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:	Ard na Greine
Name of provider:	Sunbeam House Services CLG
Address of centre:	Wicklow
Type of inspection:	Unannounced
Date of inspection:	06 February 2025
Centre ID:	OSV-0001689
Fieldwork ID:	MON-0046170

About the designated centre

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

Ard Na Greine is a designated centre operated by Sunbeam House Services Company Limited by Guarantee. The centre provides residential services to people who are fully ambulant, with moderate support needs. Residents are encouraged and supported to live as independently as possible within their local community. The designated centre can provide for a maximum of four adults with intellectual disabilities, of mixed gender who are over the age of 18 years. This designated centre was originally two houses that have been combined to become a large home with six bedrooms. The ground floor comprises a kitchen, sitting/dining room, a bedroom with en-suite bathroom and a utility room. Upstairs has four bedrooms, one sitting room, an office and two bathrooms. There is an enclosed garden space to the rear of the property. The staff team consists of social care workers and is managed by a full-time person in charge, with support of a deputy manager and senior manager. The person in charge, is also responsible for another designated centre.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	2

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Thursday 6 February 2025	10:00hrs to 16:00hrs	Kieran McCullagh	Lead
Thursday 6 February 2025	10:00hrs to 16:00hrs	Ann-Marie O'Neill	Support

What residents told us and what inspectors observed

The purpose of this unannounced inspection was to monitor the care and welfare, and support arrangements for residents living in the centre and assess compliance with the regulations. Inspectors used observations, conversations with residents, staff, and a review of documentation, to inform their judgments. Overall, the findings from this inspection showed the provider had made improvements since the previous inspection in November 2024. However, further improvement was required under Regulation 8: Protection. This is discussed throughout the body of this report.

This designated centre was originally two houses that have been converted into one large residential home with six bedrooms. The centre is registered to accommodate four people. Since the previous inspection, one resident had been discharged from the centre. There were two residents living in the centre at the time of this inspection and two resident vacancies. Inspectors had the opportunity to meet and speak with one resident who was present in the centre on the day of the inspection.

The centre is comprised of a kitchen, a sitting/dining room, a bedroom with en-suite bathroom and a utility room. Upstairs has four bedrooms, one sitting room, a staff office and two bathrooms. There is an enclosed garden space to the rear of the property. The staff team consists of social care workers and healthcare assistants and is managed by a full-time person in charge, with support of a deputy client service manager and senior service manager. The person in charge and deputy client service manager, are also responsible for another designated centre.

An inspector met with the resident that was present in the centre on the day of inspection and asked for their feedback about what it was like to live in the house. The resident's feedback was positive about their living arrangements. The resident explained that they had previously felt very stressed living in the house as they hadn't gotten on with a peer who had recently been discharged from the centre. They told the inspector that they now spent more time in the communal spaces in the house and were no longer staying for long periods in their bedroom or having to lock their door all the time. The resident told the inspector about their interests and activities they liked to engage in.

The resident told the inspector that they were apprehensive about any new residents moving into the house to fill the vacancy as they had previously had a bad experience and they didn't wish for things to go back to how they were. The resident said they found the house quieter and that the other resident they lived with was not always present in the house so they had the house more or less to themselves which they liked.

The person in charge told inspectors about some of the changes that had been implemented since the previous inspection in November 2024 and talked about the positive impact these changes had on residents. For example, all residents now had a dedicated key worker and were all actively working on goals for 2025. For

example, one resident had recently set a goal to attend a musical in London and had a savings plan in place to support this. Residents had also met with the provider's behaviour support specialist and one resident now had an up-to-date positive behaviour support plan on file. Improvements had also been made to the staffing arrangements in the designated centre. Since the previous inspection the provider had recruited a number of staff and the centre was now staffed by a core and stable staff team.

However, the person in charge also informed inspectors about additional arrears which had been accumulated by one resident in relation to community social club activities for 2024 which totalled €160. Previous inspection findings in November 2024 also found evidence that residents had accumulated arrears relating to pharmacy payments for medication and for rent totalling €1857.82. This is discussed further in the report under Regulation 8: Protection.

Inspectors spoke to one staff member on duty. They told inspectors they were employed as a social care worker and had been working in the centre since December 2024. They spoke to inspectors regarding the residents' assessed needs and described training that they had received to be able to support such needs, including safeguarding and medicine management. Inspectors found that staff members on duty were knowledgeable of residents' needs and the supports in place to meet those needs. Staff were aware of each resident's likes and dislikes and warm interactions between residents and staff members caring for them was observed throughout the duration of the inspection. On the day of the inspection inspectors observed residents to be relaxed and comfortable in the centre, staff engaged with them in a very kind and friendly manner, and it was clear that they had a good rapport.

From interacting with residents and observing them with staff, it was evident that they felt very much at home in the centre, and were able to live their lives and pursue their interests as they chose.

The next two sections of the report present the findings of this inspection in relation to the governance and management arrangements in place in the centre and how these arrangements impacted on the quality and safety of the service being delivered to each resident living in the centre.

Capacity and capability

This section of the report sets out the findings of the inspection in relation to the leadership and management of the service, and how effective it was in ensuring that a good quality and safe service was being provided. Inspectors found that the provider had demonstrated that they had made some progress in bringing the designated centre back into compliance with regulatory requirements. However, further improvements were required under Regulations 23, 6, 7 and 8.

There was a clearly defined management structure in place and staff were aware of their roles and responsibilities in relation to the day-to-day running of the centre. The service was led by a capable person in charge, supported by a staff team, who was knowledgeable about the support needs of the residents living in the centre. The person in charge worked full-time and were supported in their role by a deputy client service manager. They reported to a senior service manager who in turn reported to a director of operations.

There was a regular core staff team in place. They were knowledgeable of the needs of the residents and had a very good rapport with them. The staffing levels in place in the centre were suitable to meet the assessed needs and number of residents living in the centre. Warm, kind and caring interactions were observed between residents and staff. Staff were observed to be available to residents should they require any support and to make choices.

The person in charge and deputy client service manager were responsible for Ard na Greine and another designated centre. As identified on the previous inspection a review of this staffing arrangement was required by the provider as the provider had not considered the potential risks or impact the reduction in oversight over this designated centre where high levels of support was required for ongoing safeguarding concerns as well as healthcare and other support needs for residents that were living there.

The provider completed an annual review of the quality and safety of care and support in the centre and identified areas for ongoing improvement and a six-monthly unannounced visit of the centre had taken place. Subsequently, there was an action plan in place to address any concerns regarding the standard of care and support provided. As previously mentioned, additional governance and management arrangements were required regarding healthcare, positive behavioural supports and safeguarding to ensure the most optimum arrangements were in place for residents and to mitigate any potential negative impact to residents.

The next section of the report will reflect how the management systems in place were contributing to the quality and safety of the service being provided in this designated centre.

Regulation 15: Staffing

The provider had recruited three staff members to address the outstanding vacancies in the designated centre. Inspectors observed that on the day of inspection there was enough staff with the right skills, qualifications and experience to meet the assessed needs of residents at all times in line with the statement of purpose and size and layout of the premises.

The staff team comprised of the person in charge, deputy client service manager, social care workers and health care assistants. Inspectors saw evidence that the

provider and person in charge were endeavouring to ensure continuity of care for residents through the use of a small panel of relief staff and agency staff.

The person in charge maintained a planned and actual staff roster. Inspectors reviewed planned and actual rosters for the months of January and February 2025 and found that regular staff were employed, meaning continuity of care was maintained for residents. In addition, all rosters reviewed accurately reflected the staffing arrangements in the designated centre, including the full names of staff on duty during both day and night shifts.

Since the previous inspection, the provider had ensured that all staff working in the designated centre including relief and agency staff had received necessary training to ensure they had the appropriate levels of knowledge and skills to best support residents. For example, all staff had completed training in areas such as, safeguarding, complaints, Emotional Unstable Personality Disorder (EUPD) and refresher Automated External Defibrillator (AED) training.

Inspectors met and spoke with one member of staff, and found that they were knowledgeable about the support needs of residents and about their responsibilities in the care and support of residents.

Judgment: Compliant

Regulation 23: Governance and management

Since the previous inspection, inspectors observed that the provider had implemented improved systems to monitor and oversee the quality and safety of care and support provided to residents in the centre. For example, inspectors reviewed the most recent six-monthly unannounced visit to the centre and found that action plans were developed to address any issues identified. In addition, a suite of audits were in place including weekly local medicine checks, quarterly review of all medicine errors, health and safety, personal plans, infection prevention and control and fire safety.

In addition, the person in charge met with the senior service manager bi-monthly in order to enhance monitoring of the designated centre. Minutes of meetings reviewed by inspectors evidenced that meetings are taking place and agenda items covered included safeguarding, residents' assessed needs, health and safety and medicine management. Furthermore, the senior service manager has been meeting with the director of operations bi-weekly who has in turn been providing updates to the Chief Executive Officer (CEO).

However, and as identified on the previous inspection in November 2024, the person in charge and deputy client service manager were responsible for Ard na Greine and one other designated centre that also supported residents with complex needs and requiring transition and discharge supports. The person in charge spoke to inspectors about the difficulty in managing both locations and advised they had

previously raised this concern with senior management. The provider had not considered the potential risks or impact the reduction in oversight over this designated centre where high levels of support was required for ongoing safeguarding concerns as well as healthcare and other support needs for residents that were living there. This required review by the provider.

Throughout the course of the inspection, inspectors also observed that increased oversight was required, in particular areas such as healthcare, positive behavioural support and safeguarding. These findings are further reflected in the report under Regulations 6, 7 and 8.

Judgment: Substantially compliant

Quality and safety

This section of the report details the quality and safety of the service for the residents who lived in the designated centre.

Where required, positive behaviour support plans were not developed for all residents with an assessed need in this area. On the day of inspection one resident had an up-to-date positive behaviour support plan on file. Another resident residing in the designated centre had previously met with the provider's behaviour support specialist on 25 October 2024 and was still awaiting a positive behaviour support plan. Staff working in the centre had not been provided with positive behaviour support training. The person in charge informed inspectors that training had been scheduled to take place by the 28 February 2025. However, this has been flagged to the provider on all previous inspections. Staff working in the centre continued to support residents without the necessary knowledge, skills and competencies to effectively implement positive behavioural support or respond to ongoing behaviours that challenge.

The provider did not have adequate systems and processes in place that ensured residents' right to feel protected and safe from harm. The safeguarding measures in place in the designated centre, to promote and protect residents' human rights and their health and wellbeing, as well as empowering them to protect themselves, were not effective. Since the last inspection in November 2024, inspectors were informed of an additional incident of potential financial abuse in which poor practice and inadequate care resulted in a resident accumulating financial arrears relating to community social club activities for 2024. There was not an appropriate level of scrutiny and oversight of safeguarding arrangements to ensure residents' safety and welfare and safeguarding notifications had not been submitted to the Chief Inspector of Social Service in line with the regulations.

Overall, strategies in place to support residents were not effective and there remained an ongoing risk to residents of further safeguarding incidents occurring and negatively impacting on their lived experience and their human rights.

Since the previous inspection some improvements were found in relation to the management of resident's healthcare needs. Residents had received updated healthcare reviews and health support planning had also been updated. However, some improvement was required to ensure a finding from the previous inspection in relation to important healthcare appointments and information communication to inform residents' healthcare plans had not been successfully addressed and required improvement.

Regulation 6: Health care

Inspectors reviewed healthcare arrangements for residents as part of this inspection due to a previous repeated pattern of poor healthcare support and provision for residents as found during the July, September and November 2024 inspections of this centre.

This inspection found there had been some improvements since the previous inspection. Both residents that now lived in the centre had received a suite of healthcare reviews with their general practitioners (GPs) and further heathcare checks relating to their underlying medical conditions. For example, since the previous inspection one resident had received a breast check appointment, physiotherapy appointment and vaccinations for COVID-19 and flu. The second resident living in the centre had received a follow up annual health check with their GP and had received blood tests and blood pressure check and had an upcoming appointment for a female health screening check.

Residents' healthcare plans also included more information and detail in relation to health assessments that had occurred and improved records of the treatment plans they had been recommended and information in relation to upcoming appointments and support arrangements. Residents' healthcare plans also now included greater guidance for staff in how to support a resident to engage in personal checks to continuously monitor their own health.

While this was an improvement from previous inspections, further improvement was required. The previous inspection in November 2024 had identified some residents' healthcare plans did not show if the resident had been referred for a repeat screening test, when the next date for the test was due or what follow up staff had taken in response to annual check up findings.

The person in charge outlined that they had made arrangements to ensure a resident's outpatient healthcare communications and information was transferred to the designated centre in an effort to ensure the most contemporaneous information in relation to the resident's health care needs were maintained in the centre, which in turn would inform the resident's personal plan of the outcome of clinical

assessments and ensure they did not miss important appointments. However, at the time of the inspection, the resident's information was still being sent to the resident's family home only and not to the designated centre.

Inspectors were informed this was the resident's choice. However, as was found on the previous inspection, this arrangement had resulted in the resident's personal healthcare plans containing limited important information in relation to their healthcare. For example, information to demonstrate the resident had received necessary cancer screening healthcare checks relating to a past medical condition.

Therefore, while there were improvements found in relation to healthcare planning for the two residents that now lived in the centre, some improvement was still required to ensure staff working in the centre were knowledgeable of resident's health care needs and had the necessary information to create, monitor and update their health support plans as required.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

Where required, positive behaviour support plans were not developed for all residents with an assessed need in this area. One resident who required supports with behaviours that challenge had a support plan in place. Inspectors reviewed the resident's positive behaviour support plan and found that it was detailed, comprehensive and developed by an appropriately qualified person. In addition, the plan included proactive and preventive strategies in order to reduce the risk of behaviours that challenge from occurring and staff spoken with were knowledgeable of the support plan. Inspectors observed positive communications and interactions throughout the inspection between residents and staff.

The provider had not ensured that another resident with an assessed need in this area had a positive behaviour support plan on file. The provider's positive behaviour support specialist initially met with the resident on 25 October 2024 for an induction and to get a better understanding of their positive behaviour support needs. Staff working in the designated centre also submitted additional information to the behaviour support specialist on 16 December 2024 to assist with the development of the resident's positive behaviour support plan. However, on the day of the inspection, the provider had not ensured that the resident had a positive behaviour support plan on file.

Furthermore and as identified on previous inspections staff were not in receipt of positive behaviour support training. The person in charge informed inspectors that training for all staff was scheduled to take place by the 28 February 2025.

Judgment: Substantially compliant

Regulation 8: Protection

Since the previous inspection in November 2024 there had been a notable reduction in peer-to-peer safeguarding concerns that had previously been occurring due to an ongoing incompatibility of the resident group. Following the provider's discharge of a resident from the centre this safeguarding concern had been mitigated.

However, inspectors found evidence that there continued to be ineffective arrangements in place to protect residents from all forms of abuse.

During the previous November 2024 inspection, inspectors found evidence that residents had accumulated arrears relating to pharmacy payments for medication and for rent. Inspectors made a referral to the National Safeguarding Office detailing their concerns in relation to the arrears and requested that the person in charge retrospectively submit safeguarding notifications to the Chief Inspector and the National Safeguarding Office. However, safeguarding notifications were not submitted to the Chief inspector until 15 January 2025 and preliminary screening forms were not sent to the National Safeguarding Office until 20 January 2025.

The provider failed to implement steps as set out in their own safeguarding policy. For example, the provider's policy clearly states that safeguarding concerns "must be reported immediately to a Designated Officer. The Designated Officer(s) are responsible for overseeing and implementing this policy and act as the main point of contact for safeguarding concerns. The Designated Officer(s) liaise with the HSE Safeguarding and Protection Team CHO6 to ensure that all cases of acts of abuse or suspected abuse are reported as appropriate". However, the person in charge informed inspectors that there was a delay in reporting safeguarding concerns because they required sign-off by the senior service manager. It should be noted that during the feedback process at the end of the inspection, inspectors were informed that the senior service manager was not required to sign off on safeguarding incidents. This demonstrated there were discrepancies in how the provider's safeguarding policy and procedures were being implemented in practice. The provider was required to ensure all staff were made fully aware and understood the correct safeguarding procedures for reporting any allegations of potential or actual abuse.

In addition, inspectors were informed by the person in charge during this inspection that further arrears had been accumulated by one resident relating to community social club activities for 2024 totalling €160. A safeguarding notification had not been submitted to the Chief Inspector or to the National Safeguarding Office in relation to this. The person in charge was requested to retrospectively submit safeguarding notifications relating to this incident.

The provider had failed again to recognise possible financial abuse in this instance. As per the provider's safeguarding policy an indicator of financial abuse is "unpaid bills". There was a repeated pattern in this designated centre of residents' experiencing unpaid bills and accumulating arrears, which was negatively impacting

on them and required them to participate in repayment plans. All residents required support with budgeting and managing money. The provider was not providing safe and appropriate services or ensuring that the necessary protective support plans were implemented for all residents, which resulted in repeated accumulated arrears.

Inspectors reviewed preliminary screening forms submitted to the National Safeguarding Office on 20 January 2025 and observed discrepancies and lack of detail documented in the preliminary records. For example, the information and description of incidents was not comprehensive or detailed enough to describe the level of safeguarding risk or concern that had occurred. This meant that some safeguarding concerns were closed and formal safeguarding plans were not in place to manage the actual risks presenting. This required considerable review by the provider.

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	Compliant
Regulation 23: Governance and management	Substantially compliant
Quality and safety	
Regulation 6: Health care	Substantially compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Not compliant

Compliance Plan for Ard na Greine OSV-0001689

Inspection ID: MON-0046170

Date of inspection: 06/02/2025

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 23: Governance and management	Substantially Compliant

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

• The current PIC and their Deputy Manager are providing temporary cover for Ard na Greine and one other Centre with 4 residents in close proximity as the regular PIC was on leave. Ard Na Greine's regular PIC is scheduled to return on the 18.04.2025. The temporary cover was in place from Sept 2024 to April 2025.

• A recruitment initiative began on the 25.11.2024 to implement an additional Deputy Manager position for the other Centre during the temporary arrangement, the post was filled for a short period however it remained open at the time of the inspection.

• There are Bi-weekly 1:1 business meetings in place between PPIM and PIC to provide additional oversight and support to the PIC.

• There is a monthly 1:1 business meeting with the PPIM and the Operations Director.

• The PPIM has a new quarterly schedule which includes 1:1 Quality and Governance on sight meeting, 1:1 business meeting and unannounced sight visit.

• One resident was supported to transition from the designated center in January 2025, which has reduced the safeguarding concerns within the center.

• Actions have been taken to enhance support and inclusion for one resident's healthcare, which is outlined in Regulation 6.

• Actions have been taken to address positive behavior which are outlined in regulation 7.

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
• One Resident currently lives at home with their parent four days a week and is adjusting to living in the Designated Centre. The PIC is currently creating an easy-read visual information pack to be completed by 20.03.2025, to educate the resident on the importance of maintaining good health and attending appointments with staff support.

• Visual information had been provided previously, and the resident was happy to be supported to attend medical appointments on 04.11.2024 and 21.01.2025 with staff support.

• The PIC and Deputy Manager meet with resident's day service monthly, to provide overall collaborative support for maintaining the resident's health and wellbeing.

• The resident has been informed that an additional request was sent on 07.03.2025 to resident's GP, requesting the sharing of medical information with the PIC and Deputy Manager of designated Centre to ensure that they receive up to date information as to ensure they are aware and can support the resident with their healthcare needs.

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
• An additional Behavior Specialist commenced in March, there is a priority list of clients to be reviewed by the Behavior Specialist.

• A new Positive Behavior support framework training has been introduced within the organization. There are 32 sessions of the new PBS framework training planned for 2025.

• One Resident has been on holiday for six consecutive weeks in Q1 2025. The Positive Behavioral Specialist will meet the resident in March 2025 to create a plan in collaboration with the resident and staff to support with their anxieties in relation to transition to the designated Centre and other concerns that have been identified. 04.04.2025

• Four staff attended external trauma informed care training 13.02.2025 and 20.02.2025.

• Four staff have completed positive behaviour support training. Two relief staff are scheduled to attend the next training on 23.04.2025 and 11.06.2025.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
• The provider's Client Information Database allows safeguarding to be reported and escalated to the Safeguarding Team via the Safeguarding portal without requiring a Senior Manager sign off, there is a parallel step which will allow this to avoid delays.

• The incidents of the residents' arrears had been discussed internally where it was determined at the time that the incident did not meet the definition of abuse and therefore a notification was not required to be submitted. However, this matter has since been revisited, and an NF06 was submitted retrospectively. An internal Practice Development Notification has been circulated to promote clarity and share learning from this incident.
• To avoid a recurrence the following actions were taken:

o A thorough review was conducted to identify any arrears for residents.
o From December 2024, notification emails are submitted to PICs monthly where arrears are identified. Following the receipt of the notification, if a resident is identified not to be paying their rent, the PIC or key worker will meet the resident immediately to identify cause of arrears and implement an affordable payment plan and review their support plan.
o Where possible, residents will be supported to set up direct debits to pay their rent and where feasible, payments will be deducted from social welfare under household benefits scheme.

• One resident had accumulated arrears for community social club activities for 2024, a safeguarding notification was submitted on 07.02.2025. To prevent recurrence, the resident's money management assessment was reviewed on 24.02.2025. The resident has set up a direct debit for their financial outgoings. The resident has a visual financial plan for their weekly expenses. The resident has also created a savings account for their upcoming holiday abroad.

• The resident has monthly key working sessions to go through their bank statements and review their savings and spending each month.

• The resident has a support plan with verbal prompts once a week to talk through their money management plan for the week.

• The resident carries a laminated money management card for personal reassurance when in the community.

• The second resident has a money management assessment and support plan in place.
• The staff meet with the resident on a weekly basis to support the resident with completing the rental log book. The resident will then pay rent in the post office.

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 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Substantially Compliant	Yellow	18/04/2025
Regulation 06(1)	The registered provider shall provide appropriate health care for each resident, having regard to that resident's personal plan.	Substantially Compliant	Yellow	30/04/2025
Regulation 06(2)(e)	The person in charge shall ensure that residents are supported to access appropriate health information both within the residential service	Substantially Compliant	Yellow	30/04/2025

	and as available within the wider community.			
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	11/06/2025
Regulation 07(2)	The person in charge shall ensure that staff receive training in the management of behaviour that is challenging including de-escalation and intervention techniques.	Substantially Compliant	Yellow	11/06/2025
Regulation 7(5)(a)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation every effort is made to identify and alleviate the cause of the resident's challenging behaviour.	Substantially Compliant	Yellow	11/06/2025
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	28/02/2025
Regulation 08(3)	The person in charge shall	Not Compliant	Orange	28/02/2025

	initiate and put in place an Investigation in relation to any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.			