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:	Ballygunner Village
Name of provider:	Orchard Community Care Limited
Address of centre:	Waterford
Type of inspection:	Short Notice Announced
Date of inspection:	19 January 2026
Centre ID:	OSV-0009066
Fieldwork ID:	MON-0049124

About the designated centre

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

Ballygunner Village is a residential care facility for up to 7 residents at a time who present with intellectual disability and /or autism. The residents may also have co-morbidities such as mental health needs. The centre is also designed to meet the needs of any individual who requires support with their mobility and is wheelchair accessible. The designated centre comprises of two houses Ballygunner Village and Lower Grange. Both premises have individual resident bedrooms, along with kitchen, dining and living areas. Ballygunner Village provides 24-hour care 7 days a week to adults over the age of 18. Ballygunner Village works off the model of Social Care. Residents will be supported through a number of multi-disciplinary inputs including both Orchard staff and Community based support. Residents at Ballygunner Village can avail of a range of social activities, hobbies, and leisure interests on and off site. These are coordinated by the Manager/ keyworker and supported by the Care team working at Ballygunner Village. As well as good access to public transport, there will be individual cars available for transport to all external activities.

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
Monday 19 January 2026	09:30hrs to 18:00hrs	Sinead Whitely	Lead
Monday 19 January 2026	09:30hrs to 18:00hrs	Sarah Mockler	Support

What residents told us and what inspectors observed

This centre was inspected on 04 November 2025, where significant risks were identified in the centre. Very poor levels of compliance with regulations were found and there were serious concerns around premises condition, risk and medicine management. Such were the levels of concern observed, the Chief Inspector of Social Services, issued a formal warning to the registered provider regarding the operation of this centre. The provider had submitted a response to the warning letter with written assurances and actions on how compliance was going to be achieved. This inspection was to follow up on the levels of progress made in this centre.

Overall, findings indicated that while some actions had been addressed since the previous inspection, inspectors were not assured that sufficient improvements had happened in the centre to ensure the residents were safe at all times. Continued poor levels of compliance were noted in the areas of risk management and safeguarding residents in particular.

The designated centre comprises two separate homes, located approximately 10 minutes drive away from each other. The inspectors visited both premises on the morning of the inspection, with one inspector visiting the first home and the second inspector visiting the second home.

In the first premises, the inspector observed the service vehicle in the centre's driveway and noted that the window on this vehicle had been repaired since the previous inspection.

One resident was present on arrival to this first home and they greeted the inspector. The person in charge was also present and invited the inspector into the house and to sign the visitors book. The inspector chatted with the resident about how they had been doing. The inspector asked how their Christmas had been and the resident told the inspector about presents they had gotten and items they had purchased. The resident appeared at ease in their home and in the company of staff. The resident told the inspector they had no plans for the day and for the most part, the inspector observed them on the couch in the centre's living room throughout the day, watching television, eating or doing jigsaws in the kitchen with staff.

Staff communicated that the second resident living in the home had left the house earlier in the morning to go to the gym. The resident was doing this independently and unsupported by staff.

The inspector completed a walk around the premises facilitated by the person in charge. The premises was clean and in a good state of repair. Improvements were noted in the premises since the centre's previous inspection. Actions had been

completed by the provider such as paintwork, providing more storage, improvements to laundry facilities and supporting residents with organisation and cleanliness in their bedrooms.

The second resident returned to the house later in the day and engaged briefly with the inspector. They communicated that they were well when asked, and that they had enjoyed their trip to the gym.

One inspector visited the second home associated with the designated centre. The inspector was brought in through the back of the building due to identified risks and were asked to park their car in a specific place. On entering this part of the building the inspector noted two offices and a door on a key lock mechanism which lead to the main part of the home. The inspector completed a walk around with the team leader and behaviour support specialist. There was also three staff members present. The resident was in bed at this time.

The inspector saw all parts of the designated centre. It was discussed with the inspector that a painter was due on site later in the day to paint the resident's bedroom. The painter arrived later in the morning to complete the necessary works. The resident had access to a bedroom, kitchen, bathroom and sitting room. Overall, the home was clean and well maintained. All repair works that had been identified on inspection on 04 November 2025, had been completed.

The inspector briefly met with the resident while they were in the sitting room. The inspector was advised to interact in a particular manner to make sure the resident felt at ease in their presence. Staff were present during this interaction and were seen to support the resident in a kind and supportive manner. The resident presented as relaxed and called staff by name. Later in the morning the resident left the home for the day to go for a drive.

The three residents living in the designated centre did not attend any day services, training, education, employment or regular activities. One resident attended the gym daily. Staff and management communicated that this was in line with the resident needs and preferences and daily activation was determined by the residents daily requests.

The next two sections of the report present the inspection findings in relation to the governance and management arrangements in the centre, and how these arrangements impacted on the quality and safety of care for the residents.

Capacity and capability

The inspectors continued to have concerns regarding the governance and management systems in the designated centre. Inspectors were not assured that

monitoring systems were providing adequate oversight of the quality and safety of the residents' care.

Inspection findings indicated that while audits and reviews had happened since the centre's previous inspection, risk identification and management continued to be poor, along with the arrangements in place to safeguard residents.

Overall, the systems in place were not effective in driving meaningful improvements across all areas of service provision.

Regulation 23: Governance and management

Governance and management systems were failing to bring around the required improvements to ensure that the centre was meeting the requirements of the regulations. This was continuing to have an impact on the quality of care being delivered to the residents within the centre.

Following the previous inspection, the provider submitted written assurances, following formal warning, on the actions that they would be take to improve the service. The inspectors reviewed the actions and noted that seven actions remained either outstanding or not completed to a satisfactory level at the time of inspection. This included the following:

- Person in charge to take part in a structured programme of supervision
- Person in charge to engage in peer support
- Review of risk assessments
- Incident reviews to occur on all incidents
- Risk management tool box to be completed with all the staff team
- A specific education program around supplement use
- Introduction of a medication self-administration support plan

Due to the lack of formal supervision in place and relevant peer support for the Person in Charge, they were not identifying areas in need of improvement within the service. Inspectors acknowledge that a level of supervision had taken place. However, documentary evidence of this was not available on the day of inspection and inspectors were not assured that this was sufficient. The lack of resources put in place to adequately support the Person in Charge in their role was impacting on their ability to effectively manage the service. The inspectors were therefore not assured that effective arrangements were in place to bring the centre back into compliance with the regulation.

The other impact of the outstanding actions was evident in the risk management systems. For example, due to the poor review of risk assessments and a lack of incident reviews , the inspectors found significant gaps in risk management processes and poor systems in place. This was continuing to have a negative impact

on residents' care and support and will be discussed further under Regulation 26: Risk Management.

The inspectors reviewed the monthly audits that had been put on place and were completed by the person in charge to review the care and support in place. The inspectors found that the audits were of poor quality and were not identifying or driving quality improvement within the centre. For example, on review of the audit completed around finances the inspectors saw that four specific questions were asked and the answer to the questions were 'yes' or 'no'. The audit completely failed to identify the gaps in the management and oversight of the resident's finances. The audit did not identify any areas of improvement. This was not in line with what was occurring as the provider had no oversight of the resident's finances due to a lack of timely action on submitting the necessary paperwork to the residents' bank. This posed a significant financial safeguarding risk.

Similar patterns were identified in relation to medication audits. Although a medication audit was submitted following the inspection, the person in charge was unaware of this audit and the findings of it on the day of inspection, which indicated that the systems were not effective in ensuring all the local management team were provided with the information to make the relevant improvements to this aspect of the service. These governance systems in place were found to be disconnected and required review to ensure all systems were fit for purpose and effective.

Judgment: Not compliant

Quality and safety

Overall although residents lived in a clean and well maintained home and there had been some improvements since the last inspection, inspectors were concerned with poor practices found in the critical areas of risk management and resident safeguarding. These gaps did not demonstrate comprehensively reviewed quality and safe care practices nor did it demonstrate appropriate oversight and capacity on the part of the provider.

There was continued poor practices also observed in the assessment of residents needs. High quality care must be assessment led and residents should be supported and stimulated to lead fulfilled meaningful lives. This inspection found there were clear deficits in this regard in this centre.

This was found to have a negative impact on residents quality of life.

Regulation 17: Premises

The designated centre comprised of two separate premises and the inspectors completed a walkaround both houses on the morning of inspection with verbal consent from the residents. Both houses appeared in a suitable state of repair. The provider had addressed premises issues since the centres most previous inspection. This included paintwork, providing more storage, improvements to laundry facilities and supporting residents with organisation in their bedrooms.

Judgment: Compliant

Regulation 26: Risk management procedures

In November 2025 the provider was issued with immediate and urgent actions to address the serious deficits present in risk management in the centre. The current inspection identified that some actions had been taken to address risk, such as the introduction of risk assessments, control measures and incident reviews. However these systems had not been introduced in a systemic and robust manner and were still failing to adequately ensure residents were safe at all times.

A number of serious incidents had continued to occur in the centre, including a resident absconding from the centre, a resident refusing to return to the centre, and a resident locking themselves in a room without staff supervision and engaging in significant property damage.

On review of the risk assessments in relation to these risks the inspectors were not assured that they were adequate or in line with the levels of risk evident. For example, in terms of the risk assessment around managing behaviour of concern, this had not been updated to indicate that the resident had locked themselves in a room without supervision (had occurred on three occasions as documented on the risk incident report forms) or what the relevant control measures were in place. This did not provide assurance that this resident could be kept safe.

In addition, a risk assessment that was rated at one of the highest risk ratings had been removed from the risk register. When the inspectors asked how this decision was made and what was the process in relation to this it was confirmed that a discussion was had but no systematic review of the risk had occurred to a meaningful degree. This risk related to the resident refusing to return to the centre and had only started to manage to return to the centre on a consistent basis over the preceding three week period. The removal of this risk assessment was deemed premature and not in line with best practice in relation to risk management.

The inspectors asked to review the process for incident reviews. The inspectors asked to see the review of the incident whereby a resident left the centre on an electric scooter without staff permission/supervision. There was no incident review in relation to this serious event. The inspectors do acknowledge that the electric scooter was no longer as easily accessible but the lack of incident review in any

systematic manner or in line with the assurances submitted to the Chief Inspector was concerning.

Additionally, a second incident review stated that a risk assessment and care plan was required for t a specific control measure was in place around a resident travelling in a vehicle. This had not been completed.

On review of the staff meeting notes dated 11 November 2025 it stated that ' a residents inappropriate behaviour towards a staff member within the home have all been appropriately documented'. When the inspectors asked about the behaviour and sought to review this corresponding documentation, there was nothing available.

An inspector also reviewed the daily notes and it had not been recorded. This incident was reportedly of a serious nature and no risk process, such as incident form, incident review, or risk assessment had been considered or put in place. This did not assure inspectors that the systems, approach or culture of risk management in this centre was adequate.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

The inspectors noted that some improvements had happened in the area of medication management since the previous inspection. Staff had evidence of up-to-date training in medication management. Safe and secure storage facilities were in place for medication and medications had been removed from residents bedrooms. Residents all had a prescription Kardex in place that was signed and dated by a general practitioner (GP)

However, some improvements were still required to ensure safe practice at all times. This was seen in the following areas:

- It was noted that the information in one residents PRN protocol did not align with administration directions on their corresponding prescription Kardex.
- Two topical creams were observed as opened with no evidence or record of when they had been opened.
- A review of residents medication blister packs found that staff were not administering medication in accordance with the days outlined on the blister packs. This was not in line with medication management training and the ten rights of medication management and posed a risk of residents missing a dose of medication or receiving a double dose of medication.

The provider had committed to providing training and support on medication management for one resident living in the designated centre. This was an action identified on the providers quality improvement plan and on their warning letter response to the Chief inspector. This training had not occurred in line with the time

lines identified as the resident had spent a period of time away from the designated centre since the previous inspection.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

The designated centre was not suitable to meet the needs of one resident. The resident had communicated with staff and management on a number of occasions that they no longer wanted to live in the designated centre and had self-discharged from the service for twelve days in December 2024. They had also refused to return to the centre on a number of occasions. The inspectors found that measures in place were not adequately meeting their needs to a meaningful degree.

Recommendations were made by one resident's psychiatrist in November 2025 in relation to the management of their food intake. This had not been implemented into the resident's personal plan of care. This included a recommendation to encourage regular meals, post meal supervision and a weighing schedule. Staff spoken with communicated that this recommendation had not been followed. The resident had no recorded weight on file since this clinical recommendation was made. This posed a significant risk to the resident due to their history and the provider had failed to put any care plans in place to address this need and follow this recommendation. The residents previous residential placement had highlighted risks regarding food intake prior to admission.

The inspectors reviewed one assessment of need. The assessment of need is an essential document to guide the resources, supports and other aspects of care and support that are required for each individual within the centre. The inspectors found that the assessment of need was not comprehensive, accurate or reflective of the resident's needs. For example, the assessment document was incomplete. This posed a significant risk as there was no systems or record in place on how the resident’s needs were effectively assessed. For example, the assessment of need did not list the resident’s current diagnosis under the section entitled ‘Medical Diagnosis’s- Psychological or how these needs could be met. This section was blank and the resident's formal psychological assessment was not reflected on any part of the assessment of need document, which was supposed to guide staff practice.

In addition, under the need that assesses the supports around toileting, it stated 'prompting/cueing' with no other details added. This was not in line with the residents' needs. They had complex support needs around this area of toileting/intimate care and support and this was not reflected in their assessment of their needs.

A resident had been living in the centre since October 2025. The inspector could not find any details or record in relation to needs around dental, optical or other routine medical appointments. It was confirmed with the inspector that their was no

knowledge around these needs and the staff were unaware of the last times the resident attended any of these types of appointments. There was no plan in place on how these needs were going to be met and considering the residents specific assessed needs. This was a significant concern as this did not demonstrate standard care and support practices.

Activation for residents in the centre was observed to be very limited. The three residents living in the designated centre did not attend any form of day services, training, education, employment or regular meaningful activities. One resident attended the gym daily. Staff and management communicated that this was in line with the residents preferences and daily activities were determined by the residents daily requests. This was deemed sub standard by inspectors based on all evidence reviewed.

Judgment: Not compliant

Regulation 8: Protection

Overall the inspectors were not assured by the safeguarding systems in place in this centre.

Improvements were required in the area of safeguarding residents' finances. One resident had spent €8,500 from their personal finances over a three month period in 2025, following their admission to the designated centre. The inspectors saw limited evidence of tangible assets or outcomes for this resident to show for their substantive spending. The resident's previous residential placement had highlighted to the current provider on admission, that overspending was a known risk to this individual. Sufficient supports and safeguards were not put in place at point of admission to manage this risk. Inspectors acknowledge that some work had been done with this resident in recent weeks to support and manage their spending and a new restrictive practice was in place on the day of inspection. However, a significant sum of money over three months had been spent prior to this being put in place.

Another resident in the centre required full support to access their finances. To date the provider had not reviewed or put in place any measures to safeguard their finances. There were no bank statements in place and no other means to cross check expenditure/balances with spending. When the inspectors asked about this, they were told that the bank required documentation to transfer the account to the new provider for relevant oversight. Relevant documentation and an email instruction had been sent to the provider on the 13 October 2025. This had not been actioned. The inspector asked that the documentation was submitted by the end of the inspection day. The provider had completely failed to take any responsive action in relation to ensuring robust financial safeguards were put in place.

The inspectors asked for any safeguarding plans that were or had been put in place. Staff present were unaware if any safeguarding plans were in place and they could

not locate any copies of safeguarding plans in the centre on the day of inspection. This had also occurred on the last inspection. At the feedback meeting the Person Participating in Management (PPIM) assured the inspectors that all a safeguarding plans had been closed to the safeguarding and protection team and provided evidence of same. However, no copies of safeguarding plans were available in the centre on the day of inspection and there was a lack of staff knowledge in relation to the importance of knowing, understanding and accessing safeguarding plans to guide practice. This did not provide assurance that safeguarding was managed effectively in this centre.

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 23: Governance and management	Not compliant
Quality and safety	
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 8: Protection	Not compliant

Compliance Plan for Ballygunner Village OSV-0009066

Inspection ID: MON-0049124

Date of inspection: 19/01/2026

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 23: Governance and management	Not Compliant

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

Weekly governance and oversight meetings have commenced, led directly by the CEO. These meetings include the Quality Director, OCC Managing Director, Person in Charge (PIC), Team Leads, Behaviour Support Therapist, and Quality Manager/Quality Coordinators, ensuring strong senior leadership involvement and continuous oversight. These meetings are in place for a defined period to drive immediate improvements and provide assurances and will remain in place until the necessary standards and outcomes are fully embedded.

A structured weekly work plan has been developed for the PIC, supported by the Quality Assurance Coordinator and overseen by the Quality Director/PPIM. This six-week plan clearly prioritises regulatory actions and guides timely, consistent implementation to support the centre to come into compliance.

Weekly on-site support is being provided to the PIC and Team Leads by the Quality Director/PPIM to ensure hands-on guidance and strengthened governance.

Targeted training and mentoring for the PIC is underway, including a full-day regulatory mentoring session delivered on 9 March by Wolfe Training. This provides enhanced regulatory understanding and practical guidance.

A formal supervision schedule is in place for the PIC, with supervision sessions focused on governance, risk management, and regulatory compliance to ensure continuous development and accountability.

The PIC has been connected with an experienced PIC from another service to provide additional peer support, shared learning, and strengthened professional networks.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
The PIC and PBSS have undertaken a full review of all retrospective incidents to ensure there is evidence of reviews and there is evidence of incident learning that has been shared with the team.

A new incident management process has been introduced to clearly define responsibilities and ensure consistent handling of all incidents. The system is now risk-rated, includes a structured review process, and incorporates clear escalation routes. These enhancements provide strong assurance that incidents will be prioritised appropriately, monitored effectively, and resolved with transparency and accountability.

All risk assessments are being reviewed to ensure that risks identified through incidents are consistently captured, that control measures accurately reflect the supports in place, and that all known risks within the centre are appropriately identified, assessed, and recorded.

The centre's risk register has been reviewed, and absconsion risk has been reinstated. All medium-to-high risks must be escalated to the centre's risk register. In this designated centre, no high/red risks may be downgraded or removed without a documented multidisciplinary review and formal PIC approval.

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
All topical creams are labelled with opening dates, and correct administration against blister pack days are in place.

PRN protocol and Kardex have been reviewed by the Psychiatrist and has been updated to outline clearer and consistent administration guidance.

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:
Comprehensive assessments of need will be revised to ensure that all diagnoses and all the residents assessed needs are identified and have a corresponding support plan in place.

Healthcare support plans will be developed and maintained for each resident, ensuring dental, optical, medical and routine health appointments are identified, scheduled and tracked in line with each residents assessed need, will & preference.

Each residents activity planners will be revised to ensure they are structured, meaningful, to ensure regular engagement, focused on skill development and community participation.

For a resident who wishes to live in a more independent environment, a support plan will be put in place to support and guide the skills and requirements he needs to be fulfil this goal.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:

All documentation to change signatories on the resident 0126's account have been signed and submitted to the bank for processing.

Bank statements have been received, and a full audit and cross-check of all financial transactions has been completed. All transactions for residents whose finances are supported by staff have been verified and validated.

Safeguarding preliminary screenings for the financial concerns raised for both residents have screened and submitted to the HSE safeguarding team. NFO6s have also been submitted to the Authority.

All open safeguarding concerns reported to the HSE Safeguarding Team and HIQA will continue to be included in the monthly governance and oversight report submitted to the Quality Department. These safeguarding concerns will also be reviewed and discussed at team meetings to ensure staff remain fully aware of active concerns, understand required safeguarding actions, and maintain consistent implementation of all protective measures. Going forward, all staff will be required to read and sign the minutes of each team meeting to ensure that all team members have a clear and documented understanding of current safeguarding concerns and their responsibilities in implementing the required actions.

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 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	13th March 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	27th March 2026
Regulation 29(4)(b)	The person in charge shall ensure that the designated centre	Substantially Compliant	Yellow	9th March 2026

	has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine which is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.			
Regulation 05(2)	The registered provider shall ensure, insofar as is reasonably practicable, that arrangements are in place to meet the needs of each resident, as assessed in accordance with paragraph (1).	Not Compliant	Red	6th March 2026
Regulation 08(1)	The registered provider shall ensure that each resident is assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection.	Not Compliant	Red	27th February 2026
Regulation 08(3)	The person in charge shall initiate and put in place an Investigation in relation to any incident, allegation	Not Compliant	Orange	20th March 2026

	or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.			