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:	Rusheen Services
Name of provider:	Corlann
Address of centre:	Galway
Type of inspection:	Unannounced
Date of inspection:	20 April 2026
Centre ID:	OSV-0008123
Fieldwork ID:	MON-0046090

About the designated centre

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

Rusheen services is a designated centre which provides residential services in a community based setting in Galway city. The centre supports four residents who have an intellectual disability and who may also have reduced mobility. Residents have their own bedroom and there is a separate apartment available for one resident. Residents are supported both day and night by a staff team comprising nursing staff and health care assistants.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	4

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 20 April 2026	09:45hrs to 17:00hrs	Mary Costelloe	Lead

What residents told us and what inspectors observed

This inspection was an unannounced inspection carried out to monitor compliance with the regulations. This centre has had a good history of compliance. The findings from this inspection indicated generally good compliance with the regulations reviewed, however, some improvements were required to leadership presence and oversight arrangements in the centre, to some aspects of staff training, risk and fire safety management and care planning documentation.

The inspection was facilitated by the person in charge and team leader. On the day of inspection, there were four residents being accommodated in the centre and the inspector met with all residents. Residents living in the centre had complex and high support needs. Due to their communication needs, they were unable to tell the inspector their views about the care and support they received; however, they appeared comfortable, happy and content in their environment. The inspector noted frequent and positive interactions between residents and staff, with residents smiling, engaging in their surroundings and displaying signs of enjoyment throughout the day. Staff demonstrated a good understanding of residents' individual communication styles and needs. They were seen to respond appropriately to non-verbal cues, gestures and behaviours ensuring that residents preferences and wished were interpreted and respected. This contributed to a calm and supportive atmosphere in the centre. The inspector also met and spoke with a family member who visited during the day, they indicated high satisfaction with the service provided. They mentioned how they were happy with the care and support that their relative was receiving, how they had no concerns regarding the quality and safety of the service and how the family were content in knowing that their relative was being well supported by staff who knew them well.

The centre is a large dormer style detached, bright dwelling located in a quiet residential area on the outskirts of a city. The house was found to be visibly clean, well maintained, comfortable, suitably furnished and decorated in a homely manner. The main house accommodated three residents and one resident was accommodated in the adjoining self-contained apartment. All accommodation for residents was provided on the ground floor. There was a large open plan kitchen, dining area and sun lounge as well as a separate sitting room provided in the main house. One bedroom had its own ensuite shower facility while the two other bedrooms shared a fully accessible bathroom. A separate utility room was well equipped with laundry and cleaning equipment. Each bedroom and the apartment were spacious, comfortably decorated and suitably furnished. All bedrooms had televisions, adequate storage for personal belongings and were personalised with items of significance to each resident. Specialised equipment including beds, hoists, specialised wheelchairs and showering equipment were provided to meet the needs of some residents. Service records reviewed showed that there was a service contract in place, however, servicing was due and some equipment including a bed

and shower chairs needed to be repaired/replaced. The service company were contacted and arrived to service all equipment before the end of the inspection.

Residents had access to a large well maintained mature garden area, patio area and poly tunnel to the rear of the house. The garden area was provided with a variety of plants and shrubs, tress, walkways and paved areas.The poly tunnel was being used to grow a variety of fresh vegetables including carrots, lettuce and onions. There was appropriate garden furniture, parasol, garden swing and BBQ provided. Staff told the inspector how some of the residents enjoyed spending time outside during fine weather and how one resident enjoyed using the swing and tricycle while others enjoyed spending time at the poly tunnel.

All four residents were provided with an integrated individualised day service from the house. Residents could take part in a range of activities both at the centre and in the community. Suitable support was provided to residents to achieve this in accordance with their individual choices and interests, as well as their assessed needs. The centre was located in a residential area on the outskirts of the nearby city and seaside resort. The location of the centre gave residents good access to a wide range of community amenities and activities. There were sufficient vehicles to ensure that each resident could have individualised outings in line with their own choices. Residents continued to enjoy a range of activities such as shopping, day trips, and eating out. Some residents enjoyed swimming, attending music concerts and discos, bingo, the cinema and visiting horse and animal farms. Some residents preferred more sensory activities such as music therapy, rebound therapy, reflexology and massage. Residents also enjoyed spending time at home watching television or Netflix programmes, completing table top activities and listening to music. Some residents enjoyed getting out for walks in the local area and in parks, some liked visiting the local church and attending church services.

On the day of inspection, residents were supported to access their local community and outdoor environments in line with their assessed needs and preferences. Residents who required mobility support were facilitated to go for walks using their wheelchairs. One resident went out on a shopping trip to a local shopping centre and other were supported to go for walks and visit the local church. Another resident was observed listening to their favourite music on a large television. They appeared to greatly enjoy this experience as evidenced by smiling and moving their hands to the rhythm of the music.

The inspector observed that all meals were freshly prepared and tailored to meet the assessed dietary needs of residents. The kitchen was well equipped and food storage areas were well stocked with nutritious foods including fresh fruit and vegetables. Modified meals were presented in an appealing manner with clear attention given to both texture and presentation. Mealtimes experiences were observed to be unhurried with staff providing appropriate assistance while promoting dignity and comfort.

Family contact and involvement was seen as an important aspect of the service, and this was being well supported. Some residents regularly visited their families at home while others received regular visits from family members in the centre.

Several events involving families were organised throughout the year, such as a summer and Christmas party for families. One resident hosted their parents for Christmas dinner in the centre.

From conversations with staff and a relative, observations made and information reviewed during the inspection, it appeared that residents had good quality lives in accordance with their capacities, were supported to achieve best possible health and, were involved in activities that they enjoyed. Throughout the inspection it was very clear that the staff prioritised the wellbeing and quality of life of residents

The next two sections of the report outline the findings of this inspection, in relation to the governance and management arrangements in place in the centre, and how these arrangements impacted on the quality and safety of the residents lives.

Capacity and capability

The findings from this inspection indicated good compliance with many of the regulations reviewed and there was evidence of good practice in many areas. Issues identified at the previous inspection had been addressed. However, improvements were required to ensure that there were arrangements in place for effective governance, to ensure effective oversight of the service, to support ongoing monitoring, review and continuous quality improvement.

There was a clear organisational structure in place to manage the service. The person in charge worked full-time and was responsible for this designated centre as well as having other managerial responsibilities in the organisation. The person in charge was supported in their role by a team leader, staff team including nursing staff and area manager. There were on-call management arrangements in place for out-of-hours. However, the person in charge lacked sufficient on-site presence, reducing oversight and increasing risk to compliance and consistency with potential impact on the quality and safety of the service.

The inspector found that the staffing levels on the day of inspection met the support needs of residents. Many staff members had worked in the centre over a sustained time period, and knew the residents and their families well. There were no staff vacancies at the time of inspection. The staffing rosters reviewed for 19 April to 2 May 2026 indicated that a team of consistent staff was in place. The roster was well maintained, it clearly set out the staff on duty including their roles, however, the person in charge was not included on the rota.

Training records reviewed by the inspector and conversations with staff provided assurances that staff were provided with ongoing training. Records reviewed indicated that all staff had completed mandatory training and further refresher training was scheduled. Additional training had been provided to staff to support them in meeting the specific needs of some residents. However, two recently

recruited staff had not yet completed medicines training. This posed a risk to residents as both staff were rostered on duty to work alone at night-time and could not administer medication if necessary. The person in charge undertook to arrange this training as soon as possible.

The provider had systems in place for reviewing the quality and safety of the service including six-monthly provider led audits and an annual review. The annual review for 2025 was completed. The review had included consultation with families indicating positive feedback of the service. Planned improvements for the year ahead were outlined and included continuing to advocate with local county councillors and politicians in order to secure planning permission for a new side entrance to ensure a safe exit for residents using wheelchairs. Planned improvement also included continuing to promote appropriate communication supports for residents through staff training and assistance from the OT (occupational therapist), SLT (speech and language therapist) and DAT (digital assistive technology) team. The provider continued to complete six-monthly reviews of the service. The most recent review was completed in November 2025. Actions identified as a result of the review had been completed or were works in progress. For example, general maintenance issues identified had been completed, kitchen units had been repainted and planning permission for a new side entrance was being sought.

The local management team also had systems for reviewing areas such as health and safety, infection prevention and control and medication management. These reviews were taking place on a computerised system (Flex), however, many gaps were noted and further oversight of these systems were required to provide assurance that effective safety monitoring systems were in place. This is discussed further under Regulation 23:Governance and management

Regulation 15: Staffing

The staffing levels at the time of inspection met the support needs of residents and were in line with that set out in the statement of purpose. The rosters reviewed for the 19 April to 2 May 2026 showed consistent and stable staffing arrangements. There were normally three staff on duty during the day with one staff member on active duty at night-time. There was an additional housekeeping staff member on duty three days a week.

Judgment: Compliant

Regulation 16: Training and staff development

All staff who worked in the centre had received mandatory training in areas such as fire safety, behaviour support, manual handling and safeguarding. However, two

recently recruited staff had not yet completed medicines training. This posed a risk to residents as both staff were rostered on duty to work alone at night-time and could not administer medication if necessary.

Additional training in various aspects of infection prevention and control, feeding, eating and drinking guidelines, first aid, personal outcomes, epilepsy care, replacement of gastronomy tubes and risk management had been completed by staff. Many staff had completed communication training in Lámh (a manual sign system) used to support communication with residents.
Further refresher training was scheduled for some staff. A review of the minutes of team meetings showed that training requirements were regularly discussed with staff.

Judgment: Substantially compliant

Regulation 23: Governance and management

Improvements were required to governance arrangements to ensure effective oversight of the service and timely identification of areas requiring improvement.

The provider needed to ensure that the person in charge had adequate resources to fulfill their role effectively. This included adherence to the arrangements set out by the provider in the statement of purpose submitted with the application to register the centre which outlined that the person in charge allocated 50% of their working time to that role in the designated centre. While the person in charge was in regular contact with the staff team including the team leader, they did not have regular and consistent physical presence in the centre indicating that governance arrangements were not being implemented as outlined. The limited presence of the person in charge reduces oversight, increasing the risk of non-compliance, inconsistent practices and potential impact on the quality and safety of the service.

While staff in the centre were completing reviews of areas such as health and safety, infection prevention and control and medication management, many gaps were noted. For example, records reviewed showed that weekly safety audits were not completed consistently, monthly safety checks on hoist slings were not being routinely completed, the last check recorded was in October 2025 and there were also gaps in the daily fire safety checks. Corrective actions from the most recent fire drill which took place on 18 February 2026 which identified that external lights required repair had not yet been addressed.

The inspector noted that some of the information generated as a result of these reviews was not informative, for example, many pertinent questions in the medication audit were recorded as not applicable and outstanding health and safety requests were not identified in the annual safety check audit.

There was lack of evidence of appropriate management oversight of audits to ensure they were completed, reviewed and actioned, indicating a gap in governance

and risk management. Improvements were also required to aspects of fire safety management and care planning documentation.

Judgment: Not compliant

Regulation 24: Admissions and contract for the provision of services

The provider had developed written agreements for the provision of service for all residents. Issues identified at the previous inspection had been addressed. The agreements included the required information about the service to be provided, such as the financial responsibility of the residents and the support that residents would receive. The service agreements had been updated to include the current fee being charged to each resident.

Judgment: Compliant

Quality and safety

Throughout the inspection, the inspector found that residents' needs were supported by staff in a person-centred way. Staff supported residents' involvement in community activities and also supported residents to keep in contact with their families. A relative spoken with was complimentary of the care and support their family member received from staff in the centre. Residents were observed to be comfortable in their environment and with staff supporting them. The provider had adequate resources in place to ensure that residents got out and engaged in activities that they enjoyed and the staff team promoted and supported residents to exercise their rights and achieve their personal and individual goals. However, the inspector found that some improvements were required to some aspects of personal planning documentation, risk and fire safety management.

Staff spoken with were familiar with, and knowledgeable regarding residents' up to date healthcare and support needs. Residents had access to general practitioners (GPs), out of hours GP service, to nursing supports and a range of allied health services. The inspector reviewed the files of three residents and noted that comprehensive assessments of the residents health, personal and social care needs had been completed. A range of individual risk assessments had been recently updated. Support plans were in place for all identified issues including specific health-care needs. However, some specific care and support plans required further review and updating.

The house was designed and well equipped with aids and appliances to support and meet the assessed needs of the residents living there. It was comfortable, visibly

clean, spacious, furnished and decorated in a homely style. The provider had continued to invest in the building with recent renovations and refurbishments to the kitchen, windows and personal storage facilities in bedrooms.

Safeguarding of service users continued to be promoted through staff training, regular discussion and the development of comprehensive intimate and personal care plans. Staff advised that there were no safeguarding concerns at the time of inspection.

While there were systems in place for the management and on-going review of risks including fire safety measures and evacuation plans in place, improvements and further oversight were required to some aspects of fire safety management, to safety audits and other safety protocols to ensure that they were completed consistently, reviewed and any issues identified addressed in a timely manner. These are discussed further under Regulations 26: Risk management and Regulation 28: Fire precautions.

Regulation 10: Communication

Staff had continued to support residents with appropriate communication strategies, through ongoing training and supports from the OT, SLT and DAT team. Communication passports, which outlined required individual communication supports, had been developed for residents. User-friendly pictorial aids and objects of reference were being used in the designated centre to support residents and staff to communicate with each other. The use of assistive technology continued to be explored for some residents and staff spoke of a communication application which can be used on an IPad being introduced for one resident.

Judgment: Compliant

Regulation 11: Visits

Residents were actively supported and encouraged to maintain connections with their friends and families. There were no restrictions on visiting the centre. There was adequate space available for residents to meet with visitors in private if they wished. Some residents regularly visited their families at home while others received regular visits from family members in the centre.

Judgment: Compliant

Regulation 17: Premises

The design and layout of the centre was suitable for its stated purpose and met residents' individual needs. The house was found to spacious, well maintained, visibly clean, furnished and decorated in a homely style. Residents had access to secure mature garden areas. The house and gardens were accessible with suitable ramps and rails provided, the corridors were wide and free of obstructions which supported residents using wheelchairs. Residents that required assistive devices and equipment to enhance their mobility and quality of life had been assessed and appropriate equipment had been provided. Specialised equipment including beds, hoists, specialised wheelchairs and showering equipment were provided. Service records reviewed showed that servicing of equipment was overdue and some equipment including a bed and shower chairs needed to be repaired/replaced. The service company were contacted and arrived to service all equipment before the end of the inspection.

Judgment: Compliant

Regulation 26: Risk management procedures

Improvements were required to risk management. Further oversight of safety audits and other safety protocols/controls was required to ensure that they were completed consistently, reviewed and any issues identified addressed.

Records reviewed showed that daily fire safety checks and weekly safety audits were not completed consistently. Control measures identified to reduce some identified risks including monthly safety checks on hoist slings were not being routinely completed, the last check recorded was in October 2025. Corrective actions from the most recent fire drill which took place on 18 February 2026 of a night-time scenario had identified that external lights required repair, however, this had not yet been addressed and continued to pose a risk to residents.

Judgment: Substantially compliant

Regulation 28: Fire precautions

While the local management team and staff spoken with were knowledgeable regarding fire safety and evacuation, improvements were required to some aspects of fire safety management. The layout plan of the centre displayed adjacent to the fire alarm panel was not clear. The layout plan as displayed was inverted and needed to be orientated relative to the user's position at the fire alarm panel to avoid any confusion or delay in locating a fire. As discussed under Regulation 26; Risk management, daily fire safety checks were not being consistently recorded, and corrective actions identified from the last fire drill had not yet been addressed. The

inspector also noted that the door between the kitchen and main corridor was not closing properly which posed a risk of spread of smoke in the event of fire. While there was a schedule in place for servicing of the fire alarm system, the quarterly service due in March 2026 had not taken place. This was brought to the attention of the person in charge who then made enquiries and was advised that the service would take place the day following the inspection.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Residents' health, personal and social care needs were regularly assessed and care plans were developed, where required. Staff spoken with were familiar with and knowledgeable regarding the assessed needs of residents. The inspector reviewed the files of three residents. The documentation was generally found to be informative and showed evidence of regular review. However, some specific care and support plans required further review and updating to provide comprehensive guidance for staff, to reflect the changing and current needs of the resident and to ensure safe and effective care. For example, the most recent review and recommendations from the dietitian were not reflected in the care plans reviewed.

Personal plans had been developed in consultation with residents, family members and staff. Planning meetings took place annually, at which residents' personal goals and support needs for the coming year were discussed and there were regular reviews of progress throughout the year. This documentation was found to clearly identify meaningful goals for residents, with a clear plan of action to support these residents to achieve their goals.

Judgment: Substantially compliant

Regulation 6: Health care

The local management and staff team continued to ensure that residents had access to the health care that they needed.

All residents had access to a general practitioner and were supported to attend annual medical checks. Other healthcare professionals available to residents included physiotherapist, occupational therapist, speech and language therapist, dietitian, psychologist and chiropodist. The staff team included nurses and all staff had been provided with training to meet the needs of residents with specific health care needs such as, feeding eating and drinking guidance, management of gastronomy tubes and epilepsy care.

Residents were also supported to avail of vaccine and national screening programmes. The centres' advocate had met with the head of BreastCheck and was currently advocating for accessible breast screening mammogram facilities which are currently unavailable.

Each resident had an up-to-date hospital and communication passport which included important and useful information specific to each resident, in the event of they requiring hospital admission. Arrangements were in place for staff to stay with, support and advocate for residents during hospital stays.

Judgment: Compliant

Regulation 7: Positive behavioural support

Residents that required support with behaviours were being responded to appropriately, had access to specialists in behaviour management and written plans were in place. All staff had received training in order to support residents manage their behaviour. There was a reported low level of behaviour related incidents in the centre. Restrictive practices in use were being managed in line with national policy. All restrictions in use were logged and risk assessed. There was input from members of the multidisciplinary team outlining a clear rationale for their use including other alternatives tried or considered. All restrictive practices in use had been reviewed by the organisations rights committee.

Judgment: Compliant

Regulation 8: Protection

The provider had taken measures to safeguard residents from being harmed or suffering abuse. All staff had received specific training in the protection of vulnerable people to ensure that they had the knowledge and the skills to treat each resident with respect and dignity and were able to recognise the signs of abuse and or neglect and the actions required to protect residents from harm. A photograph and the contact details of the designated safeguarding officer was displayed. There were no safeguarding concerns at the time of inspection

Judgment: Compliant

Regulation 9: Residents' rights

Residents were supported to live person-centred lives where their rights and choices were respected and promoted. The privacy and dignity of residents was well respected by staff. Staff were observed to interact with residents in a caring and respectful manner. The residents had access to televisions, the Internet and information in a suitable accessible format. Residents were supported to communicate in accordance with their needs and to avail of advocacy services. Restrictive practices in use were reviewed regularly by the organisations human rights committee. Residents continued to be supported to partake in activities that they enjoyed in the centre and in the local community. Residents were supported to visit and attend their preferred religious places of interest, some regularly visited the local churches, some enjoyed attending local church services and they also enjoyed day trips to Knock religious shrine. Residents had their own bank accounts and were supported to access their money and manage their finances.
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 23: Governance and management	Not compliant
Regulation 24: Admissions and contract for the provision of services	Compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 11: Visits	Compliant
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Rusheen Services OSV-0008123

Inspection ID: MON-0046090

Date of inspection: 20/04/2026

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: In accordance with Regulation 16(1) (a) All staff in designated centre have access to mandatory training. A full training audit within the designated centre has been completed, all mandatory and refresher training has been booked and will be reviewed with Team leader on a monthly basis. PIC will ensure that staff who have not completed mandatory training will not be rostered to work on night duty.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: In accordance with Regulation 23(1) (C) The PIC allocates 50% of their managerial time and will have a more physical presence in the Designated Centre. Along with a team leader this will ensure effective delivery of care for this designated service. Regular monthly meetings have been formalized where the PIC and team leader review the delivery of service providing oversight and ensuring compliance with legislative requirements. The PIC and team leader will ensure robust quarterly auditing of all safety checks to ensure compliance and identify any areas for follow up or improvement. Along with this the PIC and team leader will carry out spot checks on completed safety audits to ensure that audits are completed as scheduled and are accurate. Any identified actions or gaps will be addressed promptly. To further strengthen auditing systems, improvements to the alerts and escalation system for missed or overdue audits, are currently under review in consultation with the Corlann West Facilities Department. A team meeting has been scheduled for June 10th 2026 to ensure that all staff are aware	

of the importance of accurately completing all safety checks. Staff reponsibilities will be clearly defined and allocated to named staff members to ensure accountability, consistency and follow up of corrective actions identified. Safety audits will be a standing item on all team meetings to further support best practice in this area.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:

In accordance with regulation 26(2) the PIC and team leader will ensure robust quarterly audits are completed to identify any follow up actions arising from fire drills and safety reviews

A team meeting has been scheduled for June 10th 2026 to ensure that all staff are aware of the importance of accurately completing safety checks including weekly safety checks, monthly sling checks and fire safety controls. Responsibilities will be clearly defined and allocated to named staff members to ensure accountability, consistency and follow up of corrective actions identified. Safety audits will be a standing item on all team meetings to further support best practice in this area going forward.

Furthermore the PIC has liaised with the Facilities department to set up weekly and monthly email reminders to the designated centre and PIC to ensure consistent completion of safety checks

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:

In accordance with Regulation 28(b) (i) the house floor plan was corrected and now reflects the layout of the premises.

In accordance with regulation 28(2) (b) (ii) corrective actions arising from night time fire drill on the 18th February 2026 have been completed.
A fire door identified as not closing effectively on the day of inspection has been repaired.
Servicing of fire alarm and extinguishers was completed on 21st April 2026.

Regulation 5: Individual assessment and personal plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:

In accordance with regulation 5(6) (d) The PIC and Team Leader have reviewed all health support plans in the Designated Centre to ensure they include the most current recommendations and comprehensive guidance for staff. One individuals dietary care plan has been updated and now includes recommendations from their most recent review with the dietician.

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	11/06/2026
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	26/05/2026
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre	Substantially Compliant	Yellow	26/05/2026

	for the assessment, management and ongoing review of risk, including a system for responding to emergencies.			
Regulation 28(2)(b)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Substantially Compliant	Yellow	28/04/2026
Regulation 28(2)(b)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Substantially Compliant	Yellow	28/04/2026
Regulation 05(6)(d)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall take into account changes in circumstances and new developments.	Substantially Compliant	Yellow	14/05/2026