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:	Station Road (1-4)
Name of provider:	Dundas Unlimited Company
Address of centre:	Louth
Type of inspection:	Unannounced
Date of inspection:	19 January 2026
Centre ID:	OSV-0005732
Fieldwork ID:	MON-0049343

About the designated centre

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

Station Road (1-4) is a full-time residential service that provides a service to eight male and female adults. It is situated in a village in Co. Louth and is in walking distance to local amenities such as shops, hairdressers and local pubs. Transport is also provided to bring residents to appointments, day services or on chosen activities. The centre consists of four two-storey community houses located beside each other. Each house has an open plan living/dining room, a small kitchen, bathroom and toilet. To the back of each house there is a small private garden. Residents receive supports on a 24-hour basis with day and waking night staff supporting them each day. The person in charge is employed on a full time basis. The staff team consists of direct support workers and social care workers. Residents have access to a number of allied health care professionals to support them with their assessed needs. Some residents attend day services, and others are supported during the day to have meaningful activities in line with their personal preferences.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	6

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 19 January 2026	13:30hrs to 19:40hrs	Anna Doyle	Lead
Tuesday 20 January 2026	08:00hrs to 14:00hrs	Anna Doyle	Lead

What residents told us and what inspectors observed

This inspection was unannounced and was conducted over two days. The last inspection of this centre was 28 February 2024 where all regulations inspected had been found compliant. This inspection was to ensure ongoing compliance with the regulations and to follow up on some notifications submitted to the Office of the Chief Inspector and the receipt of information concerning some aspects of the care and support provided.

Overall, the inspector found that significant improvements were required in a number of regulations inspected including governance and management, risk management and healthcare, and other improvements were required in training, protection and food and nutrition. As a result, of some of the issues identified immediate assurances were sought from the registered provider on the second day of the inspection in relation to the healthcare needs of the residents in this centre. In particular the concerns related to staff having the appropriate knowledge around emergency responses to residents healthcare needs which if not managed appropriately could pose a significant risk to one resident.

At the time of the inspection, the centre was registered to support eight residents. Since the last inspection of the centre in February 2024, six residents had moved out to other locations and four residents had moved into the centre. In October 2025 one of those residents had moved to another location also.

On the day of the inspection, six residents were living in the centre. One of those residents had moved temporarily to another location, due to renovation works required in their living environment. This work was still in progress at the time of the inspection and the resident was due to return to the centre in the coming days. Another resident was at home on both days of the inspection.

The property comprises of four houses that are attached to each other. House 1 and 2 supported two residents, House 3 supported one resident and House 4 was under renovation at the time of the inspection but is intended to support one resident. With the exception of House 4, each house had two bedrooms, a bathroom upstairs, a kitchen, living area, and toilet downstairs. In one of the houses there was an additional communal room downstairs. To the back of each house there was a small enclosed garden where storage sheds were provided for residents to store some of their items. In House 4, the registered provider was changing the layout of the house downstairs to support the needs of one resident. This area was being converted into a separate living area for one of the resident's to include a small separate kitchen, a bedroom, shower room and a living room. There was also an office. At the time of the inspection the registered provider was also planning the location of the residents laundry area and was deciding on the purpose and function of the existing rooms upstairs in this house.

On arrival to the centre some of the residents were out on outings and some of them were at a day service they attended. Over the course of the two days, the inspector met four of the residents, three staff, a team leader, the person in charge and the assistant director of services. The inspector also spoke to the director of services and the chief operating officer in relation to the findings of this inspection and the immediate assurances required prior to the end of the inspection.

The houses were generally clean, however, some areas needed attention in terms of upgrades to the properties. The registered provider had identified a number of upgrades that were required in audits they had completed. These were due to be completed once the renovations to House 4 was completed. However, there was no plan in place to address some recommendations made following an occupational therapy environmental review. This included adding an extra hand rail to the stairs in one of the houses.

Three of the residents spoke to the inspector. One of the residents showed the inspector around their home including their bedroom. They said they liked how their bedroom was laid out and pointed out to the inspector that their television was broken. The staff were aware of this issue and said that it had been reported. The resident said they liked their home and liked the staff. The resident was enjoying chilling out for the day and they intended to watch television as the weather was very bad. Collectively the three residents who met with the inspector said that they were happy living in the centre and of those who shared their home, they said they liked the people they shared their home with.

The residents were engaged in varied activities over the course of the inspection. Two of the residents attended a day service on a part time basis. Others liked to plan their activities on a daily basis with staff. Activities that some of the residents liked were; going for drives, shopping, spa days, overnight trips, going out for coffee and meals and one resident had been to a football match in England to support their favourite football team. Some of the residents liked to help prepare dinner, do laundry and do routine household tasks.

The staff were observed to support the residents in a kind and respectful manner and the residents appeared to get on well with the staff and were observed sitting down having fun together. The staff spoken with were aware of the individual needs of the residents, however, some staff were not familiar with some interventions that were required to be followed in care plans for some of those needs. In addition, one resident required a specialised diet and needed to be supervised during meal times. The staff informed the inspector that the resident only liked being supervised from a distance. This required staff to stand in the hall and watch the resident in the kitchen while the resident sat at the table with their back to the resident. This required review.

Residents meetings were held regularly and a sample of minutes of those meetings showed that topics discussed included, how to make a complaint, feeling safe and fire safety. As an example at one meeting residents were asked what they would do in the event of a fire. They were also informed about issues that were happening in

the centre, for example a recent audit in the centre had showed that some improvements were required and this was shared with the residents.

Notwithstanding that the residents reported that they liked their home and enjoyed a good quality of life, the inspector was not assured around the provision of safe and consistent care to the residents at the time of this inspection.

The next two section of the report present the findings of this inspection in relation to the governance and management arrangements and how these arrangements affected the quality of care and support being provided to residents.

Capacity and capability

Overall the governance and management arrangements in this centre were not ensuring a safe consistent service to the residents in this centre. As a result, as stated earlier, immediate assurances were sought on the day of the inspection in relation to the residents' healthcare needs. Improvements were also required under a number of other regulations including risk management.

Prior to this inspection, in December 2025, the Office of the Chief inspector had received information concerning safeguarding and residents healthcare needs. At that time a provider assurance report was issued to the registered provider seeking assurances around four regulations, which included, regulation 15: staffing, regulation 16: training, regulation 8: protection and regulation 6: healthcare needs. The assurances submitted to the Chief Inspector were followed up as part of this inspection process and are discussed under the specific regulations in this report. The inspector also followed up some of the information that had been notified to the Chief Inspector regarding safeguarding concerns and the oversight of residents' healthcare needs.

The governance and management systems in place at the time of this inspection were impacting on the continuity of care provided to the residents and appropriate oversight of the quality and safety of care in the centre. This required significant review.

The skill mix and number of staff was sufficient to meet the needs of the residents.

Staff had been provided with training to meet the needs of the residents, however, refresher training had not been completed for some staff in a timely manner.

Regulation 15: Staffing

As part of the provider assurance report submitted to the Chief Inspector in December 2025, the registered provider had given assurances that they were satisfied with the staffing arrangements and skill mix in place to support the residents' needs in this centre. In particular the provider was satisfied that where residents required support with their healthcare needs that a community nurse was available should staff require this support. The inspector found that while this support system was in place, as discussed under regulation 6 : healthcare, there was no record to indicate that staff had sought advise or support from community nurses when a resident had developed an infection.

The staff skill mix included direct support workers, social care workers and as stated community nurses were available as required. The staff numbers consisted of six staff during the day, and three waking night staff when all six of the residents were residing in the centre. The inspector reviewed a sample of rotas in October and December 2025 and found that those staffing levels were maintained. A review of this sample showed that where relief staff were needed that the staff members employed were consistent.

A team leader was assigned to work each day to supervise the care and support provided and at night time the most senior staff member was assigned to manage the shift.

Staff personnel files were not reviewed as part of this inspection.

Overall the inspector found that the staffing levels in the centre were maintained to assure a safe service to the residents, however as discussed under regulation 6 : healthcare, improvements were required to residents access to community nurses where there was an assessed need.

Judgment: Compliant

Regulation 16: Training and staff development

As part of the provider assurance report submitted to the Chief Inspector in December 2025, the registered provider had given assurances that staff working in the centre had received adequate training to support the residents in the centre in a safe manner. They had also identified that some additional training was required to support one resident's healthcare needs. This training included staff refresher training on how to manage an incident of choking. The inspector found from a sample of records that this had been completed. Staff spoken to were also aware of how to manage an incident of choking.

The inspector reviewed a sample of training records maintained on the registered providers training database. This system allowed the person in charge to run a report to indicate what training was outstanding. The report generated a number of outstanding refresher training programmes that were due to be completed. As an example, two staff had been due to complete medicine management competency

refresher training since October 2025 and December 2025 and there were no records to verify that this had taken place. This did not provide assurances to the inspector that all staff had completed refresher training in a timely manner.

A sample of training provided included:

- Safeguarding of Vulnerable Persons
- Fire Safety
- First Aid
- Moving and Handling
- Antimicrobial Resistance & Infection Control (AMRIC) including Basics of Infection & Prevention Control and Hand Hygiene
- Positive Behaviour Support
- Professional Management of Challenging Behaviour
- Medicine Management (including competency assessments)
- Feeding Eating, Drinking and Swallowing (FEDS)
- Health and Safety.

As stated under governance and management while the registered provider had systems in place to supervise staff in the centre, a sample viewed showed that one of these were not up to date.

Judgment: Substantially compliant

Regulation 23: Governance and management

The inspector was not assured that the management systems in place were effective in ensuring that the service provided was safe, appropriate to residents' needs, and was consistently and effectively monitored. Over the last number of months, there had been three changes to the person in charge arrangements, and a new team leader had also been appointed. This was impacting on the continuity of care provided to the residents and appropriate oversight of the quality and safety of care in the centre.

The new person in charge had only taken up the role on 05 January 2026, which was the same day that the previous person in charge had left. There had been no proper induction or handover to the centre for the person in charge who had never worked in the centre before. The handover consisted of a document outlining some aspects of the care and support that required attention. As a result, the person in charge and the staff team could not find pertinent documents relating to the care and support of the residents. The records requested by the inspector were difficult to retrieve as the management team were unaware where these records had been filed away. As well as this some of the management team were not aware of recommendations or risk management processes in place in the centre. For example as discussed under risk management, the management team in the centre did not know that a call bell was in place which was used to alert staff that support or

assistance was required in one of the houses. An occupational therapy report for a resident had also recommended a handrail for a resident to prevent falls and the management team did not appear to be aware of this.

In addition, the handover document provided to the person in charge contained incorrect information. The document stated that all staff supervision was up to date, however, the inspector found that this was not the case for one staff from a sample viewed. The document also stated that one risk assessment relating to fire was rated as a high risk (15) and needed to be reviewed every week. However, the fire risk assessment in place in the centre which had been reviewed in December 2025 showed that fire was rated as a low risk (5). As a result the inspector had to seek assurances around this on the day of the inspection. The person in charge confirmed that the information was not correct and there was no fire risks in the centre at the time of the inspection.

The annual review for the centre had been completed in January 2026, however, this document contained information pertaining to the care and support of residents in 2024. The questionnaires completed by family and residents which was used to inform this annual review, provided to the inspector were either not dated or were dated from December 2024. The inspector was therefore not assured that this was the most up to date information available.

An audit recently conducted in the centre on medicine management had found a number of improvements were required under this regulation. Some of the actions from this had not been prioritised. As an example, one resident's kardex had not been updated even though the auditor had noted that it could be a potential risk to the resident. A lack of oversight of documents also meant that it was difficult to establish if some actions from audits had been completed. An audit in June 2025 noted that a trend should be conducted in medicine errors occurring in the centre, however, the management team could not verify if this had been done.

Overall the inspector was not assured that the governance and management arrangements in the centre at the time of the inspection were ensuring a safe consistent service to the residents.

Judgment: Not compliant

Quality and safety

Overall residents spoken to reported that they had a good quality of life, liked living in their home and got to do things they liked to do. Notwithstanding, the inspector was not assured that registered provider was meeting the requirements of the regulations in relation to the safety of care provided and as a result improvements

were required under regulation 6: healthcare, regulation 26: risk management, regulation 8: protection and regulation 18: food and nutrition.

The inspector found that significant improvements were required to ensure that residents healthcare needs were being monitored and that staff knew when to respond to the residents' needs. This included a system in place to seek support if required in an emergency.

The risk management systems in place at the time of the inspection required significant review also.

The registered provider had a policy and systems in place to report safeguarding concerns in the centre. However, some of these practices required review.

Residents were provided with support around mealtimes where required. However, one resident had refused to have one recommendation outlined in their feeding, eating, drinking and swallowing plans (FEDS). This required review as the resident was at risk of choking.

Residents were supported with their general welfare and development and liked to plan activities at their own pace and in line with their preferences.

Regulation 13: General welfare and development

The inspector found that residents were supported to avail of activities in line with their personal preferences.

The residents were supported to choose meaningful activities in line with their personal preferences and two attended a formal day service.

From a review of records and talking to the residents, they were engaged in activities outside of the centre most days. Some of those activities included, going out for meals or coffee, shopping, going to the gym, cinema, spa days, going to museums and car shows. Some of the residents had been on short breaks to hotels and one had been to England to see a football match.

Residents were supported to keep in touch with family and friends, one resident spoke about contacting family members most days to catch up.

Judgment: Compliant

Regulation 17: Premises

The houses were generally clean, however, some areas needed attention in terms of upgrades to the properties. The registered provider had identified a number of upgrades that were required in audits they had completed. These were due to be completed once the renovations to House 4 was completed.

In House 4, the registered provider was changing the layout of the centre downstairs to support the needs of one resident. This area was being converted into a separate living area for one of the residents to include a small separate kitchen, a bedroom, shower room and a living room. There was also an office. At the time of the inspection the registered provider was also planning the location of the residents laundry area and was deciding on the purpose and function of the existing rooms upstairs in this house.

An occupational therapy report for a resident had recommended a handrail for a resident to prevent falls, this needed to addressed.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

Staff had been provided with training to support residents who required specialised diets. Interventions that related to food and nutrition were recorded in residents' personal plans. However, on the day of the inspection, the staff informed the inspector that one resident did not like the recommendations made by a speech and language therapist,in relation to their feeding, eating, drinking and swallowing plan, which was to be supervised during their meals. As a result the staff informed the inspector that they had to observed the resident from a distance. This required review.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

As discussed under regulation 23, the inspector were not assured that some of the risk assessments included in the risk register for this centre was appropriately risk rated. For example; the risk assessment for fire safety was risk rated as a low risk even though other documents stated that the risk was high.

One resident who had a specific healthcare need which could require an immediate response from staff to contact emergency services, had a system in place to alert other staff in the centre, that assistance was required in that particular house. The alert system included two bells that were connected to a device to alert staff. The inspector asked a staff member to press the bell to see how long it would take for

other staff to respond. Three minutes after pressing this device, no staff had attended the house. When the inspector went to the office to check if staff had heard the alarm, the inspector was informed that the alarm had sounded but none of the management staff knew what the alarm was for or that this was an alert system in the centre for staff who may need support. Immediate assurances were provided in relation to this under regulation 6: health care.

As well as this it was unclear if some of the control measures included in risk assessments could be effectively implemented. For example; a number of risk assessments referenced that a control measure included access to a defibrillator machine in the local community. However, it was unclear from speaking to one staff if they would know how to use this machine if required. This needed to be reviewed to ensure that all staff were aware of the procedure to follow.

Judgment: Not compliant

Regulation 6: Health care

As part of the provider assurance report submitted to the Chief Inspector in December 2025, the registered provider had given assurances that residents healthcare needs were provided for, including a residents right to refuse treatment, and that where care plans were updated following a review by allied health professionals, that the community nurse was informed.

Residents appeared to have timely access to allied health professionals, however, some recommendations from these professionals had not been implemented. It had been recommended on one resident's plan that a second rail should be installed for a resident on the stairs to prevent the risk of falls, this had not been completed at the time of the inspection as discussed under governance and management of this report.

The inspector reviewed a sample of residents' personal plans regarding healthcare needs and cross-checked these plans with observations regarding how these plans were implemented in practice. The inspector found that significant improvements were required in this area.

Medical care records, including documentation where medical treatment was refused was not always clearly documented. For example, one resident had a risk assessment in place outlining the supports they should have in place when they refused to attend a medical appointment, this included being provided with education around this. There were no documents to support this.

There were significant deficiencies in documentation. As an example; there was limited information recorded on residents daily records to monitor some health needs. As an example; a resident had sustained a bruise on their leg, which had resulted in cellulitis and a subsequent ulceration in the area where the bruise had initially been noted. The inspector observed that staff were not recording how they

were monitoring this. For example, it was noted on the residents' plan that they had been referred to the GP when the area became red. However, there was no indication of when this redness had first been observed and who it was reported to. There also had been no referral to the community nurse for advice on this matter.

The inspector also noted in another resident's care plan that this resident was at risk of aspiration and if the resident vomited, their oxygen saturation levels should be checked as this could present a risk of aspiration to the resident. However, there was no records indicating how the resident was monitored after one episode of vomiting in Jan 2026.

It was recommended in another care plan that a monitoring chart needed to commence after meals to observe for coughing or reflux. There were no records to verify that this had commenced at the time of the inspection.

The inspector also spoke to a number of staff about the interventions in place to support this resident who was at risk of aspiration and had been hospitalised as result of this on six occasions over the last year. The inspector found that the staff were not clear about the interventions recorded in the residents plan. As an example, when the residents' oxygen saturation levels reached a certain level, there were specific responses indicated in the plan. One of those interventions included when to call for an ambulance, and another intervention included when staff should check the residents oxygen saturation levels. Some staff were not clear about the exact interventions recorded. As well as this, the staff worked alone in the centre and when the inspector asked how staff called for assistance in an emergency, such as when the residents' oxygen saturation levels were reduced, the staff indicated that they would press the alarm bell located in the residents' kitchen and/or sitting room. However, as stated under risk management, no staff responded to this when the alarm button was pressed in the centre. As a result of these concerns, immediate assurances were sought from the registered provider to address those concerns.

The registered provider, developed a written assurance plan on the day of the inspection to address those concerns. Those assurances included that:

- the Community Nurse Manager and the Community Nurse would review the individual care plans for residents to ensure all information is clear, accurate, and reflective of current clinical guidance
- an emergency meeting would be held with all staff working in Station Road to ensure they were clear on the healthcare needs of residents. This included the guidance in place for the monitoring of residents' presentation, completing observations, and when to seek further emergency medical attention
- the Community Nursing Team will engage with the remaining staff members between the 21st and 22nd January to ensure consistent understanding and implementation of these plans
- a formal protocol would be developed, and the risk assessment updated to include the allocation of a designated staff member carrying a pager to provide immediate support where required

- a management team meeting has been schedule for the 21.01.2026 to discuss and address all issues that have arisen during this inspection.

Judgment: Not compliant

Regulation 8: Protection

As part of the provider assurance report submitted to the Chief Inspector in December 2025, the registered provider had assured that they had systems in place to safeguard residents. This included, a clear policy, a no zero tolerance to abuse, and a system in place to assure that allegations of abuse were reported, investigated and that safeguarding measures were put in place to keep residents safe. The inspector found that the registered provider had these systems in place at the time of this inspection. All staff had completed training in adult safeguarding and were clear when spoken to about the reporting procedures in place. Residents were also provided with support and advice about keeping safe. However, one risk assessment for a residents stated that from time to time they could raise some safeguarding concerns that could be unfounded. However, there was no clear guide in place around how these concerns should be managed and when an investigation may or may not be warranted. This required review.

In addition, as stated in section 1 of this report the Chief Inspector had received information regarding safeguarding concerns in the centre. The inspector followed up on all incidents that had been notified to the Chief Inspector over the last year and found that the provider had investigated them, reported them to the relevant authorities and, where required, had taken actions to safeguard the residents. Some incidents were still being investigated at the time of this inspection.

The registered provider was also in the process of reviewing a recent complaint that had been received in relation to a safeguarding incident in the centre. The assistant director of services provided the inspector with a sample of documents that had been reviewed as part of this investigation. The inspector was therefore assured that this was being investigated by the provider at the time of this inspection.

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	Substantially compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Substantially compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 6: Health care	Not compliant
Regulation 8: Protection	Substantially compliant

Compliance Plan for Station Road (1-4) OSV-0005732

Inspection ID: MON-0049343

Date of inspection: 20/01/2026

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:

The Person in Charge & Assistant Director of Service have undertaken a comprehensive review of all existing supervision records and has updated the supervision schedule to clearly document all planned supervision dates for each staff member.

The Person in Charge has commenced supervision with staff and will have all Quarter 1 supervision sessions with the staff team completed by the end of February 2026. The monitoring of supervision completion will be completed weekly by the Assistant Director of Service until such time as all quarter one supervisions are completed. Going forward it will be monitored monthly through Governance meetings between the PIC and Assistant Director of Service.

Ongoing support is being provided to the Person in Charge through a structured mentoring plan. This mentoring arrangement is designed to further strengthen the Person in Charge's capacity in their role and to ensure that staff are appropriately supported in developing and maintaining the knowledge and skills required to meet residents' care and support needs.

The Person in Charge has completed a review of all training records within the centre. This is being monitored on a weekly basis by the Person in Charge & Assistant Director of Service, to ensure that all staff maintain up-to-date mandatory training in a timely manner.

One staff member who was due to complete their Medication Management competency refresher training at the time of the inspection has now completed this training. The remaining staff member is currently on leave and is scheduled to complete their refresher training upon their return on 9th March 2026.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:

A comprehensive review of the Governance and Management arrangements within the centre has been completed by the Provider. As part of this process, a structured mentoring plan has been implemented to support the Person in Charge. This mentoring support is scheduled for two days per week and will be reviewed after 6 and 12 weeks. The Person in Charge has also been provided with a full induction programme. These measures are intended to strengthen leadership capacity, enhance continuity of care for residents, and ensure appropriate oversight of the quality and safety of care delivered within the centre.

A review of the handover process has been completed to ensure that when a handover document is prepared it is validated by the Assistant Director of Service prior to being handed over to the incoming PIC. Additionally, where possible handovers between PIC's will include an in-person handover period by the outcoming PIC. If this is not possible the assigned Assistant Director of Service will complete this handover period. This process is being piloted and will be formalised into a handover Standing Operating Procedure.

A full review of documentation within the centre has been undertaken by the Person in Charge in collaboration with the Assistant Director of Services. All documentation is now organised and readily accessible for review by staff and management.

A comprehensive review of residents' individual risk assessments has been completed. All current control measures and risk ratings have been clearly identified and updated to accurately reflect the risks present. These are discussed regularly at daily handovers and at staff team meetings to ensure ongoing awareness and risk management.

The handrail identified as a control measure to reduce the risk of falls for a resident has now been installed.

The Person in Charge is currently collating information for the 2025 Annual Review. Feedback from residents and families will be gathered through questionnaires as part of this process. All documentation collected will be appropriately dated to clearly demonstrate when the information was obtained.

All actions identified in the recent Medication Management Audit have been reviewed. The Person in Charge, in conjunction with the Community Nurse, has followed up to ensure that required actions have been completed and that all relevant information is accurately reflected in residents' care plans and medication administration records.

In reference to Regulation 16: Staff Training and Development, a full review of supervision records has been completed. An updated supervision schedule is now in place, clearly outlining supervision dates for all staff. The Person in Charge has commenced supervision sessions with the staff team and will have completed all Quarter 1 supervision sessions by the end of February 2026.

All actions identified with this Compliance Plan will be monitored for completion and effectiveness during monthly Governance meetings. Ordinarily monthly Governance is completed by the PIC and Assistant Director of Service. To enhance this process, the assigned Director of Service will attend these meetings for the next 6 months.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:

A comprehensive review of the premises was completed post inspection with the Maintenance Team and senior management team. The following actions have been completed:

A refurbishment of House 4 has been completed to include the conversion of a separate living space on the ground floor for one resident, comprising a kitchenette, bedroom, shower room, and living room. The bespoke layout is designed to meet the assessed needs of the resident. Updated floor plans have been finalised and will be submitted to the Chief Inspector with an application to vary the registration of the centre, to ensure the Statement of Purpose is accurate.

A handrail has been installed in House 3, as recommended by Occupational Therapy.

A deep clean of all houses within the centre has been completed.

Cleaning checklists have been reviewed and strengthened to ensure accurate and consistent documentation of cleaning arrangements throughout the centre. Cleaning standards are now included as a standing agenda item at staff meetings.

The Person in Charge (PIC) / Team Lead will conduct daily checks of all houses to ensure that cleanliness standards are maintained.

A maintenance plan has been developed in collaboration with the maintenance team to ensure that any further identified upgrades are completed in a timely and structured manner.

Regulation 18: Food and nutrition	Substantially Compliant

Outline how you are going to come into compliance with Regulation 18: Food and nutrition:
The Speech and Language Therapist has reviewed the resident's current Feeding, Eating, Drinking and Swallowing (FEDS) plan. The resident FEDS plan has been updated to ensure that the plan incorporates more person-centred outcomes that reflects the resident's preferences, while continuing to appropriately assess, monitor, and manage any associated risks related to their feeding, eating, drinking and swallowing needs.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
A comprehensive review of residents' individual risk assessments has been completed. All current control measures and risk ratings have been clearly identified and updated to accurately reflect the risks present. These are discussed regularly at daily handovers and at staff team meetings to ensure ongoing awareness and risk management.

A formal protocol has been developed outlining the allocation of a designated staff member to carry the pager during each shift, ensuring immediate response and support when required. The nominated staff member is clearly identified in the daily allocation and handover record, and this responsibility is communicated and confirmed with the team at the beginning of each shift.

All staff in the house have completed first aid training which includes actions to take in the event of a medical emergency including a practical demonstration in the event of a choking episode. Staff are aware to follow the guidance received from the 999-call handler who will provide clear guidance to staff in the management of emergencies including the use of Automated External Defibrillator.

Regulation 6: Health care	Not Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:

All actions outlined as part of the immediate assurances provided have been completed, these include.

1. The Community Nurse Manager and the Community Nurse reviewed the individual care plans for residents to ensure all information is clear, accurate, and reflective of current clinical guidance. The revised care plans clearly outline the actions required when a health concern arises, including guidance on how staff should monitor the issue and the appropriate thresholds for escalation to the community nursing team, HSCPs, GP or emergency services.
2. An emergency meeting was held with all staff working in Station Road on the 20th of January to ensure they were clear on the healthcare needs of residents. This included the guidance in place for the monitoring of residents' presentation, completing observations, and when to seek further emergency medical attention.
3. The Community Nursing Team engaged with the remaining staff members between the 21st and 22nd January to ensure consistent understanding and implementation of all healthcare plans. This process has further strengthened staff understanding and supported consistent implementation of care interventions.
4. A formal protocol was developed, and the risk assessment updated to include the allocation of a designated staff members carrying a pager to provide immediate support where required
5. A management team meeting has held on the 21.01.2026 to discuss and address all issues that have arisen during this inspection.

The Person in Charge will monitor daily records relating to residents' care and support needs to ensure that monitoring processes are adhered to and that recording practices are contemporaneous. Where any escalation is required, this will be clearly documented, with the rational and outcome of the escalation.

Care plans will be included as a standing agenda item at all future team meetings to ensure ongoing review and oversight.

Educational materials have been developed to support residents in understanding and preparing for medical appointments. This information is discussed with residents during key working sessions and documented accordingly. A dedicated folder has been established to store accessible educational resources for both residents and staff.

The handrail identified as a control measure to reduce the risk of falls for a resident has now been installed.

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:

A support plan has been developed by the Person in Charge in collaboration with the Behaviour Support Specialist to guide staff in responding appropriately when a resident raises concern that may be unfounded. This type of concern maybe seen in the context of the resident's overall behaviour and therefore the plan provides clear guidance on the management of such concerns. The plan also outlines clearly the criteria for when a concern requires formal review or investigation. This support plan has been discussed and explained with all staff.

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)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	13/03/2026
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.	Substantially Compliant	Yellow	13/03/2026
Regulation 18(3)	The person in charge shall ensure that where residents require assistance with eating or drinking, that there is a sufficient number of trained staff	Substantially Compliant	Yellow	20/02/2026

	present when meals and refreshments are served to offer assistance in an appropriate manner.			
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	20/02/2026
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.	Substantially Compliant	Yellow	30/03/2026
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and	Not Compliant	Orange	20/02/2026

	ongoing review of risk, including a system for responding to emergencies.			
Regulation 06(1)	The registered provider shall provide appropriate health care for each resident, having regard to that resident's personal plan.	Not Compliant	Red	20/01/2026
Regulation 08(3)	The person in charge shall initiate and put in place an Investigation in relation to any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.	Substantially Compliant	Yellow	20/02/2026