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:	Alpine Services
Name of provider:	Ability West
Address of centre:	Galway
Type of inspection:	Unannounced
Date of inspection:	12 November 2025
Centre ID:	OSV-0004069
Fieldwork ID:	MON-0043793

About the designated centre

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

Alpine Service provides respite care to 5 male and female people with an intellectual disability who require a support level ranging from minimum to high, and who are over 18 years of age. The service provides planned, short-term, recurrent respite breaks of varying durations. The centre is a large, well-equipped building linked to a day service in a rural town. All residential accommodation is on the ground floor of the building, and residents have their own bedrooms during respite breaks. The centre is centrally located and is close to amenities such as shops, restaurants, a church, and pharmacy service. Residents are supported by a staff team which includes the person in charge, social care workers and care assistants. Staff are based in the centre when residents are present and a staff member remains on duty at night to support residents. The person on charge is based in the centre.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	4

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 12 November 2025	10:00hrs to 16:00hrs	Mary Costelloe	Lead

What residents told us and what inspectors observed

This inspection was a short notice announced inspection carried out to monitor compliance with the regulations and to follow-up on the findings of the previous inspection carried out in November 2023. The inspection was facilitated by the team leader and area services manager. The person in charge was on leave at the time of inspection. During the course of the day, the inspector also met with two respite service users and one staff member. Overall, there was generally good compliance with the regulations reviewed, however, improvements were still required to some aspects of fire safety management, and further oversight was required in relation to infection, prevention and control and to some personal planning documentation.

Alpine services provides a respite service for 19 service users. While the centre is registered to accommodate up to five service users, the team leader advised that a maximum of four were being accommodated on any one night. There was currently one service user residing in the centre on a full-time emergency basis, however, there were plans in place for this service user to be accommodated in a new residential service. Service users normally availed of respite stays on a rotational basis and the length of stays varied between one to three nights per week. Service users were supported to attend their day services programmes during the weekdays while availing of respite. The team leader outlined how consideration was given to the compatibility of service users when planning respite stays to ensure that they all enjoyed their break.

Service users required varying supports in line with their assessed needs. Some service users were in good health, were relatively independent and required minimum supports while others had more complex health care and support needs. Staff spoken with were very knowledgeable regarding the individual needs, preferences, dislikes and interests of service users. There were stable staffing arrangements in place. Some staff worked both in the day and respite service over many years and knew the service users well. Staff were observed to interact with service users in a friendly and respectful manner. From observations in the centre, it was clear that that service users and staff had a good rapport.

The centre is single storey but connected to a two-storey building which is used by day services. All residents are accommodated in single bedrooms which were spacious and bright. One bedroom was provided with overhead ceiling hoist, specialised bed and designed to facilitate service users with mobility issues. There was adequate personal storage space provided in each room and there were lockable storage facilities available for service users to store personal items between stays. Service users had chosen their own bed linen which was laundered and appropriately stored between stays. Service users shared a large well-equipped shower room and two toilets. Service users had access to a large kitchen, dining room and day room. These communal areas were shared with the staff and service users from the day service between 10.00 and 16.00 during the weekdays. There was also a shared utility room used for laundry and storage of cleaning equipment.

The inspector noted that some cleaning equipment was stored inappropriately and there was lack of clear guidance in relation to infection prevention and control protocols for these shared spaces. This will be discussed further in the main body of the report.

Residents had access to a secure outdoor paved garden area which contained a variety of colourful pots and plants and a range of outdoor furniture. The building was found to be generally well maintained, some improvements and repair works had been identified by the local management team and had been logged on the maintenance system. The centre was located in a rural town and close to a number of larger towns with good access to a range of facilities and amenities. The centre had its own minibus which service users used to go on outings, day trips and attend activities.

The inspector met with two service users when they returned from attending their day programme during the the afternoon. One service user was unable to tell the inspector their views on the service but appeared relaxed and content in the company of staff and seemed comfortable and familiar in their surroundings. They were supported to have a cup of tea in the dining room and then were observed making one of their favourite jigsaws while they waited for dinner in line with their preferred evening routine. Staff outlined how this service user enjoyed going for a daily therapeutic drive in line with the protocol recommended by the psychologist. They also enjoyed going for long walks, going shopping, eating out and attending the cinema. The provider had plans in place to provide a full-time residential placement for this service user in a new designated centre. The service user was supported to regularly call to the new house for short familiarisation visits and had been supported to go on shopping trips to choose furniture for the new house.

The other service user told the inspector how they enjoyed availing of respite breaks in the centre. They were complimentary of staff working in the centre. The mentioned how they enjoyed eating out on some evenings, going for drives to places of interest, and relaxing watching television. They advised that they got on well with other service users and staff and how they regularly planned outings as a group. They confirmed that they had been involved in participating in fire drills and knew what to do in the event of fire. They advised that they felt safe when staying on respite.

In summary, the inspector observed that service users were treated with dignity and respect by staff. From conversations with staff and service users, observations made while in the centre, as well as information and photographs reviewed during the inspection, it was evident that service users had choices in their lives and that their individual rights and independence was very much promoted while they availed of the respite service.

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 the service users.

Capacity and capability

The findings from this inspection indicated good compliance with many of the regulations reviewed and there was evidence of good practice in many areas. However, improvements were still required to some aspects of fire safety management, as well as improvements and further oversight also required to the management of infection, prevention and control procedures and to personal planning documentation.

There was a clear organisational structure in place to manage the service. The management arrangements within the centre were in line with the statement of purpose.

The person in charge worked full-time in the centre. They were supported in their role by the team leader, area services manager and staff team who included nursing staff. There were on-call management arrangements in place for out-of-hours.

The inspector found that the staffing levels on the day of inspection met the support needs of respite users. The team leader advised that there were no staff vacancies with a full compliment of staff available. Most staff members had worked in the centre over a sustained time period and knew the service users well and had developed good relationships with them and their families. Staff spoken with were knowledgeable regarding service users up-to-date support needs, they advised that staffing levels in the centre were flexible in order to meet the assessed support needs and number of respite residents availing of the service at any given time. The staffing roster reviewed for November 2025 indicated that a team of consistent staff was in place to ensure continuity of care and support. The staff member in charge of each shift was clearly outlined. Photographs of staff on duty were displayed so that respite users could be reminded or check as to which staff were on duty.

Staff training records reviewed indicated that all 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 service users.

The provider had systems in place to monitor and review the quality and safety of care in the centre. The provider had continued to complete six monthly and annual reviews of the service. The latest review took place in October 2025. Some actions identified as a result of this review had been addressed including a review of medication management practices, however, other actions such as updating progress in personal plans had not yet been completed.

The local management team continued to regularly review areas such as risk, fire safety, infection, prevention and control, service users finances and restrictive practices. However, some audit processes required review as they had failed to identify issues and associated risks in relation to fire and infection prevention and control. Monthly team meetings were taking place at which identified areas for

improvement were discussed and learning shared. Minutes of a recent team meeting reviewed indicated that discussions had taken place regarding the findings and actions from the most recent provider led audit. While there was evidence of consultation with service users with weekly house meetings taking place on Fridays, this arrangement did not support consultation with all service users, many who were not availing of respite at weekends. While staff outlined that all service users were consulted with and supported with choices during their stays, the documentation reviewed did not reflect this.

Regulation 15: Staffing

The registered provider had ensured that the staff complement and skill-mix was appropriate to the number and assessed needs of the service users in the centre. The staffing levels at the time of inspection met the support needs of service users. The inspector found that the staffing levels were in line with levels set out in the statement of purpose. There were stable staffing arrangements and a team of consistent staff in place.

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 to support them to safely meet the support needs of service users including various aspects of infection prevention and control, administration of medications, epilepsy care, feeding, eating and drinking guidelines, peg (percutaneous endoscopic gastrostomy) feeding, person centered planning, a human right based approach to care and open disclosure. There were systems in place to ensure all staff were provided with refresher training as required and further refresher training was scheduled.

Judgment: Compliant

Regulation 23: Governance and management

While there was clear governance and management arrangements in place, improvements and further oversight was required to some aspects of fire safety management, to the management of infection, prevention and control and to personal planning documentation.

The issues identified in relation to fire safety management at the last inspection had not been fully addressed. The fire alarm panel was situated in the shared entrance lobby area located between the day centre and the respite centre, the alarm panel served both centres. While the fire alarm system was fully addressable, the layout plan for the entire building was still not displayed adjacent to the fire panel. This posed a risk and could result in a delay in identifying and locating a fire.

The provider had completed an audit of all fire doors in the designated centre section of the building in April 2025. The recommended works identified to numerous fire doors had yet to be addressed and needed to be progressed. The team leader had received an email on the day prior to the inspection advising that the works were planned for the week of 24 November 2025.

Improvements and further oversight was required to infection, prevention and control procedures particularly in relation to the areas of the centre which were shared with the day services including the kitchen, dining room, sitting room and utility room. There was lack of infection, prevention and control protocols, cleaning schedules, cleaning logs for these shared spaces which posed a risk of cross contamination and spread of infections. There was no formal protocol between services outlining responsibilities and monitoring of these areas. Further oversight was also required to personal planning to ensure progress in relation to service users individual goals and to ensure that progress updates were reflected in the personal planning documentation.

Judgment: Substantially compliant

Quality and safety

The inspector found that the local management team and staff were committed to promoting the rights and independence of service users and ensured that they received an individualised safe service. The provider had adequate resources in place to ensure that service users had opportunity and engaged in activities that they enjoyed while availing of the respite service. Respite users spoken with indicated that they liked the centre, enjoyed availing of the service and partaking in a range of outings and activities during their stays. As discussed earlier in the report, improvements required to aspects of fire safety and infection, prevention and control had the potential to impact on the quality and safety of the service.

The inspector reviewed the files of two service users. Files reviewed were found to be informative and up-to-date. There were comprehensive assessments of need completed along with a range of individual risk assessments. Care and support plans had been developed for all identified issues including complex health care issues. There was evidence that recommendations of allied health professionals were reflected in care plans. There were systems in place for regular review and updating of care and support plans when required.

Service users were supported to identify meaningful personal goals while availing of the respite service. Service users, their families and staff from the designated centre, were involved in this process. However, there were no progress updates documented in both files reviewed, therefore, it was not clear if service users had been supported to progress or achieve their chosen goals. The most recent provider led audit completed in October 2025 had also identified this issue. The team leader advised that the issue was scheduled to be discussed with staff at this months team meeting.

Due to the intermittent nature of residents' respite breaks in the centre, their healthcare arrangements were mainly supported by their families. Service users had access to general practitioners (GPs), out of hours GP service and a range of allied health services while availing of the respite service as required.

The centre was spacious, comfortable and visibly clean. The team leader confirmed that some identified repair works to floors and ceilings and provision of suitable storage for cleaning equipment was planned. They advised that these works would be completed once the service user currently residing on full-time emergency basis moved into their new accommodation.

There were systems in place for ensuring oversight of medication management practices. All staff had received training in medicines management. Respite users brought their medicines to the centre when staying for respite. There were systems in place for checking and logging all medicines on the arrival of service users to the centre and again when they were leaving. All service users continued to retain their own choice of pharmacist. The team leader advised that a number of medication related issues had been identified when completing checks on the receipt of medicines from respite service users' families and these had being logged as medication errors. However, there had been no recent medication errors in the administration of medicines in the centre. A recent medication management review dated 6 November 25 carried out by a nursing manager in the organisation had not identified any issues relating to medication practices in the centre. The team leader advised that all families had been recently communicated with by letter outlining for example, the importance of ensuring correct medications and labels. Medicines management had also been discussed with staff at a recent team meeting.

While there were systems in place for the management and on-going review of risks in the centre, risks identified on the day of inspection relating to infection, prevention and control practices had not been recognised as a risk. The person in charge had systems in place to regularly review and update the risk register. Risk management was discussed routinely at team meetings. Issues identified at the previous inspection relating to risk ratings had been addressed to accurately reflect risk in the centre. For example, fire safety, medication management, behaviour that challenge and safeguarding were now included as being the top five risks in the centre.

Some issues identified in relation to fire safety management at the last inspection had not been fully addressed. This action is included under Regulation 28: Fire Precautions. 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 were taking place involving all staff and service users and had included day-time and night-time scenarios. The records of recent fire drills reviewed indicated that service users could be evacuated in a timely manner in the event of fire or other emergency. One bedroom was designed to facilitate bed evacuation for those residents who were not mobile.

Regulation 17: Premises

The design and layout of the centre was suitable for its stated purpose and met service users individual needs.

The design of the centre and outdoor spaces promoted accessibility. The centre had been suitably designed to meet the needs of service user's who were wheelchair users.

Service users 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 and equipment including specialised beds and hoists were serviced on a regular basis to ensure they were safe for use.

The provider had identified some required improvements works including repair works to floors and ceilings and provision of suitable storage for cleaning equipment. There were plans in place to address these identified works.

Judgment: Compliant

Regulation 25: Temporary absence, transition and discharge of residents

There were plans in place for three service users to move into full-time residential services. The provider had applied to register a new residential centre and the application was under consideration by the Chief Inspector. All three service users and their families had been consulted with regarding the planned transition. All service users had transition plans in place to ensure that they could transition in a safe and planned manner. Service users continued to complete short familiarisation visits to the new house and had been involved and consulted with regarding their preferred colour schemes and furnishings.

Judgment: Compliant

Regulation 26: Risk management procedures

Improvements were required to ensure that risk management systems in place identified all risks in the centre including the associated risks of shared communal spaces and a shared fire alarm system with another service. While the risk register was regularly reviewed and discussed, it was not fully reflective of risk in the centre.

Judgment: Substantially compliant

Regulation 27: Protection against infection

Improvements and further oversight were required to infection, prevention and control procedures particularly in relation to the areas of the centre which were shared with the day services. Communal areas including the kitchen, dining room, sitting room and utility room were shared with the day service users and staff between 10.00 and 16.00 during the weekdays. There was lack of infection, prevention and control protocols, cleaning guidance schedules, cleaning logs for these shared spaces which posed a risk of cross contamination and to spread of infectious diseases.

There was no formal protocol between respite and day services outlining accountability and responsibilities and monitoring of these areas.

Judgment: Not compliant

Regulation 28: Fire precautions

Improvements were still required to fire safety management. The compliance plan submitted following the last inspection had not been fully implemented. The fire alarm panel was situated in the shared entrance lobby area located between the day centre and the respite centre, the alarm served both buildings. While the fire alarm system was fully addressable, the layout plan for the entire building was still not displayed adjacent to the fire panel. This posed a risk and could result in a delay in identifying and locating a fire particularly given given that the day service section of the building is not occupied at night time, is a large two storey building and there is only one staff member on duty at night time in the adjoining respite centre.

The provider had completed an audit of all fire doors in the designated centre section of the building in April 2025. The recommended works identified to numerous fire doors had yet to be addressed and needed to be progressed.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

Service users' health, personal and social care needs were assessed and care plans were developed, where required, however, improvements were required to some aspects of personal planning documentation. The inspector reviewed a sample of two respite users files and noted that care and support plans had been developed for all identified issues including complex health care issues. Support plans were found to be individualised, person centered and provided clear guidance for staff.

While personal plans clearly outlined goals for individual service users, progress reviews and updates were not reflected in the records reviewed, therefore, it was not clear if service users had been supported to progress or achieve their chosen goals.

Judgment: Substantially compliant

Regulation 6: Health care

The local management and staff team continued to ensure that service users had access to the health care that they needed.

Service users access to healthcare professionals was usually arranged and supported by their families, although support from day service and designated centre staff was available as required. Service users continued to have access to their family general practitioners while availing of the respite service.

Judgment: Compliant

Regulation 7: Positive behavioural support

All staff had received training in supporting service users manage their behaviour. Service users who required support had access to psychology services and had positive behaviour support plans in place. Staff continued to promote a restraint free environment. While there were some restrictions in use, there were clear rationales outlined for their use, as well as evidence of consultation and consent recorded. There were risk assessments completed, and multidisciplinary input into the decisions taken for restrictions in use. The restrictions in use had been referred to the restrictive practice committee and had been recently reviewed and approved.

Judgment: Compliant

Regulation 8: Protection

The management team had taken measures to safeguard service users from being harmed or suffering abuse. All staff had received specific training in the protection of vulnerable people to ensure that they had the knowledge and the skills to treat each resident with respect and dignity and were able to recognise the signs of abuse and or neglect and the actions required to protect residents from harm.The support of a designated safeguarding officer was also available if required. Staff had received training in managing behaviours of concern. There were individualised positive behaviour support plans in place for service users which were informative, identified triggers and supportive strategies. The team leader outlined how consideration was given to the compatibility of service users when planning respite breaks to ensure all respite users were safe and enjoyed their stays. There were no active safeguarding concerns at the time of inspection.

Judgment: Compliant

Regulation 9: Residents' rights

The local management and staff team were committed to promoting the rights of service users. All staff had completed training on promoting human rights in health and social care.

The service users had access to information in a suitable accessible format, as well as access to the Internet and televisions.

Service users were allocated their own bedroom for the duration of their respite stay. There was adequate personal storage space provided in each room and there were lockable storage facilities available for service users to store personal items between stays.

There was evidence of consultation and involvement of service users with regard to their planned transitions to full-time residential placements.

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 16: Training and staff development	Compliant
Regulation 23: Governance and management	Substantially compliant
Quality and safety	
Regulation 17: Premises	Compliant
Regulation 25: Temporary absence, transition and discharge of residents	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Alpine Services OSV-0004069

Inspection ID: MON-0043793

Date of inspection: 12/11/2025

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	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The Team Leader and Day Service Manager met on 27/11/25 to create a formal infection, prevention and control protocol, cleaning schedules and a cleaning log for the shared spaces: Kitchen; Dining Room; Sitting Room and Utility Room of the designated centre which is now in place. The Team Leader and PPIM will continue to review all cleaning logs and identify any issues with the Day Service Manager. On the 20/11/25 Team Leader requested a layout plan of the entire building from the Director of Estates and Transport, the full groundfloor was emailed to Team Leader and PPIM on 1/12/25 with first floor to follow. These will be printed, laminated and displayed adjacent to the Fire Panel by 12/12/25. Works on Fire Doors in the designated centre commenced on 26/11/25 and will be completed by 8/12/25. The Team Leader discussed with the staff team on 18/11/25 that all person centred plans and goals needed to be reviewed and updated as each goal is progressing. Each key worker will review and update chosen goals by 12/12/25 and then review at least monthly or as chosen goals are progressed or completed.	
Regulation 26: Risk management procedures	Substantially Compliant
Outline how you are going to come into compliance with Regulation 26: Risk management procedures:	

The risk register was reviewed on 28/11/25 and updated to reflect all risks in the centre, including the associated risks of shared communal spaces and a shared fire alarm system. Control measures were added to reflect what is required to meet the standards of a shared communal space and a shared fire alarm system. These included further training from the company who installed the fire alarm system and implementation of cleaning schedules and cleaning logs for the shared spaces.
The risk register will be reviewed and updated accordingly as these control measures are put in place. Control measures will be in place by 12/12/25.
All staff have training completed in Infection Prevention and Control and this is monitored by the Team Leader and PPIM at least monthly. Refresher training is completed every 2 years by staff.
All staff have fire training completed. This is monitored by the Team Leader and PPIM at least monthly. Refresher training is completed every 3 years by staff.
Training records for all day service staff are maintained by the day service manager and can be reviewed by the Team Leader and PPIM on request.

Regulation 27: Protection against infection	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
The Team Leader and Day Service Manager met on 27/11/25 to create a formal infection, prevention and control protocol, cleaning schedules and a cleaning log for the shared spaces: Kitchen; Dining Room; Sitting Room and Utility Room of the designated centre which is now in place. The Team Leader and PPIM will continue to review all cleaning logs and identify any issues with the Day Service Manager.
The Team Leader will discuss the formal protocol in place with the Staff Team ay the Team Meeting on 10/12/25. The Day Service Manager discussed the implementation of formal protocol with the day service staff team on 18/11/25 and will discuss further with the staff team on 9/12/25.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
On the 20/11/25 Team Leader requested a layout plan of the entire building from the Director of Estates and Transport, the full groundfloor was emailed to Team Leader and PPIM on 1/12/25 with first floor to follow. These will be printed, laminated and displayed adjacent to the Fire Panel by 12/12/25.

Works on Fire Doors in the designated centre commenced on 26/11/25 and will be completed by 8/12/25.

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: The Team Leader discussed with the staff team on 18/11/25 that all person centred plans and goals needed to be reviewed and updated as each goal is progressing. Each key worker will review and update chosen goals by 12/12/25 and then review at least monthly or as chosen goals are progressed or completed.

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Substantially Compliant	Yellow	08/12/2025
Regulation 26(1)(a)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: hazard identification and assessment of risks throughout the designated centre.	Substantially Compliant	Yellow	27/11/2025
Regulation 26(1)(b)	The registered provider shall ensure that the risk management	Substantially Compliant	Yellow	09/12/2025

	policy, referred to in paragraph 16 of Schedule 5, includes the following: the measures and actions in place to control the risks identified.			
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.	Not Compliant	Orange	30/11/2025
Regulation 28(4)(a)	The registered provider shall make arrangements for staff to receive suitable training in fire prevention, emergency procedures, 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.	Not Compliant	Orange	12/12/2025

Regulation 05(7)(c)	The recommendations arising out of a review carried out pursuant to paragraph (6) shall be recorded and shall include the names of those responsible for pursuing objectives in the plan within agreed timescales.	Substantially Compliant	Yellow	30/11/2025
Regulation 05(8)	The person in charge shall ensure that the personal plan is amended in accordance with any changes recommended following a review carried out pursuant to paragraph (6).	Substantially Compliant	Yellow	10/12/2025