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:	Rathmore Residential Services
Name of provider:	Kerry Parents and Friends Association
Address of centre:	Kerry
Type of inspection:	Unannounced
Date of inspection:	08 July 2025
Centre ID:	OSV-0003430
Fieldwork ID:	MON-0047489

About the designated centre

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

This designated centre is comprised of three separate houses in close proximity to each other in the same rural village. A maximum of 15 adult residents can be accommodated and residents present with a diverse range of needs and abilities between the three houses and within the houses themselves. One house is purpose built; all facilities are at ground floor level and are designed and laid out to suit residents with higher physical needs. Residents avail of full time residential services; there is one bed allocated to the provision of respite and six residents would normally avail of this service. The provider aims to provide quality person-centred services to each resident in partnership with their family and connected to their community and support networks. The staff team is comprised of support staff, social care staff and nursing staff.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	14

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
Tuesday 8 July 2025	08:15hrs to 16:30hrs	Robert Hennessy	Lead
Tuesday 8 July 2025	08:15hrs to 16:30hrs	Lucia Power	Support

What residents told us and what inspectors observed

This was an unannounced inspection of Rathmore residential services undertaken following information submitted to the Chief Inspector of Social Services. The inspectors were met at the door by a staff member and then spoke with the person in charge. The designated centre was comprised of three house which were in various locations in the town. The first house visited was the largest house where 10 residents lived. The inspectors met with the 10 residents living there and met with one resident in each of the other houses.

The inspectors spoke with 10 of the residents in the first house visited. These residents were well dressed and were receiving kind and respectful support from staff through the day. One resident was met in the corridor sitting on a chair and spoke with the inspectors. The resident remained in the chair throughout most of the day. Staff reported that this resident liked to participate in work undertaken by the catering staff in the kitchen and would be usually busy assisting there but the catering staff was on leave the day of the inspection.

Another resident spoke with the inspectors and told them they felt safe in the house. They spoke about attending concerts and visiting family. The resident told the inspectors that they had participated in fire drills in the designated centre. Other residents spoke with the inspector while they were having their breakfast and this was relaxed experience for the residents. Residents were seen singing and listening to music during the morning of inspection. Two residents were met later in the day in the other two houses of the centre. They reported they felt safe and happy in their homes. One resident had just returned from their day out with staff and told the inspectors that they liked living their and preferred it to a house they had previously lived in.

One resident did speak to an inspector regarding their lack of social activities, not being able to attend their day service and their inability to attend appointments. This was due to a new wheelchair they had received which was required for them but not suitable to be used in transport due to the position of the chair. The resident had advocated for themselves and had contacted relevant people to seek support in finding a solution to the transport issue. The management team in the centre were fully aware of the concern and were assisting the resident with activities in the centre and getting the resident's friend from their day service to visit. The senior management team of the registered provider were also aware of the issue and had contacted the resident to assist them in this matter. The staff and resident told the inspector that a new occupational therapist had been to visit and discuss with the resident how this concern maybe overcome.

Residents were seen enjoying meal times with breakfast being served in an unhurried manner and at various times to suit the residents. There was a lunch time

meal served which provided a pleasant smell near the kitchen/dining area of the centre. Staff again were supporting residents in an unhurried manner at this time.

The residents were being supported by the staff in a kind and respectful manner. The staff respected the privacy and dignity of the residents throughout the day. From the staff interactions with residents is was clear that they knew the residents and their needs well.

The first home visited by the inspectors was purpose built and had communal and private space for the residents. The designated centre had homely furniture and was decorated with pictures and artwork of the residents. The bedrooms that were viewed were personalised and this was the case throughout the three homes. Areas of the first home visited required attention in relation to fire doors, flooring and the kitchen area which is outlined under Regulation 17 premises. The other two houses of the centre were seen to be homely. The entrance area to one of the houses was extremely hot due to the weather outside and was not suitable for residents to use at the time. Other areas of the premises of the designated centre that required attention are outlined under Regulations 17 and 28.

The next two sections of the report present 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 the service being delivered.

Capacity and capability

The inspectors found that the local management and staff team in the designated centre were very familiar with the residents living there and were committed to providing a service that met their assessed needs. The person in charge and staff team knew their responsibilities well and were working towards providing a person centred service.

There was an organisational structure in place. The senior management team were all on various types of leave on the day of the inspection. This was in line with information received prior to the inspection and how the registered provider had been slow to respond to queries and submit information when requested by the Chief Inspector in relation to fire safety in the designated centre. This is further discussed under various regulations in the report. An urgent action was issued to the registered provider seeking assurances around the governance and management of the designated centre.

Documentation reviewed included the statement of purpose in the centre which contained the information required by the regulations. The registered provider had policies, in relation to Schedule 5 of the regulations, in place but some of these

policies had not been reviewed in the last three years as required and this was a repeat finding from the previous inspection.

Regulation 14: Persons in charge

The registered provider had ensured that a person in charge had been appointed to work full-time in the designated centre and that they held the necessary skills and qualifications to carry out their role. Their remit was over this designated centre. The person in charge was seen to know the residents well and were seen to encourage residents to voice there concerns on what was happening in the centre. The person in charge was facilitating regular staff and residents' meetings to ensure that information was communicated effectively with all parties in the designated centre. The person in charge knew their role in relation to the regulations well.

Judgment: Compliant

Regulation 15: Staffing

There were an actual and planned roster was made available to the inspectors during the inspection. It was evident that the designated centre was appropriately staff in relation to the size and layout of the centre and in relation to the residents' needs. The staff team were providing support and care to residents in a consistent manner. Staff spoken with during the inspection were knowledgeable of the residents' needs. The staff team were seen to interact with residents in a kind and respectful manner during the day of the inspection.

Judgment: Compliant

Regulation 16: Training and staff development

The person in charge had an effective system in place for identifying and monitoring the training needs of the staff team. Staff had access to appropriate training for their roles. Some training was outstanding for staff in relation to positive behaviour support de-escalation and intervention techniques and safeguarding. Dates were provided to the inspectors following the inspection to assure that staff had been booked onto these training sessions. Training in relation to fire safety and information submitted to the chief inspector by the registered provider is discussed under Regulation 28.

Judgment: Compliant

Regulation 21: Records

An inspector reviewed the providers staffing files for their eight registered centres. This was to ensure the provider was compliant with regulation 21(1)(a) - records of information and documents in relation to staff specified under schedule 2.

The inspector reviewed these files at the providers main office as all the files were stored in the central office. The provider had given permission to the inspector by prior arrangement.

The inspector reviewed a sample of forty eight files over the eight designated centres, these included staffing roles such as person in charge, care assistants, nursing and social care staff. The inspector also reviewed staff who had permanent and relief contracts of employment.

All staff files reviewed had up to date Garda vetting which was furnished within a three year period. All other information as outlined under schedule 2 was in the staff files - For example contracts of employment, references, evidence of person's identity, employment history and all other documents under schedule 2.

Judgment: Compliant

Regulation 23: Governance and management

The local management team in the centre i.e. the person in charge and the deputy manager in the centre were keeping good oversight of the service being provided. Staff and residents meetings were taking place regularly to keep lines of information open in the centre. The local management team was promoting residents rights and they were striving to implement the registered provider's policy in relation to residents' finances and were working on ways to expand community access for a resident as their wheelchair was not suitable for the current transport available.

On the day of the inspection there was a deficit in members of the senior management team being available. This was acknowledged on the day of the inspection as not being sufficient. There was a lack of oversight for fire safety risks in the centre and the upkeep of the premises in the designated centre. Findings in relation to the premises also identified concerns in protection against infection. The concerns in relation to fire safety and premises is discussed under the relevant regulations.

An urgent action was issued to the registered provider under this regulation. There were concerns over the response from the registered provider in regards to fire safety work and upkeep of the premises in the designated centre.

There was not a clearly defined management structure for a period of time in the designated centre which meant the registered provider being unresponsive to requests for information to the Chief Inspector, the provider is ultimately responsible for ensuring these requests are submitted. The inspectors also reviewed provider assurance reports the provider had submitted to the chief inspector in relation to governance and management and safety of residents and actions they had agreed to complete. On the day of inspection a number of these actions had not been followed through on, and there was information the chief inspector requested that was still outstanding.

Judgment: Not compliant

Regulation 3: Statement of purpose

The registered provider had developed a statement of purpose. This document had been reviewed in the previous 12 months in July 2025 and outlined the care and support needs that residents received in their home. The document contained the information outlined in Schedule 1 of the regulations and was available to the residents and the inspector on the day of the inspection.

Judgment: Compliant

Regulation 4: Written policies and procedures

The registered provider had ensured the policies had been developed to meet the requirements of Schedule 5 of the regulations. From a review of these documents it was not evident that policies had not being reviewed in the last three years. This included the registered providers policy on closed-circuit television (CCTV), visitors, and the creation of, access to, retention of, maintenance of and destruction of records. The policy in relation to the provision of information to residents was not made available to the inspectors during the inspection. This was a similar repeat finding from the previous inspection of the designated centre.

Judgment: Not compliant

Quality and safety

An immediate action was issued to the provider in relation to the risk of fire an fire safety at night. The registered provider responded to this by placing an extra staff member at night to reduce the evacuation times of residents in the event of the fire. More information in relation to fire precautions in the designated centre is discussed under Regulation 28: Fire precautions.

Areas throughout the premises of the designated centre required attention. The inspectors viewed the premises and a list of the findings is outlined under Regulation 17: Premises. Areas of the premises that required also affected the centre in relation to infection control but the information is listed under the one regulation.

Risk management was well managed in the centre with appropriate risks identified and control measures put in place with the exception of a risk identified in relation to fire precautions. Medications in the designated centre were well managed with new systems and documentation being put in place to ensure medications were managed safely.

The individual assessment viewed by the inspectors were seen to be well completed and comprehensive. Residents' personal plans contained goals which were not extensive for residents and that there was a lack of evidence of review. Residents' health care needs were well met by the registered provider.

Residents safety in the centre was well managed with residents saying they felt safe in the designated centre. Safeguarding concerns were dealt with in line with the registered provider's policy. Staff had training in the area of safeguarding and residents had intimate care plans in place to support residents in this area.

The resident rights in the centre were being upheld by the staff and management teams. Rights in relation to residents' finances were highlighted by management in the designated centre and work was ongoing to come into line with the registered provider's policy in this area. One particular resident had lost access to social outings, their day centre and appointments. Extensive work had been undertaken by the management team to improve this for the resident but at the time of the inspection this had not been resolved.

Regulation 17: Premises

The premises was spacious, provided equipment to assist and was made homely with furniture and artwork. Resident had ample private and communal space in the centre. However, action was required in relation to areas of the premises such as:

- kitchen units in one part of the centre were damaged and worn (this was identified in a audit by the registered provider to be repaired by the 30/04/2025)

- areas of flooring throughout one home of the centre was rising, this was in the corridor of the home, in the utility and some of the residents' bedrooms
- there was evidence of leaks in the ceiling throughout the centre with some repairs completed but areas of the plaster work were not finished smoothly
- there were exposed wires hanging in areas throughout the centre
- the skirting area between the walls and floor in the larger building of the centre was breaking away from the walls in numerous places with areas of the walls damaged behind this
- there were holes in the ceiling in areas of the centre
- areas of the centre required repainting
- an entrance area to one of the homes of the centre was build with glass this was extremely hot and could not be used by residents on the day to relax in
- there were rusty planters and a rusty handrail in one of the areas of the centre
- the flat roof in one of the homes, which ran alongside the fire exit staircase, was covered in moss.

Some of these concerns are also related to Regulation 27 Protection against infection but are dealt with under this regulation.

Judgment: Not compliant

Regulation 26: Risk management procedures

There were processes and procedures in place to identify, assess and ensure ongoing review of risk. This included ensuring that effective control measures were in place to mange centre specific risks. The person in charge ensured regular reviews were being completed, with the most recent documented to have been completed in May 2025.

Risks had been escalated as required, but control measures identified did not overly reduced the risk in relation to fire safety, this is discussed under Regulation 28.

Individual risk assessments were also found to have been subject to regular review and control measures reflective of the supports being provided to each resident and their specific needs.

Judgment: Compliant

Regulation 28: Fire precautions

Fire safety equipment such as lighting, extinguishers and the fire alarm had been serviced in a timely manner. Fire safety checks were being completed by staff in the centre in a daily basis.

An immediate action was issued in relation to this regulation, with concerns identified over the ability of staff to evacuate residents in a timely manner at night and this risk being increased by some fire safety doors not operating correctly. The registered provider provided assurances by putting an extra staff on at night time to assist the residents in the event of a fire in the designated centre. There was a risk assessment in place which identified this as a high risk but it was not evident that this had been documented as discussed at senior management level. The inspectors had been informed that this had been discussed verbally with senior management. The risk assessment did not contain the control measures to mitigate the risk.

An overall schedule of works had been outlined by the registered provider in relation to fire safety works that needed to be completed in the centre. Repeated request had been made by the Chief Inspector for updates on these works and scheduled dates for when these works were due to be completed.

The registered provider had provided information to the Chief Inspector regarding fire safety management in the centre. Actions from this document which had not been completed included:

- setting up a monitored alarm for one part of the centre, was due to be completed on 23 May 2025
- 20 out of 30 staff members had not completed fire evacuation training including simulated evacuation which was due to completed on 18 April 2025.

On the day of the inspections it was seen that:

- a number of fire doors were not operating correctly with gaps and not fully closing
- an automatic door closure was not operating correctly
- fire daily safety checks were being completed but did not identify any issues with the fire doors in the centre.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

The registered provider had developed a policy on the safe administration of medicines which was reviewed in August 2024. Residents' medication documentation contained the information required by the registered provider's policy.

Staff spoken with told inspectors about the processes relating to the storage, disposal and administration of medicines. Inspectors also reviewed documentation

recording the completion of these processes. New documentation was now in place to ensure medication was managed in a safe manner and processes in place to manage medication being received from the pharmacy. There were PRN (medication given when required) protocols in place to guide staff and to record how well the PRN worked. Staff were double signing medication checks and there was a weekly PRN check in place. There was a dedicated medication fridge to store medication appropriately when required. There was no controlled medication stored in the designated centre on the day of the inspection.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

Findings in relation to residents' personal plans varied. Support plans were in also seen to be in place that provided good guidance to staff about the supports residents required to meet their health care needs.Residents' personal plans and assessments were by the inspectors. These assessments and plans had been reviewed in the previous 12 months.

The person centred goals that were viewed by the inspectors were not extensive and lacked evidence of review. For example one resident had identified a goal as more community involvement and another resident had a goal identified of going to the cinema. It was not clear whether these goals had been completed from the documentation viewed. Goal setting and implementation was identified as a concern for the management of the centre and they were aware of the concern before the inspectors identified the issue. The management identified that a person had been employed by the service shortly before the inspection to enhance the quality of the centre and it was hoped they would work in the area of goals setting for the residents.

One resident had five falls recorded since the beginning of 2025 in the incident log of the centre. The resident's fall prevention screening assessment tool had not being completed or reviewed since August 2024.

Judgment: Substantially compliant

Regulation 6: Health care

The registered provider was providing access to appropriate health care for residents. The residents had access to a general practitioner. here was detailed information recorded in each residents' personal file about their health care needs and how these were supported in the designated centre. Health care action plans were in place for identified health care needs and the records reviewed showed that

residents were supported to access appropriate health care and had access to appropriate health and social care professionals. Mental health supports were provided where required and residents had add access to a psychiatry services as required. Documentation also showed that residents' medications were being reviewed where appropriate. There was nursing support daily in the centre to assist the residents with their health care needs.

Judgment: Compliant

Regulation 8: Protection

The inspectors reviewed the safeguarding documentation in place for the centre. The documentation showed that any reported incident, allegation or suspicion of abuse since the previous inspection were being responded to by the person in charge, including investigations and actions taken.

Training records reviewed showed that the person in charge had ensured that almost all staff had received appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse. Training dates for the remainder of the staff were provided following the inspection.

Residents that spoke with the inspectors said they felt safe in the centre. Residents had extensive and informative intimate care plans in place to support them in this area. Staff were seen to implement residents intimate care plans in respectful and dignified manner ensuring that bathroom doors were closed and obtaining consent to assist residents in this area.

Judgment: Compliant

Regulation 9: Residents' rights

Residents living in the designated centre had access to their own bank accounts. 11 of 13 residents still had bank accounts with one institution where staff members withdrew money on behalf of residents. It was not evident if residents had been consulted with regarding this process. 11 out of the 13 residents used the same institution and it was not clear whether this was the choice of the residents. Two residents had now moved to different institutions and work was undertaken to assist the other residents to move to other financial institutions of their choosing.

One resident spoke with the inspectors about not being able to access the community because of the wheelchair they were using and it not being suitable for current transport. The resident was currently not able to leave the centre. This meant the resident was not able to attend appointments which were either

postponed or held virtually. All levels of management in the organisation were aware of the issue and were working on a solution for the residents' concern. The resident was being provided with activities within the designated centre but wished to return to their day service and meet their friends. Staff had facilitated their friends visiting the home on special occasions and had provided in house activities in the home, such as art and crafts. The resident was supported to contact advocacy services and local political representatives to see if they could assist in finding a solution to the resident's concern. A specialist occupational therapist had been sourced by the organisation and they had begun to work with the resident to find a suitable means of transport for them.

Judgment: Substantially 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 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 21: Records	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Compliant
Regulation 4: Written policies and procedures	Not compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Rathmore Residential Services OSV-0003430

Inspection ID: MON-0047489

Date of inspection: 08/07/2025

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:
All 3 ADOS`S have returned from leave to their posts.
Funding for additional ADOS and clerical grade 4 has been secured for a period of 12 months to enhance senior management oversight. Proposal to assign responsibility for Day Services to one ADOS, leaving the remaining three to support residential and respite services with a regional model of North and South of the County.
The ADOS department has a reporting structure in place to escalate if actions are not going to be completed in time. The additional administrative staff will support the Services department to review action plans regularly to highlight deadlines. The administration staff will monitor ADOS emails while on leave to identify actions required.
Protocol around the escalation of red risks to be developed and circulated.
Red risk to be discussed at Operations meetings monthly, or more frequently when required.
Operations Department are monitoring the progress of the Fire Remedial Works.
Quarterly meetings scheduled with Operations and Services to discuss and progress the Fire Remedial Works, more frequently when required.
Additional staffing has been put in place for night duty as an interim measure in the DC to support safe evacuation in the event of a fire until Tearmann Lodge is in compliance with the Fire Regulations.
Recruitment campaign completed and successful candidate has accepted the post as PIC to allow the designated Centre to be split into two which will enhance the oversight in the 3 houses. All actions from the provider assurance response submitted to HIQA on 25.04.2025 have now been completed. The provider forwarded the requested information to HIQA on 31.7.2025 this information is also attached.
Fire Evacuation training for all three houses has been completed.
The monitoring of the fire alarm is now in place for Tearmann Lodge.
The provider will develop a contingency plan in the event that the capacity of the senior team is impacted by unplanned and significant absence.

Regulation 4: Written policies and procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
The provider is committed to a schedule to review all policies that require update or review.

Policy in relation to the provision of information to residents is in place and has been reviewed. See attached.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
Repairs have been completed to the most affected floor covering in hallway. A requisition has been submitted to maintenance to carry out repairs to the kitchen units and counters. The hanging wires are now contoured.

When conservatory area is in use, blinds drawn and fans provided to cool down area to support the residents if area is hot. A requisition has been submitted for additional blinds for inside the front door. A protocol will be put in place for same. The rusty planters and handrail have been removed and replaced. A requisition has been submitted to remove moss from the flat roof. A discussion will be held with Operations in relation to works required for skirting, ceiling and painting works. All other actions identified under premises will be addressed as part of the scheduled fireworks and floor works.
Service of fire doors scheduled for the week of 25.8.2025 to identify works required.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Fire alarm monitoring is now in place and fire evacuation training has been completed for all staff. Information requested by the Chief Inspector was submitted on 31.7.2025 with the timescales for completion of works included, same attached. All red fire risks are now included in the senior team meetings and the Board. Fire Regulations and Red risks on agenda for Senior Team meetings.

Fire risk has been reviewed and controls have been updated to include a third night duty staff which has reduced the risk rating from high to moderate.
Service of Fire doors arranged for week of the 25.8.2025.

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:
Quality Improvement Project Planning meeting was held on 10.7.25 with Compliance Lead, Persons in Charge and Clinical Nurse Specialist. Resident's goals were discussed. Goal planning progress sheet created and is currently being trialled in Rathmore Services. We have developed a goal easy read format that is more supportive and inclusive for residents will and preference in their goal setting.

All Falls Stratify Tools are reviewed within recommended guidelines. Residents with high incidents of falls will be reviewed more frequently after falls incidents.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
An Easy Read Money Management Guide has been developed and implemented. It covers items such as where my money comes from and how it's used to rights under the ADM and practical tools for budgeting, shopping and planning. This universal support is being rolled out across services to facilitate financial discussions at keyworker meetings, resident forums and as part of the care planning in my assessment of need.

A best practice example of an easy read support plan is in place and has been shared across all centres for supporting residents with their individual banking and money management. It supports a template for an accessible personalised support plan detailing how a resident can be supported to know and understand their personal financial situation thus improving autonomy and decision making.

The Personalised support plans for finances now include a Consent Journey — a practical tool that maps how information is introduced, supported, and revisited over time, ensuring the person is meaningfully involved in financial decisions at a pace that suits them. This approach affirms each person's right to be supported in all decisions about their life, including how their money is managed.

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.	Not Compliant	Orange	29/04/2026
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Not Compliant	Orange	31/12/2025
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.	Not Compliant	Red	14/07/2025

Regulation 23(1)(b)	The registered provider shall ensure that there is a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.	Not Compliant	Red	14/07/2025
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	15/09/2025
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.	Not Compliant	Red	08/07/2025
Regulation 28(4)(a)	The registered provider shall make arrangements for staff to receive suitable training in fire prevention, emergency procedures,	Not Compliant	Orange	15/08/2025

	building layout and escape routes, location of fire alarm call points and first aid fire fighting equipment, fire control techniques and arrangements for the evacuation of residents.			
Regulation 04(2)	The registered provider shall make the written policies and procedures referred to in paragraph (1) available to staff.	Substantially Compliant	Yellow	31/12/2025
Regulation 04(3)	The registered provider shall review the policies and procedures referred to in paragraph (1) as often as the chief inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.	Not Compliant	Orange	31/12/2025
Regulation 05(1)(b)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out subsequently as required to reflect changes in	Substantially Compliant	Yellow	31/08/2025

	need and circumstances, but no less frequently than on an annual basis.			
Regulation 09(2)(b)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability has the freedom to exercise choice and control in his or her daily life.	Substantially Compliant	Yellow	30/09/2025