Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Disabilities (Children).

Issued by the Chief Inspector

Name of designated centre:	The Maples
Name of provider:	Talbot Care Unlimited Company
Address of centre:	Co. Dublin
Type of inspection:	Unannounced
Date of inspection:	04 February 2026
Centre ID:	OSV-0008092
Fieldwork ID:	MON-0034287

About the designated centre

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

The Maples provides a residential respite service for up to five male and female adults aged 18 and over, who have an intellectual disability, autism, or acquired brain injury, who may also have mental health difficulties or behaviours of concern. The objective of the service is to provide a therapeutic home environment. It is a social care led service staff by direct support workers, with nursing staff available on site. The designated centre consists of a two-story detached house with a separate single occupancy apartment on the outskirts of a large town in north County Dublin, and each service user has use of a single-occupancy bedroom, multiple communal areas and garden spaces.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	5

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 4 February 2026	09:30hrs to 17:00hrs	Brendan Kelly	Lead

What residents told us and what inspectors observed

This was an unannounced inspection of The Maples completed to assess the provider's ongoing compliance with The Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities Regulations 2013.

For the most part, the inspector found that the provider was meeting their regulatory requirements. The inspection found however, that improvements were required in governance and management, premises, behavior support and staff training. These areas are discussed later in the report.

The Maples is a large two-storey house located on its own outside a large town in North Co. Dublin. This is a respite centre offering respite to male and female adult service users. The centre is registered for a maximum of five residents at any one time. On the day of inspection there were five residents present.

On the day of inspection, the inspector used a variety of sources to help form judgements on the provider's compliance with the regulations. The inspector completed a walk around of the premises, met with and spoke to four residents and two of the front line staff team and reviewed documentation from the centre.

On arrival the inspector was greeted by a member of the staff team and then met with the person in charge. On a walk around of the premises the inspector observed a main house and also a self-contained apartment. The main building consisted of a ground floor of two bedrooms both en-suite, a kitchen, dining room, two sitting rooms, a staff office, utility area and a toilet. The first floor consisted of a further two bedrooms one of which was en-suite, office space, a staff room, storage rooms and two bathrooms.

The inspector also completed a walk around of the self-contained apartment intended for single occupancy. This area of the centre consisted of a sitting room, bedroom and wet room. On the walk around with the person in charge a number of maintenance issues were identified that will be detailed later in the report.

The inspector had the opportunity to briefly meet with the resident who was staying in the apartment. The resident met the inspector in the sitting room and appeared to be happy and comfortable with the staff member assigned to support them for the day.

The other residents availing of respite came back to the premises later in the day. On their return for lunch the inspector had the opportunity to speak with two further residents. Both residents met the inspector together and appeared to get on very

well with each other. The residents indicated that they are both very happy when they use the respite service.

One resident spoke about their room indicating that that were happy with the size of the room and that they can bring what they like from their family home. The second resident spoke about being able to ring home when they want using their mobile phone. This resident also spoke about their YouTube channel and that they are supported by staff to work on their channel while in respite.

The residents spoke positively about their peers, calling the residents they are staying with 'our friends'. The residents also spoke well of the staff supporting them. The residents indicated they are happy with the level of activity staff offer and engage in. They spoke about going to a local pub the day before and going for regular drives and activities.

A fourth resident came back to the respite centre later in the afternoon. They sat with the inspector in the dining room and showed the inspector their bedroom. The resident informed the inspector that they 'more than like it here'. They indicated to the inspector that they like everything about the centre and would not change anything. The resident also spoke positively about their peers, calling them 'friends'.

The resident showed the inspector their room for their stay. The resident had brought a number of items from home and had made the room as they wished. The resident had their own en-suite and told the inspector they were very happy with the room. The inspector observed the resident engaging positively with members of the staff team.

The inspector met with a team leader and a staff nurse from the front line team. Both staff displayed a strong knowledge of the plans that were in place for the residents currently in the centre. The staff indicated they were happy with the supports in place for them from the person in charge. The staff spoke positively regarding the supervision process and the guidance from the person in charge.

Throughout the course of the inspection the inspector observed a positive atmosphere in the centre. The interactions between the residents and staff were friendly and person-centered. Both residents and staff appeared to be at ease in each others company.

The next two sections of the report will outline the providers capability and capacity to manage the centre and it's resources and how this impacts on the quality of service experienced by the residents.

Capacity and capability

Overall the inspector found that the provider had systems in place to ensure that care and support provided to residents was of good quality. However, while the provider had a system of audits in place to capture areas of improvement, the inspector was not assured that the audits were effective in identifying required improvements.

Judgments from the provider's own unannounced audits were contradictory from the evidence observed during this inspection. Time lines identified in provider led audits had also not been adhered to with no rationale provided for missed time frames.

The provider had ensured a strong and consistent staff team were in place to support residents. The staff team in the main had been in receipt of regular relevant training, however, improvements were required in relation to behaviour support training.

Supervision processes within the centre were strong as were the record keeping systems observed by the inspector.

Regulation 15: Staffing

The provider had ensured a full staff team was in place in the centre with no vacancies. The centre did not use agency staff with contingency plans present for planned and unplanned leave consisting of the provider's relief panel or the permanent team taking on extra shifts.

The provider had actual and planned rosters in place that were maintained locally by the person in charge as part of their oversight responsibilities. On the day of inspection the inspector reviewed the rosters for January 2026.

The rosters outlined the names and grade of each staff including the person in charge. The person in charge has management responsibility for this centre only and is on site Monday to Friday. At weekends governance is provided by team leaders who work weekend shifts. The provider also implements an on-call system until 20:00 and a night manager who is responsible from 20:00 onwards.

From the review of the roster the inspector was assured that there were no occasions when the provider could not source cover for vacant shifts. The inspector did not observe any staff who required induction.

The staff who met with the inspector spoke competently about their roles in the centre. The staff were comfortable speaking with the inspector and spoke positively regarding their experience with the provider.

Judgment: Compliant

Regulation 16: Training and staff development

The provider had a suite of mandatory training in place as outlined in their policy and statement of purpose. The provider used an online log to monitor staff training. The person in charge maintained the log as part of their oversight responsibilities. The person in charge also maintained a supervision schedule for all staff.

On the day of inspection the inspector reviewed the provider's training log and supervision processes including the supervision records of two staff.

The person in charge reviewed the training log on a regular basis. They flagged to staff when dates for online training courses were expiring with staff expected to send the person in charge the certificate of completion for the identified training. The person in charge updated the log when certificates were observed. The person in charge flagged to the provider's human resources department when classroom trainings were required. The provider's human resources scheduled the classroom based training and copied the person in charge in any communications to staff.

Staff had completed training in areas such as:

- medication management
- safeguarding
- fire safety
- GDPR
- open disclosure
- manual handling

The inspector observed that 14 of the 16 staff in the centre had not completed an additional classroom based training on behavior support despite the centre accommodating residents who required behavior support including residents who were 2:1 staffed. The inspector was shown evidence by the end of the inspection that the sessions for the staff had been scheduled. Sessions would begin later that same week with all staff receiving the training by April 2026. The provider had identified this training as a quality enhancement initiative. The providers required mandatory training in relation to behaviour support had been completed by the staff team.

The person in charge compiled and maintained a supervision plan for the centre. The inspector reviewed the supervision schedule and observed that all staff received supervision in line with the provider's policy.

The inspector reviewed two of the staff supervision records on the day of inspection. The inspector observed there was a section for a staff agenda and another section for the manager's agenda. The records showed that actions were identified in the sessions. The inspector also observed evidence of learning for the staff team. For example in one session the staff member had been involved in a medication error.

The error was discussed and a plan of action put in place to support the staff member going forward.

Judgment: Substantially compliant

Regulation 21: Records

The provider had ensured all required records were maintained in the centre as outlined in the regulations. The inspector observed that all key documents in relation to the operation of the centre were kept on site including the statement of purpose and resident's guide.

The provider maintained staff files through their human resources department. The inspector observed that key information such as supervision records were maintained with staff confidentiality in mind as records were in a locked cupboard.

Information and records regarding the day to day operations of the centre were made readily available to the inspector on the day of inspection. The provider used an online system to maintain resident records as well as paper based folders.

Judgment: Compliant

Regulation 23: Governance and management

The provider had a system of governance in place that involved a team leader who reported the the person in charge. The person in charge reported to an assistant director of services who had recently taken up this post.

The provider had ensured to complete provider led unannounced six monthly audits as required by the regulations. There were also a number of governance and local team meetings occurring in the centre.

On the day of inspection the inspector reviewed the provider's annual review, previous two completed six monthly audits, governance meeting and local team meeting minutes. Following a review of the provider led annual review and six monthly audits, the inspector was not assured of how effective the audits were at identifying actions required to enhance and improve service delivery.

The inspector reviewed audits from April and November 2025. In the April 2025 unannounced audit Regulation 7: Positive Behavior Support was not reviewed despite ongoing concerns over the past two years from the person in charge regarding the lack of access to appropriate behavior support plans (PBS) for some residents. In the November 2025 audit the provider commentary states 'appropriate PBS plans in place and ongoing reviews to ensure these supports remain relevant'.

This commentary is at odds with the evidence observed by the inspector and confirmed with the person in charge. Further detail regarding positive behavior support plans is discussed later in this report in Regulation 7: Positive Behavioural Supports.

The April 2025 audit identified an action for an infection prevention and control audit to be completed by September 2025. This audit was not completed until November 2025, however, it was not identified in the provider's November 2025 audit as being outstanding.

Staff training was identified by the provider in their annual review, April and November 2025 unannounced audits. In particular the staff requirement for classroom based training on behavior support. The time lines for the training to be completed was December 2025. As identified earlier in the report on the day of inspection 14 of the 16 staff still required training.

In the November 2025 audit Regulation 17: Premises was found to be complaint. On the day of inspection the inspector identified maintenance issues that required repair. These maintenance issues are detailed in the section of this report concerning Regulation 17: Premises. The inspector reviewed the most recent meeting minutes and observed that these key areas were not discussed. Added to this, the most recent meeting also identified that there were no major issues regarding premises.

The provider has a system in place for regular meetings between the person in charge and assistant director of services. On review of these meetings the inspector was not assured that the agenda allowed for a comprehensive review of key areas such as restrictive practice and behavior support. The provider's respite services do not have access to the provider's behaviour support team or restrictive practice committee. Reviews of these processes are left to the local teams with reviews taking place at governance meetings.

Judgment: Not compliant

Quality and safety

In the main the provider was providing a safe and quality service for residents availing of respite breaks. Improvements were required in relation to premises works and the systems in place for positive behaviour support.

The provider had strong systems in place in regard to risk management, individual assessments and care plans. The premises was clean and homely with systems in place to ensure the premises was free from possible infection outbreaks.

Resident rights were a clear focus within the centre despite residents staying for short intervals. The provider also had adequate systems in place to accommodate residents with additional nutritional needs.

Regulation 13: General welfare and development

The inspector reviewed progress notes, spoke to staff and residents and reviewed activity albums in the premises to help form a judgment on resident welfare and development.

The inspector was assured that while staying the centre the residents were supported to have a fun time engaging in activities of their individual and group liking. For example the inspector spoke to one resident who had an individual preference for recording maintenance videos for their YouTube channel. The resident spoke about how this is supported by the staff team who help with the making of videos for the resident. The resident also spoke about how they were looking forward to going out with their peers together later in the day.

The inspector reviewed progress notes of two residents staying in the centre on the day of inspection. The inspector reviewed the notes of the residents last three stays in the centre. The inspector observed evidence of a variety of activities that the residents had been engaging in on this and previous stays. For example, there was evidence of residents maintaining contact with families via phone and video calls. Residents had been into the local community visiting pubs, restaurants, coffee shops and walks.

The inspector reviewed an activity album that the person in charge updated on a regular basis to show visuals of activities residents engaged in. The inspector saw evidence of residents engaging in trips to places such as garden centres and museums. There was evidence of themed parties taking place in the location such as Halloween parties and summer barbecues. Activities such as music groups and baking were also taking place in the premises.

Judgment: Compliant

Regulation 17: Premises

The inspector completed a walk around of the premises with the person in charge. During the walk around the premises was observed to be homely with a large compilation of photographs of residents engaging in activities in the hallway. Each room was suitably decorated including in the self-contained apartment.

The inspector observed that the premises was clean and tidy throughout including bathrooms and storage areas.

Notwithstanding the above, on the walk around with the person in charge a number of maintenance issues were observed that required repair. The inspector observed cracked floor tiles in the entrance hallway. On a walk around of a bedroom the inspector observed cracked, broken and peeling plaster below pipe work that may have indicated the presence of a leak.

In another bedroom a fire door had a number of screw holes where the provider had relocated a door closer. When the inspector enquired if since the holes had been present had the provider assured themselves that the fire door had not been compromised. The inspector was informed there had not been a review of the fire door since the works had taken place. However, in the day following the inspection the provider submitted evidence to the inspector that the door had now been inspected and had not been compromised.

The inspector also observed upstairs on the landing that there was a hole in the floor. The hole in the floor had been covered up which increased the risk as the inspector only became aware of the hole when walking on it. The person in charge contacted the providers maintenance department who arrived a short time later. By the end of the inspection the provider's maintenance department had repaired the hole in the flooring.

As identified earlier in the report, none of these issues had been identified in the provider's own unannounced audits and governance meetings both of which suggested there were no premises issues.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

The provider had ensured that residents who had additional food requirements had their needs met while on a respite stay. For example one of the residents who uses the service is gluten intolerant. On the day of inspection the inspector reviewed the systems in place to ensure the residents specific needs were met.

The provider had a care plan in place for the resident's gluten intolerance which was reviewed by the inspector. The inspector observed guidance for staff on how to prepare gluten free foods, menu plans for this resident, what foods the resident needs to avoid and also what the impacts are for the resident if they consume gluten.

The inspector also completed a walk around of the premises and observed gluten free foods stored in a separate location to ensure the resident had their own choice of foods.

The provider also ensured the kitchen was fully equipped to ensure home cooked meals were prepared. The inspector observed staff cooking a home cooked meal on the day of inspection. The location had ample storage for food and the inspector observed a selection of cereals, fruit, vegetables and snacks for residents.

The residents in the centre gave feedback in a questionnaire that they would like to try foods from around the world. Following this feedback the provider held a world food day where residents sampled food from Greece, Italy, Mexico, Nigeria and India.

The residents who met with the inspector all spoke highly of the food prepared in the premises.

Judgment: Compliant

Regulation 26: Risk management procedures

The provider used an online system to record, monitor and review risk in the premises. There were both individual and location specific risk assessments. The person in charge maintained the risk registers as part of their oversight responsibilities.

On the day of inspection the inspector reviewed a sample of risk assessments contained in the register and spoke to staff regarding risk in the premises. Overall the premises did not have any red or high orange risk ratings and risk was well managed.

The person in charge identified safeguarding as one of the key risks in the location. The inspector observed a risk assessment in place for safeguarding. The risk assessment had been reviewed in February 2026 and control measures included areas such as staff training, safeguarding plans and notifying relevant persons of any safeguarding concern.

The inspector also observed location specific assessments in place for lone working, complex behaviour, fire and staffing levels.

Each resident who used the service had risk assessments in place. The inspector reviewed risk assessments in place for the residents present on the day of inspection. The inspector observed that key areas of risk for the residents were assessed for such as epilepsy, infection control, absconding, emergency evacuation plans and falls. The inspector reviewed the risk assessment in place for epilepsy. Control measures included staff training, rescue and regular medication and when each are to be administered and staff response during a seizure.

The provider held quality and risk management meetings that were attended by persons in charge from across the provider's remit, members of the providers quality team and senior management team. The inspector reviewed minutes of the

November 2025 meeting. Agenda items include policy reviews, service care and provision, health and safety, data monitoring and trends and centre updates.

The inspector met with and spoke to staff regarding key risks in the centre. For example, the inspector spoke with the staff member supporting the resident with epilepsy. The staff member was aware of the key control measures from the risk assessment and spoke confidently about risk in general within the centre.

Judgment: Compliant

Regulation 27: Protection against infection

The provider had ensured that a series of checks were in place on a daily basis to ensure the premises remained clean and infection free. The provider had also an infection prevention audit as part of the audit schedule and an infection prevention and control (IPC) risk assessment.

The daily checks, audit and risk assessment were reviewed and actioned by the person in charge as part of their oversight responsibility. On the day of inspection the inspector completed a walk around of the premises and reviewed the above documentation.

The premises was observed by the inspector to be clean and tidy. Each bathroom was clean with ample supplies of hand soap and sanitizers available.

The IPC risk assessment had been reviewed in February 2026. The risk assessment control measures included staff training, waste management guidelines and outlined the provider's IPC link person.

The provider's own IPC audit had been completed by the person in charge in November 2025. The inspector also reviewed the daily checks completed by the staff team. Checks were in place for areas such as bedrooms, bathrooms, kitchen, high touch areas, fixtures, fittings, and skirting boards.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The provider used an online system to store individual assessments and plans for each of the residents. The person in charge was responsible for ensuring plans were reviewed on a regular basis. Plans were used to inform and guide staff in supporting residents with identified needs and personal preferences.

On the day of inspection the inspector reviewed the care plans of two of the residents in the centre and spoke to members of the staff team regarding resident care plans.

The provider had ensured each resident had an individual support plan. Plans were also in place for intimate care, epilepsy, health and well-being. The plans observed by the inspector were last reviewed by the person in charge in January 2026.

The inspector reviewed the individual support plan for both residents. Guidance was in place for staff in areas such as resident personal needs, skin integrity, eating and drinking, mobility, sleeping preferences, pain and medications.

The residents' intimate care plans offered guidance for staff in the level of independence each resident had in relation to personal care. How a resident prefers oral care, showering, toileting, skin care, shaving and hair care. The inspector observed that guidance was individual to each resident and clear for the staff supporting the resident.

The staff who met with and spoke to the inspector showed a strong knowledge of the plans in place. Staff spoke about the epilepsy and medication plans in place for the resident they were working with. Staff also spoke confidently about both of the individual support plans.

Judgment: Compliant

Regulation 7: Positive behavioural support

The inspector reviewed both the provider and local systems regarding behaviour support and was not assured that the systems and plans in place were effective. The inspector was informed that residents availing of respite services are not in a position to access the provider's multi-disciplinary team supports. In the case of behaviour supports, plans came from the resident's day service or via an external private company not linked to the provider.

The provider currently supports residents who require 2:1 staffing at different times while availing of respite and the inspector reviewed these resident's behaviour support plans. The inspector observed that the plans were not reviewed on a regular basis. One plan had not been reviewed since September 2024 and the other plan since June 2023.

One plan had been completed by the resident's behaviour support specialist from their day service which is an external provider. The inspector observed evidence of the person in charge making attempts via email to get access to a more recent and updated behaviour support plan, however this had not been successful.

The inspector observed evidence of the person in charge linking with an external private company who had completed the second behaviour support plan reviewed.

The provider had been informed of a change in behaviour specialist for the resident in August 2025. The provider was informed that this person would be in contact regarding the resident and their plan. On the day of inspection no contact had been made with the provider.

On review of the plans, a recommendation was made stating "ongoing monitoring of the implementation of intervention strategies by a behaviour analyst is strongly recommended". The inspector did not observe any monitoring of the intervention strategies. A further recommendation stated that the behaviour support plan should be "viewed as a live document". The inspector was not assured plans were viewed as live documents given the length of time since an appropriate review.

As discussed earlier in this report, the provider's own internal auditing process outlined that behaviour support plans are regularly reviewed to ensure they are relevant and the regulation was judged as compliant. The local team were compiling behaviour support guidance based of their known knowledge of the residents. The inspector observed that none of the local team have any formal behaviour support training. As also identified earlier in this report the provider had not ensured all staff had received appropriate classroom based behaviour support training.

The inspector was also not assured regarding the sharing of key information regarding resident behaviours with relevant day services. The inspector observed an incident report regarding a resident behaviour on their first overnight stay. The incident was discussed with resident representatives with the representatives stating they had not observed this behaviour before. However, in conversation with the resident's day services post incident, the provider was informed they were aware of the behaviour stating it is a regular occurrence. The inspector enquired as to the frequency of contact with day service prior to the resident starting overnight stays with the provider confirming there was no contact.

Judgment: Not compliant

Regulation 9: Residents' rights

The provider ensured resident rights were a focus within the centre. The inspector observed evidence of regular resident meetings taking place. Meetings occur weekly as new groups of residents attend for respite. The inspector reviewed the minutes of the meetings and observed they were individual to each group that was in the centre that week.

The meetings focused on meal planning, activity planning, health and safety, safeguarding, rights, restrictions, advocacy and resident feedback.

The inspector also observed a copy of the providers annual review contained in the residents meetings folder which was discussed with the residents. An easy read document regarding healthy eating was also in place and discussed with residents.

Residents who met with and spoke to the inspector spoke positively regarding their involvement in the centre during their stay. Residents spoke about being able to choose the activities they engage in and the food that is prepared. Residents also spoke about being able to contact family or have visitors as they wished. The inspector also observed on the centres training log that all staff had completed rights based training.
Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 21: Records	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	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for The Maples OSV-0008092

Inspection ID: MON-0034287

Date of inspection: 04/02/2026

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: All staff are scheduled for and will complete the classroom-based Positive Behaviour Support training by the 30.04.2026, to ensure they have the appropriate skills and knowledge to support residents who present with behaviours of concern as part of a continuous professional development programme. Training sessions have already been scheduled and commenced in February 2026. The Person in Charge will monitor attendance and ensure that all staff complete the training as scheduled. Certificates of completion will be collected and recorded on the centre's training log. The Person in Charge will review the training matrix weekly to ensure all mandatory and refresher training remains up to date.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The provider will strengthen governance and oversight systems to ensure that service delivery is effectively monitored and that areas requiring improvement are identified and addressed in a timely manner by the following: A review of the current auditing practices will be completed to ensure audits accurately reflect practice within the centre and identify areas for improvement. The preparation of the 6 monthly Providers Led unannounced audits has been reviewed to ensure that all information sources are used to develop lines of enquire for the auditor. The next six-monthly unannounced provider led audit will include a focused review of key areas including behaviour support, staff training, restrictive practices, and premises. The	

nominated person to complete this audit will be independent of the current management structure of the centre.
Clear action plans with assigned responsibilities and timelines will be included in all audits and tracked to completion.

Governance meetings between the Person in Charge and Assistant Director of Services will be continue monthly, and will ensure structured review of:
Behaviour support plans, Restrictive practices, Training compliance, Premises and maintenance issues, Incident trends and risk management.

All actions arising from provider level reviews, will be carefully monitored for implementation during monthly Governance Meetings.
The Person in Charge has developed and will maintain a local action tracker to monitor progress on all audit actions and ensure timelines are adhered to. Progress will be reported to Assistant Director on weekly basis.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
A full premises review has been carried out by the PIC, Assistant Director and the Maintenance manager on 12.03.26
Maintenance issues identified during the inspection have been addressed to ensure the premises remains in a good state of repair.

Cracked floor tiles in the entrance hallway have been allocated for repair by an external contractor, this will be completed by 09.04.2026
Damaged and peeling plaster identified in one bedroom has been repaired and inspected to confirm there are no underlying leaks.
The previously identified hole in the landing floor has been repaired by the maintenance department.
The fire door that had screw holes following relocation of a door closer has now been inspected and confirmed to be fire compliant.

The Person in Charge will continue to complete weekly environmental checks of the premises.

Any further maintenance issues identified will be logged and submitted to the provider's maintenance department for prompt action.

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
A full review of all residents' positive behaviour support requirements has been undertaken to determine a baseline for overall requirements for Positive Behaviour support within the centre.
Engagement has taken place with each resident through an appropriate and accessible means to obtain feedback on their experience. This has been conducted through

observation and trending of incidents. This will be an ongoing process, to ensure the welfare of the residents is continually monitored.
All staff are scheduled for and will complete the classroom-based Positive Behaviour Support training by the 30.04.2026, to ensure they have the appropriate skills and knowledge to support residents who present with behaviours of concern as part of a continuous professional development programme.
The Person in charge has liaised with all external agencies / day services involved in the care and support of all residents who attend the respite service to improve interagency communication and the sharing of key information including PBS plans. This will continue on a regular basis.
A review of the preadmission assessment process has taken place. Following the preadmission assessment conducted with the resident and their representatives, The Person in Charge will link with day services in advance of first visits to determine if there are any areas of concern that have not been previously identified.
The Provider is in the process of identifying key personnel within the centre to complete a Practice Certificate in Multi-element Behaviour Support (MEBS) with the Callan Institute. The next available intake to this course in September 2026.

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	30/04/2026
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	09/04/2026
Regulation 23(1)(b)	The registered provider shall ensure that there is a clearly defined management structure in the designated centre that identifies the lines of authority	Not Compliant	Orange	01/05/2026

	and accountability, specifies roles, and details responsibilities for all areas of service provision.			
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	30/05/2026
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 the standard of care and support.	Not Compliant	Orange	30/05/2026
Regulation 07(1)	The person in charge shall ensure that staff have up to date	Not Compliant	Orange	30/04/2026

	knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.			
Regulation 07(2)	The person in charge shall ensure that staff receive training in the management of behaviour that is challenging including de-escalation and intervention techniques.	Not Compliant	Orange	30/04/2026