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:	A2
Name of provider:	Peamount Healthcare
Address of centre:	Co. Dublin
Type of inspection:	Unannounced
Date of inspection:	17 November 2025
Centre ID:	OSV-0005387
Fieldwork ID:	MON-0048291

About the designated centre

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

The designated centre is comprised of three individual units and is located on a shared campus setting in West County Dublin. It provides 24-hour residential support services to persons with intellectual disabilities and at the time of inspection was registered for 15 individuals. The three units of the centre had similar layouts and included an entrance hallway, a living and dining room, a small kitchen area, accessible bathrooms and individual bedrooms for residents. The staff team was comprised of a person in charge, a social care leader, staff nurses, carers, an activity coordinator and household staff members.

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
Monday 17 November 2025	13:00hrs to 19:30hrs	Brendan Kelly	Lead
Monday 17 November 2025	13:00hrs to 19:30hrs	Karen Leen	Lead

What residents told us and what inspectors observed

This report outlines the findings of an unannounced risk based inspection undertaken in November 2025. The inspection was scheduled to inspect against the provider's compliance plan submitted to the Chief Inspection of Social Services subsequent to an inspection in the designated centre on the 10 and 11 February 2025. A number of non compliant Regulations were identified in the February inspection and the compliance plan detailed measures to be taken in order to address the levels of non compliance found. This inspection found that significant concern remained in the area of fire safety in particular utilising staff resources to support safe evacuation.

The inspection found that the provider had made some improvement in governance and management concerns as identified on the previous inspection. In addition the provider had recruited additional staff to fill previous vacancies. However, inspectors were not assured that the systems in place under Regulation 28: fire precaution were appropriate in order to ensure safe evacuation of residents in the event of a fire. Inspectors found that the provider had self-identified a number of concerns related to staffing levels and fire safety. These were highlighted through the centre risk register and in records of fire evacuation drills completed in February 2025, however, the provider had failed to set appropriate control measures to ensure safe evacuation of residents could be met in the event of a fire.

The designated centre is made up of three houses located on a campus setting in West Dublin. The centre is registered for 15 residents, at the time of the inspection there were eight vacancies. Inspectors found that each house that comprises the centre was homely, with pictures portraying a number of milestone gatherings with family and friends and recent holidays. In each home that inspectors visited, residents were observed relaxing on comfort chairs, listening to music or enjoying a snack. The inspectors had the opportunity to visit all houses that make up the designated centre and met all residents.

On arrival to the first house, inspectors were greeted by one resident. The resident had returned home from an exercise class completed in the providers wellness centre, located on the campus grounds a short walk from the resident’s home. The resident told the inspectors their plans for Christmas and their excitement that they would be staying with family.

The second house was home to three residents. The inspectors were introduced to residents by the support staff and were informed that they were planning to out for a drive in the afternoon, that they were waiting on confirmation of the availability of the float staff for support. The float staff was a staff that was available to all three houses in the designated centre to assist with resident activities in the centre and also to facilitate staff breaks.

The inspectors asked if they could view the residents' home. The support staff was supporting one resident in the living room and told inspectors that they could complete a walk through of the house. While the inspectors were talking to one resident they asked if they would like to show the inspectors their home. The resident agreed and showed the inspectors their bedroom and the communal areas of their home. While completing the walk through, one inspector heard a resident calling for assistance from the bathroom. The support staff could not hear the resident due to the distance from the bathroom to the living room. The resident remained in the bathroom and was calling for assistance with the door open. The inspectors immediately informed the staff member that a resident required support. The support staff came to the bathroom door and closed the door informing the resident they would be back to help in a minute. The support staff was then required to return to the living room to inform residents there that they would be back. There was no additional staff available to support residents in this house at that time as staff were on breaks and the float staff was covering a break in the house next door. The inspectors later went to review the door system in the main bathroom and found that residents could not close the door when using the bathroom as a self-closing mechanism was placed on the wall behind the door and met the door at the top for closure.

Throughout the course of the inspection, inspectors observed warm and friendly interactions between residents and support staff. Residents were observed availing of activities in their home and coming and going from their home to visit the wellness centre based on the campus setting. In the afternoon, inspectors observed residents to be attending bus drive in the local community and one resident going to do their grocery shopping with a support staff.

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

Capacity and capability

This inspection was completed to review the registered provider's progress in completing actions identified in their compliance plan as a result of the level of non-compliance identified in February 2025. The inspectors were not assured that the provider had implemented the actions outlined in their submitted plan in totality and effectively.

While there was a clear governance structure in place with clear reporting structures, the inspectors were not assured the centre had the appropriate staffing levels to meet the assessed needs of all people using the service. In particular staffing levels at night time did not provide the inspectors with assurances in regard to safe fire evacuation procedures.

Regulation 15: Staffing

On the day of the inspection, the inspectors found that the centre was operating with three whole time equivalent vacancies. The person in charge utilised regular relief staff from the providers' relief panel. Inspectors observed that agency staffing was used in the centre during periods of unexpected staff leave such as sick leave. Agency staff on duty were found to work shift patterns that ensured they were working with regular support staff.

Inspectors reviewed rosters from August, September and October 2025 and found that the person in charge maintained both a planned and actual roster for the centre.

Inspectors were not assured that the provider had sufficient staffing in place to support the evacuation needs of all residents in the designated centre from 21:00 to 08:00. This concern is detailed further in the section of the report that discusses Regulation 28: Fire Precautions.

In the main inspectors observed positive interactions between the residents and the staff team on duty. However, in one location a staff member indicated it was their first time working in the premises. The staff member was unsure of plans for the afternoon or evacuation procedures for the residents. The staff member spoke about going for drives telling the inspectors that the people using the service "only go for a drive".

Following the conversation with the staff member the inspectors reported their concerns to the person in charge to ensure alternative staffing arrangements were implemented.

Judgment: Substantially compliant

Regulation 23: Governance and management

The inspectors found that while the provider had made improvements in addressing staff vacancies within the designated centre, the provider was not utilising the resources available in the centre in a manner that met the assessed needs of residents. The inspectors found that there were insufficient resources available to support residents while staff where taking their legally required rest breaks. This was placing residents at potential risk such as staff not being available to support with personal care or unfamiliar staff without the appropriate knowledge of residents' needs or knowledge required for safe evacuation.

The inspectors reviewed reports from provider led six-monthly unannounced visits to the designated centre completed 25 February 2025 and 30 June 2025 and found

that these unannounced visits had failed to identify a number of risks and concerns in the designated centre. For example, the six-monthly unannounced visit completed in 25 February 2025 had not identified the ongoing concerns in relation to the safe evacuation of residents from the designated centre, despite fire drills taking place in the centre on the 21 February 2025 taking greater than the stated safe evacuation time for the centre.

Inspectors were not assured that there were adequate resources to support residents in the event of a night time fire drill in order to ensure safe fire evacuation. The provider had not responded with appropriate control measures following risks identified through evacuation procedures and as highlighted on the centre's risk register in relation to safe staffing levels and fire evacuation.

The person in charge had implemented a number of audits within the designated centre. The findings of these audits were presented to the staff team at monthly staff meetings promoting a culture of shared learning. The inspectors found that the person in charge reflected the findings from local audits through the quality enhancement plan (QEP) for the designated centre.

The inspectors reviewed staff meetings from August, September and October 2025 and found that each staff meeting support staff gave an overview of each residents current goals and plans. Information from residents meetings were also discussed by the staff team at each staff meeting.

Judgment: Not compliant

Quality and safety

While the inspectors observed residents using the service to be happy in their homes, the inspectors were not assured that the registered provider had systems in place to ensure resident safety.

Concerns were brought to the providers attention in regard to their emergency response plans with an urgent compliance plan being issued in regard to Regulation 28: Fire precautions on the day following the inspection.

The inspectors also raised concerns to the provider regarding their risk management systems, resident welfare and development and the personal plans of the people using the service.

Regulation 13: General welfare and development

The provider had systems in place to identify and review areas of welfare and development for the people using the service. On the day of inspection the inspectors reviewed resident personal plans and cash book ledgers to help form a judgment on resident welfare and development.

The inspectors observed that not all residents welfare and development was being promoted to its fullest potential. For example one resident cash ledgers and person centred plan were reviewed. The person centred plan discussed a sample of activities the resident enjoys as gardening, cooking and baking. On review of the residents cash ledgers, there was no evidence for September or October 2025 that the resident had purchased any materials that would allow them to engage in these activities. There were 27 entries to the ledger in the months of September and October 2025, four of these entries were to purchase ice-cream with remaining 23 entries for shopping, clothes, medication and parking.

The resident had a meaningful activities document in their plan, however, this had not been reviewed since 2023. The residents financial passport review date was January 2025 with no evidence of a review taking place. The resident also had a planned monthly tracker of home enjoyment activities. There was no evidence of any update for the months of August and September 2025 while there were infrequent entries for October and November 2025.

A second resident's personal plan was reviewed by the inspectors. Again, the meaningful activities document had not been reviewed since 2023. Goals were in place for this resident such as buying Christmas clothes, feeding ducks and buying beauty products. However, there was no evidence of functional assessments to determine what goals are important to residents. The inspectors did not observe any evidence of resident input in goal development or review to determine the success and personal development from goals.

The inspectors reviewed multi-disciplinary team meeting minutes for one resident. One of the actions identified in the minutes was for the resident to move bedrooms. On the day of inspection this had yet to be completed despite first being identified in July 2025. The inspectors did not observe any evidence regarding any rationale for the length of time taken or a revised time line for completion.

Judgment: Not compliant

Regulation 26: Risk management procedures

The inspectors reviewed the risk register in place for the designated centre and found that it was subject to regular review by the person in charge and the provider’s quality department with the most recent review completed on 19 September 2025. The inspectors found that the risk register identified a number of

findings which had not been suitably addressed by the provider in order to ensure that the service provided to all residents is safe and appropriate to resident's needs.

The inspectors identified a number of actions highlighted on the risk register for the centre had not been appropriately actioned by the provider. For example in relation to one premises in the designated centre the risk register identified that "there is a risk of residents not evacuating in the event of a fire due to staffing supports not being in place leading to reduced safety". Inspectors found that no immediate action had been taken by the provider in order to address the significant risk posed to residents in the event of a fire. The inspectors issued an urgent action to the provider, this will be discussed under Regulation 28: fire precautions.

The risk of falls had been identified for residents in the designated centre. The inspectors found that falls management plans and assessments were in place for residents and that the provider had a falls committee. However, inspectors found that as part of the control measures identified for the management and support of residents with falls prevention was an annual medical review for residents. Inspectors reviewed the files of three residents who required a falls assessment and found that an annual medical review was not in place for two residents, with no previous medical review completed within the last 12 months.

Inspectors found that a standardised Quality Enhancement Plan (QEP) was maintained for the centre and subject to a quarterly review by the person in charge and a member of the provider's quality department. However, the QEP had failed to identify the fire risk which was identified on the risk register and by inspectors during the course of the inspection. Furthermore, the provider had completed an environmental review of the designated centre on 21 February 2025 to further reduce the risk of fire in the centre. Inspectors found evidence that a fire drill completed on 21 February 2025 demonstrated a night time evacuation time of over six minutes. Inspectors requested a copy of the environmental review completed by the senior management team during the course of the inspection, this document was not available for inspectors to review.

Judgment: Not compliant

Regulation 28: Fire precautions

Inspectors found that emergency evacuation systems put in place by the registered provider were not always effective. A review of three fire drills conducted by the provider in February 2025 showed that the night time emergency response plan involved a nurse attending the location of a fire from another location on the site. The success of the emergency evacuation plan depended on the staff member being free to attend at the moment of the emergency. The provider has evidence of a fire drill completed on 21 February 2025 where the staff member could not attend for

over six minutes which compromised safe evacuation. In that situation the time to complete the evacuation was over seven minutes. This compromised both a resident who requires 2:1 support and a staff member in the location where the potential fire was present. As a result, the inspectors issued the provider with an urgent action in relation to Regulation 28: Fire Precautions.

Following the inspection of the designated centre in February 2025 the provider submitted detail in their compliance plan that following the inspection, two fire drills had been completed on 19 February and 24 February 2025. These were both recorded as having an evacuation time which was within a safe timeframe. Inspectors found evidence that a third fire drill had been completed on 21 February 2025 which was outside the providers identified safe time for evacuation with residents evacuation taking greater than six minutes. The provider had not included this evacuation time in the compliance plan submitted following the inspection.

Furthermore, the provider had also submitted as a response to an urgent action issued during the course of the February 2025 inspection, that an additional night staff would be placed in the centre. The provider had removed the additional staff on 15 February 2025 due a resident vacancy in the centre. This was not reviewed following the previously mentioned drill taking place on 21 February 2025 despite the risk register maintained for the designated centre documenting the risk to residents not evacuating in the event of a fire due to staffing supports not being made available.

A review of the residents' personal emergency evacuation plans (PEEPS) showed a lack of detail in guiding staff to safely evacuate residents. For example one resident's plan states that 'as a last resort the resident should be physically supported to evacuate the premises' however, there is no guidance as to what physical supports are to be provided. The inspectors did not observe any information in the PEEPS that guided or supported staff in communicating evacuation procedures in emergency situations to the people using the service.

The resident PEEPS were also not in line with the providers own fire policy. For example, the provider policy states that resident PEEPS should outline in what order residents are evacuated, however, this not indicated in the documents.

Also, staff spoken to on the day of inspection was not aware of evacuation procedures despite working alone with residents for the first time. Inspectors were not assured that the staff member could safely evacuate residents and reported this concern to the person in charge following meeting the staff.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

The provider has implemented a new care plan document for each of the persons using the service. The care plans are monitored and reviewed by the front line team and management team to ensure their accuracy and review.

The inspectors reviewed two resident's care plans and were not assured that the information contained could guide staff practice in meeting the assessed needs of the people using the service. For example, nursing care plans were in place for identified care needs such as epilepsy, impaired mobility, communication and osteoporosis. However, none of the nursing care plans related to these areas observed by the inspectors had been subject to review or update.

One resident had a diagnosis of epilepsy. In one health assessment document the last seizure for the resident is dated March 2025. However, in a separate epilepsy record sheet the date in March is empty with no record of a seizure. In this same epilepsy record sheet the resident has had a further three seizures that had not been documented in the health assessment document or in the nursing care plan for epilepsy. A third document relating to seizure recording stated that the resident has had 13 seizures to date in 2025, of those 13 there were only two epilepsy review forms completed.

Guidance for staff was found to be misleading. For example, one residents personal care section discusses a residents oral care. This section of the plan states the resident requires full support from staff. However, in a separate section of the plan staff are informed that the resident requires only verbal prompting.

Inspectors observed evidence that not all sections of the plans were subject to regular updates to help evidence optimum resident well-being. For example, according to records of resident oral hygiene neither resident had oral hygiene completed in the evening time for the month of November. Bowel charts were also completed infrequently, one resident had 11 entries in their bowel chart for the month of October.

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	
Regulation 15: Staffing	Substantially compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 13: General welfare and development	Not compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Not compliant

Compliance Plan for A2 OSV-0005387

Inspection ID: MON-0048291

Date of inspection: 17/11/2025

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 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: There is ongoing recruitment in the centre to fill the vacancies. The centre has 3 relief staff on a line who are covering vacant posts, this ensures consistency for residents. In the event of short notice unplanned leave, relief staff are utilised in the first instance where possible. Following a review of resident PEEPs, additional night staff have been allocated on a permanent basis. A staff nurse is available for support if required, and the site is managed by a CNM3 out of hours manager. A review of staffing rosters has been completed to ensure appropriate cover during all staff breaks. Fire evacuation plans have been updated.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: There is ongoing recruitment in the centre to fill the vacancies. The centre has 3 relief staff on a line who are covering vacant posts, this ensures consistency for residents. In the event of short notice unplanned leave, relief staff are utilised in the first instance where possible. Following a review of resident PEEPs, additional night staff have been allocated on a permanent basis. A staff nurse is available for support if required, and the site is managed by a CNM3 out of hours manager. A review of staffing rosters has been completed to ensure appropriate cover during all staff breaks.	

Fire evacuation procedures have been reviewed. Additional fire drills will be conducted at varying times, including night-time, to test evacuation effectiveness

The risk register has been reviewed and updated. Clear control measures and review dates have been assigned for all identified risks, with particular focus on staffing levels and fire evacuation
Training will be provided to staff completing the provider's audit tool for six-monthly unannounced visits, citing the importance of specific review of staffing resources, fire evacuation procedures, and outcomes of recent fire drills. Findings will be escalated and tracked through governance structures
Audit findings will continue to be shared at staff meetings. The Quality Enhancement Plan (QEP) will be updated quarterly to reflect emerging risks, audit outcomes, and improvement actions.

Regulation 13: General welfare and development	Not Compliant

Outline how you are going to come into compliance with Regulation 13: General welfare and development:
A review of all residents' personal plans was completed to ensure activities, goals, and supports reflect individual preferences and promote meaningful engagement.
Staff have been reminded of their responsibility to support residents to access preferred activities.
PIC will provide additional training at staff meetings and daily huddles regarding the care planning process and documentation guidelines.
A care plan audit tool is in the process of development, and training will be provided for same.
Staff will support residents to purchase materials required for preferred activities (e.g. gardening, cooking, baking). Staff have been reminded of appropriate cash ledger recording to ensure activity-related expenditure is clearly recorded and linked to residents' goals.

All meaningful activities documents will be reviewed and updated in consultation with residents. Review dates will be clearly documented and monitored through monthly audits.
The PIC, in collaboration with the CNM1 and key workers, will support residents to plan meaningful, person-centred activities. This will be achieved through resident–key worker meetings and house meetings to ensure activities reflect residents' interests and preferences. Residents will be supported to participate in activities both on and off campus.
The PIC will provide guidance and support to staff in documenting meaningful activities and in supporting residents to set and achieve personal goals. A weekly activity planner will be maintained by the PIC. The PIC will also ensure that residents' interests checklists are kept up to date, reflecting assessed needs, personal wishes, and required supports,

in collaboration with the multidisciplinary team (MDT).
A schedule of financial passport reviews has been implemented. Outstanding reviews will be completed. Review dates will be clearly documented and monitored through monthly audits.
All residents care plans are reviewed annually or more frequently if needed. This will be documented clearly on each resident's care plan.

Staff have received refresher training by PIC on completing activity trackers. Compliance will be monitored through monthly audits, and gaps will be addressed promptly

Residents are actively engaged in setting and reviewing their goals, with their input clearly recorded. A structured goal review process is in place to monitor progress, outcomes, and resident satisfaction, with all reviews documented in residents' personal plans. Resident feedback is sought informally on an ongoing basis and documented formally during key worker meetings and house meetings.
Residents are supported to complete annual residents satisfactory survey.

All outstanding MDT actions have been reviewed.
PIC will monitor actions, assign responsibility using SMART goal framework, and document rationale for delays or revised timelines

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
A full review of the centre's risk register has been completed. All risks have been prioritised according to severity, with clear control measures, responsible persons, and review dates assigned

Immediate interim control measures have been implemented, including increased staffing supports and revised evacuation procedures. This matter was addressed through an urgent action issued by inspectors and is being managed under Regulation 28: Fire Precautions

There is a process in place to review, manage and escalate risks to the registered provider. These risks must be escalated by the PIC in a timely fashion.

All residents requiring falls assessments have been reviewed.
The PIC works collaboratively with GP to ensure the Annual Medical Review is completed. A tracking system has been implemented to ensure future reviews are completed within required timeframes. The completion of the Annual Medical Review is supported by the named nurse for each resident.

The QEP has been reviewed and updated to include fire safety and evacuation risks. We will continue to discuss environmental reviews with the residents, then escalate and document via MDT or Transfer Committee as required.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions: Night-time evacuation arrangements have been reviewed. Staffing levels have been revised to ensure staff required to respond to a fire are immediately available on-site and not dependent on availability from another location Additional night staffing has been permanently allocated following review of fire drill outcomes. The PIC escalates fire evacuation times in a timely fashion when they are deemed as unsafe. This allows the Registered Provider to take appropriate action following review of the risk assessment. All residents' PEEPs have been reviewed and rewritten to include detailed physical support requirements, communication strategies, equipment needed, and staff ratios required for safe evacuation PEEPs have been aligned with the provider's fire policy, including clearly outlining the order of evacuation for residents. Compliance will be monitored through audits Communication needs and supports during evacuation have been incorporated into each resident's PEEPs, including use of visual aids, prompts, and reassurance techniques A mandatory fire safety and evacuation competency check has been introduced. Staff will not work alone until they have demonstrated knowledge of evacuation procedures and residents' PEEPS. This is demonstrated to the senior staff member on duty who is completing the induction. Fire safety training has been refreshed for all staff. Supervised fire drills will be conducted to ensure staff competence, with outcomes documented and reviewed Fire drills will be conducted at varied times, including night-time and lone-working scenarios

Regulation 5: Individual assessment and personal plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
A full review of all resident care plans was completed to ensure content is clear, accurate, and reflective of residents' current assessed needs.

A review schedule has been introduced for all nursing care plans. Outstanding reviews have been prioritised and review dates clearly documented

All epilepsy-related documentation has been reviewed and reconciled. A single standardised seizure recording system has been implemented to ensure consistency between health assessments, seizure records, and care plans

Care plans have been cross-checked to remove conflicting information. Clear levels of support required for personal care tasks are now outlined in one consistent section of each plan

Documentation requirements have been reiterated to all staff. A copy of the guidance document for completing the care plans is available in each bungalow. Compliance with daily care records, including oral hygiene and bowel charts, will be monitored through monthly audits and discussed with staff through staff meetings and daily huddles.

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 13(1)	The registered provider shall provide each resident with appropriate care and support in accordance with evidence-based practice, having regard to the nature and extent of the resident's disability and assessed needs and his or her wishes.	Not Compliant	Orange	31/12/2025
Regulation 13(2)(b)	The registered provider shall provide the following for residents; opportunities to participate in activities in accordance with their interests, capacities and developmental needs.	Not Compliant	Orange	31/12/2025
Regulation 15(1)	The registered provider shall ensure that the	Substantially Compliant	Yellow	30/06/2026

	number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.			
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	30/06/2026
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding	Not Compliant	Orange	30/06/2026

	the standard of care and support.			
Regulation 23(3)(a)	The registered provider shall ensure that effective arrangements are in place to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.	Not Compliant	Orange	31/03/2026
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.	Not Compliant	Orange	31/12/2025
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	31/12/2025

Regulation 28(1)	The registered provider shall ensure that effective fire safety management systems are in place.	Not Compliant	Red	15/12/2025
Regulation 28(2)(b)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Red	15/12/2025
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 procedure to be followed in the case of fire.	Not Compliant	Red	15/12/2025
Regulation 05(2)	The registered provider shall ensure, insofar as is reasonably practicable, that arrangements are in place to meet the needs of each resident, as assessed in accordance with paragraph (1).	Not Compliant	Orange	31/12/2025
Regulation 05(4)(b)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the	Not Compliant	Orange	31/01/2026

	resident which outlines the supports required to maximise the resident's personal development in accordance with his or her wishes.			
Regulation 05(6)(c)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall assess the effectiveness of the plan.	Not Compliant	Orange	31/01/2026
Regulation 05(6)(d)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall take into account changes in circumstances and new developments.	Not Compliant	Orange	31/01/2026