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

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| Name of designated centre: | Baile Geal Residential Service |
| Name of provider: | Barróg Healthcare Limited |
| Address of centre: | Cork |
| Type of inspection: | Unannounced |
| Date of inspection: | 15 January 2026 |
| Centre ID: | OSV-0008798 |
| Fieldwork ID: | MON-0048629 |

## About the designated centre

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

Baile Gael is a detached bungalow residence in the outskirts of a large town. The centre can provide full-time residential support to three adults over the age of 18, of both genders, with an intellectual disability and/or autism. Residents are supported by social care workers, support workers, the person in charge and a team leader. Each resident has their own bedroom and other rooms in the centre include bathrooms, a multipurpose room and a kitchen.

**The following information outlines some additional data on this centre.**

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| Number of residents on the date of inspection: | 3 |

## 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 |
|---|---|---|---|
| Thursday 15 January 2026 | 09:00hrs to 17:00hrs | Deirdre Duggan | Lead |
| Thursday 15 January 2026 | 09:00hrs to 17:00hrs | Robert Hennessy | Lead |

## What residents told us and what inspectors observed

From what inspectors observed, at the time of this unannounced inspection residents in this centre were being offered a tailored service that took into account their individual needs and preferences. Residents were seen to be provided with opportunities for community access and activity in line with their individual preferences. This inspection found improved compliance with the regulations but some ongoing issues were identified in relation to the premises and the fire safety precautions in place. Also, due to some delays in submitting the required documentation, an application to vary a condition of registration of the centre to reflect the accurate layout of the centre had not yet progressed.

This centre comprises a detached bungalow located in a residential area of a large town. Some ongoing issues were identified in relation to the premises, although improvements had been made since the previous inspection. Each resident has their own bedroom, bathroom and laundry facilities. Communal space is limited in this centre but each resident also had access to their own living and dining areas and residents did not tend to spend significant amounts of time with each other. Inspectors noted that while some equipment had been provided, the kitchen facilities available to one resident required further improvements to ensure that this resident had access to safe and appropriate facilities for meal preparation and cooking. Comfortable seating and televisions were provided in each residents' area of the centre. An enclosed garden area is also available to residents to the rear of the centre and some sports equipment was viewed in this area.

The centre opened in May 2024 and was fully occupied at the time of this inspection. This centre accommodates young adults and had been adapted to provide individualised full time residential services for three residents. The centre comprised of a two bed main unit with an adjacent garden room converted for use as a living and leisure space for one resident by day. Another section of the premises had been adapted to provide an individualised apartment area for one resident that could be accessed from the main building but also had a separate entrance used by the resident.

Overall, inspectors saw that efforts were being made to provide a homely environment for residents that was also in line with residents' assessed needs. The premises in the main part of the centre was seen to be well maintained and decorated, as was a separate sitting room area used by one resident. Efforts had been made to personalise the centre to reflect residents' personalities and preferences. However, in the apartment area there were some actions required around painting, flooring and the layout of the kitchen which is addressed under Regulation 17: Premises. Bedrooms were personalised and contained personal photographs that were important to the residents. There was ample storage for

residents in the bedrooms areas and bathrooms had mobility aids for residents to use.

All three residents were in the centre when the inspection commenced and left for planned activities during the morning and afternoon. The inspectors had an opportunity to meet all of the residents of this centre, although some of these interactions were brief. Residents were observed relaxing in their individual living areas, taking part in a planned fire drill, watching TV and using multimedia devices, and moving around their own areas of the centre. Residents living areas were seen to be set up in line with their individual preferences. Two residents told an inspector that they were looking forward to attending their day service and interacted about things that were of interest to them. Both of these residents were seen departing for their day service as planned. A third resident was observed using a tablet device and interacted briefly with an inspector. They also departed the centre later in the morning to spend the day with family as planned.

Inspectors observed a number of interactions between staff and residents that indicated that residents were comfortable and familiar with the staff that supported them. Staff were observed to be familiar with how residents communicated their preferences and to support residents in a respectful manner and staff were seen to respond quickly to residents.

Aside from the two members of management that made themselves available on the day of the inspection, inspectors spoke with staff working in the centre on the day of the inspection. Staff reported that they felt residents were safe and well cared for in the centre and that the provider was responsive to any issues or concerns raised. Staff spoken with told the inspector that they would be comfortable to raise concerns, including safeguarding concerns or complaints. Staff also spoke about supervision meetings they had taken part in and were positive about the training provided to them to support them in their roles. Inspectors did not have an opportunity to meet with family members during this unannounced inspection.

Overall, the findings on this inspection indicated that residents were afforded a good quality of life in this centre and there was good compliance with the regulations. Some ongoing issues in relation to the premises and fire precautions were noted, although there had been significant improvements since the previous inspection. The next two sections of the report present the findings of this inspection in relation to the governance and management arrangements in place in the centre, and how these arrangements impacted on the quality and safety of the service being delivered.

## Capacity and capability

A previous inspection of this centre in December 2024 had identified that the provider was in breach of a condition of their registration whereby changes had

been made to the internal layout of the centre. A further inspection in August 2025 also identified non compliance with the regulations across a number of areas and an urgent action had been issued to the provider following that inspection. Issues were identified in relation to the premises, fire safety, risk management, protection and access to specific records in the centre.

This unannounced risk based inspection found that that the provider had put in place resources in the centre to address most of the premises issues identified and improvements had been made since the previous inspection. Substantial action had been taken by the provider to address previous non compliance found in the centre and this inspection found that overall, management systems were now in place to provide for good quality services that met residents' needs. However, it was identified that some further action was required to bring the centre fully into compliance with the regulations around premises and fire safety precautions.

A clear management structure was in place in the centre. The person in charge had remit over this designated centre alongside another designated centre. The person in charge, reported to an Operations Manager, who reported to a Head of Operations Manager, who in turn reported to the Director. Both the person in charge and the Operations manager, who was named as a person participating in the management (PPIM) of the centre made themselves available and came to the centre to facilitate the inspection and meet with inspectors. Both these individuals were seen to be committed in their roles and were aware and up-to-date with any issues present in the centre and the plans in place to address these. At local level, the person in charge led a team consisting of a deputy manager, a team lead, senior support workers and care assistants.

Staffing levels in the centre were good and provided for individualised care and support for each resident. While some vacancies were reported on the staff team, there were efforts to ensure that regular and consistent staff supported individuals and the person in charge told inspectors about how this was considered and planned for in the centre. By day usually six staff supported residents and by night three waking staff were available. Local management also worked on site regularly and were available to provide supports if required. This meant that staffing levels were sufficient to ensure that residents that required 1:1 or 2:1 supports in their home or community were afforded this and were afforded choices in how they spent their day that were not curtailed by staffing. Staff reported they were well supported in the centre and were provided with training appropriate to their roles.

Overall, this inspection found that there was evidence of improved compliance with the regulations in this centre and this meant that residents were being afforded safe person centred services. Some further improvements were required to ensure that one resident had access to fully appropriate kitchen facilities and that all fire precautions had been fully considered. The next section of the report will reflect how the management systems in place were contributing to the quality and safety of the service being provided in this designated centre.

## Regulation 16: Training and staff development

The training needs of staff were being appropriately considered and this meant that staff were equipped with the skills and knowledge to ensure that residents could be provided with safe and good quality care and support appropriate to their needs. The inspector reviewed a training matrix for seventeen staff that were also named on the centre roster. This matrix showed that staff were provided with training appropriate to their roles and that the person in charge maintained good oversight of the training needs of staff. Staff spoken with confirmed that they were well supported in the centre and staff had access to regular supervision meetings also. Staff also reported that they received an induction to the centre that was in line with the needs of the residents living in the centre. For example, new staff shadowed or worked alongside familiar staff for a period prior to working with a resident.

The matrix reviewed showed that mandatory training provided included training in the areas of behaviour, safeguarding and fire safety. Generally, the training reviewed was up-to-date and where a staff member was due training refresher training was scheduled. Some staff were indicated as out-of-date for fire safety training. These staff had received fire safety training and their certificates indicated that they were in date. However, the person in charge told the inspector that due to a change in the providers' policy, it was now mandatory to complete this annually and this meant that these staff were due refresher training and indicated as out-of-date of the matrix. This is covered under Regulation 28: Fire precautions.

Judgment: Compliant

## Regulation 21: Records

A number of records maintained by the provider were reviewed during the course of the inspection. These included records pertaining to residents of the centre, records relating to fire safety, and copies of important documents kept in the designated centre including the current statement of purpose.

The sample of records viewed during this inspection provided evidence that the registered provider was ensuring that records of the information and documents specified in Schedule 3 and Schedule 4 of the Regulations were being maintained and were available for inspection.

Judgment: Compliant

## Regulation 23: Governance and management

Overall, the governance arrangements in place in this centre had been effective in improving compliance with the regulations since the previous inspection. However, some ongoing issues were identified in relation to the premises and fire precautions in place. While improvements had been made in these areas, further action was required to ensure that the premises was fully meeting the needs of all residents and all fire safety risks had been fully addressed.

As referenced in the capacity and capability section of this report, a previous inspection had identified that the provider was in breach of a condition of registration. The provider had submitted an application to vary to reflect premises changes that had occurred in the centre and this would ensure that they were operating under the conditions of registration applied to this centre going forward. Some further documentation had been requested but not yet submitted at the time of this inspection. This was discussed with the management of the centre during the inspection.

At the time of this inspection there was a clear governance structure in place and overall, management systems in place were ensuring that a good quality, person centred service was being provided to residents. The local management team had been enhanced since the previous inspection and a deputy manager, team leader and senior support staff were in place to support the person in charge in maintaining oversight of the centre. The person in charge told inspectors about how the shift pattern had been designed to ensure that oversight was maintained at weekends also. The person in charge was seen to have the capacity to maintain good oversight of this centre and maintained a good presence in the centre and an individual identified as a person participating in the management (PPIM) of the centre was also visiting the centre regularly. Management were responding to incidents that occurred in the centre and for the most part, management systems were in place to ensure that the service provided was appropriate to residents' needs.

Documentation reviewed by inspectors during the inspection such the annual review completed in September 2025 and associated action trackers showed that the provider was maintaining oversight of the service provided in this centre and indicated that governance and management arrangements in the centre had improved also.

Staff spoke with the inspector and reported that they felt comfortable to raise concerns and that issues raised were taken seriously and responded to by the management of the centre. Team meeting minutes documented that staff were informed about issues such as safeguarding and learning from incidents was discussed. A supervision schedule was also in place that showed that staff received regular formal supervision.

Judgment: Substantially compliant

## Quality and safety

The wellbeing and welfare of residents in this centre was maintained by an overall good standard of evidence-based care and support. Individualised services were provided to the three individuals that lived in this centre. While overall, this inspection found that the provider had taken action since the previous inspection and improvements had been made, some ongoing issues were identified in relation to premises and fire safety.

Residents were supported by a committed local management and staff team in the centre. Staff working with residents on the day of the inspection were observed to be familiar with residents and to support them in line with their preferences and support needs.

Documentation in place about residents was seen to provide good guidance to staff about the supports residents required to meet their healthcare, social and personal needs. The inspectors reviewed a number of documents throughout the day of the inspection, including two residents' personal plans, health and social care support plans, specific local protocols, daily notes and safeguarding plans. The documentation viewed was seen to be well maintained, and information about residents was up-to-date and person-focused. There was evidence that efforts were being made to consider how residents were supported to make choices about their daily lives.

Individualised plans were in place that contained detailed information to guide staff and ensure consistency of support for residents. These plans were subject to regular review and included meaningful goals that aligned with residents' interests. Support plans were in place to guide staff on all areas of service provision to residents.

There were some restrictive practices in use in this centre and these included specific measures in place to address safeguarding concerns in the centre. These restrictions were seen to be in place to promote the safety and wellbeing of residents. However, one resident was seen to be restricted in accessing appropriate kitchen facilities by the arrangements in place and further improvements were required to ensure that this resident had fully appropriate kitchen facilities for meal preparation and cooking to ensure that they were fully provided with choices in this area. This is covered under Regulation 17: Premises.

Staff and management told the inspector that they felt residents were safe and well cared for in this centre and that staffing levels in the centre were appropriate and adequate to meet the needs of the residents supported there. The findings of this inspection indicated that this was an accurate reflection of the services provided in the centre.

## Regulation 17: Premises

From what inspectors observed during a walk around of the centre, there had been improvements since the previous inspection. However, some further improvements were required to ensure that the premises was fully meeting the needs of all residents. One resident still did not have access to fully suitable cooking and food preparation facilities.

Most of the premises was well maintained and provided private and communal spaces for residents to use. Each resident had access to their own sitting room/ relaxation area. A maintenance tracker had been put in place and this meant that there was improved oversight of any outstanding or newly identified premises issues. However, further actions were required in the following areas of the self-contained apartment in the centre:

- Mat in the self-contained apartment which was inside the exit door did not properly fit there and was folded up this was a potential trip hazard for the resident.
- There were holes in the flooring where a radiator had been removed. This would also represent a risk with infection prevention and control.
- There were areas of the centre where the paintwork required attention.
- While items had been purchased and a sink had been installed in a resident's kitchen area the area still required review. There was no space for the resident to prepare food on the kitchen worktop areas as there was appliances covering all spaces and also appliances being stored on the sink. The hob that was in place for the resident to cook was at a height that may involve a risk for the resident. This was the only kitchen that the resident was able to access in the centre as part of the safeguarding controls put in place.

It is acknowledged that the provider responded promptly to the concerns raised by inspectors and a facilities manager attended the centre on the day of the inspection and met with inspectors to review the actions required.

Judgment: Not compliant

## Regulation 26: Risk management procedures

There were arrangements in place for managing risk in the centre and documentation reviewed included the risk management policy, risk assessments, emergency procedures and incident logs. Both centre specific and individual risk assessments were in place and were seen to be subject to regular review. The risk management policy of the registered provider contains the identified specific risks and the control measures involved in the management of them. Emergency procedures were clear and were place to mitigate the risks in relation to fire, power failure and flooding for example. The registered provider was being responsive to incidents in the centre and learning and actions were evident from these incidents. Incident logs were kept and there was documentation such as weekly resident reports that demonstrated there was review of incidents that occurred. Clear staff

protocols were put in place to prevent similar incidents taking place and some of these were reviewed by inspectors. Staff for example were guided by protocols in place to take a different route to go through the centre when there was a risk to the residents.

There was also evidence of positive risk taking in the centre. For example, action was taken to mitigate against specific risks and this was ensuring that residents were being afforded opportunities to partake in activities in line with their own preferences.

A potential hazard identified in relation to the storage of laundry pods was discussed with management of the centre on the day of the inspection and they committed to addressing this in a manner that would have the least impact with the specific needs of one resident.

Judgment: Compliant

## Regulation 28: Fire precautions

While overall, fire safety systems were in place in the centre to protect residents from an outbreak of fire, the registered provider had not fully ensured that containment measures in place would be fully effective and not all staff had up-to-date fire safety training.

The documentation in place reviewed showed that fire equipment had been serviced. Quarterly and annual fire safety checks were taking place in the centre on the fire alarm system and fire safety lighting. Fire doors that were checked by an inspector were operating correctly. A fire drill took place in the designated centre during the inspection. An inspector reviewed resident personal emergency evacuation procedures and residents were seen to be supported in line with these procedures during the fire drill.

However, some issues were identified:

- There were gaps in fire daily checks undertaken by staff with some incomplete documentation viewed in relation to this.
- Inspectors also observed that were gaps in the ceiling in two areas of the centre where it could not be assured that these did not pose a risk in relation to spread of fire in the event that one occurred in the centre.
- Two staff required fire safety training and had not received same. Four staff required refresher training also. This training had been scheduled for the month following the inspection.

Judgment: Substantially compliant

## Regulation 5: Individual assessment and personal plan

Personal plans were in place for residents and a sample of two of these were reviewed. The person in charge had ensured that an annual assessment of need had been completed for residents and the registered provider had arrangements in place to meet the assessed needs of the residents living in this centre. For example, appropriate staffing was in place to meet the assessed needs of the residents living in the centre. Some issues in relation to one residents' access to kitchen facilities is covered under Regulation 17: Premises.

The person in charge had ensured that personal plans were in place for residents that reflected their assessed needs and outlined the supports required to maximise residents' personal development in accordance with their wishes, age and nature of their disability. Personal plans were subject of a review, carried out annually or as changing circumstances required.

Comprehensive documentation was viewed in residents' personal files to guide and inform staff about the supports residents required to meet their healthcare, social and personal needs. Plans in place were updated regularly and person centred planning meetings had taken place within the previous year. Inspectors saw that goal planning was documented in the centre and that residents were being afforded opportunities to set and achieve goals that aligned to their interests and that ongoing review of these goals was comprehensive. For example, one resident who went swimming daily had a goal to visit a waterpark. It was noted that the first attempt to achieve this goal was unsuccessful but that learning had been considered and a second attempt was very successful.

Judgment: Compliant

## Regulation 8: Protection

The findings of this inspection indicated that the registered provider had appropriate measures in place to protect residents from abuse. Training records reviewed showed the person in charge had ensured that all staff had received appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse. Staff and management spoken with during the inspection were familiar with safeguarding procedures and reported that residents were safe and well protected in the centre.

An inspector reviewed the records relating to the Garda vetting for staff in the centre and these indicated that all staff named on the staff roster had been appropriately vetted and that the provider and person in charge had oversight of this through human resource software available to them. Police clearance from relevant authorities had been received for staff that had lived outside of the country.

Safeguarding information was available to staff and designated officer had been appointed by the provider and was available to staff.

While some notifications of a safeguarding nature had been submitted to the Chief Inspector from this centre since the previous inspection that indicated some incompatibility between residents, measures had been taken to address this and ensure that residents did not negatively impact on one another. For example, one resident had their own self-contained apartment and protocols were in place to minimise some identified risks associated with a resident accessing another residents' identified living area. Another concern relating to staff practice in the centre had also been identified, investigated and action taken to prevent re-occurrence and ensure that all staff were aware of new protocols put in place to manage a specific risk when staffing was reduced at night.

An inspector reviewed documentation, including safeguarding plans put in place, and spoke with the person in charge and staff about these incidents. It was seen that prompt action was taken to address and respond to any safeguarding concerns that arose. Safeguarding concerns that had arisen since the previous inspection had been notified to the Chief Inspector had also been reported to the Health Service Executive (HSE) Safeguarding and Protection Team and a review of residents' daily notes and incident reports indicated that safeguarding concerns were being recognised and reported as appropriate.

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 16: Training and staff development | Compliant |
| Regulation 21: Records | Compliant |
| Regulation 23: Governance and management | Substantially compliant |
| **Quality and safety** | |
| Regulation 17: Premises | Not compliant |
| Regulation 26: Risk management procedures | Compliant |
| Regulation 28: Fire precautions | Substantially compliant |
| Regulation 5: Individual assessment and personal plan | Compliant |
| Regulation 8: Protection | Compliant |

# Compliance Plan for Baile Geal Residential Service OSV-0008798

## Inspection ID: MON-0048629

## Date of inspection: 15/01/2026

**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 23: Governance and management | Substantially Compliant |
| Outline how you are going to come into compliance with Regulation 23: Governance and management:<br><br>The Registered Provider has strengthened governance arrangements to ensure that regulatory actions are effectively monitored, progressed and embedded within routine oversight structures. The application to vary the condition of registration was resubmitted following feedback from HIQA and is currently awaiting review. The Registered Provider will continue to monitor the status of this application and will respond promptly to any further queries from the Chief Inspector.<br><br>A Regulatory Compliance Tracker has been established to monitor all inspection actions, with clear ownership and target completion dates assigned. Progress against these actions is formally reviewed at scheduled Compliance Review Meetings and Governance Meetings, where regulatory compliance remains a standing agenda item to ensure oversight, accountability and timely escalation where required. Where facilities-related works experience delay, this is escalated through established governance structures to ensure appropriate oversight and resolution.<br><br>These measures ensure that management systems are structured, transparent and aligned with regulatory requirements | |
| Regulation 17: Premises | Not Compliant |
| Outline how you are going to come into compliance with Regulation 17: Premises:<br>The Registered Provider acknowledges that further structural and environmental works are required within the self-contained apartment area to ensure the premises fully meets the assessed needs of the resident accommodated there. The ill-fitting mat at the apartment exit will be removed and replaced with a properly fitted non-slip mat to eliminate the identified trip hazard. Flooring deficits where a radiator was previously | |

removed will be repaired and fully resealed to ensure a safe, level and cleanable surface in line with infection prevention and control standards. Identified areas requiring decorative repair will be completed as part of the planned works.

A comprehensive review of the apartment kitchen has been initiated, as modifications are required to ensure the resident has safe and appropriate access to food preparation and cooking facilities. This will involve reconfiguration of the kitchen layout to provide adequate worktop preparation space, safe positioning of appliances, and formal reassessment of the suitability and height of cooking equipment. Where required, environmental modifications will be completed to ensure the kitchen layout aligns with the residents' assessed needs and safeguarding arrangements. Updated risk assessments and staff guidance will be implemented following completion of works.

All premises-related actions are recorded on the centre compliance tracker and monitored through established governance and compliance review meetings until they are fully completed.

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|---|---|
| Regulation 28: Fire precautions | Substantially Compliant |

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

The Registered Provider has taken action to strengthen fire safety arrangements within the designated centre and acknowledges that some further works are required to ensure full compliance. Fire safety training was completed on 02 March 2026, and any newly recruited staff are scheduled on the earliest available training date. A revised mandatory training policy has been implemented, incorporating a two-strike attendance rule whereby staff who fail to attend scheduled mandatory training on two occasions are removed from the roster until training is completed.
Gaps identified in ceiling areas will be subject to remedial sealing works to ensure effective fire containment measures are in place, with confirmation of works retained on file. Staff have been re-briefed regarding the accurate completion of daily fire safety checks, and oversight of documentation is reviewed through established management and governance processes to ensure consistency.
These measures aim to ensure that fire detection, containment and training arrangements are robust, monitored and aligned with regulatory requirements.

## Section 2:

## Regulations to be complied with

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

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

| Regulation | Regulatory requirement | Judgment | Risk rating | Date to be complied with |
|---|---|---|---|---|
| Regulation 17(1)(a) | The registered provider shall ensure the premises of the designated centre are designed and laid out to meet the aims and objectives of the service and the number and needs of residents. | Not Compliant | Orange | 31/05/2026 |
| Regulation 17(7) | The registered provider shall make provision for the matters set out in Schedule 6. | Not Compliant | Orange | 31/05/2026 |
| 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. | Substantially Compliant | Yellow | 31/05/2026 |

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|---|---|---|---|---|
| Regulation 28(2)(a) | The registered provider shall take adequate precautions against the risk of fire in the designated centre, and, in that regard, provide suitable fire fighting equipment, building services, bedding and furnishings. | Substantially Compliant | Yellow | 31/05/2026 |
| Regulation 28(2)(b)(ii) | The registered provider shall make adequate arrangements for reviewing fire precautions. | Substantially Compliant | Yellow | 31/05/2026 |
| Regulation 28(3)(a) | The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires. | Substantially Compliant | Yellow | 31/05/2026 |
| Regulation 28(4)(a) | The registered provider shall make arrangements for staff to receive suitable training in fire prevention, emergency procedures, building layout and escape routes, location of fire alarm call points and first aid fire fighting equipment, fire control techniques and arrangements for the evacuation of residents. | Substantially Compliant | Yellow | 31/05/2026 |