services (ADOS) will complete a review of resident documentation within the designated centre to provide assurance that medication protocols, emergency healthcare documentation, care plans and associated records are current, complete and reflective of residents' assessed needs. Any gaps identified will be assigned for corrective action and tracked to completion.
Due Date: 11th August 2026 - Completed

• The ADOS will ensure that all outstanding Governance Audits and governance meeting records are completed, signed and appropriately retained within the designated centre. Going forward, governance meeting minutes will be signed and retained following each meeting, with completion monitored through the centre's governance arrangements and Provider-Led Audits.

Due Date: 31st August 2026 -Completed
• The ADOS will provide on-the-floor mentoring and support to the PIC and Team Leaders to strengthen local governance arrangements, including the identification and escalation of documentation gaps relating to medication protocols, emergency healthcare documentation, care planning and other resident-specific records.

Due Date: 31st August 2026 – Ongoing
• The PIC will ensure that actions arising from local governance reviews, audits and identified documentation gaps are clearly recorded, assigned to a responsible person and tracked through to completion. Outstanding or recurring issues will be escalated to the ADOS through the established governance arrangements.

Due Date: 11th August 2026 - Ongoing
• The ADOS will complete a review of the centre governance and audit schedule to identify any outstanding monthly audits, unannounced provider visits and annual reviews. Any outstanding governance activity will be completed and a forward schedule maintained to ensure required reviews are completed within prescribed timeframes and are available within the centre.
Due Date: 31st August 2026 - Completed and ongoing
• The previously identified action to replace the attic hatch with a fire-resistant hatch (see Regulation 28: Fire precautions, where this work is confirmed complete) is formally closed out. The ADOS will confirm that this and all other previously identified but uncompleted audit actions are verified as closed through the centre's governance and audit tracking system, so that repeat non-completion of identified actions does not recur.

Due Date: 30th August 2026 - Completed
• All resident documentation, including care plans, swallow plans and other associated clinical guidance documents, will be reviewed to ensure information is accurate, current and consistent across all associated records, with any conflicting information corrected.

Due Date: 11th August 2026- Completed
• Governance and audit systems will be reviewed to ensure that records accurately identify the individual completing each audit and that governance records and team meeting minutes relate specifically to Towlaght House and its residents. Access arrangements will be reviewed to ensure former employees' system access cannot be

used to complete or record governance activity.

Due Date: 11th August 2026 Completed

• The PIC and ADOS will review the centre's regulatory notification requirements and associated tracking arrangements to ensure that all required notifications are submitted to the Chief Inspector within the prescribed statutory timeframes. The notification omissions identified during the inspection will be reviewed and addressed.

Due Date: 11th August 2026 Completed

• The ADOS will verify completion and effective implementation of the above actions, including a sample review of resident documentation, governance audit records, governance meeting minutes and evidence of completed corrective actions. Any outstanding or recurring governance concerns will be escalated through the organisational governance framework.

Due Date: 31st August 2026 - Completed and ongoing

• The Registered Provider is currently recruiting a senior governance role to provide additional executive-level oversight and assurance to the CEO. This role will strengthen the organisational governance framework through enhanced oversight of regulatory compliance, quality and safety, risk management and the implementation and verification of compliance actions across designated centres.

Due date : 30th October 2026

Regulation 13: General welfare and development	Not Compliant

Outline how you are going to come into compliance with Regulation 13: General welfare and development:
• Education, coaching, competency-based assessment and on-the-floor mentoring will be provided to core Team Members to ensure they are familiar with each resident's daily and weekly activity planner, understand how to support meaningful engagement and accurately document activities offered, participation and refusals. Where gaps in knowledge or practice are identified, additional coaching, mentoring or training will be provided.

Due Date: 30th August 2026 – Implemented and Ongoing

• The Person in Charge (PIC) will ensure that each resident's daily and weekly planner reflects their individual preferences, interests, assessed needs and opportunities for

meaningful social and community participation. Planners will be reviewed and updated where required to ensure activities remain appropriate and person centred.

Due Date: 11th August 2026 – Implemented and Ongoing

• Where a resident declines a planned activity, this will be appropriately recorded. Patterns of repeated refusal or reduced engagement will be reviewed by the PIC to understand any potential barriers to participation and to identify alternative activities or supports where appropriate in conjunction with the behavioral specialist

Due Date: 11th August 2026 – Implemented and Ongoing

• The Assistant Director of Services (ADOS), in conjunction with the PIC, will review a sample of daily and weekly planners and associated activity records through the monthly governance process to provide assurance that residents are being offered appropriate opportunities for meaningful engagement and that any identified risk of social or community isolation is being appropriately addressed.

Due Date: 11th August 2026 – Implemented and Ongoing

• The ADOS will verify implementation of the above actions through review of supporting records and evidence of residents' participation and engagement. Any identified gaps or recurring concerns will be assigned for corrective action and monitored through the centre's governance arrangements.

Due Date: 31st August 2026 - Completed and ongoing

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
• The Person in Charge (PIC) will complete a comprehensive review of the Centre Specific Risk Register and all resident-specific risk assessments to ensure that identified risks are current, appropriately assessed and supported by effective control measures. Any gaps identified will be addressed and the relevant risk assessments updated accordingly.

Due Date: 30th August 2026 – Completed

• As part of this review, the PIC will review all restrictive practices in use within the designated centre to ensure that they are appropriately identified, documented and

reflective of residents' current assessed needs. Any identified issues will be addressed through the appropriate governance arrangements.

Due Date: 30th August 2026 – Completed

• In response to the immediate action issued by inspectors on the day of inspection, a system was put in place immediately to ensure staff have access to all residents' bedrooms in an emergency, including clearly labelled and accessible keys for every resident.

Due Date: 4th of August 2026: Completed (day of inspection).

• The locking arrangements within the centre will be formally reviewed on an ongoing basis to ensure residents have appropriate access to lock and unlock their own doors, with any necessary locks changed, while staff always retain appropriate emergency access.

Due Date: 11th August 2026 – Completed

• All incidents, including behavioural incidents involving loud vocalisations or banging, will be recorded on the centre's incident management system in line with the provider's policy. Staff will be supported to correctly identify and record such incidents as part of the safeguarding competency assessments described under Regulation 8: Protection.

Due Date: 5th August 2026 – Completed and ongoing

• The PIC will complete a retrospective review of incidents within the centre to ensure that relevant incidents have been appropriately recorded, assessed and reflected within resident-specific risk assessments. Incident trends will be reviewed to identify recurring risks, learning and any required changes to control measures.

Due Date: 15th September 2026

• The PIC will verify that control measures documented within resident-specific risk assessments are implemented in practice, including controls relating to residents leaving the centre, emergency access to bedrooms, availability of spare keys and identified staff training. Where a control measure is no longer appropriate, the risk assessment will be formally reviewed and updated and any restrictive practice considered through the appropriate governance process.

Due Date: 30th August 2026- Completed
• The Assistant Director of Services (ADOS) will verify completion of the risk and restrictive-practice review, including a sample review of the Centre Specific Risk Register, resident-specific risk assessments and associated control measures. Any outstanding actions or areas requiring further improvement will be tracked through the centre's governance arrangements.

Due Date: 30th August 2026 – Implemented and ongoing

The Registered Provider is currently recruiting a senior governance role to provide additional executive-level oversight and assurance to the CEO. This role will strengthen the organisational governance framework through enhanced oversight of regulatory compliance, quality and safety, risk management and the implementation and verification of compliance actions across designated centres.

Due Date: 30th October 2026

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• A fire evacuation drill will be completed using minimum staffing levels, including evacuation of residents via the rear exit of the building. The outcome of the drill will be documented and reviewed by the Person in Charge (PIC), and any learning or required improvements identified will be actioned.

Due Date: 11th August 2026 – Completed

• The identified fireproofing works attic space have been completed by the appointed contractor. (Fireproof hatch)

Due Date: 30th August 2026- Completed

• All residents' Personal Emergency Evacuation Plans (PEEPs) will be reviewed and updated to ensure that they provide clear, resident-specific guidance on the supports required to safely evacuate each resident in the event of a fire. The updated PEEPs will be made available to staff and reflected in fire evacuation arrangements.

Due Date: 11th August 2026- Completed

• A completion report and relevant certification for the fire-safety works will be obtained from the appointed contractor and retained within the centre's fire-safety records, providing documented assurance that the identified works have been completed and appropriately certified.

Due Date: 30th August 2026- Completed

• Appropriate fire extinguishers will be installed on the third floor of the centre to ensure that suitable firefighting equipment is readily accessible in the event of a fire emergency.

Due Date: 30th August 2026- Completed

• Following completion of the above actions, the PIC will review the centre's fire-safety

arrangements to ensure that the updated PEEPs, evacuation procedures, firefighting equipment and certification relating to the completed works are appropriately reflected within the centre's fire-safety documentation.

Due Date: 30th August 2026- Completed

• The emergency light identified as having failed previous quarterly testing will be inspected and repaired or replaced as required, with evidence of completion retained within the centre's fire-safety records. The PIC will review current fire-safety servicing reports to ensure that any outstanding defects or remedial actions are identified, assigned and tracked to completion.

Due Date: 11th August 2026- Completed

• The Assistant Director of Services (ADOS) will verify completion of the actions arising from the inspection, including review of the fire drill record, updated PEEPs, evidence of installation of the additional firefighting equipment and certification/completion documentation for the fire-safety works. Any outstanding action will be escalated and tracked through the organisational governance framework until completed.

Due Date: 30th August 2026- Completed and Ongoing

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
• The Person in Charge (PIC) will review all individual Health and Personal Care Plans to ensure that they contain clear and relevant practical guidance for staff, reflect each resident's individual needs and preferences, and are consistent with associated care documentation and organisational policy. Any gaps or inconsistencies identified will be corrected.

Due Date: 30th August 2026- Ongoing

• The PIC will complete a review of all current safeguarding plans within the designated centre to ensure that they are up to date, appropriately documented and readily accessible to staff responsible for their implementation. Any actions arising from the review will be addressed and tracked to completion.

Due Date: 30th August 2026- Completed

• The PIC will complete safeguarding competency assessments with all relevant Team Members within the designated centre to provide assurance that staff understand their safeguarding responsibilities, the safeguarding arrangements relevant to residents and

the actions required where a safeguarding concern arises. Where a Team Member does not demonstrate the required level of competency, individual mentoring and support will be provided, followed by reassessment.

Due Date: 30th August 2026- Ongoing

• Safeguarding and associated care-plan requirements will continue to be reinforced through staff supervision, team meetings and on-the-floor mentoring, with any identified gaps in knowledge or practice addressed promptly by the PIC.

Due Date: 30th August 2026- Ongoing

• The PIC, supported by the ADOS, will complete a retrospective review of incidents and relevant daily records within the designated centre to identify any incidents that may meet the threshold for safeguarding review. Any safeguarding concern identified will be managed, investigated, reported and supported by an appropriate safeguarding plan in accordance with national safeguarding policy and organisational procedures.

Due date 15th September 2026

• The safeguarding concern notified to the Chief Inspector in March 2026 will specifically be reviewed and, where not already completed, will be formally reported to the National Safeguarding Office, fully investigated, and supported by a documented safeguarding plan in accordance with national safeguarding policy. This was investigated and appropriate regularity process was followed. Completed April 2026

Due Date: 5th of August 2026- Completed

• The Assistant Director of Services (ADOS) will verify completion and implementation of the above actions through a sample review of Health and Personal Care Plans, safeguarding plans and completed competency assessments. The ADOS will provide assurance that identified actions have been completed and that staff have access to the information required to safely support residents. Any outstanding or recurring concerns will be escalated through the organisational governance framework.

Due Date: 30th of August 2026- Completed and Ongoing

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 13(2)(b)	The registered provider shall provide the following for residents; opportunities to participate in activities in accordance with their interests, capacities and developmental needs.	Not Compliant	Orange	31/Aug/2026
Regulation 13(2)(c)	The registered provider shall provide the following for residents; supports to develop and maintain personal relationships and links with the wider community in accordance with their wishes.	Not Compliant	Orange	31/Aug/2026
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the	Not Compliant	Orange	15/Oct/2026

	number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.			
Regulation 15(3)	The registered provider shall ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.	Not Compliant	Orange	15/Oct/2026
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Not Compliant	Orange	15/Sep/2026
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	15/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	Not Compliant	Orange	31/Aug/2026

	and effectively monitored.			
Regulation 23(1)(f)	The registered provider shall ensure that a copy of the review referred to in subparagraph (d) is made available to residents and, if requested, to the chief inspector.	Not Compliant	Orange	31/Aug/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	15/Sep/2026
Regulation 28(2)(c)	The registered provider shall provide adequate means of escape, including emergency lighting.	Substantially Compliant	Yellow	15/Sep/2026
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	15/Sep/2026
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre	Substantially Compliant	Yellow	30/Aug/2026

	and bringing them to safe locations.			
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	15/Sep/2026
Regulation 08(3)	The person in charge shall initiate and put in place an Investigation in relation to any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.	Not Compliant	Orange	15/Sep/2026