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:	Ashfield Lodge
Name of provider:	Nua Healthcare Services Limited
Address of centre:	Cavan
Type of inspection:	Unannounced
Date of inspection:	23 September 2025
Centre ID:	OSV-0008980
Fieldwork ID:	MON-0048362

About the designated centre

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

Ashfield Lodge is a full-time residential service located in Co Cavan. The house is located in a rural setting a residents are supported to access nearby towns. The service has been adapted to suit the needs of three residents. There is one self-contained apartment and in the larger main part of the house there are two more apartments. Each resident has their own living area. Residents receive twenty-four-hour care and support by a staff team comprising social care workers and assistant support workers.

The following information outlines some additional data on this centre.

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
Tuesday 23 September 2025	15:45hrs to 21:00hrs	Eoin O'Byrne	Lead
Wednesday 24 September 2025	09:30hrs to 13:00hrs	Eoin O'Byrne	Lead
Tuesday 23 September 2025	15:45hrs to 21:00hrs	Brendan Kelly	Support
Wednesday 24 September 2025	09:30hrs to 13:00hrs	Brendan Kelly	Support

What residents told us and what inspectors observed

This inspection was unannounced and was initiated following the receipt of unsolicited information that raised concerns in several areas, including: staffing practices, food and nutrition provided to residents and reporting and response to incidents.

The concerns raised were reviewed during the inspection process. Inspectors found that some of the issues were substantiated. Over the course of the inspection, 13 regulations were reviewed. Of these, 4 were found to be substantially-compliant:

- Regulation 23: Governance and Management
- Regulation 15: Staffing
- Regulation 18: Food and Nutrition
- Regulation 29: Medicines and Pharmaceutical Services.

The impact of these findings will be discussed in detail under the relevant sections of this report.

The inspection was conducted over two days and during that time inspectors met with three residents, spoke with six staff members, met with two directors of operations and the person in charge.

The designated centre was observed to be a busy environment, with residents actively engaging in various activities such as spending time in the garden and going out with staff. The centre was large, clean, and well-presented. There was a high staff presence, with each resident supported by two staff members daily, contributing to the busy atmosphere.

On day 1of the inspection an inspector spoke with one resident in the garden. The resident shared positive experiences, including attending an art exhibition and going for a walk. They expressed a desire to live closer to family and confirmed that plans were in place to facilitate this move.

The second resident was not formally interviewed but was observed over the two days. They appeared comfortable with staff and were a recent admission, with staff still familiarising themselves with their needs.

On day 2, an inspector met briefly with the third resident, who expressed satisfaction with their home and its peaceful rural setting. They discussed family and sporting interests and mentioned plans to visit a nearby village with staff support.

Inspectors found that residents were active outside their home and were supported to pursue personal interests. For example, one resident had expressed interest in attending a music group, and staff were encouraging this.

Staff were observed to interact with residents in a manner that respected their rights and promoted their well-being. During periods of intense behaviour or upset, staff provided reassurance and support in line with behaviour support guidance.

Staff demonstrated appropriate knowledge in areas such as: safeguarding, incident reporting procedures and residents care and support plans. However, gaps were identified in some staff members' knowledge regarding medication administration, which will be addressed under Regulation 23.

The inspection identified both strengths and areas requiring improvement within the designated centre. While residents were observed to be actively engaged and supported in a respectful and person-centred manner, concerns were found regarding governance oversight, staffing, training, nutrition, and medication management. These findings highlight the need for targeted actions to ensure compliance with regulations and to enhance the overall quality and safety of care provided to residents.

The following sections of this report will present findings related to Governance and Management, and how these impact the quality and safety of the service delivered.

Capacity and capability

A review of the centre's leadership and management arrangements identified that improvements were required to ensure effective monitoring of all aspects of service provision. Specific concerns were noted in relation to:

- safe staffing levels
- staff knowledge regarding medication administration
- medication storage practices and
- monitoring of food and nutrition provided to residents.

Inspectors were informed of a staffing deficit of 3.4 whole-time equivalent (WTE) vacancies across the social care worker and assistant support worker grades. The impact of this deficit will be discussed in further detail later in the report.

Positively, in the days following the inspection, the provider submitted written assurances regarding recruitment efforts. Two new staff members were scheduled to commence employment on 6 October 2025, with a third staff member due to start on 13 October 2025, thereby addressing the identified vacancies.

In the interim period, the provider confirmed that all outstanding shifts, as specified in the planned roster, would be covered by staff from other services operated by the provider. This arrangement was to remain in place for the final days of September and the full month of October 2025.

Inspectors found that some staff members had limited knowledge of the medications they were administering, including potential side effects. This highlighted a need for improved performance management to ensure staff were adequately informed and competent in this area.

Further concerns were identified regarding medication storage, where staff were not adhering to established guidelines. These issues had not been identified by management prior to the inspection, indicating a gap in oversight.

Concerns were also raised regarding the monitoring of food and nutrition provided to residents. Similar to the medication storage issue, staff were found to be non-compliant with guidelines, and management had not detected these deficiencies prior to the inspection.

The inspection identified that residents were generally well supported in their welfare and development, with evidence of meaningful engagement in social activities and efforts to maintain family connections. Staff training and supervision practices were largely compliant with policy, and staff reported feeling supported in their roles.

However, the inspection also highlighted governance and management issues requiring attention, particularly in relation to staffing levels, medication management, and oversight of food and nutrition. While the provider responded promptly with assurances and interim staffing arrangements, further improvements were necessary to ensure robust performance management and effective service monitoring.

Regulation 15: Staffing

During the course of the inspection, it was identified that the designated centre was experiencing staffing challenges. At the opening meeting, the person in charge confirmed that there were 3.4 WTE vacancies across the social care worker and assistant support worker grades.

The staff team provided care to three residents, each of whom required 2:1 staffing support during daytime hours. At night, one resident required 2:1 support, while the remaining two residents require 1:1 supervision.

A review of staffing rosters for the period 1st to 23rd September 2025 revealed that on 12 separate days, staffing levels were insufficient to meet the assessed needs of the residents. This resulted in 15 shifts (12 day shifts and 3 night shifts) requiring additional cover. On 13 of these occasions, the provider was unable to source the necessary staff, resulting in residents not receiving their prescribed staffing support.

Contingency measures were implemented which included redeployment of staff from other services and the person in charge and deputy person in charge undertaking direct care shifts.

On two occasions, staff rostered for day shifts were required to complete sleepover shifts to maintain minimum coverage. On 22nd September 2025, two day shifts and one live night shift remained unfilled. The person in charge was required to work directly with residents, which impacted their ability to carry out their managerial responsibilities.

During the inspection, inspectors observed an incident where multiple staff members were required to support a resident in distress. Three staff members were involved in maintaining the resident's safety and supporting them during this episode. As a result, another resident did not receive their prescribed 2:1 staffing support, which had the potential to negatively impact their wellbeing.

Inspectors also spoke with a staff member who described the challenges and pressures of working in the centre during periods of reduced staffing.

These staffing deficits represent a concern regarding the provision of adequate staffing to meet the assessed needs of residents. Inspectors were satisfied as noted earlier that there was a plan in place to address the vacancies but there was a period where the failure to consistently maintain prescribed staffing levels posed a risk to the safety and quality of care provided to residents.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Inspectors reviewed the centre's training matrix, which demonstrated compliance with both mandatory and site-specific training requirements. Certificates were examined for four staff members, confirming completion of training in the following areas:

- safe administration of medication
- Autism and Asperger's
- protection and welfare and
- safety intervention.

In addition, inspectors reviewed a multidisciplinary team (MDT) report which identified a need for staff to receive training in attachment and trauma-informed care to meet the assessed needs of one resident. Evidence was provided confirming that this training was delivered to the staff team in August and September 2025.

While staff had received training relevant to medication administration, one inspector identified concerns regarding staff knowledge in this area. This concern will be addressed under Regulation 23: Governance and Management.

The person in charge maintained a comprehensive supervision schedule in accordance with the provider's policy, which requires two formal supervision sessions per year. The schedule also included probation dates for new staff.

Three supervision records were reviewed, including those of two frontline staff members and one newly appointed member of the management team. All records demonstrated a high standard of supervision, consistent with policy expectations.

Inspectors spoke with a staff member who had been employed at the centre since May 2025. The staff member expressed positive views regarding the centre's management, induction, and probation processes, and reported feeling well supported in their role.

Judgment: Compliant

Regulation 23: Governance and management

Inspectors reviewed the governance and management arrangements in place at the designated centre. While systems had been established to support oversight and accountability, gaps were identified in several key areas, including:

- medication management,
- food and nutrition provided to residents,
- staff members' understanding of the medications they were administering.

These issues had not been proactively identified by the local management team, which includes the person in charge and deputy person in charge, prior to the inspection. This indicates a lack of effective oversight and highlighted the need for improved monitoring and quality assurance processes at local level.

Inspectors also identified concerns relating to performance management of the staff team. Interviews with three staff members regarding residents' prescribed medications revealed mixed and, in some cases, limited knowledge of the rationale for administration and potential side effects. This was particularly concerning given the nature of the medications and the seriousness of potential side effects. For one resident, medication formed a significant component of the therapeutic response to their mental health needs, underscoring the importance of staff having a clear understanding of its use and implications.

Although staff had received training in the safe administration of medication, the findings suggest that additional support and oversight were required to ensure staff were adequately equipped to support residents safely and effectively.

Despite these concerns, inspectors found that there was effective oversight of resident care and support, with appropriate arrangements in place to maintain resident safety. At the time of inspection, residents' needs were being met, and staff were observed to engage with residents in a respectful and supportive manner.

A review of governance documentation showed that a weekly reporting system was in place. Reports were completed by the management team and shared with senior management and members of the provider's multidisciplinary team. Reports reviewed from August 2025 up to the inspection date demonstrated a focus on adverse incident review and learning from events, which was a positive aspect of the governance framework.

Additionally, audit reports relating to resident admissions and progress were found to be well-written and reflective of individual needs, with clear documentation of the steps being taken to support residents.

In summary, while there were appropriate systems in place relating to care and safety, the inspection revealed weaknesses in governance, particularly in relation to medication oversight and nutritional support. Improvements were required to strengthen local management oversight and ensure consistent quality across all aspects of service delivery.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

As part of the inspectors' preparation for the inspection, they reviewed the notifications submitted by the provider. This review showed that, per the regulations, the person in charge had submitted the necessary notifications for review by the Office of the Chief Inspector.

Judgment: Compliant

Regulation 34: Complaints procedure

Over the course of the inspection, inspectors reviewed the centre's complaints log and spoke with staff members regarding the complaints process.

Centre management demonstrated strong knowledge of the complaints procedure and were able to clearly outline the pathway for managing complaints, which was consistent with the registered provider's policy. Inspectors observed that easy-read information regarding the complaints process and key personnel was available within the centre, supporting accessibility for residents.

Staff members interviewed during the inspection were able to competently and confidently describe the complaints process. They provided examples of concerns they would raise on behalf of residents, indicating a proactive and informed approach to safeguarding resident welfare.

Judgment: Compliant

Quality and safety

The inspection concluded that each resident was receiving a bespoke, person-centred service tailored to their individual needs and abilities. Inspectors found that the provider had conducted comprehensive assessments of residents' needs, which informed the development of personalised support plans. Guidance documents were available to assist staff in delivering appropriate and consistent support.

Inspectors observed that:

- positive behaviour support plans were in place and appropriately implemented
- potential and actual risks were being effectively managed
- residents' general welfare was being actively promoted by the staff team.

However, concerns were identified in specific areas, notably food and nutrition and medication storage practices. These issues are discussed in detail under their respective sections, but the primary concern in both cases related to insufficient oversight of staff practices.

In conclusion, the provider, person in charge, and staff team were delivering a person-centred service, although some areas required improvement to ensure consistent quality and safety.

Regulation 13: General welfare and development

The inspection process identified that the general welfare and development of residents was being actively promoted within the centre. Residents were supported, as far as possible, to engage in activities that they enjoyed and found meaningful.

A review of three residents' personal plans provided evidence of individualised support in identifying and participating in social activities. For example, one resident attended an art exhibition on the first day of the inspection, reflecting their personal interests.

There was also clear evidence of efforts to maintain family connections. One resident was supported to visit their family on a weekly basis, while staff made efforts to sustain family links for the other two residents.

Two residents spoke positively about their living arrangements, expressing satisfaction with their current environment. Throughout the inspection, residents appeared at ease in their surroundings and in their interactions with the staff team supporting them

Judgment: Compliant

Regulation 18: Food and nutrition

Inspectors reviewed the arrangements in place for the provision of food and nutrition to residents. While residents were observed to be supported in accessing meals and snacks throughout the day, gaps were identified in the monitoring and oversight of nutritional intake.

An inspector reviewed the food and fluid intake charts for all three residents. For one resident, ten consecutive days of records were examined and for the other two residents, the five most recent days were reviewed.

A weight management plan was established for one resident, and an inspector reviewed this plan along with the resident's food and fluid charts for the previous five days. The review revealed that staff members were not adhering to the weight management plan, as the resident was consuming regular snacks and meals that were not healthy options. The plan stated that the resident should have three meals and three snacks per day, but the reviewed information did not reflect this.

Furthermore, discussions with a staff member raised concerns that unhealthy snack options, such as biscuits, were being used to encourage the resident to engage in tasks or activities. This practice was not documented in the resident's support documents and was not in line with the weight management plan.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

An inspector reviewed the risk management systems in place at the designated centre and found them to be appropriate and effective. There were clear systems established to identify and respond to risks, and evidence that learning was promoted following adverse incidents.

The inspector examined the risk management plans for two residents and found that these were:

- linked to individual care plans
- informed by assessments of need and
- aligned with behaviour support guidance.

Risk control measures implemented to maintain resident safety were also reviewed. While some measures were restrictive, they were found to be proportionate to the level of risk and necessary to ensure safety.

A review of adverse incidents occurring between August 2025 and the inspection date revealed that incidents were happening regularly, with two of the three residents presenting with behaviours that placed themselves and others at risk of injury. Staff responses to these incidents were found to be in line with behaviour support guidance, and residents' safety was maintained.

Inspectors directly observed one such incident during the inspection. A resident engaged in behaviours that posed a risk to themselves and others. Staff responded appropriately, using empathetic communication, environmental management, and supportive strategies to help the resident regulate. Following a prolonged period of dysregulation, the resident was successfully supported to calm.

The inspection found that risk management systems were appropriately implemented, with clear links between individual risk plans, care plans, and behaviour support guidance. While adverse incidents occurred regularly, staff demonstrated effective and empathetic responses that prioritised resident safety.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

The inspection findings regarding medication storage and administration practices had negative implications for resident safety and service quality. Inspectors identified:

- unsafe storage practices, including expired, unlabelled, and duplicated medications
- excessive stock of PRN (as required) medication beyond what was clinically required, indicating poor inventory control.

These issues reflect inadequate oversight, and failure to comply with best practice guidelines, which could compromise the health and wellbeing of residents.

While centre management acted promptly to rectify the issues by returning incorrect and excess medications to the pharmacy, the findings underscore the need for improvements in medication management protocols.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Over the course of the two-day inspection, inspectors reviewed the personal plans and associated care and support plans for all three residents. The review found that the plans were reflective of the current and evolving needs of each resident. The were informative and practical, providing clear guidance on how best to support each individual

Inspectors observed that staff members were familiar with the content of these plans and demonstrated a strong understanding of each resident's needs. Staff were seen responding appropriately to residents and were able to articulate their support strategies confidently during discussions with inspectors.

These findings indicate that the centre was delivering individualised and responsive care, underpinned by effective planning and staff awareness.

Judgment: Compliant

Regulation 7: Positive behavioural support

Inspectors reviewed the arrangements in place to support residents who present with behaviours of concern. The review found that aspects of residents' personal plans were appropriately focused on positive behavioural support, and that residents were receiving appropriate input, including regular engagement with members of the provider's multidisciplinary team.

Staff had received training in positive behaviour support, and there was evidence of bespoke training provided to enhance staff understanding of individual residents' presentations.

An inspector reviewed the positive behaviour support guidance for two of the three residents. These documents were found to be informative with a focus on promoting positive outcomes and reducing incidents. The guidance documents provided clear guidance on interpreting behaviours, responding appropriately, and supporting residents post-incident.

The inspection also identified a high volume of restrictive practices in place within the designated centre. Inspectors reviewed These were reviewed through adverse incident records, PRN medication usage and observed practice during the inspection

The appraisal found that restrictive practices were proportionate to the level of risk in the centre and were being used to maintain resident safety.

Inspectors observed staff responding to incidents in line with behaviour support guidance. For example, during one incident, staff used empathetic communication, environmental management, and supportive strategies to help a resident regulate after a prolonged period of dysregulation.

In summary, the inspection found that residents were supported through well-developed behaviour support plans and trained staff. While restrictive practices were in use, they were proportionate and implemented with a clear focus on safety and positive outcomes.

Judgment: Compliant

Regulation 8: Protection

Inspectors reviewed the systems in place to ensure that residents were safeguarded from all forms of abuse. The review found that appropriate safeguarding measures were in place within the designated centre.

Staff members had received training in safeguarding, and four staff were interviewed regarding the management and reporting of safeguarding concerns. Each staff member demonstrated appropriate knowledge and understanding of safeguarding procedures.

Where safeguarding concerns had arisen, the person in charge responded in a manner consistent with best practice. Inspectors reviewed evidence that investigations had been conducted and that relevant statutory bodies had been notified in accordance with regulatory requirements.

These findings indicate that the provider has implemented effective safeguarding systems, and that staff are well-informed and responsive in ensuring the protection and welfare of residents.

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	Substantially compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 13: General welfare and development	Compliant
Regulation 18: Food and nutrition	Substantially compliant
Regulation 26: Risk management procedures	Compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Ashfield Lodge OSV-0008980

Inspection ID: MON-0048362

Date of inspection: 24/09/2025

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: 1. The Person in Charge (PIC) and the Director of Operations (DOO) completed a review of all unfilled shifts for October 2025 and utilised support staff from the Relief Panel and additional Centers to ensure that safe staffing levels are maintained. Date Completed: 26 September 2025 2. There are four (4) full-time team members who have been recruited to the Team, and they are due to complete their induction on 27 October 2025. Following their 4-day Induction, they will start their employment in the Centre and be added to the November roster. Due Date: 03 November 2025 3. The Centre-Specific Risk Register, that includes minimum safe staffing levels, was reviewed and deemed appropriate to meet the needs of the Individuals in the event of unexpected absenteeism resulting in the reduction of full prescribed staffing levels. This will be regularly risk-assessed, in conjunction with utilization of the escalation policy, to ensure safe staffing levels are maintained. Due Date: 03 November 2025	
Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
1. The Person in Charge (PIC) will complete a full review of each Individuals Dietician report. Following this the PIC will ensure that the information from these report's is discussed with each team member to ensure they are aware of the recommendations within the reports and will support everyone to adhere to the recommendations whilst being mindful of the wishes and preferences of the Indiviudal. Team members will undertake a Test of Knowledge to further underpin their understanding of this and the PIC will conduct daily and weekly checks to ensure the plan is being followed.
Due Date: 21 November 2025
2. On the floor mentoring will occur with all Team Members to ensure knowledge and adherance to the plans in place for all Indiviudals.
Due Date: 31 December 2025
3. PIC will discuss food and nutrition at the Team Meeting every month for the next 3 months to strengthen the Team Members knowledge and confidence working in line with the Individuals plans.
Due Date: 30 January 2026
4. The PIC will review each Individual's nutritional log on a daily basis. If concerns are noted that Dietician recommendations are not being adhered to, the PIC will complete a supervision with the Team Member and complete a Key Working session with the Individual to ensure clear rationale and their views are documented.
Due Date: 30 November 2025
5. The PIC will utilise the performance management process to address any non-adherence to the Dietitian recommendations and the plans in place to support the Indiviudals to ensure accountability.
Due Date: 30 November 2025
6. The PIC will continue to plan for management cover in the Centre across the seven days where reasonably practicable to do so, this is to provide management oversight on a daily basis of adherence to the plans in place and appropriate supervision and support to the team.

Due Date: 30 November 2025

7. As part of Continuous Professional Development, staff are to be provided with information regarding the medication prescribed for each Individual, including purpose of medication and side effects to increase their knowledge and understanding of same.
Due Date: 07 November 2025

Regulation 18: Food and nutrition	Substantially Compliant

Outline how you are going to come into compliance with Regulation 18: Food and nutrition:
1. The Person in Charge (PIC) will complete a full review of each Individuals dietician reports. Following this the PIC will ensure that the information from these report's is

discussed with each team member to ensure the Team are aware of the recommendations within the reports and will support everyone to adhere to the recommendations whilst being mindful of their wishes and preferences.

Due Date 30 November 2025

2. From the PIC's review above, Team Members will undertake a Test of Knowledge to further underpin their understanding of the nutritional needs of the Individuals and the PIC will conduct daily and weekly checks to ensure the plan is being followed.
Due Date: 08 November 2025

3. The PIC will review each Individuals nutritional log on a daily basis. If concerns are noted that Dietician recommendations are not being adhered to, the PIC will complete a supervision with the Team Member and complete a Key Working session with the Individual to ensure clear rationale and their views are documented.

Due Date: 30 November 2025

4. The PIC will use the performance management process to address any non-adherence to the Dietitian recommendations should the team members fail to follow the plans in place.

Due Date: 30 November 2025

5. PIC will oversee the weekly meal planner prior to it being active in the centre and will ensure that there is always to be the recommended "crunchy" snacks in line with Multi element Behavioural Support Plan (MEBSP) to offer ID425 such as apples and raw carrots.
Due Date: 30 November 2025

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
1. The Person in Charge (PIC) will complete a weekly medication audit which will be submitted to the Director of Operations (DOO) for review to identify corrective actions and ensure effective measures are taken to address any non-conformances.

Due Date: 30 November 2025

2. As part of Continuous Professional Development, staff are to be provided with information regarding the medication prescribed for each Individual including purpose of medication and side effects to increase their knowledge and understanding of same.

Due Date: 07 November 2025

3. The PIC will ensure that they are maintaining a safe level of stock within the centre in line with the monthly ordering of medications and excess or surplus stock will be returned to the pharmacy. This will be captured on the weekly medication audit that the Director of Operations (DOO) will review to identify any corrective actions and ensure effective measures are taken to address any non-conformances.
Due Date: 14 November 2025

4. The Director of Operations (DOO) will conduct a weekly check on the completed medication audit and provide additional guidance to the Person in Charge (PIC) and the team members should this be required.
Due Date: 30 November 2025

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 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Substantially Compliant	Yellow	03/11/2025
Regulation 18(2)(d)	The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which are consistent with each resident's individual dietary needs and preferences.	Substantially Compliant	Yellow	30/11/2025
Regulation 23(1)(c)	The registered provider shall ensure that management	Substantially Compliant	Yellow	30/01/2026

	systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.			
Regulation 23(3)(a)	The registered provider shall ensure that effective arrangements are in place to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.	Substantially Compliant	Yellow	30/01/2026
Regulation 29(4)(c)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that out of date or returned medicines are stored in a secure manner that is segregated from other medicinal	Substantially Compliant	Yellow	30/11/2025

	products, and are disposed of and not further used as medicinal products in accordance with any relevant national legislation or guidance.			