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:	Tara Glen
Name of provider:	Embrace Community Services Ltd
Address of centre:	Meath
Type of inspection:	Short Notice Announced
Date of inspection:	09 March 2026
Centre ID:	OSV-0009087
Fieldwork ID:	MON-0048194

About the designated centre

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

Tara Glen is a designated centre operated by Embrace Community Services Ltd. This centre can support males or females 18 years and over with a capacity of four people living in the centre. The centre can cater for people with intellectual disabilities, physical disabilities, Autism spectrum disorder, and acquired brain injuries. Residents will be supported by social care model of care. Social care staff or direct support workers are available 24 hours a day to support the residents and the centre is managed by a person in charge. The person in charge is supported by two team leaders. Each resident has their own bedroom and there are several communal spaces for residents to use and have visitors in private.

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
Monday 9 March 2026	10:15hrs to 18:30hrs	Karena Butler	Lead

What residents told us and what inspectors observed

On the day of this short-notice announced monitoring inspection, the inspector found a relaxed and warm atmosphere where the residents, for the most part, were receiving a good standard of person-centred care in their home. They appeared relaxed and comfortable in the company of a staff team who understood their individual needs.

While the service was performing well in many areas, the inspection did identify some areas for improvement to ensure the safety and care in the centre would be consistently met. The inspector observed that one resident was not being supported in line with their assessed communication needs. In addition, some minor improvements were needed regarding behavioural support, premises upkeep, and fire precautions. These points are discussed in detail later in this report.

The inspector had the opportunity to meet and observe the three residents that were living in the centre. One resident had alternative communication methods and did not share their views with the inspector. They were instead observed in their home after they arrived back from their day service programme. They appeared relaxed and comfortable in the presence of the staff on duty.

One resident explained they were happy living in the centre and, for the most part, the food was nice but sometimes the curries were a little too spicy for them. They said they were happy for the inspector to mention that to staff. When the inspector brought this to the attention of management, they took on board the feedback and began discussing using a milder recipe or purchasing a different sauce, demonstrating a responsiveness to residents' feedback and preferences.

During the course of the inspection, the inspector had the opportunity to speak with two staff members on duty, the person in charge, and the newly appointed person in charge who was due to assume the role.

Staff were observed to be calm, friendly and respectful in their interactions with residents. For example, staff were attentive to residents' comfort and preferences during the inspection. While the inspector and staff were speaking in the kitchen area, staff asked a resident who was also in the kitchen area, if they would prefer the conversation to take place in another location. The resident initially indicated that they were fine, but then changed their mind. This choice was respected, and the inspector and staff moved to another location in the house. This demonstrated that staff were attentive to the needs of residents, responsive to their preferences and respected their choices.

The provider had arranged for staff to receive training in human rights. One staff member noted that prior to this role and having this training, they may have struggled to find quality time to actively listen to residents. They explained that they

now ensured they dedicated enough time for residents to feel truly heard. They now ensured they promoted individual choices so that each person would be heard and have a say. For example, they provided individual choices with meal planning for dinners so that it did not always have to be a group decision.

The inspector had the opportunity to speak with two family representatives on the day of this inspection. Feedback received was positive. They said they had no concerns at present and that if they were to have a concern they would feel comfortable raising it to staff or management. One representative stated that staff were "very accommodating" and that "nothing is a problem". They said that the 'staff were good at promoting their family member's independence'. They said it was 'clear to them that their family member was happy to return to the centre after family visits.'

The other representative stated that the staff team 'were supportive' to their family and their family member living in this centre. They said that 'staff were lovely'. They went onto say that the 'staff were doing incredible work with their family member and how far their family member had come on since moving in.'

The inspector observed the house to be bright and tidy. The sitting room and sun room had televisions for use. Each resident had their own bedroom. The bedrooms had adequate storage facilities for any personal belongings. There was a front and back garden. The front garden was mainly used for parking. The back garden had a picnic table and benches that residents could use during good weather.

The next two sections of this report present the findings of this inspection in relation to the governance and management in the centre, and how governance and management affects the quality and safety of the service being provided.

Capacity and capability

This centre was newly registered in September 2025, and this inspection was the first inspection of the centre since residents had moved into it.

The purpose of this inspection was to monitor if the provider was operating it in compliance with the S.I. No. 367/2013 - Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (the regulations).

The provider's governance and management arrangements were found to be appropriate in order to ensure the quality and safety of the service. For example, there were monthly audits scheduled in order to assess the centre's compliance levels and identify any actions required, such as medication.

From a review of a sample of rosters across four months, the inspector found that there was appropriate staffing in place to meet the assessed needs of the residents.

Staff had received training, including refresher training that would facilitate them to safely support the residents in line with their assessed needs. For example, medication management.

The inspector also found that residents had received a contract of care that laid out the services and conditions of their service, and they were provided with an opportunity to visit the centre prior to moving in.

Regulation 15: Staffing

The inspector found that there were sufficient staff available, with the required skills to meet the assessed needs of residents.

The inspector reviewed a sample of rosters over a four-month period from December 2025 to March 2026. The review demonstrated that planned and actual rosters were being maintained. While the centre did not have a full staffing complement and required two staffing posts to be filled, the inspector was informed that one post was filled and the candidate was undergoing pre-employment checks.

In the meantime, two consistent relief staff were filling any required shifts on the roster. This arrangement facilitated continuity of care. Safe staffing levels, as determined by the provider, were found to always be maintained in the centre.

One family representative communicated that staff were 'very kind to their family member'.

While full staff personnel files were not reviewed, the inspector did review a sample of seven staff members' Garda Síochána (police) vetting (GV) certificates as well as five police clearance certificates where applicable. All GV certificates were completed within the last three years. This demonstrated that the provider had arrangements for safe recruitment practices in line with best practice and the requirements of Schedule 2 of the regulations. In addition, the inspector observed the qualifications of all the staff that worked in the centre and found that they had appropriate qualifications to support the residents.

Judgment: Compliant

Regulation 16: Training and staff development

The provider had ensured staff had access to training and development opportunities in order to carry out their roles effectively. In addition, training was made available in areas specific to residents' assessed needs.

The inspector reviewed the certification of eight training courses for all staff working in the centre, as well as the training oversight document.

Examples of the training staff had completed included:

- safeguarding vulnerable adults
- training related to positive behaviour supports that included de-escalation techniques
- medication management
- first aid
- epilepsy awareness and emergency epilepsy medication administration
- hand hygiene
- introduction to Autism
- fire safety.

Staff had also received additional training to support residents, such as training in human rights. Further details on this have been included in the 'what residents told us and what inspectors observed' section of the report.

From speaking with the person in charge and from a review of three staff members' files, this confirmed to the inspector that supervision was occurring as per the frequency decided by the provider and that it was an opportunity to raise concerns if they had any.

Judgment: Compliant

Regulation 23: Governance and management

The provider had effective governance and management systems in place, ensuring an overall good standard of care and support to residents and good levels of compliance with the regulations.

There were clear lines of authority and accountability in this service. The centre had a clearly defined management structure in place which was led by the person in charge supported by two team leaders. A staff member spoken with was familiar with the reporting structure, and the on-call system for out of hours support.

There were management systems to ensure that the service provided was safe, consistent and monitored. A schedule of audits was in place to assess the quality and safety of care and support provided to residents in the centre, including infection prevention and control (IPC), health and safety, restrictive practice, and care plans.

While the centre was not yet open six months, there were arrangements in place for the completion of an annual review and unannounced provider-led visit reports every six months as per the requirements of the regulations.

The inspector observed from a review of the records of the team meeting minutes that they were occurring monthly. A review of three team meeting minutes, December 2025, January and February 2026, demonstrated that any incidents that occurred within the centre were reviewed for shared learning with the staff team. Topics at meetings included, discussions on the residents, complaints, rights, restrictive practices and safeguarding.

Furthermore, both staff spoken with communicated that they would feel comfortable going to the person in charge or provider if they were to have any issues or concerns.

Judgment: Compliant

Regulation 24: Admissions and contract for the provision of services

Residents were safely supported when moving into the centre through transition planning and compatibility assessments and they were afforded a contract of care outlining the terms and conditions of the service.

From a review of a sample of two residents' information related to their transitions to this centre, the inspector noted that residents were supported in moving to the centre through an individual transition plan. The transition planning also included a compatibility review of residents, which helped to promote residents' safety and well being. Prospective residents were provided with an opportunity to visit the premises in advance of admission.

From speaking with a family representative, they informed the inspector that they and their family member had a chance to visit the centre prior to moving in.

Additionally, from a sample of two contracts of care reviewed, the inspector saw that residents were provided with a contract of care that laid out the services and conditions of their service and fees to be charged to the resident and they were given the opportunity to sign it.

Some improvements were required to the contracts to ensure they fully guided the reader to all applicable information and to ensure the information was presented in a manner that was not vague. However, the assistant director had already identified that improvements were required and was developing a revised document, which they showed to the inspector.

Judgment: Compliant

Quality and safety

Overall, the inspection found that residents living in this service were supported in line with their assessed needs. However, improvements were required in relation to assuring residents' communication was supported as per their assessed needs. Some improvements were required with regard to positive behavioural supports, the premises, and fire precautions.

While a staff member spoken with was very familiar with the means by which a resident communicated, improvements were required in how communication was facilitated in the centre to ensure it was in line with residents' assessed needs.

There were arrangements in place to promote positive behavioural supports for residents. However, the inspector observed that additional information and guidance was required in one resident's behaviour support plan.

There were adequate systems in place to safeguard residents. For example, there was a safeguarding policy in place to guide staff should they have any safeguarding concerns.

The provider had ensured that assessments of residents' health and social care needs had been completed and care plans developed for any identified needs.

In addition, the inspector found that residents were supported to engage in activities of interest to them.

For the most part, there were appropriate and suitable fire safety management systems in place, such as arrangements for regular servicing of detection and alert systems. However, the inspector noted some areas that required enhancement or improvement.

The inspector observed the house to be clean and tidy which also facilitated in the arrangements for good infection prevention and control (IPC). However, some minor improvements were required to the premises to ensure it was maintained to the most optimum standard.

Regulation 10: Communication

This inspection found that while staff understood a particular resident's communication style, communication had not been adequately accommodated within the centre in line with the resident's assessed needs.

While a resident, with limited verbal communication, had been assessed by a relevant professional to determine their communication needs and support they may require, recommendations made by the speech and language therapist (SLT) were not being followed through on in the centre. The inspector was not assured that the resident was being supported in line with their assessed needs. This meant that staff were not acting as effective communication partners as recommended by the SLT and a behaviour therapist, in order to fully support and promote the resident's communication.

Some of the recommendations not being followed through on included:

- ensuring that staff did not present choices without an accompanying visual support
- ensuring the image had the name of the item underneath
- utilising a talking mat, as recommended
- for staff to use simple sign language signs starting with three to four of the most relevant
- introducing destination cards and expanding vocabulary with a communication board with initially 16 symbols no smaller than 5cm x 5cm.

From a review of two residents' communication support plans, the inspector found that there was limited guidance for staff on how best to support one particular resident with their communication and how the resident may communicate. Their plan did not state if the resident could reliably answer 'yes/no' to questions. It did not guide staff as to the common phrase a resident used when happy or that they may say a shortened version of the phrase when becoming anxious. While a core staff spoken with was very familiar with the resident's communication style, the lack of appropriate guidance put the resident at risk of inconsistent support particularly with part-time staff.

The resident's behaviour support plan recommended that there was a range of visuals available to represent the resident's wide range of interests and needs, such as preferred foods and swimming etc. This had not been fully implemented and the inspector observed there were limited visual aids available in the centre to support residents' understanding and promote choice of their daily routine. Towards the end of the inspection, the team leader was in the process of arranging for more visual aids to be printed and available in the centre.

There were some social stories available to help support residents' understanding of certain topics, such as understanding what happens when you tell the truth or when you lie.

The inspector also observed that residents had access to televisions and the Internet while in the centre which would support their communication.

Judgment: Not compliant

Regulation 13: General welfare and development

The person in charge had ensured that residents had access to opportunities for leisure and recreation. Residents engaged in activities at their home and in the community and were supported to maintain relationships with family.

Residents were supported to attend day service programmes if they wished. One resident attended five days a week and another attended an education programme approximately two days per week.

One resident had a 24/7 wraparound service in this centre, while another availed of this approximately three days a week. They made their own decisions on what activities and or social events to participate in each day and week.

A review of the two residents' activity planners over a one-week period in March 2026 showed that residents were being offered activities based on their interests. For example, lunch outings, kickboxing, shopping, attending the gym, swimming, a specific social club, and coffee outing. From speaking with two residents, they confirmed that they had a say in what activities they participated in.

Residents were supported to set and achieve personal goals in order to enhance their quality of life. For example, from a review of a sample of two different residents' goals, they were undertaking goals related to increasing social activities without overwhelming them. The other resident wanted to practice their swimming with the hope of getting onto the Special Olympics team.

Judgment: Compliant

Regulation 17: Premises

While the layout and design of the premises generally met residents' needs and the house was observed to be tidy, some maintenance issues and enhanced cleaning were required to ensure the environment was fully safe and comfortable. The facilities of Schedule 6 of the regulations were available for residents' use, including cooking and laundry facilities.

Regarding the maintenance issues, the inspector observed two leaks; maintenance staff had self-identified one in the sun room on the day of this inspection, while the inspector identified the second leak on the ceiling of one resident's bedroom.

While a new boiler was installed in November 2025, the inspector found that a carbon monoxide alarm was yet to be fitted which was an outstanding action from the original boiler service in September 2025. The assistant director communicated

to the inspector that it was an oversight that it hadn't been installed and would arrange to have it fitted as a priority.

In addition, pillow protectors were required for residents' pillows in order to ensure they were hygienic for use as one resident's pillow was observed to be stained.

Furthermore, some minor patches of mildew were observed on some areas of one resident's bedroom window as well as the sitting room window. Mildew would increase the risk of respiratory illness for residents and therefore required review.

Each resident had their own bedroom with sufficient space for their belongings. One family representative stated that their family member's bedroom was "ten out of ten".

There were different communal areas in order to provide residents with an opportunity for space and choice, such as a sitting room, and a sun room.

There were facilities in place to support hand hygiene, such as hand wash and disposable towels. There was a colour-coded system in place for the cleaning of the centre to minimise the chances of residents receiving a healthcare-related illness. For example, there were colour-coded mops and buckets in place and they were found to be stored correctly.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

Risk management systems ensured that risks were identified, monitored and there were arrangements for them to be regularly reviewed.

There were systems in place to manage and mitigate risk and keep residents safe in the centre. There was a policy on risk management available and each resident had a number of individual risk assessments on file so as to support their overall safety and wellbeing. For example, a resident was at risk of accidentally hurting themselves if a razor was left out unsupervised. The provider ensured that control measures were implemented to mitigate the risk to the resident. For instance, staff were directed to supervise the resident when a razor was present and for the item to be stored securely when not in use.

The inspector examined a sample of the adverse incidents that occurred since the centre opened. Incident report forms were completed after these incidents, and wherever possible, lessons were identified to reduce recurrence and discussed at staff meetings to share learning. The inspector found that appropriate responses and reviews were taking place after incidents. For example, after a medication administration error occurred, the resident's general practitioner (GP) was contacted for advice.

On review of other arrangements in place to meet the requirements of this regulation, the inspector observed that the centre had installed a new boiler in order to ensure it was safe and effective for use for the residents.

Judgment: Compliant

Regulation 28: Fire precautions

For the most part, there were suitable fire safety practices in place which included staff having received training in fire safety. However, some improvements were required regarding evacuation lighting and fire door containment.

While there was emergency lighting internal and external to the side of the building, there was no emergency lighting externally at the back of the house to support residents to the final assembly point in the event of an emergency and power cut.

There were fire containment doors in place fitted with self-closing devices. All of the fire containment doors were tested and found to close properly themselves. However, two doors were found to have a larger than recommended gap between the door and the frame which could allow for fire to spread more easily through the building in the event of an emergency. The inspector also observed no doors were fitted with smoke containment seals to contain the spread of smoke in the event of a fire. The provider was required to review their smoke and fire containment measures in the centre and make arrangements to address any deficits.

A review of three fire practice drills demonstrated that regular fire evacuation drills were being completed in order to familiarise the residents with safe evacuation in the event of an emergency. One drill was completed during hours of darkness as required. The provider had waking night staff on duty which should help residents to be supported in a timely manner in the event of a fire or other emergency.

The inspector found from a review of the three personal emergency evacuation plans (PEEPs), that they outlined the residents' support requirements during an emergency.

In addition, the inspector found that there were detection and alert systems and firefighting equipment in place, each of which was regularly serviced.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Residents' needs were assessed and there were care plans in place as required to guide support.

The inspector reviewed a sample of two assessment of need documents and found that they appropriately identified their healthcare, personal and social care needs.

These assessments were used to inform care and support plans that guided staff as to what supports residents required. For example, hospital care plans in case a resident required a hospital stay, and an epilepsy care plan and protocol. The protocol for the administration of emergency epilepsy medication was signed by a medical professional.

Judgment: Compliant

Regulation 7: Positive behavioural support

Residents were supported to experience best possible mental health. Where required they had access to the support of a behaviour support therapist. However, further information was required in the document that guided staff as to how to best support one particular resident.

From a review of the two residents' files, the inspector observed that where required, residents had a positive behavioural support plan or guidelines to facilitate staff when supporting a resident in a particular area. Both were reviewed by the behaviour specialist to ensure that the residents were receiving appropriate supports.

One behaviour support plan was found to outline strategies that staff needed to follow to support the resident in times of distress at different stages of their presentation. However, not all applicable information was contained. For instance, it did not describe the risk of the resident hitting out while in a vehicle and what proactive and reactive strategies staff should follow for this risk.

The plan did not refer to restrictive practices that were in place to support the resident with behaviour that may cause themselves or others distress. It did not refer to a chemical restraint that the resident could be administered and when to refer to the chemical restraint protocol for administration guidelines.

The plan and chemical restraint protocol referred to "scripting" that a resident may say; however, there was no elaboration of what this meant in order to adequately guide staff.

While this information was known to a staff member spoken with, the absence of this information could put the resident at increased risk of inconsistent care particularly from temporary staff that may not know the resident as well as the core staff. Therefore, this required review.

Judgment: Substantially compliant

Regulation 8: Protection

There were suitable arrangements in place to protect the residents from the risk of abuse. For example:

- there was an organisational safeguarding policy in place
- staff had received training in safeguarding vulnerable adults
- there was a reporting system in place with a designated officer (DO) nominated for the organisation
- a staff member spoken with was able to identify who the DO was to the inspector, and the identity of the DO was displayed in the hall.

The inspector reviewed safeguarding incidents since the centre opened and found that any potential safeguarding risks were escalated, reviewed, and reported to the relevant statutory agencies. There were safeguarding plans in place to minimise the chances of recurrence of incidents.

Both family representatives and the two staff members spoken with felt comfortable raising concerns. At the time of this inspection, neither the family representatives nor the staff members spoken with had any concerns. While one resident spoken with said that while they sometimes didn't always get on personally with another peer, they felt safe in the centre. The other resident spoken with communicated that they felt safe in the centre and both residents said they would tell staff if they felt unsafe.

Two residents raised a concern with the inspector on the day of the inspection. The concerns were escalated to the person in charge and assistant director who confirmed that the matters would be thoroughly investigated. The residents were satisfied with this response. Following the inspection, the provider submitted notifications to the Chief Inspector of Social Services in relation to the matters raised and how they were dealing with those concerns. This demonstrated that safeguarding matters were taken seriously and investigated as required.

One staff member spoken with was familiar with the steps to take should a safeguarding concern arise including a witnessed peer-to-peer incident or an unwitnessed disclosure. For example, they explained they would separate the individuals involved in a peer-to-peer incident, they would reassure and check for injuries and seek medical attention if required. They would report the incident and complete the necessary incident forms.

From a review of the two residents' files, the inspector observed that there were care plans in place that outlined residents' support needs and preferences with regard to the provision of intimate care.

The inspector also found, from a review of one resident's finance records over March 2026, that staff were completing daily balance checks to ensure the residents' money was safeguarded. A staff member completed a count of the money in the presence of the inspector and the count was found to be accurate. This demonstrated that the oversight systems for safeguarding residents' finances was working as required.
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	Compliant
Regulation 23: Governance and management	Compliant
Regulation 24: Admissions and contract for the provision of services	Compliant
Quality and safety	
Regulation 10: Communication	Not compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Compliant

Compliance Plan for Tara Glen OSV-0009087

Inspection ID: MON-0048194

Date of inspection: 09/03/2026

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 10: Communication	Not Compliant
Outline how you are going to come into compliance with Regulation 10: Communication: Communication passport to be updated by the Person in Charge (PIC) to be reflective of the communication recommendations. Due Date: 15th of March 2026 (Completed) Person in Charge (PIC) to bring Resident's communication recommendations to Team Meeting to ensure Team Member knowledge of same. Due Date: 31st of March 2026 (Completed) Person in Charge (PIC) to reimplemented visual aids utilised for Resident's communication. Due Date: 9th of March 2026 (Completed) Person in Charge (PIC) to review appropriate Destination Cards and purchase same. Due Date: 20th of April 2026 (Awaiting delivery) Person in Charge (PIC) in conjunction with the training department to organise Lamh training and ensure Team Members complete same. Due Date: 31st of May 2026	
Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: Person in Charge (PIC) to ensure Carbon Monoxide Detector is implemented in Centre. Due Date: 15th of March 2026	

(Completed)

Person in Charge (PIC) to purchase additional pillow protectors for the Centre and Residents to be advised of use of same.
Due Date: 12th April 2026
(Completed)

Person in Charge (PIC) in conjunction with Maintenance Manager to identify source of leak, correct same, and repair damage.

Due Date: 10th of April 2026
(Completed)

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Person in Charge (PIC) in conjunction with Maintenance Manager to implement lighting in the rear and sides of the property.

Due Date: 31st of May 2026

Maintenance Manager in conjunction with fire service provider to review fire doors and correct same.
Due Date: 18th of March 2026
(Completed)

Maintenance Manager in conjunction with construction surveyor to review suitability of fire doors in place against current regulatory requirements.
Due Date: 13th of March 2026
(Completed)

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
Person in Charge (PIC) in conjunction with the Behaviour Specialist to review Positive Behaviour Support Plan (PBSP) to ensure it is reflective of current Risk Assessments, Restrictive Practive, PRN protocol, and Scripting. All Team Members were informed of updates.
Due Date: 30th of March 2026
(Completed)

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 10(1)	The registered provider shall ensure that each resident is assisted and supported at all times to communicate in accordance with the residents' needs and wishes.	Not Compliant	Orange	31/05/2026
Regulation 10(2)	The person in charge shall ensure that staff are aware of any particular or individual communication supports required by each resident as outlined in his or her personal plan.	Not Compliant	Orange	31/05/2026
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair	Substantially Compliant	Yellow	03/05/2026

	externally and internally.			
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Substantially Compliant	Yellow	03/05/2026
Regulation 28(2)(c)	The registered provider shall provide adequate means of escape, including emergency lighting.	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	18/03/2026
Regulation 07(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.	Substantially Compliant	Yellow	30/03/2026