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:	Woodcrest
Name of provider:	Cheeverstown House CLG
Address of centre:	Dublin 6w
Type of inspection:	Unannounced
Date of inspection:	23 July 2025
Centre ID:	OSV-0003556
Fieldwork ID:	MON-0047133

About the designated centre

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

This designated centre comprises of three two-storey community residential houses, all located between two towns in Co. Dublin. The centre provides care and support to men and women with intellectual disabilities over the age of eighteen. The designated centre is registered to accomodate 11 individuals in total. House one can provide full-time residential care for three male individuals. The house consists of four bedrooms with one bedroom having an en-suite bathroom. There is a kitchen, dining room and sitting room with a garden area out the back. House two can provide residential care between Monday and Friday for up to three female individuals. The house consists of four bedrooms, a dining room, a kitchen and sitting room. One bedroom has an en-suite bathroom and there is a shared toilet and shower upstairs and a downstairs toilet. House three is registered to provide full-time residential care for up to five individuals. The house consists of single bedrooms, a kitchen/dining area and a sitting room. There are two bathroom/shower rooms with toilets upstairs including a downstairs toilet. There is a garden area out the back. The person in charge shares their working hours between the three houses within the designated centre. There are staff nurses, social care workers and core support staff and resource staff employed in this centre to support the residents.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	7

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 23 July 2025	10:30hrs to 18:30hrs	Karen Leen	Lead
Wednesday 23 July 2025	10:30hrs to 18:30hrs	Brendan Kelly	Support

What residents told us and what inspectors observed

This report outlines the findings of an unannounced risk inspection of this designated centre. The inspection was conducted to assess compliance with the regulations following receipt of unsolicited information to the Office of the Chief Inspector. Overall, the inspectors of social services found that residents were supported to enjoy a good quality of care in the centre and that their independence both in their home and local community was supported by a dedicated staff team. However, improvements were required in relation to Regulation 21: Records and Regulation and 28: Fire precautions. These are outlined in the body of the report.

Woodcrest is made up of three houses located in South Dublin. Two of the houses are neighbouring houses in a small housing estate and the third house is located a short drive away in a neighbouring town. All three of the houses are close to a number of local amenities including forest walks, large community parks, shopping centres, library, restaurants and pubs. Residents have access to centre transport, with residents informing the inspectors that they also avail of public transport to attend activities in the community. The designated centre provides residential service for up to nine adults with an intellectual disability, at the time of the inspection there were two vacancies.

The inspectors had the opportunity to visit all premises that make up the designated centre over the course of the inspection and had the opportunity to meet and speak with a number of of people about the quality and safety of care and support in the centre. This included meeting six of the seven residents living in the centre, four staff members, the area manager and the director of operations. Documentation was also reviewed throughout the inspection detailing how care and support is provided for residents, and relating to how the provider ensures oversight and monitors the quality of care and support in this centre

The first house is home to five residents, and comprises of a large sitting room, kitchen-dining area, five resident bedrooms, bathroom and shower room, staff office, staff sleep over bedroom and a garden to the rear of the house. Inspectors had the opportunity to meet with three residents. One resident told the inspectors that they loved their home. They were being supported by staff to go for a short walk to the local village and to get their hair cut. The inspectors met with the resident again on their return from their activity. The resident was sitting in the kitchen having their lunch with a peer and two staff members. Both residents told the inspectors that they have lived in the house together for a long time. They explained how all five residents get on very well and will often do activities together. For example, residents had chosen to go on holidays together earlier in the year and had a second holiday planned for later in 2025.

The inspectors met with another resident on their return from work. The resident was initially supported by a staff member to talk to the inspectors. However, the resident then asked to have time to talk to the inspectors alone. The resident said

that they work three days a week and had recently asked the support staff to identify new roles that they could do as part of their employment. They outlined that the staff team had met with them and their employee support officer to go through details of their work and what they can do to further develop their role. The resident discussed that they had been working for over ten years and had made a number of friends and local connections as a result.

The second house had capacity for two residents. The premises comprises a sitting room, kitchen, two resident bedrooms, staff sleep over room and office and a garden to the rear of the property. The inspectors met with one resident in the company of staff. The resident had returned from attending their local day service and was spending time in their room completing a jigsaw. Support staff asked the resident if they would like to say hello to the inspectors and they gestured that they would like to. The inspectors observed the resident sitting at an activities table in their room, support staff explained that the resident likes to complete jigsaws and listen to music in the evening on return to the centre. Support staff explained that following this period the resident would avail of a number of activities in the local community such as a walk to the local village or parks, meals out, music groups, holidays, spa day and afternoon tea. The inspectors observed staff supporting the resident by using short and clear sentences, giving the resident time to answer and assisting the inspectors to identify the meaning behind non-verbal communication strategies utilised by the resident.

The third house is home to two residents. The premises comprises a sitting room, kitchen and dining room, three resident's bedrooms (one with en-suite), staff office and sleep over room and large bathroom. The property had a large garden to the rear. The inspectors observed a seating area which residents could avail of during periods of warm weather. The inspectors were brought on a tour of this house by two residents. The residents showed the inspectors their bedrooms and the communal areas. One resident told the inspectors that they were very proud of their home and that they like to have family and friends over to visit. One resident brought the inspectors to their room and showed them a recent certificate they had completed and the framed photograph of them at their graduation with loved ones and friends. Another resident spoke to the inspectors using Irish sign language (ISL) and hand gestures, support staff were available to further support the resident where required. However, the inspectors found that the resident had developed a number of communication mechanisms which further supported their form of communication.

Residents were consulted with about the running of the centre through weekly resident forums. These forums included meal planning and discussion on relevant topics such as rights and safeguarding. Residents had the opportunity to meet with the provider's designated officer when they wished to do so. Monthly key working sessions were another forum which residents could use to speak about their experiences and plan activities. The person in charge had identified the need to review goal documentation and completion of the goal information for residents in the centre.

In summary, from what residents told us and what inspectors observed, it was

evident that residents were supported to lead busy and active lives in the centre. They lived in houses which were located close to transport links and amenities and there were an adequate number of staff to support them engage in activities outside of their homes. Each of the houses had a relaxed and friendly atmosphere, and residents appeared to be content and comfortable.

The next two sections of the report will present the findings of this inspection in relation to the governance and management arrangements in the centre, and how these arrangements impacted the quality and safety of the service being delivered.

Capacity and capability

This section of the report sets out the findings of the inspection in relation to the leadership and management of the service, and how effective it was in ensuring that a good quality and safe service was being provided. Overall, the inspectors found that the centre was well governed and that there were systems in place to ensure that risks pertaining to the designated centre were identified and progressed in a timely manner. However improvements were required in relation to Regulation 21: Records.

There was a clearly defined management structure in place and staff were aware of their roles and responsibilities in relation to the day-to-day running of the centre. The service was led by a capable person in charge, supported by a staff team, who were knowledgeable about the support needs of the residents living in the centre. The person in charge worked full-time and was supported by an area manager.

The inspectors found that the provider had ensured that there were suitably qualified, competent and experienced staff on duty to meet residents' current assessed needs. The provider had identified this centre as a priority area for staffing due to the assessed needs of residents, the inspectors found that there was a contingency plan in place in the event a staff could not report for duty.

The provider had ensured that there was an effective complaints procedure for residents to utilise. The procedure had been prepared in an easy-to-read format to aid residents' understanding.

Regulation 15: Staffing

On the day of the inspection the provider had ensured there was enough staff with the right skills, qualifications and experience to meet the assessed needs of the residents at all times, in line with the statement of purpose and size and layout of

the designated centre. The inspectors reviewed rosters from May, June and July 2025 and found that the centre operated in line with the identified safe staffing levels. Furthermore, the inspectors found that the provider had a clear contingency plan in place in the event of staff being absent from the roster.

The staff team comprised of the person in charge, staff nurses, social care workers and health care assistants. At the time of the inspection the centre was operating at the identified whole time equivalence. The inspectors had the opportunity to speak with four staff during the course of the inspection. Staff noted that vacancies that occurred on the roster, for example, due to staff leave entitlements were covered by permanent staff or regular relief. Staff discussed that agency staff was rarely utilised due to residents' assessed needs. On a review of the rosters from May, June and July 2025, inspectors observed that only one night shift was covered by an agency staff and that during this shift they worked alongside a permanent staff member.

The staff spoken to during the course of the inspection were found to be knowledgeable about the support needs of residents and about their responsibilities in the care and support of the individuals who lived in the designated centre. Inspectors found that staff were developing resident's goals and plans to further enhance and maintain residents independence in their home and in the community.

Judgment: Compliant

Regulation 21: Records

During the course of the inspection, the inspectors identified that a number of documents set out by the provider to enhance residents care and support were not utilised in a manner that identified current issues arising in the centre or actions for their completion. For example, the inspectors reviewed the last two six monthly unannounced provider visits to the centre completed November 2024 and May 2025. These records demonstrated that a number of actions had been repeated from the November 2024 and transferred into the May 2025 audit. Examples of repetition included, the need for staff to be booked into manual handling training and hand hygiene and the identification of blinds in the kitchen that required cleaning. The inspectors found that these issues had been addressed following the initial six monthly unannounced audit in November 2024 but were repeated in the May 2025 audit.

Inspectors reviewed four residents files and found that for two residents, records required review and archiving. The inspectors found that the manner in which they were maintained could lead to contradictory information in relation to most recent reviews for individuals. Furthermore, inspectors found that for one resident information for the ongoing support and care in relation to a diagnosis was stored in a manner which did not lead to clear guidance for staff. The person in charge had developed an agency and relief induction pack for the centre, however inspectors found that essential information for all of the residents key support needs were not

identified on the relief and agency induction checklists. The inspectors acknowledge that the provider had implemented a full staff team in this centre in order to support residents with particular support required and to support specific medical diagnosis.

Inspectors reviewed person centred goals for five residents in the centre, inspectors found that identified goals had long time lines for completion and review. For example, one goal for a resident to go to the shop and purchase magazines had a review period and goal completion of eight months. Inspectors found that the goals identified did not reflect the activities completed by residents in the centre. For example, residents were participating in local music groups, swimming lessons, attending sports and music events and working in a local radio station. The person in charge had completed a personal plan audit in May 2025 and identified that residents 'my life plan' required a review in order to be more reflective of individuals wishes and activities they participate in. However, at the time of the inspection this review had not been completed.

Inspectors found that staff meetings were occurring in the centre every six to eight weeks, which were chaired by the person in charge. However, improvements were required in relation to the meeting minutes held. Inspectors found that the minutes did not detail the agenda topics discussed in a way that would guide staff practice for those absent from the meetings.

The inspectors reviewed areas of good practice, including documentation for agency and relief staff which identified specific individual likes. These likes portrayed to staff levels of support that residents required and measures such as how a resident likes to take their cup of tea.

Judgment: Substantially compliant

Regulation 23: Governance and management

The provider had arrangements in place to assure that a safe, high-quality service was being provided to residents and that national standards and guidance were being implemented.

There was a clear management structure in place with clear lines of accountability. It was evidenced that there was regular oversight and monitoring of the care and support provided in the designated centre and there was regular management presence within the centre. There were adequate arrangements for the oversight and operational management of the designated centre at times when the person in charge was off-duty or absent.

The inspectors reviewed the action plan created following the provider's last two six-monthly unannounced visits to the centre in November 2024 and May 2025. As previously discussed inspectors found that the six-monthly unannounced visits contained repeat findings or duplication of information. However, the inspector found that the person in charge maintained a suite of audits in the centre, including

medication management, person centre plan, health and safety and finance audits. This suite of audits had clear actions and inspectors found that the findings were on the agenda of staff meetings in the centre.

There were effective arrangements for staff to raise concerns. In addition to the support and supervision arrangements, staff attended team meetings which provided a forum for them to raise any concerns. Inspectors reviewed staff meetings held in the centre in April, May, June and July 2025 and found that staff had an opportunity to raise concerns. Staff spoken to on the day of the inspection discussed that the person in charge was present in the centre to support residents and staff members. As previously discussed, the minutes held from staff meetings required review in order to accurately update staff who were not in attendance.

Judgment: Compliant

Regulation 24: Admissions and contract for the provision of services

The provider had prepared a written policy on the referral, admission, transition and discharge of residents. The inspectors were provided with evidence of how the provider had followed pre-admission procedures to be assured that the centre was suitable for meeting the assessed needs of all residents. At the time of the inspection there was two vacancies in the centre. The inspectors reviewed, the pre-admission support journey for one resident. The inspectors observed that the resident had been given opportunities to visit the centre and meet with peers. Furthermore, prior to any visits taking the place in the centre the provider had met with residents in the centre to discuss the possible transition of a new resident to the centre. The inspectors found that the person in charge had made a referral to the speech and language therapy department to ensure that residents had accessible information in relation to possible admissions to the centre. The inspectors reviewed two accessible social stories devised by the speech and language therapy department, the social stories included Irish sign language pictures used by residents as part of their communication profile.

Inspectors reviewed discharge summaries of residents in the centre and found that they included review and support of the providers multidisciplinary team, social work and the person in charge. Furthermore, the inspectors found that the provider had made relevant referrals to external stakeholders to further support residents transitioning from the centre.

There were contracts of care in place for all residents. The inspectors reviewed four contracts of care and found that they were signed by the residents or their representatives. The contracts of care were written in plain English, and their terms and conditions were clear and transparent. The residents' rights with respect to visitors were clearly set out in the contracts, as were the fees and additional charges

or contributions that residents made to the running of the designated centre.

Judgment: Compliant

Regulation 34: Complaints procedure

The registered provider had implemented an effective complaints procedure for residents, which was underpinned by a written policy. The policy outlined the processes for managing complaints, the relevant persons' roles and responsibilities, and information for residents on accessing advocacy services. The procedure had been prepared in an easy-to-read format which was readily available in the centre, and had been discussed with residents to help them understand it.

At the time of the inspection there was one open complaint in the centre. This complaint had been made by a staff member who was advocating on behalf of an individual with their consent. This complaint was a recent complaint and the provider was working in line with their policy. They had responded to the complainant and were working to resolve the complaint to the resident's satisfaction.

Inspectors had the opportunity to speak with six residents across the three houses that make up the designated centre. All residents spoken with discussed that they are happy in their home and feel supported by staff. One resident said that a peer in the house had a seat on the providers advocacy group. The resident explained that their peer member attended this meeting monthly and would then inform residents in all of the houses in the centre of outcomes. The resident showed one inspector a picture of the resident on the notice board of the house, this picture demonstrated that the resident was part of the providers advocacy group and residents could come with concerns or items for the meetings agenda. Residents discussed that they know who to talk to if they are not happy with any aspect of the running of their home.

The person in charge kept a log of all complaints and complements made in the centre. The inspectors found that the complaints were reviewed regularly with the person in charge completing quarterly audits.

Judgment: Compliant

Quality and safety

This section of the report details the quality and safety of the service for the residents who live in the designated centre.

The inspectors found that the person in charge and staff were aware of residents' needs and knowledgeable in the person-centred care practices required to meet those needs. Improvements were required in relation to Regulation 28: Fire precautions in the centre.

The provider had ensured that the risk management policy met the requirements as set out in the regulations. There were systems in place to manage and mitigate risks and were endeavouring to keep residents and staff members safe in the centre. Individual and location risk assessments were in place to ensure the safe care and support provided to residents.

Residents were supported to maintain important relationships. For example, family and friends could freely visit residents in the centre, and residents were supported to visit families outside of the centre. Residents informed the inspectors that family and friends were always welcome and attended the centre to celebrate milestone events for individuals.

Regulation 17: Premises

The inspectors found the atmosphere in the designated centre to be warm and encouraging of each residents' wishes. Residents met with, appeared to be very happy living the centre and with the support they received. Residents chose to speak to the inspectors alone, while other residents requested staff support to discuss their home and their lives.

Residents had their own bedroom which were decorated to their individual style and preferences. One resident brought the inspectors on a tour of their home. The resident showed the inspector their room and items which were important to them, these items included pictures of loved one and musicians that they liked to listen to. Resident bedrooms were decorated with achievements such as college certificates, graduation certificates and medals from various sporting activities.

The registered provider had ensured that the premises was designed and laid out to meet the aims and objectives of the service and the number and needs of residents. The centre was maintained in a good state of repair and was clean and suitably decorated. The inspectors found that each of the premises that made up the designated centre had a number of communal and private areas were residents could meet with visitors and friends. Private garden areas were also available to the residents to avail of in times of good weather.

Judgment: Compliant

Regulation 26: Risk management procedures

Where there were identified risks in the centre, the person in charge ensured appropriate control measures were in place to reduce or mitigate any potential risks.

The person in charge had completed a range of risk assessments with appropriate control measures, that were specific to residents' individual health, safety and personal support needs. There were also centre-related risk assessments completed with appropriate control measures in place. Risk assessments reviewed by the inspectors included environmental risk assessments, for example, slips trips and falls, safe patient moving and handling, lone working and fire risk assessments. Residents' individual risk assessments were also completed in areas such as maintaining community independence, epilepsy care, diabetes management and maintaining relationships.

The person in charge completed a quarterly review of incidents and accidents occurring in the centre. This review was discussed at staff meetings. When required, identified trends in incidents and accidents were escalated to the provider and additional control measures were implemented.

The designated centre had an emergency plan in place which covered events such as power, heating or water outages in the centre. Each of the houses in the centre were equipped with emergency packs. Staff spoken to were aware of the emergency plans in place.

Judgment: Compliant

Regulation 28: Fire precautions

During the course of a walk through of the designated centre, inspectors observed that four resident's bedroom doors had been propped open by furniture such as cabinets or dressers. One sitting room door had been held open by a box and another sitting room door in a second premises could not close due to the close location of a couch to the door. Furthermore, inspectors found that an oxygen cylinder had not been stored correctly as per safety guidelines. Once brought to the attention of the provider and staff in the centre all doorways were cleared of obstructions and the oxygen cylinder was restored to an appropriate location in the centre.

Inspectors reviewed daily checks completed by staff which noted that all fire doors and exits where clear of obstructions and functioning as required, this included the completion on the day of the inspection. However, as previously mentioned the inspectors observed a number of obstructions which could cause significant barriers to fire containment in the event of a fire.

The provider had completed a number of works to the centre in relation to fire containment. Residents spoken to during the course of the inspection, told the inspectors how to respond in the event of a fire. Residents told the inspectors that they know the importance of ensuring that fire doors are not obstructed in order to

contain a fire should it occur in the centre. Furthermore staff spoken to were knowledgeable of fire procedures and had received the appropriate fire training.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

The inspectors reviewed five residents' assessments of needs, and found that they were comprehensive and up-to-date. The assessments were informed by residents, their representatives and multidisciplinary professionals were appropriate. As previously discussed, inspectors found that some records reviewed under residents assessments of needs required archiving.

Inspectors found that of the five resident assessments of needs reviewed each resident had a hospital passport, which endeavoured to further support residents should they be required to spend time in hospital. Furthermore inspectors found for one resident that the person in charge and staff team had completed an enhanced mulitidisciplinary hospital passport.

The person in charge carried out regular audits of the documentation within the personal plans to ensure information within them was relevant and up-to-date. The person in charge had completed an audit of residents person centred goals in May 2025 and had identified the need to review the goals in line with the activities and interests of residents.

Residents had monthly keyworker meetings in relation to the achievement of goals identified and possible barriers identified. Residents told the inspectors that they have a number of activities and goals that they had completed this year. One resident discussed with the inspectors that they had recently gone on holidays with the support of staff and had another holiday booked for September 2025.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Compliant
Regulation 24: Admissions and contract for the provision of services	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Compliant

Compliance Plan for Woodcrest OSV-0003556

Inspection ID: MON-0047133

Date of inspection: 23/07/2025

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 21: Records	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records: All actions within the 6 monthly provider visit will be completed within timeframe stated. All individual plans of care will be reviewed and updated and any archiving plans will be removed and archived appropriately to ensure that they are in line with regulation Schedule 3. All residents key support needs will be identified or referred to on the relief and agency induction checklists. All actions following the review of residents 'My life plans' will be completed to reflective individuals wishes and activities that are meaningful to them. This review will encompass a review of goal planning ensuring the promotion of quality of life outcomes. Agenda topics will be included to the meeting books for the Centre to guide and support practice and will have agreed timeframe for completion	
Regulation 28: Fire precautions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: Fire doors in the Centre that are linked to acoustic device mechanism, and had been found to be held open using objects due to frequent activations, will be replaced with magnetic hold-open devices by the 30/09/25. These fire doors will operate as intended, remaining free from obstruction ensuring it is in compliance with this regulation.	

All daily fire safety checklists will accurately reflect current practices and will be completed as intended.

Additional Fire Training and supports will be provided to the staff and the residents in this Centre to ensure awareness and containment of fire and the new magnetic devices on installation.

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 21(1)(b)	The registered provider shall ensure that records in relation to each resident as specified in Schedule 3 are maintained and are available for inspection by the chief inspector.	Substantially Compliant	Yellow	31/10/2025
Regulation 21(3)	Records kept in accordance with this section and set out in Schedule 3 shall be retained for a period of not less than 7 years after the resident has ceased to reside in the designated centre.	Substantially Compliant	Yellow	31/10/2025
Regulation 28(2)(b)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Substantially Compliant	Yellow	30/09/2025
Regulation	The registered	Substantially	Yellow	30/09/2025

28(3)(a)	provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Compliant		