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:	Sky Services
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Galway
Type of inspection:	Unannounced
Date of inspection:	01 October 2025
Centre ID:	OSV-0005035
Fieldwork ID:	MON-0042929

About the designated centre

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

Sky Service provides full-time residential care and supports 10 individuals of mixed gender who are over 18 years of age, and who have an intellectual disability. These individuals may also have complex needs such as physical, medical, mental health, mobility and or sensory needs and may require assistance with communication. The centre is comprised of two houses, one in a town, and the other nearby in a rural area. The houses meet the needs of residents with suitable assistive equipment, single bedrooms, gardens and comfortably furnished rooms. Residents in the centre are supported by a staff team that includes team leaders in each house, nurses, social care workers and care assistants. Staff sleep in one house, and there is a staff member on waking duty in the other house.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	10

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 1 October 2025	09:00hrs to 17:10hrs	Maureen McMahon	Lead

What residents told us and what inspectors observed

This was an unannounced inspection carried out to assess the provider's compliance with the regulations. There was considerable improvement found to be required to fire safety, premises, risk management and medicines management. These will be discussed in more detail later on in this report.

The inspection was facilitated by the person in charge and team leader. The inspector also had the opportunity to meet eight members of staff across both locations, and nine residents who lived in this service. Due to the assessed communication needs of these residents, some were unable to speak directly with the inspector about the care and support they received; however, many of them did greet the inspector and appeared content.

The designated centre comprised of two houses, which were located a short drive from each other. The first house that the inspector visited was a bungalow dwelling in a rural setting which was home to five residents. These residents had lived together for a number of years. A new resident was admitted to this house in May 2025. The residents in this house mostly got on well, the provider had identified some areas for supports to ensure the well-being of all residents and these were well managed on the day of inspection. Residents in this house were very socially active and liked to regularly get out and about. Residents required support with their assessed needs relating to communication, healthcare, intimate care, others were identified as a falls risk and required on-going supervision. Their home comprised of individual bedrooms, shared bathrooms, and a sitting room, dining area, utility and kitchen. They also had access to a well-maintained garden area with ramped access and handrails. Their bedrooms were personalised to their own taste. All residents had access to televisions in their bedrooms. One resident had personalised photographs of family and friends and souvenirs from travel abroad. Another resident had a large picture of their favourite football team displayed. Residents had comfortable armchairs in their bedrooms to relax and watch television. The second house, was based in a town in a residential area, and was home to five residents. Again, these residents had lived together for a number of years. Safeguarding measures were in place in this house and the person in charge demonstrated they were well managed. Their assessed care and support needs related to healthcare, personal and intimate care needs. This house is supported by nursing input in the management of residents' health conditions. This home was also a bungalow dwelling with individual bedrooms, shared bathrooms, large open plan kitchen, dining, and living area. These residents also had access to a garden area.

Upon the inspector's arrival to the first house, they were greeted by a staff member and a resident. The atmosphere in the house was welcoming, with staff supporting residents with morning routines. Throughout the morning residents were supported to have breakfast at their leisure and plan their day. These residents led active lifestyles and were supported to have a wraparound support. Some residents enjoyed swimming, walking, going to the gym, and cycling. Recently some residents

had attended the Galway rally along with supporting local fundraisers for the Irish Hospice Society. Residents accessed their local amenities, such as the pubs, shops and restaurants. The inspector spoke to a resident who described their plans for the upcoming weekend, to attend a country western concert and have an overnight stay in a hotel. Another resident had plans to travel abroad later in the year for a sun holiday. Staff spoke to the inspector about the importance of routine for residents' so as to effectively support their care and welfare needs.

The inspector saw residents had access to the multidisciplinary team, with the physiotherapist visiting a resident on the day of inspection. Upon the inspector's arrival to the second house, four residents were in the main living area having a meal. A tropical fish tank provided a colourful focal point to the main living area. One resident was resting in bed due to their healthcare needs on the day. These residents also liked to get out and about, but due to their care and support needs, much of these outings were locally based. Residents responded well partaking in sensory based activities.

The staffing arrangements for this centre comprised of both nurses, social care workers and social care assistants. Many of the staff working in the centre had supported these residents for a number of years and were very knowledgeable on their care and support needs. Agency staff were required to support the roster in one house, the provider ensured that only familiar agency staff were allocated.

In summary, there were many examples of where care was provided to a good standard. However, this inspection did find a number of improvements that required the attention of the provider. The provider needed to review their internal monitoring and oversight arrangements to ensure they are capable of identifying issues like those found in this inspection.

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

Capacity and capability

There was a clearly defined management structure in place. Based on the findings of this inspection, this structure supported the provision of a good-quality service to residents. The provider had established systems of quality assurance for maintaining oversight. While these systems were effective in some areas, improvements were required to ensure that reviews were robust and effectively evaluated the care, support and facilities provided.

There was a suitably qualified and experienced person in charge to manage the centre. They were familiar with residents who lived in the centre and their assessed needs. The person in charge was supported in their role by a team leader who

worked full time in the centre. Day-to-day management of the centre was the responsibly of the team leader. The person in charge retained overall responsibility for governance and oversight. The person in charge delegated tasks, such as the rotas to the team leader, with regular meetings to maintain effective oversight. The person in charge described how they maintained an active presence in the centre. The inspector observed a resident warmly greet the person in charge and refer to a recent phone conversation they had shared. A staff member spoken with confirmed they had access, support and guidance as needed from the person in charge. There were on-call management arrangements in place for out-of-hours. The inspector reviewed staff meetings minutes in one location. There was good staff attendance at the meetings and areas such as training, activity planning and personal outcomes were discussed.

The centre presented as adequately resourced though further investment in the upkeep of the premises was required. This will be discussed under regulation 17. These resources included the provision of comfortable accommodation, transport, access to Wi-Fi and televisions. The staff rota accurately reflected the staffing levels, staffing arrangements and skill mix in place in the centre. The provider had ensured that staff were suitably trained for their roles.

The provider had systems in place to oversee the quality and safety of care in the centre, such as an annual review of the centre and unannounced audits by the provider which were carried out twice each year. The provider had sought feedback from from residents and their representatives as part of this review. This feedback was positive and described a centre that is homely with good communication between the centre and resident representatives. However, these monitoring systems did require review to ensure their overall effectiveness, as a number of the findings from this inspection had not been identified by the provider themselves through their own internal monitoring and oversight systems.

There was a clear and transparent complaints procedure available to residents. Records reviewed confirmed the provider had implemented the centre's complaints procedure in the handling of complaints.

Regulation 15: Staffing

Staffing numbers and skill-mixes were based on the assessed needs of each resident.

The inspector reviewed the staffing roster for September 2025, which showed that sufficient staffing levels were being maintained and that additional staff were also being rostered as required to support weekend outings and activities. The staff duty rota was planned and prepared in advance and overseen by the person in charge. The inspector saw that where there were changes, the replacement staff member was clearly indicated on the duty rota.

The inspector spoke to the person in charge, team leader and three staff members

during the course of the inspection, and found them to be knowledgeable about the support needs of residents. Staff were observed to support residents in accordance with the care plans of each resident, and in a caring and respectful way.

Judgment: Compliant

Regulation 16: Training and staff development

The provider had ensured that staff who worked in the centre had received appropriate training to equip them to provide suitable care to residents.

Staff had received mandatory training in areas such as fire safety, positive behaviour support and safeguarding residents from abuse. In addition staff had received other relevant training, such as medication management, first aid and autism awareness. Staff who required refresher training were identified by the management team, and these staff were scheduled to attend the required training in the coming weeks. Recently recruited staff had undertaken an induction into the centre and were booked to attend all mandatory training.

The person in charge and team leader completed one-to-one formal supervision with the staff team twice annually. A planned schedule was in place for 2025.

Judgment: Compliant

Regulation 23: Governance and management

The providers governance and management systems required review to ensure the service delivered was subject to effective ongoing monitoring and evaluation.

The provider had ensured that the centre was subject to ongoing monitoring and review, such as provider unannounced audits undertaken every six months.These audits had taken place in November 2024 and July 2025. These audits did not identify the centres risk management system was not maintained or accurate based on residents' assessed needs. In addition areas identified by the provider in November 2024 remained outstanding in July 2025 with no evidence of a quality improvement plan to address these issues. For example, improvements to personal evacuation plans for residents and the centre emergency plan were identified in November 2024 and were also identified as requiring improvement as part of this inspection.

The provider had prepared an annual review for 2024 and this was available in the centre. The person in charge had completed audits in the centre each quarter, these were reviewed for quarter two 2025. The inspector found disparities between the findings of these local systems for monitoring and observation on the day of

inspection. For example, a medication management audit did not identify the areas for improvement noted during the inspection. This will be further discussed under regulation 29.

Judgment: Not compliant

Regulation 24: Admissions and contract for the provision of services

The provider had prepared written agreements for the provision of residential service to residents. However, the inspector found a resident admitted to the centre four months prior to the inspection did not have an up-to-date contract of care.

The inspector read a sample of two service agreements, and found that they included relevant information, including fees to be charged and facilities provided

Judgment: Substantially compliant

Regulation 31: Notification of incidents

The person in charge was aware of the requirement to make notifications of certain adverse incidents, including quarterly returns, to the Chief Inspector of Social Services within specified time frames. The inspector reviewed incident records for July, August and September 2025 and found that the person in charge had notified the Chief Inspector of any adverse incidents occurring in the centre as required by the regulations.

The inspector saw a quarterly review undertaken by the person in charge for quarter two 2025. The person in charge told the inspector these quarterly reviews are used to identify trends in the centre.

Judgment: Compliant

Regulation 34: Complaints procedure

The provider had suitable processes for the management of complaints in the centre. The procedure had been made available in an easy read version and was clearly displayed as required by the regulations. The provider had an up-to-date complaints policy to guide practice

The person in charge maintained a log whereby any complaints were recorded, including any actions taken to address the complaint. At the time of inspection, the

person in charge had an ongoing complaint, which had been progressed using the provider's complaints procedure.

It was evident residents and their representatives were supported to raise any concerns. Resident's weekly meetings discussed complaints and there was a transparent process for the management of complaints.

Judgment: Compliant

Quality and safety

Residents' assessed needs in this centre were well-known to staff, and good practices were found in relation to these. Safeguarding of residents was promoted and staff spoken with were very clear on their role in relation to responding and reporting safeguarding concerns. However, there were considerable improvements found to be required in relation to premises, risk management systems, fire precautions and medicines management.

The inspector identified that fire safety arrangement required significant improvement. An immediate action was issued to the provider in relation to one fire door that was defective, this was promptly rectified. In addition, improvements were needed to ensure evacuation plans were effective. The inspector requested the provider review the fire doors in the centre to ensure the hardware in place offers adequate protection in the event of a fire.

Residents in the centre were supported to communicate effectively. The inspector observed that residents had access to personal tablets and a range of media, including television and radio. Visual aids were used throughout the centre to support communication, for example to show the planned activities residents were hoping to partake in.

Overall, the design and layout of the premises was suitable. For example, residents' bedrooms were personalised to reflect their individual choices and preferences. The communal areas were homely and provided a welcoming atmosphere for residents. The inspector found improvement was required to storage overall in the centre, corridors were used to store equipment such as wheelchairs and mop storage was not in line with infection prevention best practice. Improvement was also required in the overall cleanliness of the centre.

The provider had systems for the assessment, management and ongoing review of risk. However, the findings of the inspection found that significant improvement was required in how risks are identified, assessed, managed, and reviewed in the centre.

Despite medication management being subject to regular monitoring, upon review of medication management practices, there were a number of improvements found which hadn't been identified by the provider by their own internal oversight

arrangements. These relate to the prescriptions and administration practices, and also to the storage of creams for residents.

Regulation 10: Communication

The provider had ensured that residents were supported to communicate in accordance with their needs and wishes. The provider had an up-to-date communication policy to guide staff.

The inspector reviewed the communication profiles for two residents. The communication profiles contained specific information is relation to the residents' communication strategies and how to interpret their spoken and non-verbal communication. Throughout the inspection the inspector saw staff engaging with residents in line with the recommendations set out in their communication profiles, for example, speaking clearly and directly to a resident. When speaking with the inspector, staff demonstrated good knowledge of residents' communication needs and supports. The inspector observed visual aids, such as menu options, to support residents understanding.

Judgment: Compliant

Regulation 17: Premises

The design and layout of the centre was suitable for its stated purpose and met the residents' individual needs. However, improvement was required to ensure the premises was suitably maintained.

The centre was made up of two houses, which could accommodate ten residents for residential care. During a walk around of the centre, the inspector found areas that required deep cleaning, such as the utility and bathroom in one house. The inspector observed paint that was chipping and an area of extensive dampness in the utility of one house. The utility room had a drying rack that limited accessibility due to its size. The inspector saw sponges that were heavily soiled left on a window sill. The provider had identified maintenance work was required to the utility area where dampness was present, no date was known for this work to commence. Storage of equipment required improvement, for example, two wheelchairs, a mobile hoist and a weighing chair were stored at the end of a corridor in one house. Throughout the day, a standing hoist was also noted to be stored in communal area and close to emergency exits, this posed a risk to residents and staff. The inspector saw miscellaneous items stored behind a fire door causing obstruction, for example individual golf clubs. The storage of mops also required review, the inspector saw mops left on the floor after use with no appropriate storage area assigned.

Judgment: Not compliant

Regulation 18: Food and nutrition

Residents' nutritional needs were well met. Residents had choice around food and dining options. The centre had a well equipped kitchen where food could be stored and prepared. Supplies of fresh food were observed in the centre. The inspector saw that food choices and preferences were discussed with residents and a visual menu was in place.

The inspector observed staff preparing meals on the day, meals were freshly prepared and appeared wholesome and nutritious. Staff spoken with were knowledgeable on the nutritional needs of each resident. A resident explained to the inspector that they had choices when eating in the centre, and that the food is always good. Another resident was observed having their main meal, it was evident they were enjoying this and staff were observed to be attentive to the residents needs during this meal time.

Judgment: Compliant

Regulation 26: Risk management procedures

The arrangements in place for the assessment, management and ongoing review of risk were not adequate. The inspector brought this to the attention of the person in charge who accepted that the review of risk in the centre required significant work.

Improvements were required to how risk was assessed in this centre. Incident reporting was a fundamental function as to how risk was identified in this centre. However, incidents reviewed for July, August and September identified a risk for a resident in relation to experiencing unwitnessed seizures, which could impact their safety due to the potential for falls and injury. The provider had not reviewed the falls management plan or related risk assessments to ensure the optimal supports for the resident and the most up-to-date guidance was available for staff on the management of this situation.

Furthermore, there was a risk register maintained by the person in charge for each house. Again, this did not reflect the risks identified in the centre on the day of inspection. The provider had risks identified that were not current, such as outbreaks of infectious diseases and the use of hand sanitiser and smoking. In addition, a risk assessment for skin integrity completed in August 2023, identified a high risk to a resident, the inspector did not find any further assessment was undertaken or action in relation to this assessment.

The provider had prepared an emergency plan in the event of certain situations

arising, such as loss of power or heat. The inspector read this and found it was not up-to-date and required review to ensure staff have the most up-to-date information in the event of an unplanned emergency.

The observations of this inspection found that the provider had not accurately assessed risks in the centre and a comprehensive review of risk was needed to ensure controls are in place and consistently implemented.

Judgment: Not compliant

Regulation 28: Fire precautions

Fire safety equipment such as alarm systems, fire extinguishers and emergency lighting were all in good working order and serviced regularly. However, during a walk around of the centre, four fire doors were found to be not functioning correctly, therefore impacting on fire containment. The inspector issued an immediate action in relation to one fire door that posed a significant risk to the safety and welfare of residents. The provider took immediate measures to rectify this and confirmed the door was operating correctly on the day after the inspection.

On visual inspection of door locks and handles, it was not evident whether the locking mechanism and fittings provided adequate protection in the event of a fire. The provider was requested to seek further guidance on this matter from a competent person.

The inspector reviewed all personal emergency plans in one house and found further detail was required to guide staff in the event of a fire. The centre emergency plan was reviewed by the inspector and person in charge. The steps outlined in this plan were not in line with the current practices of evacuation in the centre as discussed with staff on duty. The provider needed to review its evacuation plans and escape routes to confirm their effectiveness in the event of an evacuation.

Fire drills records were reviewed from February 2024 to September 2025. The provider had identified issues with a fire door not closing on 18 September 2025, this issue was not rectified on the day of inspection. In addition, the inspector noted corrective actions were not appropriately followed up or triggered, for example, where a bed was noted difficult to evacuate, this record did not identify a corrective action was required. The inspector saw a night time fire drill was not completed since February 2024. The provider had undertaken simulated fire drills; however, the conditions under which these were conducted did not adequately demonstrate competency in fire evacuation, as no residents were involved.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

The inspector reviewed records relating to medication management such as prescriptions, storage arrangements, ordering and receipt of medication and records of administration. There were significant areas for improvement found to be required which related to the prescription records, receipt of medications and also the storage of liquid or cream products once in use.

The inspector reviewed two prescription sheets, improvement was required to ensure the dosage of each medication was clear, for example, the prescription sheet stated one tablet and the dispensing system stated the dosage in units, such as mg.

Medication storage was reviewed by the inspector. This identified that as-required medications were used by multiple residents, for example, one box of medication to treat pain was shared between all residents. This posed a risk to safe administration of medicines, as the dispensing label is unable to be verified against the prescription sheet for each resident. The provider's medication management policy was reviewed, this states each medication must have a dispensing label with clear instruction and in addition medicines are individual to each resident.

During a walk about of the centre, the inspector saw medicated creams left in a communal bathroom, this storage was inappropriate and this product had no date of opening or a pharmacy dispensing label. The inspector saw liquid medications in use in the centre were not labelled with the date opened, for example, liquid medication and eye drops were seen to be open and in use but no date was identifiable. This posed a risk to the product expiring and becoming unlicensed for use.

Judgment: Not compliant

Regulation 8: Protection

The provider had safeguarding procedures in place to support staff in identifying, reporting, responding and managing concerns in relation to the safety and welfare of residents. The person in charge had ensured that all staff had received appropriate training in relation to safeguarding residents and there was a designated officer available to the centre. Staff spoken with were clearly able to demonstrate their responsibilities in relation to the protection of vulnerable adults.

The inspector saw from a review of incidents and accidents for a sample of July, August and September 2025 any allegation or suspicion of abuse was appropriately investigated. On the day of inspection the provider had one active safeguarding plan and from discussion with the person in charge they had good oversight of the control measures in place.

On review of residents' weekly meetings, the inspector saw that safeguarding was

discussed on a regular basis. Information presented was accessible and in the appropriate format based on residents assessed communication needs.

Judgment: Compliant

Regulation 9: Residents' rights

This centre promoted residents' capacity to exercise personal independence and make choices in their daily lives. However, improvements are required to ensure personal information is not displayed in communal areas. For example, a whiteboard in the kitchen displayed details about a resident's personal care needs. In addition the provider did not fully protect residents' privacy regarding financial matters, as personal banking information was accessible within the centre.

Residents were supported to avail of national screening programmes where appropriate, such as the national bowel screening programme. Information regarding residents human rights and access to advocacy services were displayed in the centre. The inspector saw a resident had been invited and consented to partake in national research in the area of aging and disabilities and this was planned for the day of inspection. The provider had promoted residents rights and had ensured residents were registered to vote.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Admissions and contract for the provision of services	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 17: Premises	Not compliant
Regulation 18: Food and nutrition	Compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Sky Services OSV-0005035

Inspection ID: MON-0042929

Date of inspection: 01/10/2025

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: In order to come into compliance with the Regulation: The provider will strengthen governance and management systems by having more effective ongoing monitoring and oversight. To address the issues identified, the person in charge has reviewed Risk Assessments and Risk Register for accuracy therefore ensuring it accurately reflects residents' needs, going forward it will be regularly checked and verified for accuracy. The emergency plans for each Resident and has also audited and a monthly audit of the medication management process has now been completed. In addition going forward all Audit findings will be analyzed and action plans put in place to respond to audit findings more promptly with a named person responsible and clear target dates for completion. The Provider and Person in Charge remain committed to continuous improvement and with this in mind the following actions will also be completed: • Conduct a full review of existing governance systems, including audit tools, reporting templates, and follow-up mechanisms. • Quarterly Audit Checks will take place and they will be meeting held by the Person In Charge and Team leader, and key staff to review audit outcomes, risk updates, discuss and concerns and review Quality Improvement plans progress.	
Regulation 24: Admissions and	Substantially Compliant

contract for the provision of services	

Outline how you are going to come into compliance with Regulation 24: Admissions and contract for the provision of services:
The provider acknowledges the finding regarding the absence of an up-to-date contract of care for one resident. Therefore immediate action was taken following the inspection to ensure the resident's contract of care was completed and signed

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
In order to come into compliance the Person in Charge is committed to responding to sort the issues identified out— including dampness, chipping paintwork, inadequate storage, cleaning standards, and inappropriate equipment placement.

Immediate corrective actions were taken to ensure residents' safety and comfort, including the removal of stored items obstructing corridors and fire exits, replacement of soiled cleaning materials, and temporary relocation of equipment to safe designated storage areas.

The provider has now implemented a comprehensive maintenance and environmental improvement plan to ensure the premises is maintained to a consistently high standard and supports residents' well-being and safety.

Actions Taken:

1. A Deep clean was undertaken of the utility & bathroom areas
2. The issue to Repair dampness & repaint affected areas is currently been repaired by an external contractor following the source of the issued been identified
3. There is now a Designated safe storage for all equipment
4. The Person In Charge is also in the process of Installing proper mop/cleaning equipment storage

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
In order to come into compliance the Person In Charge has reviewed Risk Assessments

in the Centre and updated the Risk Register that reflects residents' needs A full review of all PEEPs, and the Centre's Emergency Plan, and the fire safety management system has been updated to ensure it provides clear, accurate, and practical guidance for all staff and residents. The Epilepsy Plan for One Individual has been reviewed and also the Falls Management Plan

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
The provider acknowledges the finding that while fire safety systems and equipment were well maintained, improvements were required in the areas of fire door maintenance, emergency planning, personal evacuation plans (PEEPs), and the effectiveness of fire drills. In order to come into compliance:
Immediate corrective action was taken following the inspection to address the malfunctioning fire door identified as a significant risk, with confirmation provided to the inspector once repairs were completed.
A full inspection of all remaining fire doors has since been completed to ensure functionality and compliance.
A full review of all PEEPs, and the Centre's Emergency Plan, and the fire safety management system has been updated to ensure it provides clear, accurate, and practical guidance for all staff and residents.
The provider remains committed to ensuring that fire safety systems are effective, proactively maintained, and subject to ongoing review to protect the safety and welfare of all residents and staff.
Actions:
1. Repair all defective fire doors immediately (Completed) 2/10/25
2. Comprehensive inspection of all fire doors (Completed) 2/10/25
3. Seek competent guidance on door locks/handles (Completed) 2/10/2025
4. Update all PEEPs with detailed guidance
5. Review & align centre emergency plan
6. Develop structured fire drill schedule including day & night drills
7. Revise drill corrective action process ongoing
8. Staff refresher training on fire safety ongoing

Regulation 29: Medicines and pharmaceutical services	Not Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and

pharmaceutical services:
The provider acknowledges the finding that significant improvements were required in medication management practices, specifically regarding the accuracy of prescription records, receipt and labelling of medications, and the appropriate storage of liquid and cream products once opened.

The provider accepts that the sharing of "as required" (PRN) medications between residents and the absence of opening dates on certain liquid and topical medications did not meet required standards for safe medicine management.

Immediate action was taken following the inspection to remove any shared medication stock and ensure that each resident's medication is individually prescribed, labelled, and securely stored. Medicated creams and liquid medicines now include the date of opening and are stored in line with the Providers medication Management Policy and infection prevention and control standards.

The provider has initiated a full review of medication management systems, including prescription documentation, ordering, receipt, and storage processes. Staff have been provided with additional guidance and refresher training in Safe Medication Management to improve standards and compliance.

Regulation 29 requirements.

Actions:

1. Removed shared PRN meds; ensured each individuals medication was labelling

2. Reviewed all prescriptions for clarity
3. Introduced medication receipt form in line with policy
4. Improvement made to storage area / and labelling of liquids & creams including staff advised to date when creams are opened.
5. Staff refresher training on meds management
6. Review and update policy implementation
7. Monthly medication audits now in place
8. Referral sent to Best Practice Group for a random external audit to occur of medication management practices by nurse whom delivers the Medication Training. Scheduled 21/11/25

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
The provider acknowledges the finding that, while the centre actively promotes residents' independence, choice, and rights, improvements were required to ensure residents' personal and financial information is fully protected in line with data protection and

privacy standards.
The provider accepts that personal information displayed on a whiteboard in a communal area and the accessibility of residents' banking information within the centre did not align with best practice for maintaining confidentiality.
Immediate action was taken following the inspection to remove all personal information from communal display areas and to secure residents' financial documentation in locked storage accessible only to authorised staff.
The provider has reviewed and strengthened procedures on information management and privacy within the centre to ensure that residents' personal and financial information is handled with respect, confidentiality, and in accordance with data protection principles.
Actions:
1. Remove personal info from communal areas immediately
2. Secure all financial info in locked cabinets
3. Review information-sharing practices
4. Staff refresher on confidentiality & GDPR
5. Quarterly GDPR audits
6. Resident engagement on privacy preferences

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Not Compliant	Orange	31/12/2025
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Not Compliant	Orange	15/11/2025
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	15/11/2025

Regulation 24(3)	The registered provider shall, on admission, agree in writing with each resident, their representative where the resident is not capable of giving consent, the terms on which that resident shall reside in the designated centre.	Substantially Compliant	Yellow	08/10/2025
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.	Not Compliant	Orange	10/11/2025
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.	Not Compliant	Orange	02/10/2025
Regulation 28(4)(b)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, in so far as is reasonably practicable, residents, are aware of the	Not Compliant	Orange	30/11/2025

	procedure to be followed in the case of fire.			
Regulation 29(4)(a)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that any medicine that is kept in the designated centre is stored securely.	Not Compliant	Orange	21/11/2025
Regulation 29(4)(b)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine which is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.	Not Compliant	Orange	21/11/2025
Regulation 09(3)	The registered provider shall ensure that each resident's privacy and dignity is respected in	Substantially Compliant	Yellow	15/11/2025

	relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.			