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:	Seirbhis Radharc Arainn
Name of provider:	Corlann
Address of centre:	Galway
Type of inspection:	Unannounced
Date of inspection:	12 March 2026
Centre ID:	OSV-0004955
Fieldwork ID:	MON-0049929

About the designated centre

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

Seirbhís Radharc Árainn provides a full-time and respite residential service to eight male residents with a mild to profound intellectual disability and or autism. Seirbhís Radharc Árainn is made up of two rural houses close to a village in a coastal area. One house is separated into three self-contained dwellings, and the other house's design and layout incorporates separate accommodation for one person. The service has eight beds in total between two houses, and provides care to people from 18 years of age to end of life. The service can accommodate people who present with complex needs such as physical, medical, mental health, mobility, communication and or sensory needs. The physical design of all three buildings renders them unsuitable at present for use by individuals with complex mobility needs or people who use wheelchairs. Residents are supported by a staff team that includes social care leaders, social care workers and support workers. Staff are based in the centre during the day and at night-time to support residents. There is transport available on-site for residents to access community based activities.

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
Thursday 12 March 2026	09:10hrs to 16:45hrs	Maureen McMahon	Lead
Friday 13 March 2026	10:00hrs to 13:00hrs	Maureen McMahon	Lead

What residents told us and what inspectors observed

This was an unannounced inspection carried out to monitor the provider's compliance with the regulations, to follow up on findings from the last inspection and also to inform the renewal of registration of the centre. During this inspection the inspector met with seven residents who lived in the centre and observed how they lived. The centre had one vacancy on the day of inspection, with the centre registered to accommodate a maximum of eight residents. One resident had been admitted to hospital in December 2025 and has not returned to the centre since. The inspector also met the person in charge, a team leader, staff members and viewed a range of documentation.

Based on the findings of this inspection, the inspector identified signification areas for improvement in key areas, including safeguarding, the condition of the premises, governance and oversight including the management of incidents, the supervision of staff and also the management of complaints. In addition, improvement was required in risk management. These findings demonstrate a need for substantial improvement to ensure the service is safe, well governed and meets regulatory requirements. Six areas for improvement found on this inspection were repeat findings from the last inspection of the centre in July 2024. This indicated the provider had not taken effective or sustained measures to meet their regulatory requirements in these areas.

The centre compromised of two houses located approximately a twenty-minute drive apart. The first house in the centre was a detached house with capacity for three residents in the main house and one self-contained apartment where one resident lived. The second house was a two-storey house that was divided into three self-contained apartments, with two residents sharing one apartment and the other two apartments occupied by one resident each. The design and layout of the first house suited the needs of residents. However, the layout of the second house required review by the provider to ensure it was suitable for all residents assessed needs. Environmental modifications undertaken in the second house in response to concerns raised during the last inspection had not been effective in ensuring noise disruption was resolved for residents living in this location.

The care and support needs of residents living in the centre varied. In one house, some residents were found to be independent with many areas of living such as personal care where as others required a high level of support in all areas of living including positive behaviour support. In the second house, many residents were found to require minimal staff supports and were active in the community. The inspector found a high level of incidents in relation to peer-to-peer were occurring in the second house of this centre.

The inspector arrived to the first house early in the morning and had the opportunity to meet with three residents before they left the centre to do their planned activities

and routines. A resident facilitated the inspector to view the main part of the house and also their bedroom. The centre had a homely atmosphere with personalised pictures throughout the centre. All bedrooms were spacious and residents had access to areas to relax, listen to music, watch television, or spend time with family and friends. The main bathroom in this house required significant improvement and this will be discussed under regulation 17. As the resident showed the inspector their home they spoke to the inspector about the care and support they received in the centre. This was very positive feedback with this resident demonstrating a high level of satisfaction with their home and the supports they received. This resident discussed at length plans for an upcoming holiday they had booked, and it was clear from staff interactions observed that staff were very knowledgeable on this residents care and support needs and preferences.

The inspector also viewed the self-contained apartment and had the opportunity to meet with the resident who lived there. This apartment was suitably sized and appropriate to the residents needs. Some improvement works were identified and were discussed with local management on the day. This resident had plans to leave the centre for the afternoon to partake in an activity. The inspector observed staff engage respectfully with this resident to seek their choices as they prepared to plan the afternoon. Residents' communication needs were well supported, and the provider actively promoted cultural diversity, including the use of each resident's preferred language.

The inspector visited the second house and met with all residents living in this location. Residents were found to be planning their day with the support of staff, one resident was engaged in a jigsaw and was supported to have space and time to do this preferred activity. Two residents made time to sit and speak with the inspector and share their views on the care and support they received in the centre. Both residents were satisfied with many aspects of their care such as the supports they received to partake in preferred activities such as concerts, holidays, visiting family or going out for meals. A resident showed the inspector pictures from a recent holiday to Kerry and discussed plans for an upcoming break. One resident described staff as nice and said the food is good. However, residents spoken with did raise concerns regarding noise disruption and one resident told the inspector this is an issue both during the day and night. The inspector discussed the complaints process with residents. Residents spoken with described having made complaints to the provider in relation to issues in the centre. Both resident's spoken with were unclear when they could expect an update on their formal complaints.

During a walk about of the second house in the centre, the inspector found significant issues in relation to the premises and the presence of mould. This will be discussed under regulation 17. In addition, an outdoor recreation room, used by a resident was not part of the floor plans of the designated centre. This was also discussed with local management during verbal feedback.

The next two sections of this report present the inspection findings in relation to the governance and management in the centre, and describes about how governance and management affect the quality and safety of the service provided.

Capacity and capability

Based on the findings of this inspection, improvements were required to ensure the service provided was safe and of a good quality for residents. It was not clear and could not be evidenced on the day of inspection that staff supervision or team meetings were happening on a consistent basis and in line with the providers own policies and procedures.

The centre was adequately resourced to meet the assessed needs of residents. Resources available included transport, Wi-Fi, and access to suitable private and communal facilities across both houses. Staffing arrangements were in place and staffing levels were in line with residents' assessed needs. Staff had completed mandatory training relevant to their roles, and had access to additional training in areas such as personal outcome measures and infection prevention and control.

Systems were in place to monitor and review the quality and safety of care and support provided to residents, including six-monthly unannounced visits and an annual review of the centre. However, this inspection found that further improvements were required to ensure that monitoring systems were fully effective in identifying areas requiring improvement across all aspects of the service and in supporting timely action. The current systems were ineffective at ensuring the service was adequately monitored and that the provider implemented all actions from previous inspections.

Improvements were also required in relation to complaints management. While complaints had been recorded, records reviewed during the inspection did not consistently demonstrate the progress, outcome, or timelines associated with complaints made.

Registration Regulation 5: Application for registration or renewal of registration

The prescribed documentation and information required for the renewal of the designated centre's registration had been submitted to the Chief Inspector of Social Services. The inspector reviewed this documentation and found that it had been suitably submitted.

Judgment: Compliant

Regulation 14: Persons in charge

The provider had appointed a person in charge to manage this centre. They were employed on a full time basis and had the appropriate qualifications, skills and experience for this role. The person in charge was responsible for two designated centres. Since the last inspection of the centre the provider had reduced the number of designated centres that this person in charge had responsibility for.

Judgment: Compliant

Regulation 15: Staffing

There were sufficient numbers of staff to meet the needs of residents both day and night taking the size and layout of the centre into consideration. A planned and actual staffing roster was maintained as required by the regulations.

The inspector reviewed a sample of rosters for a two-week period between February and March 2026. This review indicated that there was a consistent staff team who were known to residents, including any relief staff. During this review period, no agency staff were rostered to work in the centre.

Since the last inspection of this centre, the provider had put in place additional staffing in one house to ensure residents had the opportunity to access community activities and to ensure greater supervision.

Judgment: Compliant

Regulation 16: Training and staff development

The provider had ensured that staff who worked in the centre had received training appropriate to their roles and responsibilities. However, it was unclear if staff consistently received formal supervision on a regular basis.

The inspector reviewed the training matrix for the centre, all staff had received mandatory training in fire safety, positive behaviour support and adult safeguarding. Additional training in areas such as medicines management, record keeping and infection prevention and control (IPC) had also been undertaken by staff. Staff could describe their learning from training, and relate it to their role in supporting residents.

A schedule of supervision was available to view in the centre. The inspector reviewed two records of formal supervision in one location that demonstrated formal supervision meetings were held with staff. However, records were not available in the second location to view. It was unclear if staff were consistently receiving

supervision in line with the providers own requirements and some staff spoken with were unable to verify they had received supervision on a regular basis.

Judgment: Substantially compliant

Regulation 23: Governance and management

Significant improvement was required in the governance and management of this centre to ensure the service provided was safe, consistently monitored, and effectively overseen.

The inspector found that management systems in place were not sufficiently clear or effective to ensure robust oversight of the centre. Reporting and accountability arrangements were not clearly defined, and this impacted on the provider's ability to maintain effective oversight of key operational and quality assurance systems.Team meetings records were reviewed, this found that a meeting had taken place in June 2025 with the next record available for February 2026, evidencing a significant gap. Discussions with local management provided conflicting information, they indicated that additional records existed but were unavailable. However, it was noted elsewhere that a lapse in meetings had occurred and required the attention of management. The inspector found in the meeting that took place in June 2025, safeguarding concerns were not discussed between local management and the staff team. Overall, it was unclear whether meetings had been consistency held or who was responsible for ensuring these took place. This lack of consistent, well-documented meetings impacted on staffs opportunity to receive clear guidance, particularly in relation to safeguarding.

While a range of audits and monitoring systems were in place including the providers unannounced six monthly audit in November 2025, they were not consistently effective in identifying, escalating, and addressing areas requiring improvement. The inspector found deficits in oversight across a number of areas, including staff supervision, audit follow-up, risk management, premises, and resident quality-of-life concerns.

Records reviewed during the inspection did not provide assurance that governance systems were operating effectively. In addition, where issues had been identified, actions taken were not always clearly recorded, appropriately progressed, or resolved within reasonable timeframes. The inspector reviewed a transition plan for one resident, which commenced in February 2025. Modifications to the premises had not been effective in reducing noise to an acceptable level. The timeframes outlined in the transition plan were found to be unrealistic. For example, records indicated that the resident was planned to transition from the centre in quarter one 2026.

Overall, the findings of this inspection did not assure the inspector that the provider had effective governance and management arrangements in place to ensure the service was safe, appropriately monitored, and consistently reviewed.

Judgment: Not compliant

Regulation 3: Statement of purpose

The provider had developed a statement of purpose which included all the information required by Schedule 1 of the regulations.

The statement of purpose outlined a range of information about the centre, including the facilities and services in the centre, the organisational structure, and the arrangements for consultation with residents. From review of the floor plans and observations during the inspection. The inspector found an external recreational room was not included on the floor plans of the centre. This recreational room was observed to be used by a resident during the inspection.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

The inspector viewed incident and accident records for January, February and up to 12 March 2026. The inspector found that while there is a record of all incidents, five incidents where possible safeguarding concerns existed were not notified to the Chief inspector in line with the regulations. For example, incidents reviewed indicated that some residents may have been subject to psychological distress and these were not appropriately notified. This is a repeat finding of non compliance, with the most recent inspection carried out in July 2024 also findings notifications were not always notified to the Chief inspector in line with the regulations.

Judgment: Not compliant

Regulation 34: Complaints procedure

Based on records reviewed and feedback received from residents, the provider had failed to address complaints raised by residents living in the centre in line with their own procedures.

The provider had received three formal complaints in May 2025 from residents living in the centre in relation to noise disruption from a peer. A formal response was

issued in writing to each resident in August 2025. However, no further records were available to view to evidence the actions taken by the provider in response to these complaints. For example, the correspondence issued to residents detailed that local management would meet them in the coming weeks but no further information was available to verify this had occurred and the outcome of this meeting.

The inspector spoke to two residents who had raised complaints, both described having been told many months ago living arrangements would be reviewed in response to these complaints. However, both residents were unsure when this would be progressed by the provider with one resident told the inspector they were told 'changes would happen before Christmas and then January'. From discussions with local management they were unclear if these complaints were closed or remained open on the day of inspection. Records were not available to view in the centre to verify the status of these complaints.

Judgment: Not compliant

Quality and safety

Based on the findings of this inspection, significant improvements were required in relation to quality and safety regulations to ensure residents received a service that is safe and to a high standard. Key areas of concern included the premises, safeguarding practices and the providers oversight of the systems to govern these areas.

One area of the premises required prompt review by the provider to address significant mould issues. Ventilation in affected areas was found to be ineffective on the day of inspection. While the provider had identified some dampness within the centre, the full extent of these issues had not been identified or appropriately addressed.

Oversight of risk management also required improvement to ensure it accurately reflected the current risks within the centre. For example, significant changes that occurred in one house in December 2025 were not reflective in the current risk register, this impacted on the providers ability to manage risks and maintain oversight of risk management systems. In addition, actions agreed to be completed by January 2026 as part of the providers unannounced six-monthly audit in relation to individual risk registers were not completed on the day of inspection.

Feedback from resident's in one house indicated ongoing dissatisfaction with their living arrangements. These concerns had been raised through resident meetings, the complaints process, and to local management. However, these concerns did not result in a timely or effective response. This concern was also identified on the most

recent inspection of the centre in July 2024 with compliance plan actions found to be ineffective, such as sound proofing.

The findings of this inspection indicated that the providers response to previous poor findings were either ineffective or not extensive enough to address the fundamental issues of concerns effecting the quality and safety of the residents residing in the centre.

Regulation 17: Premises

The centre required significant work in order to ensure care is provided in a well-maintained safe environment. The design and layout of one house in the centre did not meet residents' needs.

The inspector found maintenance issues were outstanding in the centre across two locations. For example in one location, during a walk around the inspector found several areas requiring improvement, such as a poorly ventilated bathroom, a toilet cistern was taped closed and it was also found to be broken posing infection prevention risks. The inspector observed broken blinds throughout the centre with no safety clips in place in some rooms posing a risk to residents. In addition, a vanity unit was found to be broken and had signs of swelling from dampness. During the inspection, an external contractor attended to the centre to review all blinds and plan a date for repairs. Both houses were found to have ongoing issues with mould, for example, one bathroom was found to have extensive mould to the roof and the ventilation system in place was not working on the day of inspection. A resident also showed the inspector mould in their bedroom and described this coming from gutters outside the house with maintenance having recently reviewed this.

The inspector also viewed a self-contained apartment as part of the centre, this was found to be visibly clean however a malodour was present. Recent works had been carried out to address dampness and a crack in the ceiling of this apartment was repaired. This malodour was discussed with local management who had recently logged a maintenance request for repairs to an en-suite to address concerns over infection prevention risks in this bathroom. The inspector observed that kitchen units in this apartment did not close fully and the laminate covering was also peeling from some of the doors.

During a walk about of the second location, the inspector found the house was visibly clean with some maintenance issues found in relation to mould as discussed above. However, the design and layout of this house did not meet the needs of residents living here. Since the previous inspection, the provider had completed works to 'soundproof' one self-contained apartment as part of the compliance plan submitted to the Chief Inspector, this work was undertaken between September and November 2025. From discussions had with local management, staff, and residents

these works have not been successful, this has resulted in ongoing noise disruption for all residents living in this location.

The inspector viewed the maintenance request system in operation in the centre, some areas identified on this inspection were identified however the extent of the findings of this inspection were not evident in maintenance requests. In addition, timeframes set were unrealistic; for example, where extensive bathroom renovations were required the provider had set the time frame of one month for quotes and tendering to take place with no planned timeframe for the next stage set out. Although an external contractor visited the centre on the day of inspection to schedule works for repairs to blinds, these blinds were broken by a resident who had not lived in the centre for almost three months demonstrating the provider did not have a timely approach to the maintenance of the centre.

Judgment: Not compliant

Regulation 26: Risk management procedures

Improvement was required to ensure risk management systems in the centre were up to date and aligned to current risks in the centre.

The provider had prepared a risk register for the centre which included both local and environmental risks. Each resident had an individual risk register and risk assessments. The inspector reviewed the risk register for each location and found that the risks identified, such as behaviours of concern and fire safety were not always consistent with the risks found on individual risk registers. For example, an individual risk register identified medical issues as a high risk, however no risk assessment was in place to support this identified risk.

Overall, centre risk registers required review to ensure they were up to date and aligned to the current risks in the centre. The provider needed to review its system of risk identification to ensure that risks such as infection prevention and control are appropriately assessed and control measure are in place to mitigate risks associated with this.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

The provider had ensured that appropriate supports were in place for residents with assessed behavioural needs.

The inspector reviewed a sample of two behavioural support plans for residents with assessed needs. These plans were up to date and provided guidance to staff on

proactive and reactive strategies to follow in the event of a behavioural incident. The inspector reviewed guidance documents in relation to as required medication for the management of behaviours, this gave sufficient detail in relation to the administration of this medicine.

Judgment: Compliant

Regulation 8: Protection

Based on the findings of this inspection, residents were not protected from all forms of abuse. The inspector found the provider did not have appropriate safeguarding measures in place to protect residents from ongoing noise disruption that impacted on residents overall wellbeing. The centre had three active safeguarding plans in place in response to peer-to-peer concerns. Measures in place to support residents feel safe included emotional reassurance and planned activities away from the centre, these measures were found to not always be effective in safeguarding residents.

Incident records reviewed for January, February and up the 12 March 2026 found that frequent incidents occurred in the centre where residents were exposed to noise in their home or witnessed a peer engage in behaviours of concern. For example, an incident report detailed a resident was exposed to a peer shouting as they arrived home and on another occasion an incident report detailed a resident was subject to a peer shouting abuse at them as they ascended the stairs of their apartment.

The inspector spoke to all residents living in one house where these incidents were occurring. Two residents clearly described feeling impacted by these incidents and described to the inspector that they were unhappy with this situation. One resident described having heard shouting as they ascended their stairs to their apartment and they described this as 'annoying to them'. While another resident described the most impact for them was overnight as the noise was keeping them awake.

The inspector observed the size, layout, and the location where these incidents had occurred and found that the impact of noise disruption may be varied depending on the time of day due to the layout of the house. During the day, one resident spent time in a living room, which was located away from the source of noise. However, at night this resident's bedroom and en-suite bathroom were adjacent to the source of noise, which increased the level of disruption.

This is a repeat finding of non-compliance. The provider had recognised the impact that noise was having on residents going back to 2024, the measures implemented including sound proofing has not resulted in the lived experience of residents getting better.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 5: Application for registration or renewal of registration	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Not compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Not compliant

Compliance Plan for Seirbhis Radharc Arainn OSV-0004955

Inspection ID: MON-0049929

Date of inspection: 13/03/2026

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: In accordance with Regulation 16 (1)(b) the Person in Charge has reviewed staff Support and Supervision within the Designated Centre with both team leaders and has confirmed there is a schedule in place for staff to receive same for the rest of the year. The Person in Charge will be implementing a quarterly audit tool which includes oversight of the Support and Supervision process for all staff within the Designated Centre.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: In accordance with Regulation 23 (1)(b) the Person in Charge has reviewed the rosters within the Designated centre and amended the current format to clearly define the Senior Person on duty each day. In accordance with Regulation 23 (1)(c) the registered provider has provided guidance to all internal auditors to ensure that they review the management systems of all areas within a Designated centre during their provider visits. The Person in Charge is commencing a quarterly audit tool which will ensure that the service provided is safe, appropriate to people supported's needs, consistent and effectively monitored. The provider has enhanced overall governance by employing an additional Service Coordinator for the service area, which will result in this Designated centre having increased governance and oversight. The registered provider has reviewed the timeline of the transition plan for one person supported's transition to alternative living accommodation. This transition will now be completed by 31/07/2026.	
Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
In accordance with Regulation 03 (1) the Person in Charge will amend the floor plans to include the external recreational room and subsequently update the Statement of Purpose to reflect the change. The updated Statement of Purpose will be submitted to the Chief Inspector for review in line with the re-registration requirements for the Designated Centre.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
In accordance with Regulation 31 (1)(f) the Person in Charge has reviewed all incident reports from January to the date of inspection 12th March 2026, and has submitted retrospective notifications to the Chief Inspector. The organisations Designated Officer had previously reviewed all the above incidents and the current open Safeguarding plans are reflective of same.

Regulation 34: Complaints procedure	Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
In accordance with Regulation 34 (2)(f) and in line with organisational procedures the Team Leader will maintain a complaints log which is then escalated to the Person in Charge for review and response. The Person in Charge shall ensure that all responses to people supported and follow up actions are clearly documented on the complaints log. The Person in Charge met with all people supported on 10/04/2026 to update them on their formal complaints. The outcome of these meetings are recorded in the complaints log and these complaints remain open. The Person in Charge has committed to providing a monthly update to all people supported until such a time as their complaints are closed. In accordance with Regulation 34 (3)(b) the organisational procedures identify a nominated complaints officer. The Person in Charge has further escalated the open complaints to the nominated complaints officer on 17/04/2026. The complaints officer and the Person in Charge have completed external training on Complaints Management as arranged by the provider on the 20th and 21st April 2026. Management will discuss the complaints procedure with staff teams in the Designated centre at the next team meeting.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
In accordance with Regulation 17 (1)(a) the registered provider has reviewed the transition plan for one person supported. The proposed new service will meet this person's needs. The date of transition has been amended to take into consideration the submission and approval of an application to vary within another Designated centre. In accordance with Regulation 17 (1)(b) the Person in Charge in conjunction with the registered providers facilities department have reviewed all outstanding repair and renovation works required. A schedule of works has been developed with a completion date of all work for 01/08/2026. In accordance with Regulation 17 (7) the above

schedule of works will ensure that the registered provider has made provision for all matters set out in Schedule 6.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures: In accordance with Regulation 26 (2) the Person in Charge is reviewing all risk assessments and both risk registers within the Designated centre to ensure that they are reflective of current risks. This will be completed by 24/04/2026. To enhance management of risk within the Designated centre the Person in Charge and Team Leader will attend a refresher in Risk Management training in June 2026.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection: In accordance with Regulation 08 (2) the registered provider is progressing the identified transition plan for one person supported to individualised accommodation within another Designated centre. The timeframe for the transition plan has been reviewed with a new expected moving date of 31/07/2026. Once this transition is completed all safeguarding plans will be closed. During the interim period the Person in Charge, the Designated Officer and staff team endeavour to reduce the impact of the noise in so far as possible on other people supported's wellbeing. In accordance with Regulation 08 (3) all incidents within the Designated Centre are reviewed by the Person in Charge and the Designated Officer. All open safeguarding plans are reflective of all incidents that have occurred and will continue to be monitored. Any future incidents will be notified to the Chief Inspector as per Regulation 31.

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 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	31/05/2026
Regulation 17(1)(a)	The registered provider shall ensure the premises of the designated centre are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.	Not Compliant	Orange	31/07/2026
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	31/07/2026
Regulation 17(7)	The registered provider shall make provision for	Not Compliant	Orange	01/08/2026

	the matters set out in Schedule 6.			
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	Orange	17/04/2026
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	31/07/2026
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Substantially Compliant	Yellow	24/04/2026
Regulation 03(1)	The registered provider shall prepare in writing a statement of	Substantially Compliant	Yellow	22/05/2026

	purpose containing the information set out in Schedule 1.			
Regulation 31(1)(f)	The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: any allegation, suspected or confirmed, of abuse of any resident.	Not Compliant	Orange	13/04/2026
Regulation 34(2)(f)	The registered provider shall ensure that the nominated person maintains a record of all complaints including details of any investigation into a complaint, outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.	Not Compliant	Orange	10/04/2026
Regulation 34(3)(b)	The registered provider shall nominate a person, other than the person nominated in paragraph 2(a), to be available to residents to ensure that: the person nominated under paragraph (2)(a) maintains the records specified	Not Compliant	Orange	27/04/2026

	under paragraph (2)(f).			
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	31/07/2026