



# Report of an inspection of a Designated Centre for Disabilities (Adults).

## Issued by the Chief Inspector

Name of designated centre:	Breakfree Lodge
Name of provider:	Enable Ireland Disability Services Limited
Address of centre:	Clare
Type of inspection:	Announced
Date of inspection:	11 March 2026
Centre ID:	OSV-0002031
Fieldwork ID:	MON-0041086

## About the designated centre

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

Breakfree Lodge provides a full-time and respite service to a maximum of three adults with a physical disability. In its stated objectives, the provider strives to provide each resident with a safe home and with a service that promotes inclusion, independence and personal life satisfaction. Residents have access to day services each day and transport is available to facilitate day service activities. Residents present with a broad range of needs in the context of their disability and the service aims to have the arrangements in place to meet these needs. The premises is a bungalow style property located in a rural but populated area and is a short commute from a broad range of services and amenities. Each resident has their own bedroom. One bedroom has universally accessible ensuite facilities. Residents share communal, kitchen, dining and bathroom facilities. The model of care is social but given residents' assessed needs the staff team is comprised of social care and nursing staff under the guidance and direction of the person in charge. Ordinarily, there are two staff on duty during the day and during the night. Staffing arrangements are altered, depending on the mix of residents in the centre at any one time.

**The following information outlines some additional data on this centre.**

Number of residents on the date of inspection:	2
--	---

I

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 11 March 2026	09:30hrs to 16:30hrs	Mary Costelloe	Lead

## What residents told us and what inspectors observed

This was an announced inspection carried out following an application to the Chief Inspector to renew registration of the centre, to monitor compliance with the regulations and to follow up on issues that were required to be addressed following the last inspection in November 2024.

Throughout the inspection, it was evident that staff strived to ensure that the care and support provided to residents was person-centred in nature and that they prioritised the well-being and quality of life of residents. Overall, there was good compliance with the regulations reviewed on this inspection. The compliance plan submitted following the previous inspection had largely been addressed with improvements noted to staffing and overall governance and management. The provider had also put in place a new modular building to house an accessible laundry and storage facility. The provider still needed to progress planned improvements to install automatic opening devices to the patio doors in order to provide independent egress to wheelchair users. Other improvements were required to the upgrading of worn wooden flooring and to updating a positive behaviour support plan.

Break Free Lodge is registered to accommodate up to three residents. Two residents live in the centre on full-time residential basis and three persons avail of a respite service on a planned rotational basis. One person attends for respite at any given time ensuring that a maximum of three residents are present in the designated centre. There were no persons availing of respite at the time of inspection. The inspection was facilitated by the person in charge. The inspector also met with three other staff members who were on duty and with the adult services manager who attended the feedback meeting during the afternoon. The inspector met and spoke with both residents at intervals throughout the day, they also reviewed three completed questionnaires which residents and some respite service users had completed in advance of the inspection, all were very complimentary of staff and of the service provided.

The centre consists of a single storey house located in a rural area on the outskirts of a large town and close to a wide range of amenities. The house was found to be warm and comfortable, spacious, well maintained and visibly clean throughout. Residents had access to a large kitchen, dining room and sitting room. The house had been designed and well equipped to meet the assessed needs of wheelchair dependent residents living there. Overhead ceiling hoists were provided to all bedrooms and bathrooms to assist with mobility. Specialised equipment including chairs, beds, mattresses and showering equipment was provided. Service records reviewed showed that there was a service contract in place and all equipment had been regularly serviced. Corridors and doorways were wide and clear of obstructions which promoted the mobility of residents using wheel chairs. The kitchen had been modified and designed with height adjustable units to support residents

independence. Each resident had their own bedroom which they had personalised in line with their individual preferences including framed photographs, posters and other memorabilia of significance to them. One resident had their own accessible ensuite bathroom. The main bathroom was also suitably equipped and was shared by a resident and persons availing of the respite service. The bedrooms of both full-time residents had been designed to facilitate bed evacuation in the event of fire or other emergency. There was a new well equipped laundry room and store provided externally. The new laundry room was accessible to residents and a resident was observed using the facility during the inspection. While the communal sitting room patio doors opened directly to the garden and patio areas, access was still restricted. The provider had plans in place to install automatic opening devices to these doors in order to provide independent egress to wheelchair users however, they were still waiting on funding approval.

Both residents spoken with had a good understanding of the role of HIQA and the role of the inspector. They told the inspector that they loved living in the centre and were very happy with the service provided. Both residents had lived together in the same house for many years and advised that they generally got on well with one another. The inspector observed friendly and humorous banter between the two residents indicating a comfortable and supportive companionship between them. Both residents were provided with a wrap around service from the house. They both indicated that they could choose their own daily routines and attend their preferred activities. They mentioned how they could attend the providers day service programme when they wished or when preferred activities were taking place. One resident told the inspector how they liked to attend on the days when music therapy and baking activities were taking place. Residents advised how they enjoyed attending weekly key working meetings with their allocated key worker and could discuss, choose and plan their preferred activities and outings. They also mentioned how they could choose and plan their preferred menus each week. They talked about how they also enjoyed eating out, visiting local restaurants and coffee shops and sometimes enjoyed take away meals. Both spoke of how they were delighted with the new transport vehicle provided, and how they now had access to two vehicles which were available to support them in getting out and about as they wished.

On the day of inspection, both residents were noted to go about their own routines throughout the day. One resident went out early in the day to attend a planned wellness session and later spoke about how they had also enjoyed a trip to the local shopping centre and had lunch there. They were looking forward to visiting family members later in the afternoon and having their evening meal there. They spoke of how they enjoyed sitting in the kitchen having cups of tea and chatting with staff. The other resident advised that they preferred to get up later in the morning and plan their daily schedule. They advised that they planned to visit the local town to complete planned errands and were looking forward to going out to a local hotel for dinner in the evening. They mentioned how they liked to spend time relaxing in the house, listening to music, watching television and using their hand held computer. They spoke about their love of music, their favorite artists and how they regularly attended music concerts. They also mentioned how they were looking forward to planned day trips as part of their personal goal plans. They talked about how they

liked their bedroom and had everything that they needed there. They also spoke about their plans to redecorate their bedroom and how they were in the process of planning what type of storage units would be most suitable. They spoke very positively of the service, reporting that they were regularly consulted with and involved in decisions about their care and support. They stated that they had choices in their daily life and felt well supported by the staff team. They described the service as open and transparent. The residents also received a copy of the staff roster on a weekly basis, they mentioned how this was important as they liked to know what staff were going to be supporting them.

From conversations with residents and staff, observations made while in the centre, and information reviewed during the inspection, it was evident that residents were consulted with, were listened to, had choices in their lives and that their individual rights and independence was promoted.

The next two sections of the report outline the findings of this inspection, in relation to the governance and management arrangements in place in the centre, and how these arrangements impacted on the quality and safety of residents lives.

## Capacity and capability

There was a clearly defined management structure in place and the findings from this inspection indicated that the centre was being well managed. The local management team were committed to promoting the best interests of residents and complying with the requirements of the regulations.

The person in charge worked full-time. The person in charge was now based full-time in the centre and has had a reduction in managerial responsibility across other services in the organisation. This has resulted in increased time being allocated to the oversight and governance of the centre. This change supported managerial presence in the centre and enhanced the person in charge capacity to monitor the safety and quality of the service provided to residents. They were supported in their role by the staff team including nursing staff and adult service manager. There were on-call management arrangements in place for out-of-hours. These arrangements were clear and available to staff in the centre.

The provider had ensured that the staff numbers and skill-mix were in line with the assessed needs of residents. The inspector noted that there were adequate staff on duty to support residents on the day of inspection. There was now a full compliment of staff in place with a number of new staff having been recruited since the previous inspection. The inspector reviewed the staff rosters for March 2026 and noted that stable staffing arrangements were in place. The rosters also included the person in charge who normally worked Monday to Friday. The staff member in charge of each shift was clearly set out.

Staff training records reviewed indicated that all staff including relief staff had completed mandatory training. Additional training had also been provided to staff to support them in their roles and meet the specific support needs of some residents. Training requirements and opportunities were regularly discussed with staff at team meetings and at individual supervision meetings.

The provider had systems in place for reviewing the quality and safety of the service including six-monthly provider led audits and an annual review. The annual review for 2025 was completed and had included consultation with residents. The provider continued to complete six-monthly reviews of the service. The most recent review was completed in December 2025. Actions identified as a result of the review had been completed with the exception of the provision of the automated patio doors. For example, outstanding staff training had been completed, the new laundry room had been connected to the fire alarm system, restrictive practices in use had been reviewed, logged and notified as required to the Chief Inspector.

The local management team continued to regularly review areas such as incidents, fire safety, risk management, infection prevention and control, medication management, staff training, restrictive practices and residents records. The results of a sample of recent audits reviewed indicated satisfactory compliance. Regular staff team meetings were taking place at which the results of audits and actions required were discussed to ensure sharing of information, inform learning and improvement to practice. The inspector noted that there was a low level of reported incidents and no complaints had been received in the past year.

#### Registration Regulation 5: Application for registration or renewal of registration

The prescribed documentation for the renewal of the designated centre's registration had been submitted to the Chief Inspector as required.

Judgment: Compliant

#### Regulation 14: Persons in charge

The registered provider had appointed a full-time person in charge. The person in charge was suitably qualified and experienced for the role. The person in charge had a regular presence in the centre and was well known to residents. They were knowledgeable regarding their statutory responsibilities and the support needs of residents.

Judgment: Compliant

## Regulation 15: Staffing

The provider had ensured that there were adequate staff to meet the assessed needs of residents living in the centre. Recruitment had successfully taken place since the previous inspection and there was now a full staff compliment in place. The staffing skill-mix was appropriate to meet the needs of residents. There were normally two staff on duty throughout the day and two staff on sleep over duty at night-time. Nursing staff were also available to support and oversee residents health care needs. The rosters reviewed for the month of March 2026 showed consistent and stable staffing arrangements and were reflective of staff on duty.

Judgment: Compliant

## Regulation 16: Training and staff development

The provider had ensured that all staff who worked in the centre had received mandatory training in areas such as fire safety, positive behaviour support, manual handling and safeguarding. Additional training was provided to staff in various aspects of infection prevention and control, safe administration of medications, epilepsy care, feeding, eating and drinking guidelines, food safety management systems, advocacy and a human rights based approach to care. There were systems in place to oversee training and to ensure all staff were provided with refresher training as required. A review of the minutes of team meetings showed that training requirements were regularly discussed with staff.

Judgment: Compliant

## Regulation 23: Governance and management

The findings from this inspection indicated that the centre was being well managed. The compliance plan submitted following the previous inspection had largely been addressed. There was a clear management structure in place as well as an on-call management rota for out of hours and at weekends. The recruitment of additional staff had taken place to ensure that the designated centre was resourced in terms of staffing and in line with the assessed needs of residents.

The provider and local management team had systems in place to maintain oversight of the safety and quality of the service. The person in charge was now based full-time in the centre with increased time allocated to the oversight and governance of the centre with enhanced capacity to monitor the safety and quality of the service provided to residents. There was evidence that issues identified from a recent review of the service had been addressed with the exception of the

provision of the automated patio doors. The local management team advised that they were waiting on a decision on a grant application submitted to the Health Service Executive in order to progress this planned work.

Judgment: Compliant

### Regulation 3: Statement of purpose

The inspector reviewed the statement of purpose submitted with the application to renew registration. The statement of purpose and the associated floor plans required updating to accurately reflect all parts of the centre. For example, the new laundry and storage room provided were not included in the narrative description of facilities provided in statement of purpose or not included in the associated floor plans submitted.

Judgment: Substantially compliant

### Quality and safety

The provider had adequate resources in place to ensure that residents got out and engaged in activities of their choice and the staff team promoted and supported residents to exercise their rights and achieve their personal goals. The stable and consistent staffing supported the continuity of care and contributed positively to the overall quality and safety of the service. Residents spoken with confirmed that they were consulted with, had control over decisions regarding their care and support, their daily routines and could choose to partake in their preferred activities.

Staff were familiar with, and knowledgeable regarding residents' up-to-date health care needs. The inspector reviewed the files of three residents and noted that comprehensive assessments of the residents health, personal and social care needs had been recently updated. Support plans were in place for all identified issues including intimate care and specific health-care needs. Support plans were found to be comprehensive, informative, person centered and had been recently reviewed.

Residents had access to general practitioners (GPs), out of hours GP service and medial specialists and consultants. The person in charge outlined how residents made decisions about their care, and how refusal of interventions was also respected. A resident told the inspector how they made their own appointments with their GP and preferred to communicate with the GP by email. They also mentioned how they collected their own medications from their pharmacy as required.

Personal plans had been developed in consultation with residents and their key working staff. Key working meetings took place on a weekly basis and residents stated that they enjoyed attending, making and progressing plans. Files reviewed showed that residents had goals clearly set out for 2026. There were regular progress notes recorded with evidence that goals were being progressed and achieved.

The management team had taken measures to safeguard residents from abuse. All staff had received specific training in the protection of vulnerable people. There were comprehensive and detailed personal and intimate care plans to guide staff. Safeguarding was a standing agenda item and discussed at all staff meetings. A small number of safeguarding concerns had been notified to the Chief Inspector. These concerns were discussed with the person in charge who provided assurances that they were being managed in line with safeguarding policies. There was an interim safeguarding plan in place and the person in charge outlined how the resident was being supported in line with the recommendations set out in the plan.

The local management team had systems in place for the regular review of identified risk in the centre as well as regular reviews of health and safety, infection prevention and control and medication management. The management and staff team continued to review restrictive practices in use. Restrictions in use were being managed in line with national policy, had been risk assessed with a clear rationale outlined for their use. Residents had consented to, understood why restrictions were in place and agreeable to their use.

The local management team had fire safety management systems in place. All staff and residents had been involved in completing fire drills. Fire drill records reviewed provided assurances that residents could be evacuated safely in the event of fire. Residents spoken with confirmed that they had taken part in fire drills and advised that they had no concerns regarding fire safety management systems. The new laundry room had been connected to the fire alarm system.

The house was found to be comfortable, visibly clean, spacious, furnished and decorated in a homely style. However, the wooden flooring in some areas of the house was visibly worn and stained. The surface finish had deteriorated making it difficult to clean effectively. Residents that required assistive devices and equipment to enhance their mobility and quality of life had been assessed and appropriate equipment had been provided. There were service contracts in place to ensure that all equipment was serviced in line with service schedules.

## Regulation 11: Visits

Residents were supported and encouraged to maintain connections with their friends and families. There were no restrictions on visiting the centre. There was adequate space available to meet with visitors in private if they wished. Residents were supported to regularly visit family members.

Judgment: Compliant

### Regulation 17: Premises

The house had been designed and well equipped to meet the assessed needs of wheelchair dependent residents living there. The provider had invested in new accessible laundry facilities as well as facilities for the storage of equipment. The house was found to be warm and comfortable, spacious, generally well maintained and visibly clean throughout, however, the wooden flooring in some areas of the house was visibly worn and stained. The surface finish had deteriorated making it difficult to clean effectively. The provider also needed to progress planned improvements to install automatic opening devices to the patio doors in order to provide independent egress to wheelchair users.

Judgment: Substantially compliant

### Regulation 26: Risk management procedures

There were systems in place for the identification, assessment, management and on-going review of risk. There was a risk register in place, however, it was not structured in a way that provided a clear overview of key risks present in the centre. The management team outlined how the provider had planned a new electronic risk management system which was due to be rolled out nationally and that training was due to commence in April 2026. They advised that in the interim, a simplified excel risk register was being put in place.

There were regular reviews of health and safety, incidents, medication management as well as infection prevention and control. The recommendations from reviews were discussed with staff to ensure learning and improvement to practice. All residents had a recently updated personal emergency evacuation plan in place.

Judgment: Compliant

### Regulation 28: Fire precautions

There were fire safety management systems in place. Daily and weekly fire safety checks were taking place. There was a schedule in place for servicing of the fire alarm system and fire fighting equipment. All staff had completed fire safety training. Regular fire drills of both day and night-time scenarios were taking place involving all staff and residents. Fire drill records reviewed by the inspector provided

assurances that residents could be evacuated in a timely manner. The new laundry building had recently been connected to the fire alarm system. Emergency lighting had been installed in bedrooms since the previous inspection in order to provide safer evacuation in the event of an emergency.

Judgment: Compliant

### Regulation 5: Individual assessment and personal plan

Residents' health, personal and social care needs were regularly assessed and care plans were developed, where required. Care plans reviewed were found to be individualised, clear and informative. There was evidence that support care plans were regularly reviewed and updated as required. Care and support plans reviewed included recommendations and guidance from allied health professionals including speech and language therapist (SLT), physiotherapist and occupational therapist. For example, there was clear guidance from the SLT regarding specific requirements in relation to modified diets and feeding, eating and drinking guidelines, as well as, guidance relating to postural support protocols and sleep systems from the physiotherapist.

Judgment: Compliant

### Regulation 6: Health care

The local management and staff team continued to support residents access the health care that they needed.

Residents had regular and timely access to general practitioners (GPs) and health and social care professionals. A review of residents' files indicated that residents had been reviewed regularly by their GP, physiotherapist, occupational therapist, speech and language therapist, physiotherapist and chiropodist. Staff had been provided with training for some specific health care needs, such as, feeding eating and drinking guidance and epilepsy care.

Each resident had an up-to-date hospital passport which included important and useful information specific to each resident, in the event of they requiring hospital admission.

Judgment: Compliant

### Regulation 7: Positive behavioural support

All staff had received training in supporting residents manage their behaviour. Those who required support had access to behaviour support and behaviour guidelines were in place. The person in charge advised that the provider had appointed a nurse specialist in behaviour support. They outlined how they had recently made a referral to this specialist for a review and update to a behaviour support plan. This plan had last been reviewed in 2023 and did not sufficiently guide staff and outline proactive strategies to follow when some aspects of daily care and support was refused. The plan required updating to include person centered guidelines for staff on how to respond when the resident declined support. This is to ensure consistency and ensure that the residents dignity, autonomy and preferences are respected while promoting their well-being.

The local management team continued to regularly review restrictive practices in use with a further reduction in restrictions since the previous inspection. Residents could now easily access the laundry facilities when they wished.

Judgment: Substantially compliant

### Regulation 8: Protection

The provider had systems in place to ensure that residents accommodated were protected from abuse. All staff had completed training in relation to safeguarding. Safeguarding and associated topics were regularly discussed with residents at weekly house meetings and with staff at monthly team meetings. The contact details of the designated safeguarding officer was displayed. The inspector was satisfied that safeguarding concerns notified to the Chief Inspector were being managed appropriately in line with safeguarding policies. The person in charge confirmed that the resident was being supported in accordance with the recommendations contained in the interim safeguarding plan.

Judgment: Compliant

### Regulation 9: Residents' rights

Residents rights were promoted and respected in the centre. Residents spoken with during the inspection demonstrated a clear awareness of their rights and confirmed that they were supported to make their own decisions. Residents were supported to plan their own daily routines, including activities, outings and how they choose to spend their time.

Residents were facilitated to participate in the community and had opportunities to partake in activities of their choosing. This included attending social outings and

religious ceremonies. Residents were also registered to vote and could exercise their civil rights if they wished. Residents had access to information and communication resources in the centre. These included access to telephones, televisions, Wi-Fi, and computers which supported residents stay informed and stay in contact with family, friends and the wider community. There were good consultation practices in place. Regular opportunities were provided to residents to express their views. Weekly house and key worker meetings provided opportunities for residents to discuss their preferences, raise concerns and contribute to decisions about their care and the operation of the centre.

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
<b>Capacity and capability</b>	
Registration Regulation 5: Application for registration or renewal of registration	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Compliant
Regulation 3: Statement of purpose	Substantially compliant
<b>Quality and safety</b>	
Regulation 11: Visits	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	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
Regulation 9: Residents' rights	Compliant

# Compliance Plan for Breakfree Lodge OSV-0002031

Inspection ID: MON-0041086

Date of inspection: 11/03/2026

## 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 3: Statement of purpose	Substantially Compliant
Outline how you are going to come into compliance with Regulation 3: Statement of purpose: Floor plans were updated to include the new Laundry unit. The Statement of Purpose was updated including the new floor plans and details, submitted to DCD registration on 23.3.26 ]	
Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: Currently awaiting grant approval for automation of patio door for accessibility to residents. Plan in place to complete works by December 2026  Currently seeking quotes for sanding of the sitting room floor with a view to completion of works by September 2026 ]	
Regulation 7: Positive behavioural support	Substantially Compliant
Outline how you are going to come into compliance with Regulation 7: Positive behavioural support: 12.3.26 CNS visited Breakfree to start the process of Positive Behavioural Support. Input from CNS will be to update Positive Behaviour Support plans and provide training to staff. Date for completion 30.6.26 ]	

## 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 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	30/09/2026
Regulation 17(6)	The registered provider shall ensure that the designated centre adheres to best practice in achieving and promoting accessibility. He, she, regularly reviews its accessibility with reference to the statement of purpose and carries out any required alterations to the premises of the designated centre	Substantially Compliant	Yellow	31/12/2026

	to ensure it is accessible to all.			
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose containing the information set out in Schedule 1.	Substantially Compliant	Yellow	23/03/2026
Regulation 07(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.	Substantially Compliant	Yellow	30/06/2026