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:	An Grainan
Name of provider:	Avista CLG
Address of centre:	Dublin 15
Type of inspection:	Unannounced
Date of inspection:	05 August 2026
Centre ID:	OSV-0008100
Fieldwork ID:	MON-0051280

About the designated centre

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

In An Grainan, residential care and support is provided on a 24 hour basis for up to 17 residents over the age of 18 with an intellectual disability. The centre consists of three purpose built bungalows on a campus in an outer suburb of Dublin. Each house has six single bedrooms and suitable private and communal space to meet the needs of up to six residents. Residents are supported by a person in charge, clinical nurse managers, care staff and household staff. There are good public transport links and local access to restaurants, shops, cinema, churches and libraries.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	15

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
Wednesday 5 August 2026	09:00hrs to 18:00hrs	Brendan Kelly	Lead

What residents told us and what inspectors observed

This unannounced inspection occur to monitor the provider's ongoing compliance with The Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013. Overall, the inspection showed that while residents are happy and safe in their home, the provider's oversight and monitoring systems required improvement. Actions were identified in this inspection in regard to staffing, governance and management, premises, care plans and, risk management.

The designated centre comprises three bungalows in a campus based setting operated by the provider in Co. Dublin. The designated centre is currently registered for 17 residents and on the day of this inspection the provider had two resident vacancies. The provider has also submitted an application to vary the number of residents registered in the centre. The application will reduce the registered bed numbers from 17 to 16.

Each bungalow that made up the designated centre was similar in layout. Two of the bungalows consisted of six bedrooms, fully fitted kitchens, dining room, sitting room, accessible bathrooms, family room, sluice and laundry rooms and and area for staff. One bungalow consisted of four resident bedrooms as well as the amenities listed above. This bungalow also had a separate apartment that had one resident bedroom, a wet room for showering, sitting room and kitchen dining space. At the time of this inspection this stand alone apartment was unoccupied. The inspector observed that each resident bedroom was decorated individually to residents' liking and contained personal effects such as family photographs.

On the day of this inspection the inspector met with and spoke to the person in charge, two members of the provider's senior management team, residents in each of the bungalows and members of the staff team in each bungalow. The inspector also formed judgements on regulations through observation of interactions throughout the day of the inspection and through the review of key documentation regarding the centre.

On arrival at the centre, the inspector was met by a member of staff and the person in charge. The inspector completed a walk around of each bungalow. The inspector observed that each bungalow was warm, homely and had there was a friendly atmosphere throughout.

The inspector observed interactions between staff and residents in each centre while conducting a walk about. The inspector observed that residents in each centre were supported with morning routines in a caring, person-centred and kind manner. Some residents were having a variety of breakfasts in line with assessed eating and drinking plans. Other residents were having an extended lie in in line with their wishes and some were ready for the day. The inspector observed that each resident

appeared happy and comfortable in the presence of the staff and person in charge. The inspector observed that residents were coming and going from each centre throughout the day with staff. Residents went for walks, attended day services and went out for activities. The inspector also observed that residents in each centre all appeared comfortable in each others presence. The inspector observed residents moving freely around their homes as they wished.

The next two sections of this report will outline in greater detail the providers capacity and capability to oversee the day to day management of the centre and the impacts these systems had on on the quality and safety of the residents' lived experiences.

Capacity and capability

The governance and management systems in the centre required improvement to ensure effective oversight of the centre. The inspection showed that a number of key governance meetings minutes had been copied and pasted over several months meaning important issues were not being addressed adequately.

Actions identified from audits were also found not to be completed in line with agreed time lines.

Staffing levels in the centre were inconsistent, rosters were poorly maintained and the provider had not completed assessment of needs to inform staffing supports.

Staff working in the centre had been in receipt of both mandatory and centre specific training that meant they could meet the assessed needs of residents. Staff had also been in receipt of professional supervision from a suitably qualified and experienced person in charge.

The inspection showed that the provider had adequate systems in place for the receipt and management of complaints.

Regulation 15: Staffing

The provider was required to review the staffing arrangements in the centre to ensure residents' assessed needs could be met on a consistent basis. Rosters in the centre also required a review to ensure they were evidencing all shifts worked by permanent, relief and agency staff. In addition, the provider also had a reliance on relief and agency staff due to staffing vacancies which was impacting continuity of care.

On the day of this inspection, the inspector reviewed planned and actual rosters in the centre for the months of May, June and July 2026. The provider had three staffing vacancies at time of inspection at care assistant and nursing grade. The inspector observed a high use of agency staff each week with different agency staff being used. For example, in one week in May 2026, 12 shifts were covered by agency staff with 11 different staff. In a separate week in May 2026 23 shifts were covered by agency staff with 18 different names.

Rosters in the centre were poorly maintained, for example, the inspector observed a number of weeks where it appeared that there was only one nurse on duty at night. In reviewing these weeks with centre management it was apparent that the second nurse for these weeks was an agency nurse. However this was not recorded on the rosters. The inspector also observed evidence that not all relief and in particular agency staff were identified on the rosters. This meant that permanent staff and residents could not know who was working in the centre and the provider was not providing residents a continuity of care.

In reviewing the rosters the inspector observed that the provider reduced staffing numbers in each centre across the day. Centre management informed the inspector that the optimum number of staff across the three centres was nine staff until 18:00, six staff until 20:00, five staff until 23:00 and four staff until 08:00.

The inspector observed that in most weeks reviewed staffing numbers fell below the optimum identified by centre management. The inspector observed evidence that the reduction in staffing numbers across each day was inconsistent with no evidence given as to why this was occurring. For example, in each month reviewed staffing numbers reduced from a variety of different times in the day. Staffing reductions began from 13:00 and continued at 16:00, 17:00 and 18:00. However, there was no consistent pattern or rationale for the staffing reductions.

The inspector asked centre management if they had completed an assessment of need to assure that the provider continued to meet the assessed needs of the residents given the inconsistency of staffing supports. The inspector was informed that no such assessments had taken place.

In summary, rosters and staffing levels reviewed could not evidence a consistent staff team each day that provided a continuity of care to residents. The inspection showed that the provider had not assured themselves through comprehensive assessment of needs that staffing levels and the reduction of staffing levels was sufficient to meet the needs of residents. In addition, the provider was required to use a high number of agency and relief staff to ensure sufficient staff were in place.

Judgment: Not compliant

Regulation 16: Training and staff development

The provider had ensured that all staff working in the centre had been in receipt of the required mandatory and location specific training to meet the assessed needs of the residents.

The person in charge maintained a training matrix that evidenced the training completed by the staff team.On the day of this inspection, the inspector reviewed the training matrix and observed that the staff team had completed training in areas such as:

- safeguarding
- fire safety
- food safety
- human rights
- manual handling
- dementia

The inspector observed that where required, the person in charge had also scheduled refresher training for the staff team in areas such as:

- dementia
- food safety
- fire safety
- basic life saving

Staff working in the centre had been in receipt of professional supervision. The inspector reviewed a supervision schedule for 2026 that was maintained by the person in charge. The schedule ensured staff received supervision in line with the providers policy. The inspector also reviewed a sample of the supervision records from the centre.

Agenda items for supervision sessions included a general check in, personal development, core competencies, health and safety and, any specific issues staff wished to raise.

In summary, staff had been in receipt of the training they required to support residents in the centre. In addition the person in charge ensured that the staff team had been in receipt of professional supervision in line with the providers policy.

Judgment: Compliant

Regulation 23: Governance and management

While the provider had a clear governance structure in place, a number of oversight and monitoring systems required improvement to ensure effective oversight of the centre. Governance and team meetings were also found to be ineffective due to a lack of information sharing and relevant updates regarding residents' specific needs.

The centre was managed day-to-day by a suitably qualified and experienced person in charge. The person in charge reported to the person participating in management.

The provider had a number of monitoring and auditing systems that were used in the centre. These included an annual review, provider led unannounced audits held every six months, team meetings and, governance meetings between centre management. On the day of this inspection, the inspector reviewed a sample of the aforementioned systems and observed that improvement was required to ensure they were an accurate reflection of the centre.

For example, the inspector reviewed a sample of governance meetings from 2026. The inspector observed that meetings were not occurring on a regular basis with no schedule in place. The last meeting that occurred was in May 2026. In reviewing the meeting minutes from April and May 2026, the inspector observed that the discussions from each meeting had been copied and pasted from a previous meeting held in February 2026. This meant that the provider could not assure themselves that any new issues relating to the centre were being discussed as they arose. In addition the inspector noted that key items such as resident updates had not been discussed at any meeting meaning that staff were not being provided with specific changes to residents needs.

The inspector reviewed team meeting minutes from May and June 2026. The inspector observed that discussion topics for these meetings had also been copied and pasted. In addition, the inspector observed that not all staff had either attended meetings or had reviewed the minutes of the meetings. For example, in the May team meeting ten staff attended the meeting from a team of over 30 staff. This meant team meetings were not providing accurate up-to-date information for staff. The inspector also noted that similar to the governance meetings, key agenda items such as resident updates, safeguarding or risk management had been discussed.

As outlined in regulation 15: Staffing, the provider reduced staffing numbers across the day on centre rosters. However, no resident had an assessment of need completed by the provider to assure themselves that sufficient staffing supports remained in place to meet the assessed needs of residents. Risk assessments had also not been completed to evidence control measures in place to ensure residents were supported with assessed needs at times when staffing numbers had been reduced.

The inspector observed that provider led audits such as the annual review and unannounced audits every six months produced a variety of actions. However, the inspector observed that actions in relation to the updating and review of resident care plans and risk assessments had not been completed. This meant that staff were not always provided with detailed and accurate information in regard to meeting residents' assessed needs. For example, on the day of this inspection, the inspector reviewed one resident's care plan regarding the management of their diabetes and spoke to one staff member regarding the instruction to monitor the resident's glucose levels. The inspector observed that the guidance to staff regarding the frequency of glucose level checks was incorrect and that the staff

were unaware of how the glucose levels were checked and where this information was stored. The provider had failed to ensure updated information was available to staff despite identifying it as an action in their own audits and reviews.

In summary, the provider had a governance structure and a number of monitoring and auditing systems in place. However, the inspection showed that these systems were not being used in a manner that allowed for continuous improvement or for the identification and completion of actions in a timely manner.

Judgment: Not compliant

Regulation 34: Complaints procedure

The provider had ensured there were effective systems in place that allowed for residents and their support networks to make complaints if they so wished.

The provider had a complaints policy that guided local practice into the management of complaints. In addition to the complaints policy, the provider had a complaints log for each centre that was maintained by the person in charge.

On the day of this inspection, the inspector reviewed the complaints log from each centre and observed that where complaints had been made the person in charge resolved complaints in line with the providers policy.

The inspector also observed that in each premises the provider had ensured that easy read signage regarding advocacy services was available for residents. There were also easy reads available to residents identifying the complaints processes and complaints officers.

In summary, the inspection showed the provider had robust systems in place regarding complaints. Residents and their families were supported to make complaints should the need arise. Where complaints had been made, the inspection showed the person in charge managed complaints in line with the providers policy.

Judgment: Compliant

Quality and safety

The inspection showed that residents were happy in their home, however improvement was required with the provider's systems to ensure residents were safe.

The inspection showed that in particular risk management and care plans required significant improvement to ensure staff were provided with consistent and accurate information across all documentation in the centre.

Residents were living in centres that were homely and well maintained, however, improvements were identified as required in storage arrangements.

Effective systems were identified regarding the protection of residents from infection.

Regulation 17: Premises

The provider had ensured that the each premises that made up the designated centre was well decorated and maintained, however, the inspector observed a number of mobility aids for residents such as wheelchairs and commodes were stored inappropriately.

The inspector completed a walk around of each premises that made up the designated centre. The inspector observed that each centre was decorated individually to a high standard. Residents homes were bright and well maintained. The inspector observed that each resident had their own bedroom and that all bedrooms were decorated individually. The inspector also observed evidence of resident hobbies and personal effects such as family photographs.

In addition, the premises was laid out to meet the assessed needs of the residents. For example, where required residents had tracking hoists in their bedrooms. Bathrooms in the centre were also accessible to residents who required the use of mobility aids.

The inspector did however, observe a number of residents aids were stored inappropriately due to a lack of sufficient storage. For example, the inspector observed three commodes stored in a sluice room. This meant that the room could not be used appropriately. The inspector also observed resident wheelchairs stored in bathrooms and hallways in the centre.

Overall, each centre was decorated and maintained to a high standard. Each bungalow had been laid out to meet the assessed needs of residents. However, due to a lack of storage, some mobility aids had been stored inappropriately.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

While the provider had systems in place such as a risk management policy and risk registers in each centre, resident risk assessments required improvement. The inspector observed that not all risk assessments had effective control measures in place to guide staff practice in reducing the risks identified for residents. In addition, not all areas of risk in the centre had been adequately risk assessed.

On the day of this inspection, the inspector reviewed the risk registers and a sample of risk assessments in place for residents in each centre.

The inspector reviewed one resident's falls risk assessment, corresponding physiotherapy report and intimate care plan. The inspector observed that guidance available to staff in the three documents was conflicting and potentially placed the resident at a much greater risk of falls. The resident's risk assessment and physiotherapy report had been updated due to a recent change in the resident's mobility needs. The physiotherapy report and risk assessment clearly stated the importance of the resident having 2:1 supports for all transfers and elements of personal care. In further detail, the resident's physiotherapy report stated that elements of personal care were unsafe with single staff assistance. However, the resident's intimate care plan did not reflect these important changes nor did it provide any detail on how the resident should be supported with these tasks. The intimate care plan was a tick box check list and according to the intimate care plan the resident was independent in this task. In addition, the centre had a high volume of unfamiliar staff working in the centre, this meant that the resident was at an increased risk of falls due to the conflicting guidance and unfamiliar staff reading incorrect guidance.

The inspector also observed that the resident's physiotherapy report requested a follow up appointment in three weeks following an appointment in early March 2026 as well as regular physiotherapy sessions to continue. The resident did not have the follow up appointment until early May 2026. The inspector did not observe evidence that the resident had attended regular physiotherapy with the resident only attending one session. This meant that the resident is at increased risk of complications and falls due to the lack of physiotherapy review which was an important control measure to ensure that the risk of falls was minimised.

The inspector observed that not all areas of concern for residents were appropriately risk assessed. For example, the provider had a number of residents across all three bungalows that required 2:1 staff supports for transfers and toileting. The provider had not risk assessed how they managed the implementation of these supports for residents. This was of particular importance as the provider reduced staffing levels consistently across each day from early evening until morning in each centre. The inspector observed no clear guidance for staff in terms of the control measures required to ensure residents' safety at times when staffing numbers had been reduced.

Overall, the systems in place regarding risk management procedures were not effective in ensuring consistent and accurate information was available to staff. In

addition, the inspection showed that not all areas of risk had been appropriately assessed to evidence control measures required to ensure resident safety.

Judgment: Not compliant

Regulation 27: Protection against infection

The provider had adequate systems in place that ensured residents were protected from the risk of infection in their home.

On the day of this inspection, the inspector reviewed the systems in place, a sample of cleaning schedule records, completed a walk around of each centre and spoke to housekeeping staff to help form a judgement.

The provider had an infection prevention and control policy in place that guided staff practice in the centre. Housekeeping staff were employed by the provider who were responsible for each centre. The inspector spoke with housekeeping staff who told the inspector about their day-to-day duties. Staff showed a strong knowledge of their role and spoke about laundry, cleaning and reporting systems in the centre.

The inspector reviewed the cleaning checks completed by housekeeping staff for the month of July 2026. Checks were in place for areas such as bathrooms, kitchens and resident bedrooms. Checks had been signed off appropriately by housekeeping staff and centre management. In completing a walk around of each centre, the inspector observed that the centres were maintained to a high standard and that areas identified in cleaning checks had been completed.

The inspector also observed that all staff in the centre had completed appropriate infection prevention and control training.

In summary, the provider had ensured systems and checks were in place to ensure residents were protected from the risk of infection.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

While the provider had individual care plans in place for each resident in the centre, care plans required significant improvement to ensure they were subject to regular review and to ensure they were effectively meeting the needs of residents and guiding staff practice.

On the day of this inspection, the inspector reviewed a sample of resident care plans in areas such as:

- feeding eating and drinking
- choking
- diabetes
- kidney disease
- intimate care

In reviewing one residents care plan regarding diabetes the inspector observed that it had not been reviewed on a consistent basis. For example, the last three recorded reviews in the corresponding nursing action plan were from October 2025, December 2025 and May 2026. The inspector also observed that the guidance for staff was vague. For example, one instruction in the plan was to monitor the resident's glucose levels on a monthly basis. However, there was no guidance on how to monitor the levels, where to record the levels, what the recommended levels were and, what to do in the event levels are outside recommendations. This meant that the plan was not providing an effective management of the residents diagnosed health condition.

The inspector reviewed a second care plan regarding a resident's kidney disease. Again, the guidance in the care plan was inconsistent with day-to-day practices in the centre. For example, the plan outlined a GP recommendation to complete kidney function test every three to six months. The inspector observed that the last two kidney function tests for the resident had been completed in May 2025 and June 2026.The resident's plan also outlined the need for monitoring of fluid intake. The inspector observed that there was no guidance in terms of a rationale for the monitoring, what the recommended levels of intake needed to be and, what to look out for or how to respond if the fluid intake was not at the required level. It was unclear on how this plan was guiding staff practice.

The inspector spoke to staff regarding the practice of recording fluid intake levels. The staff member was unaware of the need to record the levels. When the inspector asked the staff member where they record the fluid intake, staff told the inspector they would be recorded in the daily notes. The inspector reviewed the daily notes for the previous week for this resident and observed no day where fluid intake levels had been recorded.

The inspector reviewed a number of other care plans that evidenced significant gaps in review dates that were outside of both the provider's policy time lines and instructions for review in specific care plans. For example, a hernia care plan for one resident had not been reviewed since October 2025 that should be reviewed quarterly, a bowel chart that should be completed daily for one resident had not been completed for 11 days in July 2026 and a choking care plan for one resident had been reviewed twice since October 2025 that should be reviewed quarterly.

Overall, the inspection showed that care plans were inconsistent in both the reviews to the ensure they were effective and in the guidance for staff to ensure plans supported residents in managing diagnosed health conditions.

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	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 27: Protection against infection	Compliant
Regulation 5: Individual assessment and personal plan	Not compliant

Compliance Plan for An Grainan OSV-0008100

Inspection ID: MON-0051280

Date of inspection: 05/08/2026

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 is committed to ensuring the designated centre is adequately resourced to meet the assessed needs of the individuals supported. The provider will undertake an assessment of need of the individuals. The outcome of this review will inform the staffing needs within the centre which will be effectively managed through rostering. The provider will review the findings and ensure that Adequate skill mix of staff allocated throughout the day is appropriate to the number and assessed needs of the residents. The provider has held recent recruitment interviews and open days on 07/09/26 Further interviews are being scheduled to fill remaining vacant posts on 4th and 5th October. The provider has recruited one staff nurse to commence in quarter 4 for a current vacancy, temporary CNM1 Interview scheduled for 28th of September. Rosters in the centre have been reviewed to ensure that they are adequately maintained. All full names of agency and relief staff will be identified in the roster. Regular relief and agency staff will be utilised where possible to ensure consistency of support to residents and to maintain continuity of care to residents. Rosters been reviewed to ensure allocation of resources is in line with individuals' preferences and needs.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The provider will ensure that governance in relation to oversight and monitoring is effective within the centre.	

HIQA regulations in context training will be provided to all PPIM and pic throughout the centre in December 2027 to enhance governance and oversight.

All audits 6, monthly and annual reviews will reflect accurately the compliance level within each regulation.

The provider will ensure that monitoring and audit systems in place will be utilized in a manner that allows for continuous improvement and completion of actions in a timely manner.

Monthly Schedule for PPIM and PIC governance meetings has been implemented.
PPIM governance meetings will be smart include all current issues arising within the centre and will include all resident updates.
PPIM meeting will also ensure all actions from previous meetings have been completed in line with allocated timeframes.

Team meetings topics will include resident updates, risk management, safeguarding to ensure staff are provided with accurate up to date information on all residents.

PIC will ensure all staff are invited to attended staff meeting, and all staff will be provided with the opportunity to read and sign all team meeting minutes.

Provider will have an assessment of need completed to ensure that sufficient staffing supports are in place to meet the assessed needs of the residents.
In the event staffing numbers are reduced risk assessment would be completed to provide evidence of control measures that are in place to ensure residents were supported with all their assessed needs.

All Care plans will be audited and risk assessments reviewed to ensure that staff are provided with detailed and accurate information to support residents assessed needs

Regulation 17: Premises	Substantially Compliant

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

The premises is currently under review to ensure adequate storage is available for residence aides. Pic Has currently reviewed all mobility aids in the centre and all excess equipment not in use has been removed.

Regulation 26: Risk management procedures	Not Compliant

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

All risk assessments will be reviewed to ensure clear guidance is available for staff in relation to the control measures required to always ensure resident safety.

All individual risk assessments will be reviewed to ensure they have effective control

measures in place to provide staff guidance in reducing risks identified for the residents.

The risk register will be reviewed to ensure it will include all current risks for the centre.

All risk assessments will be updated immediately when reviewed by a member of the MDT team and will reflect all current up to date recommendations and information.

The PIC will ensure recommendations and appointments proposed by MDT will be implemented .
All individual assessment and personal plan will be audited to ensure they're effectively meeting the needs of residents and guiding staff practise.

All care plans will ensure that all health action plans are up to date, are effective and give clear recommendations and guidelines to staff in providing effective management of the residents diagnosed health condition.

The PIC will ensure that all systems in place, regarding risk management procedures will be effective and ensure that accurate information is available to all staff.

Regulation 5: Individual assessment and personal plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:

All care plans will have an audit completed to ensure that all healthcare actions are up-to-date and have all the information required in relation to management of underlying health needs
All care plans will be reviewed 3 monthly or sooner where required
The provider will ensure that all actions from identified 6 monthly annual review, Annual reviews and care plan audits have been implemented. This is to ensure care plans are effective in guiding staff to support resident in manging their diagnosed health conditions.

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	31/01/2027
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.	Not Compliant	Orange	30/09/2026
Regulation 17(1)(a)	The registered provider shall ensure the premises of the designated centre are designed and laid out to meet	Substantially Compliant	Yellow	31/03/2026

	the aims and objectives of the service and the number and needs of residents.			
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	30/12/2026
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	30/11/2026
Regulation 05(6)(c)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall assess the effectiveness of the plan.	Not Compliant	Orange	30/12/2026

Regulation 05(6)(d)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall take into account changes in circumstances and new developments.	Not Compliant	Orange	30/12/2026