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:	Community Living Area 40
Name of provider:	Muiríosa Foundation
Address of centre:	Kildare
Type of inspection:	Unannounced
Date of inspection:	27 May 2026
Centre ID:	OSV-0008749
Fieldwork ID:	MON-0050279

About the designated centre

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

Community Living Area 40 is a designated centre located in a rural setting in Co. Kildare. The centre provides care and support for up to four residents with intellectual disabilities who have medium to high support needs. The house is a bungalow and comprises a sitting room, kitchen, utility, office, sun room, four resident bedrooms and two accessible bathrooms. There are ramps to the front and rear of the house and the house is accessible throughout and fitted with overhead hoists. The staff team comprises nurses, social care workers and support workers. Residents have access to two vehicles.

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 27 May 2026	10:10hrs to 18:30hrs	Gearóid Harrahill	Lead

What residents told us and what inspectors observed

This inspection was unannounced and completed to review the arrangements the provider had to ensure compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the National Standards for Adult Safeguarding (Health Information and Quality Authority and the Mental Health Commission, 2019), and to follow up on information received by the Chief Inspector of Social Services regarding this designated centre. The inspector had the opportunity to meet with all three of the people who lived in this centre, as well as speak with staff, observe the centre environment, and review documentary information, as evidence to indicate the lived experience of the people using this service.

On the day of this inspection, the inspector first met one of the residents who was on the way out the door to go to their day service, which they attended five days a week. The resident was eager to start their day and was in good form. The other two residents were up and being supported by staff to have their breakfast. Residents' support needs when eating required staff to be attentive to what they were doing, so the inspector carried out a premises walk with another member of staff so as not to distract the staff or residents during the mealtime.

The premises was clean, bright, spacious and suitable for the accessibility requirements of the people living here. Bathrooms and bedrooms were featured with suitable accessibility features including equipment required to safely shower and get in and out of a bed or chair. The provider advised that funding had been secured to enhance the outdoor spaces and add new garden features, the work for which was to commence in the coming weeks. The centre had exclusive use of two vehicles: one regular car which could be used for one resident, and an accessible van suitable for wheelchairs which could accommodate all three residents.

The communication support needs of residents meant that the inspector was unable to have a full verbal conversation with them, so staff sat with the residents and the inspector to support them talking about their interests and experiences. On the day of inspection, residents were supported by two regular staff members, one of whom was finishing a sleepover shift, two personnel from an agency, and an intern on a placement in this centre. All staff engaged with the residents with dignity during delivery of direct care, however, the inspector observed that much of the engagement overall was task-oriented in nature. After breakfast the inspector asked what plans the two residents at home had for their day, and those spoken about related to the next mealtime and when it was time for medicines. There were no plans to go out during the day because the staff on shift could not drive the accessible vehicle. The inspector observed periods of time during which residents were sitting in their chairs in front of the television, with staff sitting in another room. Personal plans noted what residents liked to watch but this was not what was playing. When the third resident returned home, they spent much of the afternoon

walking from room to room with limited meaningful engagement or plans for what they would be supported to do with their afternoon and evening besides having dinner.

The residents required staff who were familiar with their support needs around communication, mobilising, eating and drinking. Front-line staff had worked with these residents for a number of years and had good personal knowledge of their interests and preferred outings and activities, but noted that the day could slow down when contingency arrangements were required to cover shifts, taking longer to deliver care, and requiring regular staff to supervise the covering personnel and to prepare meals and drinks for the residents. Staff advised that the provider aimed to ensure a driver was on shift at weekends when only two staff were on duty to protect the flexibility of getting out of the house. The provider had a risk assessment related to the ability to engage in activities outside the house in the evenings and weekends, with the person in charge enabled to seek additional hours to support residents. The diaries for social activation and outings did not record anything for some of the weekends in the sample reviewed.

Staff advised that when activities were planned well, residents could ago on enjoyable trips. One resident had enjoyed an overnight stay in a hotel in April. Residents went to a Leinster rugby match and a trip to Ikea in the past week. Residents' planners for 2025 included pictures of them at agricultural events, out to lunch, and enjoying Christmas markets and winter lights. Staff showed the inspector the plans for activities requiring booking and advance planning such as going to concerts or shows for 2026, however the planning for some of this year's outcomes had not yet commenced as of the end of May.

The experiences of the residents and their representatives was gathered and reflected in the annual report for this centre. This commentary spoke highly of the front-line staff and their trustworthy and positive attitude with residents and their encouragement to ensure they enjoy and are safe in their day.

In the next two sections of the report, the findings of this inspection will be presented in relation to the governance and management arrangements and how they impacted on the quality and safety of service being delivered.

Capacity and capability

The inspector found this centre to be resourced with a committed and knowledgeable front-line team who gave examples of how they were supporting the residents to have safe and dignified care and support, and who also highlighted challenges in achieving this to their line management.

The inspector observed this centre to be frequently reliant on contingency staffing resources to cover absences, and evidence was observed to indicate that the

arrangements were not optimal to mitigate the impact on staff continuity. This in turn impacted on the quality and knowledge of personnel and the support they received to be familiar with residents and their support needs, and created additional work for the core staff team. This also resulted in some risk control measures and documentary evidence being inconsistently implemented, and the flexibility of getting out of the house being restricted.

There were suitable management and accountability structures in effect for this service and it was evidence that this facilitated front-line staff to raise their concerns, address aspects of their role they found challenging and progress their career goals.

Regulation 15: Staffing

The inspector reviewed the statement of purpose for this centre and worked rosters for the previous three months. The centre had a full complement of staff as per the statement of purpose with no vacancies in the front-line team. Training days, annual leave and sickness absence were noted on the rosters. To cover absences the provider used a combination of staff from a relief panel, staff from an external agency, and staff from other designated centres. In the main this was sufficient to ensure shifts were filled; however, this had not been done in a manner which protected the continuity of care of the residents by personnel who were familiar with their complex support needs. A review of rosters showed that in the 12 weeks prior to this inspection, there had been 20 different contingency personnel used to cover 52 shifts in this centre.

From speaking with staff and reviewing incidents occurring in centre, the inspector observed evidence to indicate that this contributed to additional responsibilities being placed on the core staff on shift, and gaps in knowledge or increased risk related to medicines, moving and handling, and quality of activation and engagement with residents.

The inspector was provided evidence to indicate that the centre was funded for three staff members at weekends based on the assessed needs of the residents, however, only used two staff. The inspector requested the assessment need utilised to determine staffing requirements for the residents who were in the centre at weekends, and how and by whom it was determined that the third funded post would not be used, however, this information was not available for review.

Judgment: Not compliant

Regulation 16: Training and staff development

The inspector reviewed a sample of minutes from team meetings and found these to discuss matters which were meaningful to the house and the residents. This included overview of adverse events, changes in residents' healthcare needs and reminders to staff to be familiar with residents' personal care plans. At management level, while the person in charge had not had a meeting with their line manager since coming into post, they had attended shared learning sessions with their counterparts in other designated centres.

The person in charge used a tracking system to be advised of when the primary team of staff had completed training required to effectively work in this centre, and when refresher courses were due. All core staff had completed courses in safe medicine management and safe moving and handling of residents. Three staff members who had been on this team more than a year had not completed training in feeding, eating drinking and swallowing (FEDS) which was important as residents in this centre required modifications to their food and drink for their safety. A separate three staff members were out of date in their mandatory training in fire safety. Residents in this centre had complex communication needs, however, staff were not required to complete training in communication modes and supports.

The inspector spoke with agency staff and found that they were not familiar with support needs of residents. In particular, the staff member was not aware of the protocols around emergency intervention medicine for residents at high risk of epilepsy seizures, and the inspector observed that they had supported them alone in the morning. The inspector asked how agency staff are inducted at the start of their shift or where they seek information to be aware of residents' current primary needs or changes which may have occurred since they last worked in the centre. The resident was shown a diary which contained one brief note.

Judgment: Substantially compliant

Regulation 23: Governance and management

The centre team was led by a person in charge who had commenced in 2026 and was primarily based in another location, attending this centre through the week. They were suitably qualified and experienced for the role of person in charge and appropriately supported by the area director. They advised the inspector that their current priority for their role in this centre was to ensure that staff were progressing personal plans and to complete staff appraisals.

The area director had completed a six-monthly unannounced audit of the service in March 2026. They highlighted areas which had improved or still required attention following their previous audit, and gave praise to the front-line team and their respectful care delivery with residents. The audit identified that following the number of residents reducing from four to three that the house was less busy, to the benefit of the current residents who required a more relaxed living environment.

During this inspection, the inspector observed means by which staff practice was monitored and information was recorded. In the main staff were recording information which was meaningful to support the residents and staff, however there were a number of gaps observed in the quality of these recording methods. For example, two recording tools were used to advise the team and manager of outings and activities enjoyed by residents, however the two tools contradicted each other. The inspector observed gaps in recording administration of medicine on the day of inspection, and recording practices which were not in line with best practice. Induction information used by contingency staff to advise them of the current support needs of residents was not available to them in a manner which ensured they were knowledgeable with their needs at the start of their shift. Following the initial creation of social and recreational plans for residents at the start of the year, there was inconsistency in how the steps and progress of these outcomes were kept under review.

The inspector observed that examples of these had all been discussed in recent staff team meetings, with staff highlighting to their manager that their duties providing direct resident support did not provide them adequate time to ensure they could complete these administrative tasks to demonstrate the work they were doing.

The inspector reviewed performance appraisals for six staff members and found these to be meaningful in their content for the duties and career goals of the team members. The minutes of these meetings included commentary of staff members' strengths, areas in which they wanted to develop their knowledge, and educational aspirations such as management courses.

Judgment: Substantially compliant

Quality and safety

In the main, health and personal care plans were person-centred, written with respect and informed by evidence-based practice. Support interventions related to physical safety were written with detail including supporting residents to mobilise, eat, drink and engage in personal hygiene safely and with due care to their dignity. The premises and equipment were suitable to support these needs.

The inspector observed examples of management and staff recognising the challenges associated with being flexible in getting out of the house and progressing personal goals related to social and recreational interests. Some of these personal goals were not observed to be progressing or having specific progress steps to achieve same recorded. Activity logs noted that when plans and resources were suitable, residents enjoyed meaningful activities out of the house, however this was a challenge particularly at weekend when staffing was at a minimum.

The inspector observed good examples of the provider identifying areas for continuous development following adverse events, using safeguarding or injury incidents as opportunities to learn, roll out new risk measures or identify patterns of concern. Staff had completed their training in safeguarding and human rights of people with disabilities, and explained examples of how they strived to utilise this training in their duties and where they felt the service could be improved for the benefit of the residents.

Regulation 10: Communication

Residents in this centre had complex communication support needs and did not communicate using full speech. There was limited evidence to indicate how holistic communication strategies had been developed or advised by multidisciplinary input. The inspector reviewed communication support plans for residents, which included some information such as how a resident may communicate that they dislike something or are distressed. However, there was limited information to support staff on how to respond to this distress, or how to speak with the residents to ensure they were understood. Residents had been reviewed by a speech and language therapist in relation to their modified diets, but not to obtain advice to develop their communication supports. Staff had received no training in communication modes and strategies.

Residents had access to television and computer tablets which they used for music, watching videos, sensory activities and relaxation. Personal plans noted examples of residents' favourite shows and one resident had classic sitcoms playing in their bedroom as they went to bed at the end of the day.

Judgment: Not compliant

Regulation 17: Premises

The premises was overall suitable for the number and assessed needs of the residents, including ramps and level access spaces for wheelchair users. The private and communal areas were pleasant, clean and suitably decorated. Residents had multiple living rooms in which they could spend time away from busier areas. Bedrooms and bathrooms were equipped with overhead hoists to support transfers. The provider was due to commence works to upgrade and add new features to the back garden.

Judgment: Compliant

Regulation 26: Risk management procedures

The inspector reviewed the risk register for this designated centre and incident management forms for adverse events. Risks related to recent events were accounted for in this register, such as peer interactions, staff leaving food or medicine unattended, or valuables going missing. Also noted were limitations on the team's ability to implement risk controls, for example supervising one resident while their housemates required the support of the only staff on site.

While risk assessments and control measures were centre-specific, some were overdue for review to ensure that they were specific to guide staff or had been updated to reflect changes with the centre or residents. In one example, risk controls instructed staff to carry out night checks of residents, but it was not clear what staff were being asked to do during these checks or how often they were expected to do so, to implement this consistently. Risk controls related to one resident having an epilepsy event outside the house had not been implemented in practice.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Residents had their needs assessed, for example, related to epilepsy, eating and drinking supports, and uses of equipment such as hoists or leg orthotics and these were person centred and detailed. Where plans were informed by staff knowledge, evidence-based practice, learning from incidents, and multidisciplinary support, they were measurable and specific. Some gaps were observed in the clarity of personal plans to support staff who were less familiar with residents and reflected the personal knowledge of the primary team, which is referenced elsewhere in this report. Care and support plans were not available in a format with which the residents could engage, however, staff walked the inspector through these documents.

The inspector reviewed personal plans for all three residents related to recreation objectives or events which would require advance planning or scheduling, such as holidays or shows. One resident's planned outcomes through 2026 had not yet happened, other that those which were part of their usual routine such as going to day service. One goal was to attend a show in the Bord Gáis theatre in June 2026, however as of the time of this inspection, nothing was planned or booked nor had it been explored what shows were on that the resident may enjoy. For another resident, they had three active outcomes for 2026, however none of these were in progress and there were no updates recorded since January 2026 of what was planned to support the resident to achieve these. For the third resident, there was

evidence available that they had enjoyed outings such as a football game and an overnight hotel stay, with pictures of them there with a big smile.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

Residents were not subject to environmental, chemical or rights-based restrictive practices in this designated centre. All restrictive practices related to the use of safety equipment used to prevent accidents related to mobility, and these were kept under review to determine their continued necessity and suitability.

Judgment: Compliant

Regulation 8: Protection

The inspector reviewed incidents notified by the provider in 2025 and 2026 of alleged or suspected safeguarding incidents. While there was no major trend in these incidents, they were reviewed and used as opportunities to improve safeguarding practice. For example, where there had been an injury for which the cause was not readily apparent, the provider had conducted a review to determine the likely cause. Where these were inconclusive, measures were still taken to reduce likelihood of environmental injury. Where a resident's money had been misplaced, an investigation commenced involving all relevant parties and the resident was reimbursed in a timely fashion. This had also resulted in the creation of new protocols and risk assessments to protect staff and residents from further incident.

Judgment: Compliant

Regulation 9: Residents' rights

The staff had completed training in a human rights based approach to social care, and some staff described what this meant to them and how they aimed to implement this training in their duties. One example given was ensuring that the residents' presence in the community is normalised, and that they should not apologise to others if residents are vocal or if they take longer to complete tasks when participating in their community. Staff noted that personal plans could be improved to be more accessible to residents. Staff also noted the importance of

ensuring that accessible facilities in locations outside of the centre are suitable for the specific needs of residents to protect their dignity when planning outings.
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	
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Quality and safety	
Regulation 10: Communication	Not compliant
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Community Living Area 40 OSV-0008749

Inspection ID: MON-0050279

Date of inspection: 27/05/2026

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant

Outline how you are going to come into compliance with Regulation 15: Staffing:

Reg. 15 (1)
A full review of staffing arrangements has been completed to ensure that appropriate staffing levels, skill mix, and continuity of care are maintained for residents with complex and assessed needs. A rolling roster will be implemented from the 10th July 2026. In the meantime, rosters have been amended to ensure regular staff are rostered.

Agreed staffing levels, based on the assessed needs of the residents, will be utilised at all times. This will ensure adequate staffing is in place to meet residents needs..

The Person in Charge will maintain oversight of staffing through weekly roster reviews to ensure that staffing arrangements remain compliant, effective, and responsive to the evolving needs of residents.

Reg. 15 (3)
A rolling roster has been devised and will be implemented from the 10th July 2026 to strengthen staff consistency and continuity of care. Each shift is structured to include regular staff members, including a staff member confident to drive the accessible vehicle, which will enhance residents' access to community activities.
Planned absences will be managed proactively, through the use of a dedicated internal relief panel, with priority given to staff who are known to the residents. Where regular relief staff are not available, agency staff will be used strictly as a last resort, and where their use is unavoidable, every effort will be made to secure regular and familiar agency personnel to maintain continuity of care and minimise disruption to residents.
Induction processes have been reviewed and strengthened to include more detailed information.
A communication book has been reintroduced as an information sharing system for all staff, including permanent, relief, and agency personnel and all staff have been reminded

that they must read all epic-care daily progress notes since their last rostered shift. This ensures that every staff member is fully informed of any changes to residents' individual support needs.

Regulation 16: Training and staff development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:

Reg. 16(1)(a)
The Person in Charge will ensure that each staff member has access to and completes all mandatory training as required, including fire safety and FEDS training. All agency staff are required to complete the reviewed and updated local induction prior to commencing shifts to ensure they are familiar with residents' needs and service requirements.

A referral to the Speech and Language Therapist specialising in AAC (Augmentative and Alternative Communication) was submitted on the 26th of June 2026 to support communication assessments for all three residents. Follow up will be undertaken to progress this referral. Once assessments and staff training are completed, recommendations will be implemented in practice, ensuring staff are equipped to support residents' communication needs.

Reg.16(1)(b)
Weekly mgmt. team meetings are conducted between the Area Director and Person's in Charge to review residents' needs across each designated centre and to address any concerns raised by managers, with peer and managerial supports provided as required. Formal support and supervision meetings between the Area Director and Person in Charge take place at least bi-annually, alongside regular informal support meetings. Ongoing oversight of staff development and performance will be maintained through the audit system and staff support & supervision meetings.

Regulation 23: Governance and management	Substantially Compliant

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

23 (1) (a)
Going forward, agreed staffing levels based on the assessed needs of the residents, will be utilised seven days a week. This will ensure the centre is adequately resourced to ensure effective delivery of care and support.

Reg 23(1)(c)
Monthly staff meetings, quarterly audits, and six-monthly provider audits are in place to monitor that the service provided is safe and appropriate to resident's needs. The Person in Charge will maintain a strong presence in the centre to oversee that monitoring systems are utilised effectively.
A team meeting was held on 25th June 2026, outlining that all outings, activities and

community involvement must be recorded electronically on epi-touch and paper records must be discontinued. Following the weekly house meeting, staff must inform the PIC of all planned activities for the week ahead. Residents' personal plans will be printed in an accessible format, including the use of pictures, to ensure they are easily understood and meaningful to each individual.

Regulation 10: Communication	Not Compliant
Outline how you are going to come into compliance with Regulation 10: Communication: Communication plans will be reviewed and updated to include clear, person-centred approaches and practical guidance for staff, supporting residents to express their needs, preferences, and choices in line with their abilities. A referral to the Speech and Language Therapist specialising in AAC (Augmentative and Alternative Communication) was submitted on the 26th of June 2026 to support communication assessments for all three residents. Follow up will be undertaken to progress this referral. While waiting for assessments to be completed, staff will avail of Total Communication/AAC tailored training programme. Once assessments and staff training are completed, recommendations will be implemented in practice, ensuring staff are equipped to support residents' communication needs.	

Regulation 26: Risk management procedures	Substantially Compliant
Outline how you are going to come into compliance with Regulation 26: Risk management procedures: Reg. 26(2) The risk register and overall risk assessment process was reviewed at the team meeting on 25th June 2026. It was identified that one risk assessment required further clarity in relation to control measures. This has now been updated to include clear and specific control measures and defined responsibilities.	

Regulation 5: Individual assessment and personal plan	Substantially Compliant
Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan: Reg. 5(4)(b) Personal plans (PCP's) were discussed at the team meeting on 25th June and will be reviewed and updated to ensure the inclusion of clear, measurable goals that reflect each resident's assessed needs and preferences. The Person in Charge will conduct quarterly reviews of each PCP to ensure that the existing system for monitoring progress is being followed and documentation/quarterly reviews are updated as per policy. PCP's will be discussed at team meetings and each keyworker will be responsible to give an update on the progress of goals for each person they support.	

Reg. (5)(5)
Personal plans (PCP's) will be printed in accessible format, including the use of pictures/photographs to enhance residents' understanding and involvement.

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 10(1)	The registered provider shall ensure that each resident is assisted and supported at all times to communicate in accordance with the residents' needs and wishes.	Not Compliant	Orange	30/10/2026
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.	Substantially Compliant	Yellow	10/07/2026
Regulation 15(3)	The registered provider shall ensure that residents receive continuity of care and support, particularly in	Not Compliant	Orange	10/07/2026

	circumstances where staff are employed on a less than full-time basis.			
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.	Substantially Compliant	Yellow	30/10/2026
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	31/08/2026
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.	Substantially Compliant	Yellow	05/06/2026
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.	Substantially Compliant	Yellow	30/07/2026

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.	Substantially Compliant	Yellow	25/06/2026
Regulation 05(4)(b)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which outlines the supports required to maximise the resident's personal development in accordance with his or her wishes.	Substantially Compliant	Yellow	30/07/2026
Regulation 05(5)	The person in charge shall make the personal plan available, in an accessible format, to the resident and, where appropriate, his or her representative.	Substantially Compliant	Yellow	30/08/2026