



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

Issued by the Chief Inspector

Name of designated centre:	Longfield House
Name of provider:	Zamab Care LTD
Address of centre:	Monaghan
Type of inspection:	Unannounced
Date of inspection:	23 February 2026
Centre ID:	OSV-0009104
Fieldwork ID:	MON-0049697

About the designated centre

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

Zamab Care Limited, provides respite and short term emergency care to children and young adults between the ages of 4 and 18 years of age. The house is a detached two storey property located in a rural setting in County Monaghan. It is surrounded by a large garden, driveways and outbuildings (currently not in use). There are four bedrooms one of which is located downstairs and three are upstairs. Downstairs there is also a playroom/relaxation room, a bathroom, kitchen and living room. Upstairs there are three bedrooms, two bathrooms and an office. To the side of the property there is a shed which stores laundry facilities. The back garden is spacious and has a trampoline, seating area and other outdoor equipment that children and young adults may enjoy. There are two vehicles provided in the centre to allow for access to varied activities in the community. The staff team comprises of social care workers, some of whom are team leaders, support staff and a full time person in charge.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	2
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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 23 February 2026	14:30hrs to 21:00hrs	Anna Doyle	Lead
Tuesday 24 February 2026	10:40hrs to 16:40hrs	Anna Doyle	Lead

What residents told us and what inspectors observed

Overall, the inspector found that the governance and management arrangements in the centre had been ineffective over the last three months. This had the potential of impacting on the safety of care provided to the residents. A number of regulations were found not compliant with the regulations, one of which required urgent attention the day after the inspection. These included, governance and management, training, records, notification of incidents, personal plans and safeguarding. There were also a number of regulations found to be in substantial compliance with the regulations which included staffing, risk management, fire safety and medicine management.

This inspection was unannounced and was conducted to monitor ongoing compliance with the regulations and was conducted over two days.

This centre was registered in November 2025 to provide respite care to four children and young adults. Since the centre became operational on 27 November 2025, two young adults had been admitted for emergency respite care, where they currently remained while awaiting admission to a residential setting, and two other young adults had received short term respite care.

Prior to this inspection the Office of the Chief Inspector of Social Services (Chief Inspector) had received information pertaining to concerns around the care and support of the residents. These concerns related to adherence to medicine management practices, governance and management arrangements in the centre and an incident that had occurred in the centre regarding a known person gaining access to the centre without a staff members knowledge. The registered provider had also notified the Chief Inspector of two safeguarding concerns that occurred in the centre since it had opened. This information was followed up on as part of this inspection.

Over the course of the inspection, the inspector met the two residents living here, two staff on duty, an operations manager, the director services, and the managing director of the company. The inspector also reviewed records specific to the residents care, and the governance and management arrangements in this centre.

On arrival to the centre, the inspector observed that the gates to the premises were closed and a number of maintenance personnel were on site completing works. One of the gates provided a number for a visitor to ring if parcels were being delivered. However, there was no indication of how other visitors should access the property. This needed to be addressed to ensure that visitors could make themselves known to staff when they arrived.

The front door of the property although locked also had no front door bell to alert staff in the centre, that a visitor was at the door. The registered provider was in the

process of addressing this and by the end of the inspection, door bells were installed on the outside gates, and the front door as a security measure to alert staff and residents that visitors were outside.

The centre comprises of four bedrooms, three upstairs and one downstairs. At the time of the inspection, two of the bedrooms upstairs were being used to accommodate staff sleep over rooms. One resident specifically requested that the inspector would not go into their bedroom, but agreed that staff could take a picture on their phone to show the inspector their bedroom. The two residents' bedrooms were spacious and had wardrobes to store their personal belongings. One resident chose to have large storage boxes to store their personal belongings also.

There was a kitchen/dining/ living room area for residents, along with another playroom/ living room. This playroom/living room was located near the downstairs bedroom and at the time of the inspection, the resident in the downstairs bedroom was mainly using this room.

Outside there was a shed that stored the washing machine and one of the residents was observed on the day of the inspection using this to wash their clothes.

There was a large garden to the back of the property that had some equipment for residents to enjoy such as a trampoline, soccer goals and a basketball hoop. Some of the paving areas around the grass area were broken and needed to be addressed. The registered provider provided two vehicles for residents to use as the centre is located in the countryside.

On arrival into the centre, the inspector was informed that one resident was out shopping for the afternoon. The other resident was playing a board game with staff and the inspector spoke briefly to the resident. The resident informed the inspector that they were happy living in the centre, but that they did not wish to talk to the inspector further. Later in the evening this resident went out for food and was planning to visit a local gym to see if they wanted to join the gym.

The other resident returned to the centre later in the evening. They were observed to be happy and smiling in the company of staff and showed the inspector their bedroom. The resident communicated using gestures and some communication aids, like pictures, and the staff were observed responding to the residents' wishes and requests. For example; the staff team had a pictures of certain items that the resident liked. The inspector observed the resident requesting a drink using the pictures provided. The inspector also observed that the staff team were gathering more pictures for the resident to put them in a more accessible format so the resident could take the pictures with them and use them when they were going on outings. This demonstrated that staff were supporting the resident to communicate their wishes.

The residents' bedroom was large and spacious and had areas where they could store their personal belongings. The resident for example, had been shopping and had some of the new clothes they had purchased that day stored away.

On the second day of the inspection, the residents also went out for the day on activities they had planned. From a review of some daily records, observing some practices and from talking to staff, the residents were engaged in meaningful activities other days. One resident liked to go to different fast food restaurants that most young adults want to frequent or try out when they open. They liked music and staff informed the inspector that the resident listened to certain cultural music.

The staff were observed to treat the residents with dignity and respect at all times and were aware of the needs of the residents. Two staff members for example; told the inspector that it was very important for one resident to be able to wash their clothes, otherwise they became anxious. This resident was observed over the course of the two days being supported by staff with this.

Notwithstanding, the inspector observed several issues pertaining to the safety and oversight of the care and support being provided. A number of issues pertaining to the premises needed to be addressed. For example; since the centre had opened some of the furniture was grubby and marked and some of the paintwork on the stairs and landing similarly was marked. The director of services informed the inspector that the registered provider had arrangements in place to replace this furniture and repaint some areas of the house. The other premises issues that needed to be addressed are discussed later in this report.

As well as this the inspector found that the oversight of the care and support being provided in the centre required significant review to ensure residents were receiving a safe quality service.

The next two section of the report present the findings of this inspection in relation to the governance and management arrangements and how these arrangements affected the quality of care and support being provided to residents.

Capacity and capability

Overall, the inspector found there had been no clear lines of accountability for decision-making and responsibility for the delivery of services to residents and the review of those services since the centre had been registered in November 2025. As a result governance and management, training, records, personal plans and fire safety required significant improvements. And improvements were also required in risk management and safeguarding.

The management systems in place were not ensuring that the service provided was safe, and consistently and effectively monitored.

The inspector found that there was no proper oversight of staff training in the centre. On the second day of the inspection, the inspector found that not all staff

had been provided with fire safety training, as a result an urgent action was issued the day after the inspection.

The number of staff on duty each day was appropriate to meet the assessed needs of the residents. At the time of the inspection, the registered provider was reliant on a core number of agency staff to ensure that staffing levels were maintained. However, the actual staff rotas were not appropriately maintained in the centre from December 2025 to January 2026.

Regulation 15: Staffing

The centre had a team of ten staff including social care workers, support workers and some agency staff to support the residents. At the time of the inspection, four staff were on duty each day to support the residents and two sleepover staff and one waking night staff were rostered on duty at night. However, the actual rota had not been maintained to an appropriate standard during December 2025 and January 2026. While the registered provider had identified this on an unannounced visit to the centre on 11 January 2026, these records had not been addressed at the time of this inspection.

At the time of the inspection a team leader was on duty for a sleepover, this meant that a team leader was always assigned to work each day.

On call arrangements was provided by senior managers to provide guidance and assistance to staff should they require it. The managing director is a qualified nurse who could provide assistance to staff and residents should they require this and provide additional training and guidance to staff about some of the residents' healthcare needs.

At the time of the site inspection in August 2025, the registered provider had provided assurances to the Chief Inspector that all staff files would be reviewed to ensure that they met the requirements of the regulations. The inspector reviewed the staff files of two new staff members employed in the organisation. They contained all the requirements of Schedule 2 except for the contracts of employment. The operations manager showed the inspector a copy of the contract of employment that had been issued to the staff member.

All staff had been vetted with An Garda Síochána (police). The operations manager was also able to provide records to demonstrate that the agency staff employed also had been vetted with An Garda Síochána.

Judgment: Substantially compliant

Regulation 16: Training and staff development

At the time of the site inspection of the centre in August 2025, the registered provider had given assurances that staff would undertake 25 training modules to ensure that a safe and quality service would be provided to the residents. The inspector found from a review of the training matrix provided that there were a number of gaps in the training records for staff. In particular, all staff had not received training in fire safety to ensure safe evacuation of the centre, this had the potential of negative outcomes for residents should a fire occur in the centre. As a result of this the registered provider was issued an urgent action plan the day after the inspection seeking assurances that this would be addressed.

The registered provider provided assurances regarding this and submitted a compliance plan which assured that all staff would have completed this by March 06 2026.

The inspector also found that some staff had not completed other training such as crisis prevention training, first aid and food safety training.

Since the centre had opened there had been no staff supervision conducted with staff even though the registered provider had stated at the time of the site inspection that this would be conducted every month with staff.

The inspector spoke to two staff who demonstrated a good knowledge of the residents' needs and outlined some of the residents' healthcare needs, and the residents' wishes and preferences.

Overall, the training provided to staff was not adequate, to ensure a safe service to the residents at all times.

Judgment: Not compliant

Regulation 21: Records

Good record-keeping is a fundamental part of good practice and an integral part of safe and effective care and support. Good records demonstrate reasons for decisions and helps to safeguard residents.

The inspector found that improvements were required in the directory of residents for the centre which is required under Schedule 3 of the regulations. The directory of residents which shows when residents were admitted and discharged from the centre was not maintained to an appropriate standard and there were gaps in some of the key information required in this document. For example, the date on which the resident first came to reside in the centre was not always recorded for each resident, and the name and address of the authority, organisation or other body which arranged the residents admission to the designated centre was not recorded

for any of the four residents who had received respite care since the centre had opened.

Some of the records such as incident report forms had incorrect details on the reports. For example; one incident report had the wrong date of birth and age of the resident, another report had indicated that a resident had engaged in a specific behaviour which was not correct when the inspector enquired about this particular incident. Some of the daily reports recorded did not have the full name of staff who completed the reports. One night report for a resident had not been completed in full to demonstrate the care and support provided to the resident during that period.

At the time of the inspection, the managing director, and director of services informed the inspector that some records pertaining to the care provided to one resident was not available in the centre. This included a record of medicines administered to one resident.

Judgment: Not compliant

Regulation 23: Governance and management

The designated centre did not have effective leadership, governance and management arrangements in place with clear lines of accountability since the centre had opened 27 November 2025. The systems in place were not ensuring that the services provided were safe, and consistently and effectively monitored.

At the time of the site inspection conducted on the 27 August 2025 to inform a decision to register the centre, the governance and managements arrangements outlined to the inspector were to include a person in charge, a director of services, who the person in charge would report to, an operations manager who would support the person in charge in their role, and the managing director (registered provider) of the service. Operation meetings were to be held every two weeks to include a review of restrictive practices, safeguarding issues and other operational issues. Regular audits were to be conducted, along with regular fire drills, supervision meetings with staff and the provision and oversight of staff training to ensure that the residents were provided with safe care.

The inspector found that these governance and management arrangements had not been maintained since the centre opened to admissions on 27 November 2025. There had been no operation meetings conducted that had been documented and available for review. A fire drill had not been conducted in the centre until 02 February 2026. Although the inspector was informed that one had been completed on 23 January 2026, there were no records to confirm this. As well as this not all staff had been provided with fire safety training.

There had been no supervisions meetings with staff since the centre had opened. The training records maintained in the centre were not up to date and when the inspector asked if the roster for the coming week included assurances that staff

had appropriate training, for example, fire safety and first aid, these assurances could not be provided. The inspector sought a review of the roster to ensure this, and this review showed that there were two days where there were no staff rostered on duty that had fire safety training completed, however at least one staff was rostered on duty that had first aid training. When this was brought to the attention of the registered provider they gave assurances that the director of services (who was trained to provide fire safety training) would complete this training on Thursday 26 February 2026.

The actual staff rota maintained for December 2025 and January 2026 did not record all of the staff names that worked in the centre each day.

Some of the records viewed by the inspector on the day of the inspection were not maintained to an appropriate standard. For example, the daily reports for residents while detailed did not always record the name of the staff who completed the report. Some incident report forms included the wrong details relating to the incident and the residents' personal details. The directory of residents also included incomplete records.

Improvements were also required in risk management to include risk assessments, medicine management records stored in the centre and the appropriate reporting of safeguarding concerns to the relevant authorities in line with legislative requirements.

There had been no regular audits conducted in the centre to ensure that the services provided were meeting the requirements of the regulations until recently. The inspector viewed a document by written by the managing director of the centre, whereby they had conducted an unannounced visit to the centre on 11 January 2026 to review the care and support. This document highlighted concerns with the governance and management of the centre some of which included maintaining documentation to an expected standard and staff rotas. Following this the managing director had a meeting with the person in charge on 12 January 2026 where they highlighted the concerns and had developed a quality improvement plan to address the concerns. This document had been created on 30 January 2026 and included a number of regulations that required review within specific time frames and outlined key roles and responsibilities of the management team. Some of the actions included restricting any new admissions to the centre until March 2026, reviewing medicine management practices, reviewing care plans and a monthly review of safeguarding concerns.

A new operations manager had been appointed 23 January 2026. At the time of the inspection this operations manager was overseeing the care and support of the residents as the person in charge was on leave. The operations manager had commenced addressing some of the issues on the quality improvement plan developed by the provider on January 2026. This included for example, a review of medicine management practices in the centre. However, the inspector found that some of the key issues had not been prioritised such as staff training and assurances around fire safety.

Given the findings of this inspection along with the quality improvement plan developed by the registered provider, the inspector was not assured that the registered provider was meeting the requirements of regulations to ensure a safe service to the residents living in this centre at the time of this inspection.

Judgment: Not compliant

Regulation 31: Notification of incidents

The inspector found from a review of incidents in the centre, that some details recorded on incident records did not match the information submitted in the notification to the Chief Inspector. For example, the registered provider had notified the Chief Inspector of one allegation of abuse that affected one resident.

However, on review of other records reported to other statutory agencies, this particular incident had affected three residents and the Chief Inspector was only notified about one of the residents.

Judgment: Not compliant

Regulation 33: Notifications of procedures and arrangements for periods when the person in charge is absent

A registered provider is required to notify the Chief Inspector when the person in charge is absent from the centre for more than 28 days. At the time of the inspection, the person in charge was on unplanned leave, the registered provider had nominated the operations manager of the centre who had started in the role 23 January 2026 to oversee this role. The registered provider was in the process of notifying the Chief Inspector of this arrangement at the time of the inspection.

Judgment: Compliant

Quality and safety

Overall, the residents appeared to enjoy a good quality of life in terms of their access to meaningful activities and choices they made. Notwithstanding, aspects of the services provided did not ensure a safe service to the residents and the

registered provider did not demonstrate compliance with some of the regulations, which could pose a risk to residents.

The inspector found that the procedures in place to report and manage safeguarding concerns did not comply with best practice.

While one resident had a personal plan in place at the time of the inspection, the other resident did not have a personal plan available even though this is a requirement under the regulations.

The oversight of fire safety, risk management and medicine management practices also required review.

Regulation 10: Communication

The inspector found that staff were communicating using residents' preferred methods of communication where appropriate.

One resident who preferred to communicate using gestures, facial expressions and some communication aids was observed being supported with this over the course of the inspection. The staff team were also developing other communication aids to assist the resident with expressing their wishes when they were in the community or away from the centre.

However, as actioned under regulation 5 the registered provider was still awaiting a full plan of this resident's care and support needs at the time of this inspection.

Judgment: Compliant

Regulation 13: General welfare and development

The residents were engaged in meaningful activities in line with their personal preferences. Over the course of the inspection and on review of recorded available in the centre, the residents took part in varied activities both inside the centre and out in the community as outlined in the first section of this report.

The residents were supported to keep in touch with their family in line with their wishes.

Judgment: Compliant

Regulation 17: Premises

At the time of the site inspection, some improvements were required to ensure that the centre met the requirements of the regulations. For example, four gates were to be installed outside and equipment was to be purchased for outside for the children and young adults availing of respite. The inspector found that these had been addressed however, other areas needed attention. This included:

- paintwork on the stairs and landing
- remedial works to the paving in the garden area
- locks on one door
- replacement of all kitchen cabinet doors
- replacement dining room chairs
- replacement sofa in the playroom.

As well these issues, there was also a list of other maintenance work that the staff team had reported. The inspector found that some of these were being addressed at the time of this inspection.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

The registered provider had a risk management policy in place which included all of the requirements under the regulations, such as the arrangements the registered provider had in place to manage an unexpected absence in the centre. This was an action following the site inspection conducted in August 2025.

The systems included a process for reporting and reviewing incidents and, the management and review of risk assessments. However, as evidenced under records, the incident report forms did not always include full and accurate details and had not been signed by the person responsible for reviewing it.

The inspector also found that some risk assessments were not risk assessed correctly and did not have additional control measures being implemented to address the risk going forward. For example, one risk assessment in relation to security was risk rated as a low risk (3), even though a visitor to the centre had been able to gain access to the premises unbeknown to staff in recent weeks. This risk assessment had not been reviewed to inform the actions the registered provider was taken to mitigate this risk going forward. Notwithstanding, the registered provider was taking some actions at the time of the inspection to address these risks.

The records in relation to whether vehicles were insured were not available for both vehicles on the day of the inspection. However, the registered provider submitted

records after the inspection which showed that vehicles had up to date insurance and were in a roadworthy condition.

Judgment: Substantially compliant

Regulation 28: Fire precautions

As actioned under training not all staff had completed training in fire safety to ensure a safe evacuation of the centre.

The records stored in the centre in relation to fire safety showed that between December 2025 and January 2026, no fire drills had been conducted in the centre. The first fire drill had been recorded in February 2026 which showed that the residents were evacuated within ten minutes with one resident being reluctant to leave as it had not been a real fire scenario. The inspector found that there was no plan at the time of the inspection to address this time line for evacuation going forward.

While there was evidence that the fire safety equipment had been serviced in February 2026, the last service record recommended that the fire equipment should be serviced in November 2025. This had not been completed. This did not provide assurances around the management and oversight of fire safety systems in the centre.

At the time of the site inspection on 27 August 2025, the registered provider had been required to conduct a risk assessment by a competent fire person to ensure that the bedroom downstairs did not qualify as an inner bedroom. The registered provider had provided a record that indicated that this had been completed and that the bedroom downstairs did not qualify as an inner bedroom.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

The registered provider had recently organised an audit of medicine management practices in the centre. This audit had identified a number of improvements around the safe storage of medicines and the records maintained. For example; the keys for the medicine cabinet had not been stored in a safe place, there had been gaps in the staff signatory sections in the administration records and some medicines had not been returned to the pharmacy as required.

The operations manager had addressed two of those actions at the time of the inspection. However, the gaps in the administration of medicines administered had not yet been recorded as potential medicine errors to inform further learning.

The inspector reviewed the records pertaining to the reconciliation of medicine for the two residents living in the centre. The records pertaining to one resident who had previously attended for respite had been removed from the centre and were not available for review.

The inspector reviewed the medicines received into the centre against the number of doses of medicines that should have been administered since the two residents were admitted to the centre and found one anomaly which accounted for one resident who may refuse the medicines prescribed. Notwithstanding, this review took a considerable amount of time, which could be alleviated if the registered provider used a more accurate method of recording this to ensure best practice. For example, some of the medicines were prescribed in liquid format, one bottle equated to 50 doses being administered to the resident, this needed to be recorded accurately to ensure that residents received the correct amount of medicine prescribed.

The inspector also found that the record for the return of medicine to the pharmacy, did not record the quantity of medicines being returned to ensure accuracy of records.

While all staff had not completed training in the safe administration of medicines – only those that were trained could administer medicines. For example, agency staff were not allowed administer medicines in the centre as they had not completed this training. Staff who spoke with the inspector were aware of the medicines prescribed to residents and why those medicines were prescribed to the residents.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

A detailed assessment of need had been conducted prior to the residents being admitted to the centre by the registered provider, including linking in where appropriate with relevant authorities, next of kin and previous support staff from other residential placements.

Residents were supported with their healthcare needs and had access to a general practitioner (GP).

One resident had a personal plan that included details about their needs and outlined the supports required to maximise their personal development and quality of life.

However, at the time of the inspection, there was no personal plan in place for one resident. The inspector was informed that the registered provider was waiting for another authority to provide this plan, however, this is not in line with the regulations which requires that a personal plan is prepared for a resident 28 days after the resident is admitted to the centre. This resident had been admitted to the centre on 19 December 2025.

Judgment: Not compliant

Regulation 8: Protection

All staff had completed training in Children's First and Safeguarding vulnerable adults. Where safeguarding concerns arise in a designated centre they are required to be reported to relevant authorities to include the Chief Inspector, and where required the National Safeguarding Team and Tusla.

However, the inspector found that one event that had occurred in the centre had not been reported correctly to the relevant authorities. For example; there was an incident in the centre that had affected three residents. The Chief Inspector had been informed that the same incident affected one resident, Tusla had been informed that it affected another resident under their care and the National Safeguarding Team had been informed that the third resident was affected. This demonstrated confusion on the part of the registered provider about the appropriate reporting procedures in place to ensure transparency and accountability. This required review to ensure that there were clear reporting structures in place when an allegation of abuse occurred in the centre.

As well as this one incident which had related to an incident of peer to peer abuse had been reported to the Chief Inspector but it had not been reported to the other relevant authorities.

At the time of the last inspection, the registered provider had prepared a child safeguarding statement that had been submitted to Tusla for review but had not been approved. The inspector found that this had been approved by Tusla prior to residents being admitted to the centre. However, the inspector found that some of the arrangements that the registered provider had committed to having in place were not always been adhered to.

For example; the registered provider had committed to ensuring that all visitors entering the centre would be signed into a visitors book, the inspector found that this record was not always maintained. The child safeguarding statement also indicated that at least one staff member would be rostered to work each day who had completed fire safety training and be a first aid responder. The registered provider could not demonstrate compliance with this on the second day of the inspection and had to be asked to review the roster for the coming week to ensure

compliance in this regard. As a result of this review, as discussed under training, an urgent action was issued.

This did not provide assurances to the inspector that all safeguarding reporting procedures that were required to be in place to protect residents and keep them safe were in place at the time of this inspection.

The staff who met with the inspector was aware of the different types of abuse and the reporting procedures in place should an incident occur. The person in charge, the team leader, the assistant director of services and the staff informed the inspector that they had no concerns about the quality and safety of care provided.

Judgment: Not 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	Not compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 33: Notifications of procedures and arrangements for periods when the person in charge is absent	Compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 8: Protection	Not compliant

Compliance Plan for Longfield House OSV-0009104

Inspection ID: MON-0049697

Date of inspection: 24/02/2026

Introduction and instruction

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

This document is divided into two sections:

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

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

A finding of:

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 15: Staffing	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 15: Staffing: The registered provider has completed a review of staffing arrangements and workforce management systems within the centre to ensure compliance with Regulation 15 requirements regarding staffing levels and the maintenance of staff rotas. A revised rota management system has been introduced within the centre to ensure that both planned and actual staffing arrangements are clearly documented. The rota now records all staff working in the centre on each shift, including day staff, sleepover staff and waking night staff, and clearly identifies agency staff where applicable. This ensures that the rota accurately reflects the staffing arrangements in the centre at all times. The planned roster for each month is developed at least 6 weeks prior to start date and published to the staff team 4 weeks prior to stated date. The rosters are reviewed and updated on a daily basis to ensure the actual roster are available after every shift. In addition, the rota system has been updated to clearly identify staff who have completed key mandatory training, including fire safety training and medication administration training. This ensures that appropriately trained staff are rostered on each shift and supports the safe delivery of care within the centre. Staff training and competency in key areas were reviewed. All staff have successfully completed Fire Safety Training, which was delivered on:</p> <ul style="list-style-type: none">• 26th February 2026• 3rd March 2026 <p>In addition, all staff have completed Safe Administration of Medication Training, delivered on:</p> <ul style="list-style-type: none">• 20th February 2026• 23rd February 2026 <p>Following completion of medication training, all relevant staff have undergone and successfully completed medication competency assessments. Only staff who are trained and deemed competent are authorised to handle and administer medication within Longfield House, in line with best practice and regulatory requirements (Regulation 29: Medicines and Pharmaceutical Services). To support safe practice and accountability, the following roles are assigned daily and</p>	

clearly documented within the handover records for each day:

- Medication Officer
- Fire Warden
- First Aid Responder

This ensures clarity of responsibility and supports compliance with health and safety, fire safety, and medication management standards.

The Operations Manager, who commenced in January 2026, is currently overseeing the service pending the commencement of a newly appointed Person in Charge. The Operations Manager has undertaken a review of previous rota documentation and has introduced a process whereby rotas are reviewed weekly to ensure that staffing records are complete, accurate and maintained within the centre as required under the regulations. As part of this process, the Operations Manager reviews the rota to ensure that staff with appropriate training, including fire safety training and medication administration training, are rostered on each shift.

Staffing levels within the centre have been reviewed and continue to be considered appropriate to meet the assessed needs of residents currently availing of the service. Four staff are rostered during the day, with two sleepover staff and one waking night staff rostered overnight. A team leader is assigned on each shift to provide additional leadership and support to staff.

Since opening, the centre has required the use of agency staff to support the delivery of care and ensure appropriate staffing levels are maintained. All agency staff engaged in the centre have appropriate Garda vetting in place and receive an induction to the service prior to commencing work.

The registered provider is actively progressing recruitment in order to strengthen the permanent staffing team within the service. New staff are currently being onboarded and recruitment remains ongoing. This will reduce reliance on agency staff and support continuity of care for residents.

A new Person in Charge has been recruited and is expected to commence on the 1st of April 2026. 3 additional team leaders have also been recruited and have commenced work at longfield house. The appointment of the team leaders and Person in Charge will further strengthen governance and oversight within the centre and will ensure that staffing arrangements, workforce planning and rota management are reviewed and monitored on an ongoing basis.]

Regulation 16: Training and staff development	Not Compliant
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Outline how you are going to come into compliance with Regulation 16: Training and staff development:

Following the findings of the inspection, the registered provider undertook an immediate review of staff training records within the centre.

In response to the urgent action issued following the inspection, All staff have successfully completed Fire Safety Training, which was delivered on the 26th of February 2026 and 3rd March 2026. This ensures that all staff working within the centre has received fire safety training. This ensured that staff have the knowledge and skills required to safely evacuate residents in the event of a fire and addressed the immediate risk identified during inspection.

Following this, a full review of the staff training matrix for the centre was completed to identify any additional gaps in mandatory training. This review included training areas such as crisis prevention and management, first aid, food safety and medication administration training.

Staff enrolled and completed the Crisis prevention and intervention training on the 5th and 6th of March 2026.

Staff enrolled and completed the food safety training on the 10th of March 2026.

Staff enrolled and completed the medication administration training on the 20th and 23rd of February 2026.

Staff enrolled and completed the First aid responder training on the 3rd of February 2026. with 3 staff enrolled to complete the first aid responder training on the 15th of April 2026.

Training sessions have been scheduled to address the remaining training requirements and staff are currently being enrolled in these training programmes. The training matrix is now actively monitored to ensure that all staff complete required training and refresher training within appropriate timeframes. A training folder has been implemented for easy access to training certificates. This folder also has an introductory page for each training course which reflects the date each staff completed the training course, the day the training course is due to expire, and the day refresher is scheduled for as required.

To further strengthen medication safety practices within the centre, a medication competency assessment tool is currently being implemented. All staff who are trained in the administration of medication are required to complete this assessment. This process supports the verification of staff competency in medication management and ensures that staff administering medication have the required knowledge and skills to do so safely and in accordance with organisational procedures.

The registered provider has also introduced a structured induction process for all newly recruited staff. This ensures that staff are familiar with the centre's policies and procedures, fire evacuation procedures, safeguarding processes and residents' support needs prior to working independently within the service.

The registered provider has also introduced strengthened oversight of staff development and supervision. The Operations Manager is currently completing staff supervision sessions with staff members working within the centre. A formal supervision schedule has been developed to ensure that staff receive regular supervision going forward. These supervision sessions provide an opportunity to review staff performance, discuss training needs, reflect on practice and support ongoing professional development.

The Operations Manager will also review training compliance when preparing staff rotas to ensure that staff with appropriate training, including fire safety training and medication administration training, are rostered within the service.

The newly appointed Compliance manager is also overseeing compliance with training requirements across the organisation. As part of this role, the Compliance manager is undertaking audits of training compliance and ensuring that training records are accurately maintained and reviewed.

<p>Training compliance will also be monitored through governance oversight processes to ensure that staff maintain up-to-date mandatory training and refresher training where required.]</p>	
Regulation 21: Records	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 21: Records: Following the inspection, the registered provider undertook a review of record management systems within the centre to ensure that all records are maintained in accordance with Schedule 3 of the Health Act 2007.</p> <p>A new Directory of Residents has been developed and implemented within the centre. This directory now contains all of the information required under Schedule 3 of the regulations, including the date of admission of residents to the centre, the date of discharge where applicable, and the name and address of the authority or organisation responsible for arranging each admission. The directory will be maintained and reviewed monthly to ensure that it remains accurate and up to date.</p> <p>A review of documentation practices within the centre has also been undertaken to ensure that all records relating to residents' care and support are completed accurately and in full. Staff have been reminded of their responsibilities in relation to record keeping, including the requirement to ensure that incident reports, daily records and other documentation are completed accurately and contain all relevant information. Staff have also been reminded to ensure that daily reports clearly identify the staff member completing the record and that all documentation relating to incidents accurately reflects the details of the event. An incident log has also been implemented to ensure a clear record of all incidents are kept and can be audited as required. This will support improved accuracy and transparency in documentation practices within the service.</p> <p>The staff rota documentation system has also been reviewed to ensure that both planned and actual staff rotas are clearly recorded and maintained within the centre. This ensures that staffing records accurately reflect the staff on duty at all times and are available for review as required under the regulations.</p> <p>The Operations Manager has implemented a system of regular documentation reviews within the centre. These reviews include oversight of incident reports, daily records, the directory of residents and other documentation to ensure that records are completed appropriately and maintained in accordance with regulatory requirements.</p> <p>In addition, the newly appointed Compliance manager has commenced a programme of weekly compliance audits across the organisation. As part of this process, records management within the centre will be reviewed to ensure that documentation systems remain compliant with regulatory requirements.]</p>	
Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:

The registered provider undertook a comprehensive review of governance and management arrangements within the centre to ensure that the service is effectively managed, monitored and delivered in a safe and consistent manner.

The management structure within the organisation has been strengthened. A new Operations Manager commenced in January 2026 and is currently overseeing the day-to-day management of the centre pending the commencement of a newly appointed Person in Charge on the 1st of April 2026. The Operations Manager is providing operational oversight of the service including staffing arrangements, documentation, incident management, training compliance and risk management.

A new Person in Charge has been recruited and is expected to commence on the 1st of April 2026. Once in post, the Person in Charge will assume responsibility for the operational management of the centre, including oversight of care practices, staff supervision, governance systems and regulatory compliance.

In addition, a Compliance manager has recently been appointed within the organisation. The Compliance manager is responsible for strengthening regulatory compliance across services and is currently undertaking weekly compliance audits to ensure that governance systems are operating effectively and in line with regulatory requirements. The registered provider has implemented a quality improvement plan for the centre following a management review of the service. This plan outlines actions to strengthen governance systems, improve documentation standards, review medication management practices and ensure that training, risk management and safeguarding processes are monitored appropriately. Progress against this plan is reviewed through governance oversight systems.

Governance oversight systems within the service have also been strengthened. A weekly governance report has been introduced to support management oversight of key operational areas including incidents, safeguarding concerns, risk management, staffing, training compliance, medication management and premises issues. This process supports improved monitoring of service delivery and ensures that any issues identified are reviewed and addressed in a timely manner.

Operational management meetings have now commenced within the organisation. These meetings provide a forum for reviewing operational matters within the centre including incidents, safeguarding concerns, restrictive practices, staffing, training compliance and risk management. This ensures that issues identified within the service are reviewed by management and addressed through structured governance processes.

Staff meetings have been established and are scheduled to take place on a fortnightly basis, or more frequently as required, to support effective communication, governance, and oversight within the service. A staff meeting took place on the 25th of February 2026 a day after the just concluded inspection and has taking place fortnightly since.

The newly appointed Compliance manager has also commenced a programme of internal compliance audits across the organisation. These audits review key areas including governance arrangements, safeguarding practices, medication management, training

compliance and record management. Findings from these audits inform quality improvement actions within the service.

The Operations Manager is also completing regular reviews of documentation, incident reports, staff rotas, training records and risk assessments within the centre to ensure that systems are operating in accordance with regulatory requirements.

Risk management practices within the centre are also under review. Risk assessments are being reviewed to ensure that risks are appropriately identified, assessed and managed and that control measures are clearly documented.

Medication management practices within the centre are also being monitored through governance systems which include weekly and monthly audits. Findings from medication audits are reviewed by management and actions are implemented to ensure that medication administration, storage and documentation practices are maintained in accordance with best practice.

Security and visitor access arrangements within the centre have been reviewed to ensure that visitors can alert staff when arriving at the premises and that staff are aware when visitors are entering the centre. A visitors' book is also in place to ensure a clear record of all visitors to the service is kept within the service.

Training compliance is now monitored through the training matrix and training folder. staff supervision processes have commenced within the centre. The Operations Manager is currently completing supervision sessions with staff members once monthly in line with the supervision schedule introduced to ensure that staff receive regular supervision going forward. This commence March 2026.]

Regulation 31: Notification of incidents	Not Compliant
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Outline how you are going to come into compliance with Regulation 31: Notification of incidents:

The registered provider has reviewed incident reporting and notification procedures within the centre to ensure that all incidents are notified to the Chief Inspector in accordance with Regulation 31 requirements.

Management oversight of incident reporting has been strengthened to ensure that incidents, including allegations, suspicions or confirmed incidents of abuse, are appropriately reviewed and notified to the Chief Inspector within the required timeframes.

The Operations Manager is currently responsible for reviewing all incident reports completed within the centre to ensure that the information recorded is accurate and that appropriate notifications are submitted where required. This review process ensures that incidents affecting residents are clearly identified and that the details recorded on incident reports are consistent with the information submitted through statutory notifications.

Incident reporting procedures have been clarified with staff to ensure that staff understand their responsibilities in relation to reporting incidents and safeguarding

concerns. Staff have been reminded of the requirement to report all incidents promptly and to ensure that incident documentation is completed accurately and in full. Incident reporting and notification practices will also be monitored through governance oversight systems.

Incidents and safeguarding concerns will be reviewed through monthly operational management meetings and through the weekly governance reporting process to ensure that appropriate actions are taken and that any learning arising from incidents is identified and shared with staff.

In addition, the newly appointed Compliance manager will review incident reporting practices as part of the programme of internal compliance audits. These audits will review incident records and notifications to ensure that reporting procedures are being implemented in accordance with regulatory requirements and organisational policy.]

Regulation 17: Premises	Substantially Compliant
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Outline how you are going to come into compliance with Regulation 17: Premises:
The registered provider has undertaken a review of the premises following the inspection to ensure that the designated centre is maintained in a good state of repair both internally and externally and continues to meet the requirements of Regulation 17. A review of the centre's maintenance log has been completed by management. This is also reviewed via weekly governance reports and monthly operations meeting.

All maintenance issues previously recorded by staff have been reviewed to ensure that they are appropriately addressed. The maintenance log has been updated to ensure that it accurately reflects maintenance works required and completed within the centre and to support improved oversight of repairs and upkeep of the premises. Staff are encouraged to continue recording any maintenance concerns within the log so that these can be addressed promptly.

A number of maintenance works have already been completed within the centre. Works have been carried out within the kitchen area and new kitchen cabinet has been installed. This has improved the condition and functionality of the kitchen and ensures that the facilities remain appropriate for use by residents and staff.

Furniture within the centre is also being reviewed and replaced where required. Replacement dining room chairs have been sourced and seating within the playroom area is being replaced to ensure that furniture remains in good condition and suitable for use by residents. A monthly health and safety audit of furniture is completed to ensure all furniture continue to be in good condition.

General maintenance works within the centre are also being addressed. Painting and remedial works are being completed to address areas where paintwork had become marked, including the stairs and landing areas. These works support the overall upkeep and presentation of the centre.

External areas of the property have also been reviewed. Remedial works to paving within the garden area are being completed to ensure that outdoor areas remain safe and

accessible for residents. The outdoor space continues to provide residents with opportunities to engage in recreational activities and outdoor leisure.

Security arrangements within the centre have been reviewed following the inspection. Doorbells have now been installed at the external gate and at the front door of the property. This ensures that visitors can alert staff when they arrive at the premises and supports improved awareness of visitors entering the property. Signs have also been erected to ensure visitors are aware they are not to access the building unaccompanied by a staff member.

The provider also engages regular maintenance contractors to carry out maintenance and repair works within the centre. These contractors are responsible for completing identified repairs and ensuring that the property is maintained in a safe and suitable condition. Management will continue to liaise with maintenance contractors to ensure that works identified through the maintenance log or routine inspections are completed in a timely manner.]

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

Risk management arrangements within the centre have been reviewed to ensure that systems are in place for the identification, assessment, management and ongoing review of risks within the designated centre in accordance with the organisation's risk management policy and regulatory requirements.

A comprehensive review of risk assessments within the centre is currently being undertaken to ensure that all identified risks are appropriately assessed and that risk ratings accurately reflect the level of risk present. As part of this process, all existing risk assessments are being reviewed to ensure that risk ratings are appropriate and that control measures in place are clearly documented and effective in mitigating risks. Where required, risk assessments are being updated to ensure that risks are accurately rated and that additional control measures are implemented where necessary.

The review of risk assessments also ensures that risk management practices within the centre remain responsive to any changes in the environment, operational practices or residents' needs. This process supports a proactive approach to risk management and ensures that risks are identified and addressed at the earliest opportunity.

Particular attention has been given to reviewing risk assessments relating to security and access to the premises. Improvements have been made to strengthen oversight of visitors entering the centre. Doorbells have been installed at the external gate and at the front door of the property so that visitors can alert staff when they arrive at the premises. This measure supports improved awareness of visitors entering the property and reduces the risk of unauthorised access.

Incident reporting systems within the centre support the identification and review of risks. Incidents occurring within the centre are recorded and reviewed to identify any

emerging risks and to ensure that appropriate control measures are implemented to reduce the likelihood of recurrence. Where incidents highlight potential risks, relevant risk assessments are reviewed and updated accordingly.

Risk management arrangements also include procedures for responding to emergencies and unforeseen events within the centre. These arrangements ensure that staff are aware of the procedures to follow in the event of an emergency and that appropriate systems are in place to support the safety and wellbeing of residents.

Risk management systems within the centre are monitored through governance oversight processes to ensure that risk assessments remain current and that control measures are implemented and reviewed on an ongoing basis.

Risk management practices will also be reviewed through the programme of internal compliance audits to ensure that risk management procedures remain effective and aligned with regulatory requirements.]

Regulation 28: Fire precautions	Substantially Compliant
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Outline how you are going to come into compliance with Regulation 28: Fire precautions: Fire safety arrangements within the centre have been reviewed to ensure that effective fire safety management systems are in place and that the safety of residents and staff is maintained at all times.

Immediately following the inspection, fire safety training was delivered to staff to ensure that all staff working within the centre had received appropriate fire safety training. This action ensured that staff have the knowledge and skills required to respond appropriately in the event of a fire and to support the safe evacuation of residents.

Fire drills within the centre have also been reviewed and a schedule for regular fire drills has been implemented. Fire drills will be conducted and recorded to ensure that staff and residents are familiar with evacuation procedures and that staff are confident in responding to emergency situations.

Personal emergency evacuation plans are in place for residents where required to support safe evacuation. These plans outline the supports residents may require during an evacuation and ensure that staff are aware of residents' individual needs in the event of an emergency.

Fire safety equipment within the centre is maintained and serviced by appropriate contractors. Fire safety equipment has been serviced to ensure that it is functioning correctly and that the centre continues to meet fire safety requirements. Servicing of fire safety equipment will continue in line with recommended servicing schedules to ensure that systems remain operational.

Fire safety documentation within the centre has been reviewed to ensure that records relating to fire drills, fire equipment servicing and fire safety checks are maintained appropriately within the centre.

Fire safety procedures have also been reviewed with staff to ensure that staff remain familiar with evacuation procedures and the actions required in the event of a fire. This supports a proactive approach to fire safety and ensures that staff understand their roles and responsibilities during an evacuation. This also includes new fire signage on the external of then property.

Fire safety arrangements will continue to be monitored through governance oversight processes to ensure that fire safety systems remain effective and that fire safety practices within the centre continue to meet regulatory requirements.]

Regulation 29: Medicines and pharmaceutical services

Substantially Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:

Medication management practices within the centre have been reviewed to ensure that appropriate and safe systems are in place for the ordering, receipt, prescribing, storage, administration and disposal of medicines in accordance with organisational policy and regulatory requirements.

An internal review of medication management practices within the centre has been completed to ensure that medication systems are safe, clearly documented and effectively monitored. This review included medication storage arrangements, medication administration records, medication reconciliation procedures and medication return processes.

Improvements have been implemented to ensure that medicines are stored securely at all times. Arrangements relating to the storage of medication cabinet keys have been reviewed to ensure that access to medication is appropriately controlled and that keys are stored securely in accordance with organisational procedures.

Medication administration records have also been reviewed to ensure that they are completed accurately and consistently. Staff have been reminded of the requirement to ensure that medication administration records are completed fully and that appropriate signatures are recorded in the relevant signatory sections.

A medication competency assessment tool is currently being implemented within the centre. All staff who administer medication are required to complete this competency assessment to ensure that they have the knowledge and skills required to administer medicines safely and in accordance with organisational policy. This process supports the safe administration of medication and promotes consistent medication practices within the centre.

Medication reconciliation practices within the centre are also being strengthened to ensure that medicines received into the centre and medicines administered to residents are clearly recorded and monitored. This includes ensuring that medication quantities are recorded accurately and that medication records reflect the administration of medicines prescribed for residents.

Procedures relating to the return of medication to pharmacies have also been reviewed. Records of medication returns are now being maintained to ensure that the quantity of medication returned is clearly documented and that medication records remain accurate. Documentation relating to medication management is maintained within the centre to ensure that records are available for review and inspection where required. This ensures transparency and supports safe medication practices.

Medication management practices will continue to be monitored through regular review of medication documentation and through internal audit processes to ensure that medication systems remain safe and effective.]

Regulation 5: Individual assessment and personal plan

Not Compliant

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

Personal planning arrangements within the centre have been reviewed to ensure that all residents have an individual support plan in place that reflects their assessed needs and outlines the supports required to maximise their personal development and quality of life. Each resident currently living in the centre now has a support plan developed by the service. These support plans incorporate information from assessments completed by the service and include care plans and guidance provided by external professionals and relevant placing authorities where applicable. This ensures that residents' needs are clearly documented and that staff have access to appropriate guidance to support residents in line with their assessed needs.

Where care plans, assessments or reports are provided by external professionals or relevant authorities, these are incorporated into the resident's support plan to ensure that the resident's needs are accurately reflected and that staff are guided by the most up-to-date information available.

Support plans outline the individual needs, preferences and support requirements of residents and provide guidance for staff in relation to areas such as communication, personal care, health needs, emotional wellbeing and daily living supports. These plans support a person-centred approach to care and ensure that staff are aware of the supports required by each resident.

Key working arrangements within the centre have also been strengthened. Key working has been enhanced to include the completion of monthly key working reports for residents. These reports provide an opportunity to review residents' wellbeing, their engagement in activities, their experiences within the service and any emerging support needs.

Key working training has been completed with staff to ensure that staff understand the purpose of key working and their role in supporting residents through this process. This supports a consistent approach to key working within the centre.

Information gathered through the key working process feeds into residents' support plans and informs the ongoing review and development of these plans. This supports a

responsive approach to personal planning and ensures that residents' plans continue to reflect their needs, preferences and experiences within the service.

Support plans will continue to be reviewed and updated as required to ensure that they remain current and reflective of residents' needs. Where additional information is received from external professionals or relevant authorities, this information will be incorporated into the resident's support plan to ensure that staff continue to have clear guidance in relation to residents' care and support needs.]

Regulation 8: Protection

Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection: Safeguarding arrangements within the centre have been reviewed to ensure that residents are protected from all forms of abuse and that any safeguarding concerns are identified, reported and managed in accordance with national safeguarding guidance and regulatory requirements.

All staff working within the centre have completed training in Children First and safeguarding. Staff have been reminded of their responsibilities in relation to safeguarding and the procedures to follow should any safeguarding concern arise. This ensures that staff remain aware of the different forms of abuse and the requirement to report any concerns promptly through the appropriate safeguarding reporting procedures.

Safeguarding reporting procedures within the centre have been reviewed to ensure that all safeguarding concerns are reported appropriately and in line with national safeguarding guidance. Where an incident, allegation or suspicion of abuse arises, the concern will be reported to the appropriate authorities including Tusla and the National Safeguarding Team where required. Reporting processes have been clarified to ensure that information recorded in incident reports and information submitted to external authorities is consistent and accurately reflects the details of the event.

Safeguarding concerns are reviewed through management oversight processes to ensure that concerns are responded to promptly and that appropriate protective measures are implemented where required. This process also supports the identification of any learning arising from safeguarding incidents so that practice within the centre can continue to improve.

Safeguarding arrangements within the centre operate in line with the organisation's safeguarding policies and procedures and in accordance with Children First: National Guidance for the Protection and Welfare of Children. The child safeguarding statement for the service has been reviewed to ensure that safeguarding procedures within the centre reflect the commitments outlined in this statement.

Visitor management arrangements within the centre have also been reviewed to support safeguarding practices. Measures have been implemented to ensure that visitors can alert staff when arriving at the premises and that staff are aware of visitors entering the centre. A visitor log is maintained within the centre to record visitors attending the service.

Staff are encouraged to raise concerns at the earliest opportunity and the service promotes a culture where safeguarding concerns are taken seriously and responded to promptly. This supports an open and transparent approach to safeguarding within the centre.

Staff supervision processes within the centre have also been strengthened. Regular supervision sessions (once monthly and as required) are being completed with staff and a supervision schedule has been introduced. Supervision provides staff with an opportunity to reflect on their practice, discuss safeguarding responsibilities and raise any concerns relating to the welfare and protection of residents. This process supports ongoing staff awareness of safeguarding practices and reinforces staff responsibilities in protecting residents from abuse.

Safeguarding practices within the centre will also be reviewed through internal compliance audits to ensure that safeguarding procedures continue to operate effectively and in line with national safeguarding guidance.]

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(4)	The person in charge shall ensure that there is a planned and actual staff rota, showing staff on duty during the day and night and that it is properly maintained.	Substantially Compliant	Yellow	01/03/2026
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Not Compliant	Red	27/02/2026
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	10/03/2026
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre	Substantially Compliant	Yellow	31/03/2026

	are of sound construction and kept in a good state of repair externally and internally.			
Regulation 21(1)(b)	The registered provider shall ensure that records in relation to each resident as specified in Schedule 3 are maintained and are available for inspection by the chief inspector.	Not Compliant	Orange	01/04/2026
Regulation 21(3)	Records kept in accordance with this section and set out in Schedule 3 shall be retained for a period of not less than 7 years after the resident has ceased to reside in the designated centre.	Not Compliant	Orange	01/04/2026
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	01/04/2026
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the	Substantially Compliant	Yellow	01/04/2026

	assessment, management and ongoing review of risk, including a system for responding to emergencies.			
Regulation 28(1)	The registered provider shall ensure that effective fire safety management systems are in place.	Substantially Compliant	Yellow	10/03/2026
Regulation 29(4)(b)	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 medicine which is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.	Substantially Compliant	Yellow	15/03/2026
Regulation 31(1)(f)	The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: any allegation, suspected or confirmed, of	Not Compliant	Orange	01/04/2026

	abuse of any resident.			
Regulation 05(4)(b)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which outlines the supports required to maximise the resident's personal development in accordance with his or her wishes.	Not Compliant	Orange	01/04/2026
Regulation 08(5)	The registered provider shall ensure that where there has been an incident, allegation or suspicion of abuse or neglect in relation to a child the requirements of national guidance for the protection and welfare of children and any relevant statutory requirements are complied with.	Not Compliant	Orange	01/04/2026