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:	Chestnut Grove
Name of provider:	Embrace Community Services Ltd
Address of centre:	Meath
Type of inspection:	Unannounced
Date of inspection:	10 June 2026
Centre ID:	OSV-0008676
Fieldwork ID:	MON-0050362

About the designated centre

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

The centre is within walking distance of a nearby town and within a ten minute drive to a larger town. The centre can cater for up to four male or female residents from the ages of 18 years and over. Individuals that are supported in this centre may have an intellectual or physical disability, Autism or acquired brain injury. Each resident has their own bedroom and there are recreational areas available within the centre. The centre is staffed 24 hours a day, seven days a week by a mixture of direct support workers and social care workers. The centre is managed by a person in charge who is supported in their role by a centre manager and two team leaders.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	3

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 10 June 2026	10:35hrs to 19:40hrs	Karena Butler	Lead

What residents told us and what inspectors observed

This unannounced inspection found that while in the main good practice was observed and residents enjoyed a good quality of life, some improvements were required particularly in relation to staffing, fire precautions, training and staff development, and governance and management. Other improvements required related to positive behavioural support and the premises. These points are discussed in detail later in this report.

During the inspection, the inspector met the three residents living in this centre. There was one vacancy at the time of this inspection. The residents used alternative communication methods and did not share their views directly with the inspector. Instead they were observed in their home for part of the evening once they returned from their day service programmes which they attended Monday to Friday.

The inspector observed that the travel time for the residents to their day service programmes could be between 45 minutes to one and a half hours each way depending on traffic. While the residents had attended those services prior to moving into this house and location, the inspector queried whether the residents would benefit from and prefer to attend a day service programme closer to their homes. The person in charge communicated that it had previously been queried and thought that it was in the best interests of the residents to remain in those services. It was believed that it would have been too much change for them to switch a service as well as move to a new home. They confirmed that they would review this arrangement again to assess if there were any alternatives that could be offered to the residents.

From speaking with a staff member, they felt that the residents were supported to have a meaningful day in line with their interests. For example, residents engaged in open top bus tours, walks in forests, beaches and mountains. They visited farms, attended the cinema and went out for coffee.

Residents were observed moving freely around their homes, spending time in the kitchen and their bedrooms. They appeared content in their environment, although one resident appeared to become anxious because of the number of people in their home due to the inspection. Staff and management advised the inspector on how best to avoid upsetting the resident, demonstrating respect for the resident's feelings.

The residents appeared comfortable in the presence of their supporting staff. For example, one resident spent time in their back garden and used the built in trampoline while their support staff remained with them. They were observed to be smiling and making happy noises. The person in charge was observed to smile when

they saw the resident enjoying themselves. They were also observed to provide reassurance to another resident when they required it and gave them high fives.

In addition to the person in charge, the house manager and the team leader, the inspector had the opportunity to speak with two of the four staff members on duty. While the person in charge, house manager and team leader demonstrated that they were familiar with the residents' support needs and likes, the two staff members spoken with required 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, staff were observed to offer a resident a choice of location to spend time in the house.

The inspector spoke on the phone with a family representative of one resident. Feedback received from this person indicated that they were very satisfied with the service provided to their relative and they communicated that they felt their family member was getting the right supports. They felt their family member was 'safe' and 'well cared for'. They also noted that 'staff were responsive to any feedback they received' and that the 'staff couldn't do enough for their family member'. They said that they felt welcome to visit the house. They also said that while they have never had grounds to make a complaint or raise a concern, they would feel comfortable doing so if necessary. They communicated that the person in charge, house manager, and the team leader were very approachable.

The house was observed to be clean and tidy. There was an accessible back garden and the front garden was accessible to residents under staff supervision.

At the time of this inspection there were no visiting restrictions in place and there were no volunteers used. There had been one recent complaint in 2026 which was being dealt with to the satisfaction level of the complainant and there were no complaints in 2025.

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

Capacity and capability

This inspection was unannounced and was undertaken following the provider's application to renew the registration of the centre. This centre was last inspected in February 2024.

This inspection identified areas for improvement in relation to staff training, consistency of staffing and governance and management.

While governance and management arrangements were in place, such as the completion of an annual review of the service, some areas required enhanced oversight. For instance, management needed better oversight of external servicing records to ensure required works were completed.

Improvements were required to ensure a consistent staff team was in place with a suitable staffing contingency plan, as well as to improve staff knowledge.

While core staff were found to have access to a suite of training in order to carry out their roles, it was not evident if agency staff had completed all required training and improvements were required to staff knowledge to ensure that training could be effectively implemented in practice.

There was a statement of purpose in place that was reviewed and updated on a regular basis as required by Schedule 1 of the S.I. No. 367/2013 - Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (the regulations). In addition, the provider had ensured that the centre was adequately insured against risks to residents.

Registration Regulation 5: Application for registration or renewal of registration

The registered provider submitted an application to renew the registration of the centre. The application contained the required information set out under this regulation and the related schedules. While some minor revisions were required to the statement of purpose and floor plans, they were completed and re-submitted the day after this inspection and found to be correct.

Judgment: Compliant

Regulation 15: Staffing

The inspector found that there was an over reliance on temporary staff in this centre and there were some occasions when certain shifts could not be filled.

At the time of inspection there were 2.5 whole time equivalent vacancies in the centre, including one whole-time team leader vacancy. It was evident that the provider was actively recruiting to fill these positions with two staff members in pre-employment checks. However, in the interim, there was a considerable reliance on agency and relief staff to cover these positions. For example, over the course of one month, 63 shifts were covered by agency staff. Over the course of the five and a half months preceding the inspection, 31 different agency staff had worked in the

centre covering 182 shifts and 107 shifts were covered by relief staff in the same period. This put residents at increased risk of not receiving continuity of care.

While it was positive that the provider had taken measures to fill staff vacancies, sustained attention to recruitment and staffing contingency plans was required to ensure that residents were supported by a consistent and familiar staff team.

The inspector found that over a four-month period, 11 shifts were left unfilled, demonstrating that the staffing contingency plan needed improvement.

Additionally, while an agency staff confirmed that they had received an induction when they initially commenced their work, the provider could not provide documentary evidence that all agency staff had received an induction on their commencement. Therefore, improved record keeping regarding induction arrangements was required to assure the provider that all staff were appropriately inducted. This was in order to ensure the residents received safe care in line with their assessed needs.

Judgment: Not compliant

Regulation 16: Training and staff development

The inspector found that all staff employed directly by the provider had undertaken any training required to meet residents' assessed needs. However, the provider could not provide sufficient evidence to confirm if all agency staff employed in the centre had also undertaken all required training and gaps in staff knowledge were identified.

The inspector reviewed the certification of four training courses for a sample of three staff on duty, as well as the training oversight documents for the core staff and available records for the agency staff. This review demonstrated to the inspector that staff members had each received training in these key areas as well as additional training specific to residents' assessed needs.

Examples of the training staff had completed included:

- safeguarding vulnerable adults
- first aid or cardiac first response
- positive behavioural support
- medication management
- epilepsy management
- human rights
- dysphagia
- training related to infection, prevention and control (IPC), for example hand hygiene
- fire safety.

However, from review of two agency staff training records, the inspector found that some improvement was required in the oversight of agency staff training to ensure that the residents were supported by a suitably trained and knowledgeable staff team. For example, it was not evident if the agency staff members had training related to positive behaviour supports, epilepsy awareness, standard and transmission based precautions, or cough etiquette and respiratory hygiene. In addition, one agency staff member required refresher training in safeguarding vulnerable adults as their current certificate expired in February 2026. While there were arrangements in place to limit the duties of agency staff in relation to some specific care and support needs, given the high levels of agency staff used in the centre and the dynamic nature of resident supervision and support observed, the inspector was not assured that all staff were appropriately trained or had the required skills to support the residents safely.

Furthermore, while core staff had completed required training courses, the inspector found that this training was not effectively embedded into practice. When spoken with, two staff members' responses were limited and did not demonstrate sufficient knowledge in several high-risk areas. For instance, staff were unclear on the administration of emergency epilepsy medication, the administration of medication during periods of distress, how to support a resident in line with their behaviour support plan, and who the designated safeguarding officer was. One staff member was unfamiliar with residents' eating, drinking, and swallowing plans. 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.

Judgment: Not compliant

Regulation 22: Insurance

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

Judgment: Compliant

Regulation 23: Governance and management

On review of the governance and management arrangements, the inspector found that improvements were required to the oversight and monitoring systems.

There was a clearly defined management structure, with a team leader, house manager, and assistant director of services in place. As previously stated, at the

time of inspection there was a vacant team leader position. It was evident that the management team were committed to providing a good-quality service; however, it was found that some monitoring arrangements required further development to ensure quality and safety risks were consistently identified and addressed.

For example, while the provider was carrying out six-monthly audits, the most recent audit did not identify the risks to residents associated with staffing deficits, and as such there was no formal improvement plan in place other than to say there was on-going recruitment. Additionally, the inspector found evidence that the provider-led audits due to be completed every six months, were not always unannounced, as required by the regulations.

It was also found that two local monthly governance audits had not taken place as prescribed by the provider. Improvement was required to ensure that internal monitoring systems were carried out in accordance with the requirements of the regulations and the provider's policies.

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

Furthermore, some actions identified in reports had not been completed. For example, the inspector also found that management were uncertain if necessary actions had been taken to address deficits in the servicing of the centre's boiler. The boiler service was completed in November 2025 and the report had listed a number of remedial actions required which were not known to management and no evidence could be produced to demonstrate they had been completed.

Judgment: Not compliant

Regulation 3: Statement of purpose

The provider prepared a statement of purpose which was up to date, accurately described the service provided and contained all of the information as required by the regulations. For example, it described the specific care and support needs that the provider intended to meet.

Judgment: Compliant

Quality and safety

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

While the provider had ensured there were many appropriate firefighting and detection systems in place in the case of an emergency, several improvements were noted as being required. For example, it was not evident if residents had been supported to practice a drill using alternative evacuation routes.

For the most part the premises was found to be suitable for the needs of the resident; however, some minor improvements were required to ensure the house was clean, could be effectively cleaned, and was in a good state of repair. For example, some gaps were observed in two floors which would make it difficult to adequately clean the floor.

Residents had access to a behaviour therapist to support them to manage their behaviours of distress they may experience appropriately. However, some restrictive practices in the centre required review to ensure they were used for the shortest duration and were the least restrictive under the circumstances.

Regulation 11: Visits

The provider facilitated residents to receive visitors in accordance with residents' wishes. There were no restrictions to visiting at the time of the inspection and a log of visitors to the centre was kept and was observed to be used in practice.

There were suitable facilities available in order to receive visitors in private. For example, residents could entertain their visitors in the sitting room. A family representative spoken with felt welcome to visit and communicated that staff were very accommodating in facilitating visits in different locations in the community.

Judgment: Compliant

Regulation 17: Premises

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

For example, the inspector observed:

- gaps in some flooring, for example the landing
- some surfaces needed to be painted, such as the door frame from the dining to kitchen areas and areas of the stairs
- there were some maintenance and housekeeping issues identified, such as broken garden furniture, a hole in the wall under the light switch in the sitting room, and cleanliness of some of the soft furnishings, as discussed with the person in charge on the day.

The majority of the identified issues had been self-identified by the provider; however, there were no set dates provided as to when they were going to be addressed. While these issues were minor, they impacted the overall homeliness of the environment and made effective cleaning difficult.

Each resident had their own bedroom, which was individually decorated. For example, one resident had sensory lights installed over their bed. There were different communal spaces available that residents could choose to spend time in together or have a private space.

The back garden had a swing bench, a swing ball game, and a built in trampoline for the residents to use.

Judgment: Substantially compliant

Regulation 20: Information for residents

There was a residents' guide that contained the required information as set out in the regulations. For example, it explained to residents how to access inspection reports, and what the arrangements for visiting were to the centre.

Judgment: Compliant

Regulation 28: Fire precautions

The inspector found that there were many adequate fire safety management systems in place, for example a suitable fire alarm system, emergency lighting, and firefighting equipment was installed and regularly serviced. However, a number of improvements were required regarding evacuation and fire containment measures.

Regarding containment measures, the provider could not provide evidence that fire-resistant materials were used in all ceilings or the attic hatch. Additionally, a review of fire doors found that there were minor issues with regard to some larger than recommended gaps between two of the doors and the frames. Furthermore, the

provider lacked evidence to show that their fire containment measures would remain effective despite the absence of smoke seals on fire doors.

Based on a review of five fire practice drills in 2026, the provider had ensured regular fire drills were taking place which included ones undertaken during hours of darkness. However, an evacuation drill had not been conducted with minimum staff levels or using alternative evacuation routes other than the front door. Consequently, the provider could not be assured that all residents could be safely evacuated from all areas of their home or in the event that minimum staffing levels were present.

The inspector observed a large build-up of lint in the dryer filter, which presented as a fire hazard. Stricter oversight was required to ensure regular cleaning and mitigate this risk.

The provider had recently introduced a new restrictive practice of locking the two side gates as a control measure to help manage the risk of recurrence of a recent incident. However, the inspector found they were padlocked. This meant that staff would have to rely on physical keys during an emergency, posing a risk to safe and timely evacuation of the residents. While the person in charge took the positive step of replacing the padlocks with coded locks on the day of this inspection, this was only done once highlighted by the inspector. The provider needed to implement a thorough review process for any further control measures to ensure they do not inadvertently compromise resident safety.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

The provider had ensured that assessments of residents' health and social care needs had been completed and care plans developed for any identified needs. For example, in place were communication plans, intimate care plans, and plans to guide staff as to residents' likes and dislikes.

From a review of two residents' information, their assessment of need, along with their support plans, were under regular review and demonstrated that multidisciplinary professionals were involved in the development of care being provided. Care and support was provided in line with their care needs and any emerging needs. For example, the inspector reviewed a plan which detailed how a resident was being supported to manage anxiety around a specific care and support need. The inspector observed the staff implement the care plan in practice and found that the staff supported the resident in an appropriate manner. A family representative spoke about the care plan and stated that 'while it was only recently being trialled, it appeared to be working well'.

Judgment: Compliant

Regulation 6: Health care

The inspector found that the health needs of the residents had been appropriately assessed, and appropriate healthcare supports were in place.

From a review of a sample of each of the residents' healthcare information, there were care plans in place for any identified assessed needs. For example, there was an epilepsy plan and associated epilepsy emergency medication protocol, and an eating, drinking, and swallowing plan in place for residents that required support in that area. Of the plans reviewed, for the most part they were found to appropriately guide staff. While there were some inconsistencies in information completed by a staff member regarding administration of an emergency medication, the signed protocol by the prescriber contained clear information. A staff member confirmed that they would refer to that if they needed to administer the medication. The inconsistencies in the information were addressed under Regulation 16: Training and Staff Development.

There was evidence that residents had access to health and social care professionals and were supported in attending appointments with GPs when required. For example, residents had access to a neurologist, psychiatrist, a nurse, and a speech and language therapist.

At the time of the inspection, the residents were in good health, and efforts were being made to maintain this status.

Judgment: Compliant

Regulation 7: Positive behavioural support

For the most part, there were appropriate supports and guidance for positive behaviour support and with the implementation of restrictive practices. However, some improvements were noted as being required.

The inspector reviewed the arrangements in place to support residents' positive behaviour support needs. Where necessary, residents received support to understand and alleviate the cause of any behaviours that may put them or others at risk. For example, there was a behaviour support plan in place devised by a behaviour support therapist to guide staff on the signs of what it may look like if a resident was experiencing distress, and the best response to take to support them effectively.

The inspector found that there were some restrictive practices in place to mitigate safety risks. For example, residents had limited access to some areas of their home. While it was evident that these measures were implemented to promote and protect residents' safety and while they were subject to review, not all restrictive practice reviews ensured that the least restrictive measure was used, and that restrictions were used for the shortest duration possible. For example, the locking away of sharps, and the locking of the kitchen area.

Judgment: Substantially compliant

Regulation 8: Protection

From a review of the systems in place to protect residents from the risk of abuse, the inspector found that sufficient safeguarding measures were in place.

From speaking with a member of staff, they demonstrated adequate safeguarding knowledge regarding what actions to take if they witnessed a peer-to-peer incident or an unwitnessed disclosure was made to them.

The provider had responded to any arising safeguarding concerns and concerns were notified to the relevant external agencies. When required there were safeguarding plans in place with control measures to help mitigate the chances of reoccurrence. For example, after an incident whereby a resident from another centre impacted two residents, the provider put a control measure in place that they would no longer travel with that resident.

The family representative, two staff members and the management team spoken with all confirmed they had no concerns and would feel comfortable raising concerns if they had any.

In addition, the inspector found that residents' finances were being checked daily to ensure their money was safeguarded.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 5: Application for registration or renewal of registration	Compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 20: Information for residents	Compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Compliant

Compliance Plan for Chestnut Grove OSV-0008676

Inspection ID: MON-0050362

Date of inspection: 10/06/2026

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
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 to establish a consistent cohort of agency staff assigned to the designated centre, promoting continuity of care during the recruitment and onboarding period.
Due Date: 30 June 2026 (Completed)
• Recruitment and onboarding will continue until all approved vacancies are filled in line with the Statement of Purpose, reducing reliance on agency staff and eliminating unfilled rostered shifts.
Due Date: 30 August 2026
• The Person in Charge (PIC) and Assistant Director of Services (ADOS) will review and update the Centre Staffing Contingency Plan. The plan will be incorporated into the Centre Specific Risk Register and reviewed through the centre's governance arrangements.
Due Date: 31 July 2026
• A standardised agency induction checklist will be implemented and maintained on the centre's SharePoint and local files. All agency staff will complete the induction prior to working independently within the designated centre, including familiarisation with residents' care plans, risk assessments, safeguarding arrangements and emergency procedures.
Due Date: 30 June 2026 (Completed and Ongoing)
• Agency utilisation, staffing vacancies and recruitment progress will be reviewed monthly through local governance meetings and escalated through the organisational governance framework to ensure staffing levels remain appropriate to residents' assessed needs.
Due Date: 31 July 2026 (Ongoing)

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 assessments and on-the-floor mentoring will be provided to all core Team Members to ensure they are familiar with each resident's care plans, risk assessments, Positive Behaviour Support Plans and safeguarding arrangements. Where competency gaps are identified, additional classroom-based training and mentoring will be provided.
Due Date: 30 August 2026 (Completed and Ongoing)

• Management will continue to undertake regular practice observations, spot checks and supervision sessions to ensure residents' care plans are understood, implemented consistently and embedded into daily practice. Where gaps in knowledge or practice are identified, immediate coaching, mentoring and additional support will be provided.
Due Date: 30 July 2026 (Completed and Ongoing)

• 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 agency staff have completed all mandatory and resident-specific training in accordance with the agreed Service Level Agreement. Any identified non-compliance will be addressed with the agency provider.
Due Date: 30 August 2026

• The Person in Charge (PIC) will complete safeguarding competency assessments with all Team Members within the designated centre. Individual mentoring and reassessment will be completed for any Team Member who does not achieve the required competency standard.
Due Date: 30 August 2026

• The Person in Charge (PIC) will complete competency assessments with all Team Members in relation to epilepsy management and the administration of PRN medication in accordance with residents' protocols. Individual mentoring and reassessment will be completed for any Team Member who does not achieve the required competency standard.
Due Date: 30th July 2026
• Education, coaching and on the spot competency-based support and mentoring will be provided to all core staff to ensure they are familiar with each resident's care plans, risk assessments, behavior support plans, and safeguarding requirements. Where indicated, additional classroom training can be provided.

Due Date: 30 August 2026 (Completed and Ongoing)
• The Assistant Director of Services (ADOS) in conjunction with the Director of Operations will review training systems with the agency provider and flag non-compliance with training agreed through service agreement.
Due Date: 30th of August 2026

• Safeguarding competency to be completed with all Team Members in the Designated Centre by the Person in Charge (PIC). Mentoring to be completed with any Team Member scoring below the required threshold.
Due Date: 30th of August 2026

• Epilepsy and PRN Protocol competency to be completed with all Team Members in the Designated Centre by the Person in Charge (PIC). Mentoring to be completed with any Team Member scoring below the required threshold.
Due Date: 30th of August 2026

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:

• Additional education and mentoring on the completion of Provider Led Audits will be provided to the Assistant Director of Services (ADOS) by an alternative member of the Assistant Director of Services Team and the Director of Operations to strengthen the identification of risks, quality improvement planning and regulatory oversight. The option to complete announced six-monthly Provider Led Audits has been removed to ensure all future audits are undertaken on an unannounced basis.
Due Date: 30th September 2026
• The Assistant Director of Services (ADOS) will meet with the Maintenance and Procurement Manager to review access to servicing and maintenance records. Evidence of all completed remedial works, including boiler servicing records, will be retained on site and communicated to the local management team to strengthen governance oversight.
Due Date: 30th July 2026
• The Person in Charge (PIC) will update medication protocols, care plans and associated documentation identified during the inspection to ensure records accurately reflect residents' assessed needs and prescribed healthcare arrangements. This was completed on the day of the inspection.
Due: 10th June 2026 (Completed)
• The Assistant Director of Services will ensure all outstanding Governance Audits are printed, signed and retained within the designated centre. Governance meeting minutes will be printed, signed during each governance meeting and appropriately filed. Compliance with this process will continue to be monitored through Governance Meetings and Provider Led Audits.
Due Date: 11th June 2026 (Completed & Ongoing)
• The Assistant Director of Services will complete on-the-floor mentoring with the Person in Charge (PIC) and House Manager (HM) to strengthen the identification of documentation gaps, including medication protocols and emergency healthcare documentation, through routine local governance audits.
Due Date: 30th August 2026

Regulation 17: Premises	Substantially Compliant

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

• All maintenance issues will continue to be recorded on the Centre Maintenance Log. Target completion dates will be assigned to each action, and progress will be monitored through local management oversight to ensure maintenance works are completed within agreed timeframes.
Due Date: 30th July 2026
• New pillows, mattresses and mattress protectors will be purchased for residents where needed to ensure furnishings remain clean, suitable and in good condition.
Due Date: 30th June 2026 (Completed)
• The damaged light switch and identified flooring defects will be repaired to ensure the premises are maintained in a good state of repair.
Due Date: 30th June 2026 (Completed)
• The damaged garden swing will be removed and replaced with suitable outdoor equipment that is safe, fit for purpose and appropriate to residents' assessed needs.
Due Date: 30th August 2026

Regulation 28: Fire precautions	Not 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 and will include residents evacuating through the rear exit and/or side gate of the building. A simulated fire evacuation has been completed using minimum staffing levels, with residents successfully evacuating through multiple designated escape routes to provide assurance that evacuation procedures can be implemented safely under different emergency scenarios.
Due Date: 30th of June 2026 (Completed)
• Fireproofing works to the ceiling and attic spaces will be completed by the appointed contractor. Works to the attic entrance were completed on 15th July 2026 to enhance fire compartmentation and address the observations identified during the inspection.
Due Date: 30th of August 2026 (Completed)
• Identified gaps around fire doors will be repaired to maintain the integrity of fire compartmentation within the designated centre.
Due Date: 11th June 2026 (Completed)
• A companywide review of all designated centres is being undertaken to identify and rectify any fire door defects. Fire safety compliance will continue to be monitored through routine audits, preventative maintenance programmes and management oversight.
Due Date: 30th of August 2026
• Certification and completion report for all fire safety works will be obtained from the appointed contractor and retained within the centre's fire safety records (Millmount folder) to provide assurance that all works have been completed and certified appropriately.
Due Date: 30th of August 2026
• The daily cleaning checklist will be updated to include a specific check confirming that the dryer lint filter has been emptied. Compliance will be monitored through routine

housekeeping checks.
Due Date: 11th of June 2026 (Completed)
• A fence will be installed at the side of the property to reduce the need for the external restrictive practice currently in place, while continuing to promote the safety of all residents and ensuring the least restrictive measure is implemented for the shortest duration necessary.
Due Date: 30th of July 2026
• Smoke seals will be installed on identified fire doors to further strengthen fire compartmentation arrangements and enhance the effectiveness of the centre's fire containment measures.

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:

• The restraint reduction plan relating to the locked kitchen area will be reviewed by the multidisciplinary team in conjunction with the Assistant Director of Services (ADOS) and the Person in Charge (PIC) to ensure the restriction remains necessary, proportionate and is reduced at the earliest opportunity.
Due Date: 30th of August 2026 (Ongoing)
• A restrictive practice log will be introduced to record all opening and closing of the kitchen door to strengthen oversight and monitoring of the restrictive practice. The kitchen door will remain open whenever the two residents to whom the restriction relates are not present within the designated centre, ensuring the least restrictive measure is implemented for the shortest duration necessary.
Due Date: 30th of June 2026 (Completed)
• The Behaviour Specialist, in conjunction with the Person in Charge (PIC) and Assistant Director of Services (ADOS), will complete a trend analysis of behavioural incidents, reviewing known triggers, staffing levels, agency utilisation and environmental factors to identify patterns and inform ongoing Positive Behaviour Support planning and risk reduction strategies.
Due Date: 30th of August 2026

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Not Compliant	Orange	30/08/2026
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	30/08/2026
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate	Not Compliant	Orange	30/07/2026

	training, including refresher training, as part of a continuous professional development programme.			
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Substantially Compliant	Yellow	31/07/2026
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Substantially Compliant	Yellow	31/07/2026
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	30/08/2026
Regulation 28(2)(b)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Substantially Compliant	Yellow	30/08/2026

Regulation 28(2)(b)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Orange	30/06/2026
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	30/08/2026
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 and bringing them to safe locations.	Substantially Compliant	Yellow	15/06/2026
Regulation 07(5)(b)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation all alternative measures are considered before a restrictive procedure is used.	Substantially Compliant	Yellow	30/08/2026
Regulation 07(5)(c)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation the least restrictive procedure, for the shortest duration necessary, is used.	Substantially Compliant	Yellow	30/07/2026