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:	Radharc Nua
Name of provider:	Health Service Executive
Address of centre:	Wexford
Type of inspection:	Unannounced
Date of inspection:	13 May 2026
Centre ID:	OSV-0002633
Fieldwork ID:	MON-0049058

About the designated centre

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

Radharc Nua is a designated centre located in a rural area in Co.Wexford. The centre provides long-term residential care to five adult residents, with intellectual disability, dual diagnosis and significant high support physical and behavioural support needs. Residents living in the centre require full-time nursing care. The staff team consists of nursing staff and support workers. The residents attend day-services attached to the organisation and also have in-house individualised activities. The centre comprises of a large two-story house located in rural location. It has five single bedrooms with two living rooms, a kitchen, dining room, sensory room, five bedrooms, adapted bathrooms and a large accessible garden.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	5

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
Wednesday 13 May 2026	10:40hrs to 19:00hrs	Lisa Walsh	Lead
Wednesday 13 May 2026	10:40hrs to 19:00hrs	Gearóid Harrahill	Support

What residents told us and what inspectors observed

This was an unannounced risk based inspection carried out over one day by two inspectors of social services. The purpose of this inspection was to assess compliance with regulations and review the registered provider's progress against their compliance plan submitted following the previous inspection. Residents living in the centre were unable to tell the inspectors about their views of living in the centre however, they were observed to interact and engage in non-verbal communications. Inspectors used observations, discussions with staff and management, alongside a review of documentation to inform judgments on the residents' quality of life.

Since 2024 there has been significant engagement with the provider who was subject to regulatory enforcement activity, in addition several inspections have taken place. The last inspection took place in November 2025 and found improvements in positive behaviour support. However, there was continued non-compliance with residents' rights and assessment and implementation of residents' personal goals. Following that inspection, a restrictive condition, 'condition 4' was attached to the centre registration requiring them to come into compliance with Regulation 9: Residents' rights by 31 July 2026.

Overall, this inspection found that some actions had been taken to enhance the premises and the provider was in the process of implementing the actions set out in their compliance plan. Following assessments completed by the provider the residents were found to not be compatible to live together. The provider had identified a resident to move from the centre with the view of reducing the number of residents living in the centre. However, this had not improved the compatibility issues with residents or improved the impact on residents' rights within the centre. Continued improvement was also required for residents' general welfare and development. Inspectors also identified that actions were required for individual assessment and personal plans, protection and communication.

On arrival to the centre, one resident was out by their music shed. Inspectors were greeted by two staff and three residents who were seated in the main entrance hall of the house and one resident had gone out, visiting with family. Inspectors introduced themselves to the residents and staff, then met with the staff nurse who was in charge. The person in charge was not present in the centre, and the inspectors were informed that they were providing support to another centre when the manager was on planned leave. Following the introduction meeting the inspectors took a tour of the premises with the staff nurse. The person in charge arrived to the centre later in the morning.

The centre comprised a large two-storey detached house with outdoor space to the front and rear of the property. There was a large entrance hall with seating, communal space consisted of a sitting room, sun-room, sensory room, snug and dining room. There was also a kitchen, which residents had restricted access to.

Four resident bedrooms were located on the ground floor, and one resident bedroom was on the first floor. There were two shared bathrooms on the ground floor and an en-suite. The en-suite attached to the resident's bedroom was locked and the resident could not access this unless they left the room and went through the snug where there was another door to access the en-suite. On the first floor there was a shared shower room located next to a resident's bedroom. This was also locked and not accessible to the resident who also required personal and intimate care support. Inspectors were informed that the resident used the bathroom located on the ground floor on the opposite side of the house instead. Inspectors were informed that the majority of residents preferred to use that same toilet. However, due to restrictions in place at different times of the day this toilet was also not accessible at all times.

There were additional spaces located in the garden area for residents. There was a shed which one resident used as a music room. There was a purpose-built structure with toilet facilities that another resident used for music also. Another shed located in a separate area was also used for a resident when they need time alone. Each of these spaces were separated by a high fence that surrounded the majority of the garden. To the immediate rear of the house the provider had completed work to remove playground equipment which was not appropriate for the residents. In place of this artificial grass had been installed and this was now a large empty open area. While work had been completed to remove the playground equipment residents were still not able to use this area functionally as there were no garden furniture or other features of interest. There was also a resident's complaint about this. Inspectors were informed that garden furniture would be purchased for this area.

Residents' bedrooms were pleasantly decorated to their own taste and with items of interest or activities they enjoyed. The centre was clean and generally well-maintained. However, there were some areas of the centre which required review. For example, the main bath used by residents was broken since the beginning of April 2026. This was residents' preference to use. While there was another bath in the centre, it was not accessible to a resident with additional mobility needs and was not pleasantly decorated with some staining around it.

To manage the compatibility issues between residents, several environmental restrictions were used as well as constant and continuous staff supervision of residents, which impacted on residents' rights. Some of these restrictions included locking of internal doors and water restrictions. The provider had trialled the removal of water restrictions, however this had been unsuccessful and this restriction was re-implemented. The provider had also trialled moving a keypad lock from the hallway door to the dining room door to reduce the impact on residents' ability to access the shared toilet they used and the sensory room. However, this had been unsuccessful and the restriction was re-implemented. Other restrictions in place also impacted residents' ability to freely access the kitchen, which also had a keypad lock. There was a hatch which opened into the kitchen when staff were there. However, this was also closed and locked when there were no staff present.

The inspectors had the opportunity to meet with all five residents living in the centre and spent a significant amount of time in communal areas observing residents and

the staff interactions. The residents did not attend any day service and were supported with activation by staff in the centre. Previous reports found that activation required improvement. Following the November 2025 inspection the provider had committed to ensuring that all staff had completed an educational session to enhance skills and goal identification for residents. The majority of staff had completed this. However, there was no plan in place to ensure that this training was rolled out to staff who missed this training or new staff starting in the centre.

During the morning of the inspection, one resident went out grocery shopping with staff and returned at lunchtime. On their return they had lunch and chatted with the inspectors. Following this they spent time in their outdoor space listening to music. Another resident went out with staff in the morning for a drive and lunch, after becoming very excited and vocal with the arrival of the inspectors. Staff informed inspectors that the resident becomes very vocal when meeting new people and can often remain vocal for very prolonged periods of time, which impacts the other residents who prefer a quieter environment.

Three residents remained in the centre for the morning and were observed to spend the majority of their time in the main entrance hall sitting or walking between there, the sitting room and the sun-room. There was music on the radio and a staff member remained in the hallway to supervise residents. While staff were supervising residents in the house, inspectors observed limited meaningful engagement or interaction outside of task-oriented care such as mealtimes, with residents spending extended time sitting or pacing the entrance hall or their outdoor buildings.

Mealtimes were completed in two sittings due to residents' assessed needs and risks identified. Two residents went into the dining room for lunch at 12.30pm approximately. Inspectors were informed that these residents usually ate together. During this time, the door to the hallway was locked and the other residents waited in the entrance reception area while listening to music. When they finished eating staff supported the residents to use the toilet and go back out into the entrance hallway. Then the remaining two residents went into the dining room for their lunch. Residents ate beans, mini waffles and chicken goujons for their lunch. One resident declined this and had buttered crackers instead. Residents were provided with a spoon for the beans, however no other cutlery was available to them and there were no condiments available for residents to easily access. Once all residents finished eating the hall door was unlocked.

Following lunch, one resident took a nap in an armchair in the entrance hallway and the other residents continued to either sit in the entrance hallway or walk within the communal areas. A resident who had been out for lunch returned to the centre in the early afternoon and spent time sitting with an inspector and other residents in the dining room. Following this they spent time in the main reception area sitting or walking. Two residents who had not been out yet, then went out for a drive with two staff. However, they were assessed as both needing two staff when they were out in the community. They returned in the late afternoon. Later in the evening

some residents sat in the sitting room with staff watching television and others sat in the main entrance hallway.

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.

Capacity and capability

Overall, inspectors found that actions taken to come into compliance with general welfare and development and residents' rights following previous inspections had been ineffective in bringing about change to improve the quality of life for residents. The provider had taken steps to begin to improve the premises of the centre with residents' bedrooms pleasantly decorated and some reconfiguration in the garden area. However, further actions were required to ensure the premises was meeting the assessed needs of the residents.

There was a dedicated, stable staff team who were providing care for the residents. There were sufficient staff resources to meet the assessed needs of the residents.

Regulation 23: Governance and management

There was limited evidence to show progress by the provider against their plan to come into compliance with residents' rights since the last inspection. This was discussed with the person in charge throughout the inspection. Some high level meeting minutes from senior management meetings, which the person in charge was not part of, were reviewed. Inspectors were informed about another premises the provider was completing building works to, which they planned on submitting an application to register as a designated centre. Senior management had decided following review of residents' needs to transition a resident from this centre into this proposed new centre. This would reduce the number of residents in the centre. However, this transition would not affect any change to the resident compatibility issues, based on observations, incidents and on the provider's compatibility assessments completed. It also would not change the impact on residents' rights in the centre. Inspectors were informed that further transitions would occur, however there were no plans for this, and senior management said they had no other premises available.

Inspectors found that there were established management structures in place in the centre, with key roles clearly identified within the management team to oversee the operation of the centre. There were management systems in place, however these were not robust and at times ineffective to ensure that the service provided was

safe, appropriate to residents' needs, consistent and effectively monitored. For example, inspectors had observed some incidents where there was a physical engagement from a resident towards staff and inspectors at different times during the inspection. While these were used as a communication signal this was reflective of an assessed need for a low arousal environment. These incidents were witnessed by fellow peers and had an adverse impact on them. Staff and the management team stated that similar incidents to those observed were 'happening all the time', however, these were not being documented. Other incidents that were recorded had limited information and did not fully detail what had happened. Some occasions such as residents discovered with bruising or cuts, were noted on a body chart but there had been no incident forms filled or any review of these to determine the likely cause. This was not in line with the providers process and resulted in no review by the management team. While there was a monthly review of incidents that were recorded, this reported on the number of incidents but did not analyse or trend the information and no actions were found to have been put in place. There was limited information how the numbers of adverse events guided outcomes in light of near-misses or incidents avoided due to the restrictions in the living environment.

Furthermore, several of the incidents reviewed demonstrated the compatibility issues with residents. While the provider had completed compatibility assessments, staff were not familiar with these assessments, their outcomes, their actions, or how they were contributing to the ongoing development of personal plans.

The provider had completed an unannounced six-monthly visit in December 2025, with the auditor on site from 07:30am to 10:30am, observing morning routines. The incidents reflected in this were in relation to falls and the trialled reduction of restrictive practices; the report did not reflect the frequency of events which indicated non-compatibility. This report was ineffective in capturing and actioning key areas of concern in the centre as highlighted during inspection, including meaningful engagement and activation of residents outside of task-oriented care.

Other regulations impacted by management systems that were ineffective were the notification of incidents, individual assessment and personal plans, communication, general welfare and development, and protecting residents from abuse, which are all detailed under each respective regulation. They are detailed under each regulation.

Judgment: Not compliant

Regulation 31: Notification of incidents

The inspectors reviewed records of incidents and adverse events occurring in the centre in recent months. A number of these events had not been notified to the Chief Inspector of Social Services. In addition, some restrictive practices identified in the centre had not been reported in quarterly returns. For example, residents who

did not have access to ceramic or glass items, a resident whose phone was secured by staff, a serving hatch in the kitchen which was locked at times, and bathrooms with locked doors which could not be accessed by residents.

Judgment: Not compliant

Quality and safety

Inspectors observed kind staff who were working towards providing care to residents to meet their assessed needs. However, this inspection identified areas where improvements were required to ensure a good standard of care and support was provided to residents. Specifically in relation to residents' rights, general welfare and development, safeguarding, individual assessment and personal plans and communication.

The provider was working towards improving the garden area for residents and progress had been made in this area. The playground equipment had been removed, and new artificial grass had replaced this. There was no garden furniture, however the provider informed inspectors that this had been requested.

Regulation 10: Communication

Residents in this centre had complex communication support needs and did not communicate using full speech. However, there was limited evidence to indicate how holistic communication strategies had been developed or advised by multi-disciplinary input. In one example reviewed, care and support plans for a resident indicated that they should be provided with pictures to support decision-making and develop their planners and schedules. However, staff advised that this had not been in place for a long time, and inspectors observed no meaningful use of non-spoken communication modes during the day. The same resident had no referral to a speech and language therapist to obtain advice to develop their communication supports. Resident meeting minutes referred to the use of pictorial choice boards by other residents, however it was noted that staff were unsure if the residents understood them. Communication support guidance in place was not being updated to reflect changes to the residents needs or where communication strategies were noted as ineffective.

Residents had access to television in the sitting room, but it was not evident that residents were supported to access media they enjoyed. The television was set to the news, or quiz shows which residents did not engage with. Meeting minutes

noted that residents would benefit from streaming videos to watch what they enjoyed, however this was not possible as the house did not have Internet.

Judgment: Not compliant

Regulation 13: General welfare and development

Following the November 2025 inspection, the provider had committed to ensuring that all staff had completed an educational session to enhance skills and goal identification for residents. The majority of staff had completed this. However, there was no plan in place to ensure that this training was rolled out to staff who missed this training or any new staff starting in the centre.

The inspectors reviewed staff meetings and activation diaries which were to be used to ensure that residents were provided with meaningful recreational opportunities and were engaged in enjoyable and varied activation at home and in the community. The records of these logs were filled for most days but with generic commentary. For example, stating the resident went for a drive without indicating where, why, for how long they went, or if they did anything while out. Staff had been requested to record this information in team meetings to ensure activation was in line with residents' interests and goals. As referenced elsewhere, inspectors observed residents spending extended periods of time pacing around the main entrance hall, sleeping or sitting with limited meaningful social or recreational engagement. These are repeated findings from previous inspections.

Judgment: Not compliant

Regulation 17: Premises

Overall, the centre was clean and generally well-maintained. Residents' bedrooms were pleasantly decorated to their own taste and with items of interest or activities they enjoyed. One resident recently had their bedroom redecorated.

Following on from previous inspections, the provider had completed work to remove playground equipment, which were not appropriate for the residents. In place of this artificial grass had been installed and was now a large empty open area. While work had been completed to remove the playground equipment residents were still not able to use this area functionally as there was no garden furniture. Residents meeting minutes recorded their wish for garden furniture and there was also a resident's complaint in relation to this. Inspectors were informed that garden furniture would be purchased for this area.

Some other areas of the centre required review to ensure it met the needs of residents. For example, the main bath used was broken since the beginning of April 2026. This was residents' preference to use. While there was another bath in the centre, it was not accessible to a resident with additional mobility needs and was not pleasantly decorated with some staining around it that could not be cleaned.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Inspectors reviewed personal goals related to life skills development, such as, learning to budget money or complete household tasks independently and discussed these with staff members. While the conclusion for these outcomes was set out, there was limited evidence to indicate how keyworkers were assured that these skills were progressing unless they were the ones to work with the resident that day. Progression notes on the success and achievement of these outcomes was not measurable. For example, for a resident whose goal was developing their independence with money, the progress notes listed items bought for their home, with no commentary on whether this was used to indicate the development of the resident's skills. In another example, the life skill was pouring a drink for themselves from a jug, however it was not evident how this could be progressed as the resident did not have access to these. In a third example, the goal due to be completed the week after this inspection, was to attend agricultural events at a cinema, however staff did not know what this meant and there was no evidence to indicate what was planned to happen.

In plans related to social, personal and health care needs of residents, inspectors observed examples of plans which were identified as not effective or not implemented to good effect, but which had not been reviewed or revised to reflect this. In incident records related to positive behaviour, inspectors observed eight incidents in March 2026 which recorded that the positive behaviour support strategies had been implemented but had not had any effect in deescalating the event. The plan had been reviewed in March 2026 with the commentary that no changes were required. The associated plan had not been revised since September 2025 to review that guidance for staff in light of the feedback that the plan was not effective.

In support plans related to communication needs of residents, records indicated that the strategies described did not provide assurance that residents understood what was being communicated, or strategies described in plans had been ceased because they were not effective in meeting their objective.

Two residents had been assessed as both needing two staff when they were out in the community. When they went out together, they were accompanied by only two staff. Inspectors were informed that following changes to one of the resident's

health they no longer required two staff, however their assessment in place had not been updated to reflect this.

Judgment: Not compliant

Regulation 8: Protection

While the provider had systems in place to protect residents from harm and investigate any incident or allegation of abuse, these were not effective. Following a review of incidents and adverse events occurring in the centre in recent months, inspectors identified that there had been several incidents which had not been recognised as potential safeguarding concerns, meaning that they were not reported, screened and no safeguarding plans had been put in place following these incidents. For example, incidents in which residents were upset or distressed by the presentation of their housemates, were bumped into, woken up at night or had their had their food taken were not screened or reported as a concern for the safeguarding of residents. Where residents had been found with bruising or bleeding of unknown origins, these were also not being screened as safeguarding concern.

Judgment: Not compliant

Regulation 9: Residents' rights

As previously mentioned, there was limited evidence to show progress on the provider's plan to come into compliance with resident's rights since the last inspection. From information and plans provided to the inspectors during the inspection it would not be possible for the provider to come into compliance by the 31 July 2026, as set out in condition 4 of the provider's registration. The residents had been assessed by the provider to be incompatible to live with each other. To manage this several restrictive practices were in place, and residents were under constant and continuous supervision. The provider had identified a resident to transition from the centre to a new centre, which the provider was in the process of renovating. This would reduce the number of residents living in the centre by one, however this would not affect any change to the resident compatibility issues based on the assessments completed. It also would not change the impact on residents' rights in the centre.

Inspectors reviewed documentation for a resident who needed a decision-making support as they had no family or other legal representative in place. The provider had ensured that an application form to the Decision Support Service had been made in April 2026. However, this remained unresolved at the time of inspection.

The resident had been in this position for a prolonged period and this has been highlighted in previous inspections.

Inspectors observed additional restrictions in use which impacted some residents' privacy and dignity in relation to their intimate and personal care. For example, one resident had a toilet and shower located adjacent to their bedroom on the first floor. However, inspectors observed that this was locked. Inspectors were informed that the resident used the bathroom located on the ground floor on the opposite side of the house instead. This impacted negatively in particular at times when the resident required enhanced personal care and had to cross through communal spaces when their dignity was compromised. Another resident had a toilet as part of their bedroom en-suite, however this door was also locked, and the resident could not access this unless they left their bedroom and went through another room where there was another door to access the en-suite.

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 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Not compliant
Quality and safety	
Regulation 10: Communication	Not compliant
Regulation 13: General welfare and development	Not compliant
Regulation 17: Premises	Substantially compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Radharc Nua OSV-0002633

Inspection ID: MON-0049058

Date of inspection: 13/05/2026

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
A governance and oversight team has been established, chaired by the Head of Service with terms of reference agreed to ensure the residents experience a good quality of life and specifically address the issues raised in the inspection report. The team will meet fortnightly initially for 8 weeks after which the frequency of meetings will be reviewed and potentially progress to monthly meetings with a further review in 6 months.
This Committee comprises of the Head of Disability Services, Area Director of Nursing, Persons Participating in Management, the Person in Charge, Quality Patient Safety Advisor, External Project Officer, a Principal Social Worker Manager and input from a Safeguarding Officer. The purpose of this committee is to ensure the Designated Centre comes into compliance with the regulations.

The Provider is establishing a Residential Planning and Placement Committee. This will comprise of the Area Director of Nursing, Assistant Director of Nursing, Clinical Nurse Manager 3, an Advanced Nurse Practitioner in Positive Behaviour Support, Advanced Nurse Practitioner in Chronic Disease Management, Clinical Nurse Manager 2 for Day Services and an independent external representative. The Person in Charge will attend meetings and make representations as appropriate, to ensure residents' assessed needs are represented and that identified actions are progressed without delay.

The Provider has conducted a comprehensive review of the existing Compatibility Assessment Tool to strengthen the evidence base, improve transparency in decision-making, and clearly define responsibility and accountability. This review has resulted in revision of the current compatibility assessment form, which is now underpinned by a formal policy. The policy is supported by up-to-date evidence from relevant research literature. Oversight of Compatibility Assessments reviews will be provided by the Residential Planning and Placement Committee.
The Provider will ensure Compatibility Assessments are reviewed as required, with the

Residents, the Person in Charge and with the input from the Residential Planning and Placement Committee. Outcomes of the Compatibility Assessments will be used by the Person in Charge to inform further development and review of Residents Personal Plans. The Compatibility Assessments will be available in each Resident's Personal Plan. The Person in Charge will implement recommendations from the Residential Planning and Placement Committee are discuss at team meetings.

The number of residents living in the Centre will reduce in the coming weeks from five to four. The Provider has reviewed the current restrictions in use in the centre, and in view of the pending reduction in number of residents has devised a proposal with the aim of eliminating and reducing a number of environmental restrictions in use currently and referred this to the Rights Review Committee for consideration.

The Provider will be supported by the Quality Patient Safety Advisor to review Residents' Individual Risk Assessments in collaboration with the Person in Charge and keyworkers.

The Quality, Safety and Service Improvement Office will support the development of an enhanced incident review process to identify trends, recurring themes and learning opportunities.

The Provider will continue to ensure that all incidents involving Residents are reviewed by the Advanced Nurse Practitioner prior to escalation on the National Incident Management System. All injuries of unknown origin will be reported in line with the National Incident Management System so that they will be included in the existing monthly Senior Manager Incident Review process. Identified learning and feedback from monthly Senior Manager Incident Review will become a standing item on the agenda at the Designated Centre monthly team meetings.

Staff accidents will continue to be escalated to Director of Nursing / Person Participating in Management for review and screening and further escalation as required.
The Provider has revised the resident body chart to facilitate the accurate documentation of individual injuries and to support the recording and tracking of the subsequent investigation process.
The Provider and Advanced Nurse Practitioner will deliver workshops for staff on incident recognition, categorisation, documentation and reporting. These workshops will include improving staff awareness of the impact of Residents' behaviours on peers and ensuring this is accurately reflected in documentation and will inform interventions.

The Provider will introduce a workshop on best practice in record writing which will be delivered to staff. This will focus on enhancing the quality, accuracy, and consistency of documentation, ensuring that records are clear, contemporaneous, and aligned with regulatory requirements and organisational policies. The training will also reinforce staff understanding of their responsibilities in maintaining appropriate records to support safe, accountable, and person-centred care.

The Person in Charge has submitted referrals to the Speech and Language Therapy Department to review Residents' communication passports and communication support plans. The reviews will ensure communication needs are comprehensively assessed, historical CATTS communication assessments are considered, and appropriate

personalised communication systems are developed and implemented for each Resident.
The Provider will ensure recommended communication supports, including pictures, objects of reference and communication systems, are consistently available to Residents and used by all staff in the Designated Centre.
The Provider will support a review of each resident's Personal Plan to ensure that a meaningful, individualised, and person-centred approach is consistently adopted by staff in the planning and delivery of care and support.
The Advanced Nurse Practitioner (ANP) will review and analyse behaviour monitoring documentation to identify patterns, trends, and potential triggers for behaviours of concern. This analysis will inform the development and revision of Positive Behaviour Support Plans, support staff in implementing evidence-based interventions, and address any cultural practices or service-related factors that may impact on the effectiveness and consistency of behavioural support strategies.
The Provider has arranged for a Safeguarding Officer to visit the Designated Centre and hold a Safeguarding Workshop with staff. This workshop will focus on the Safeguarding Vulnerable Adults at Risk of Abuse Policy, recognition of incidents or events that are considered safeguarding concerns and discussion of practical case examples.
The Provider will implement the 'Adult Safeguarding Practice Guidance on Injuries of unknown origin', published by the National Safeguarding Office which comes into effect 01/07/2026.

The Provider will review its approach to conducting the six-monthly unannounced visits to the Designated Centre. The six-monthly unannounced inspection report will place particular emphasis on areas requiring improvement and will include any outstanding actions arising from the most recent compliance plans. The findings of the report will be used by the Provider to inform and support the governance and management oversight of the centre.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
The Provider will be supported by the Quality, Safety and Service Improvement Office in developing an enhanced incident review process that will facilitate the identification of trends, recurring themes, and opportunities for learning and service improvement.

The Provider will strengthen existing arrangements to ensure all resident incidents continue to be reviewed by the Advanced Nurse Practitioner prior to escalation on the National Incident Management System. All injuries of unknown origin will be reported in accordance with the National Incident Management System to ensure they are captured within the existing monthly Senior Management Incident Review process.
The Person in Charge will implement a system that learning outcomes, trends, and feedback identified through the monthly Senior Management Incident Review process

become a standing agenda item at the Designated Centre's monthly team meetings to promote shared learning and continuous improvement.
The Provider has revised the resident body chart to facilitate the accurate documentation of individual injuries and to support the recording and tracking of the subsequent investigation process.
The Provider, in collaboration with the Advanced Nurse Practitioner, will deliver workshops for staff on incident recognition, categorisation, documentation, and reporting. These workshops will also focus on enhancing staff awareness of the impact of residents' behaviours on their peers and ensuring that such incidents are accurately documented, appropriately categorised, and used to inform care planning and intervention strategies.
The Provider, in collaboration with the Rights Review Committee will review the restrictive practice register to ensure all restrictive practices are appropriately documented, proportionate, regularly reviewed and remain the least restrictive option for the shortest possible duration.
The RRC will review requests relating to the use of alternative items (e.g., non-ceramic or non-glass crockery). Enhanced risk assessments will document the rationale, decision-making process and justification for restrictions if required.

Regulation 10: Communication	Not Compliant

Outline how you are going to come into compliance with Regulation 10: Communication:
The Person in Charge has submitted referrals to the Speech and Language Therapy Department to review residents' Communication Passports and communication support plans.
These reviews will ensure that residents' communication needs are comprehensively assessed, with consideration given to historical CATTS communication assessments where available. The reviews will also support the development and implementation of personalised communication systems tailored to each resident's individual needs.
The Provider will ensure that all recommended communication supports, including pictures, objects of reference, and other communication systems, are consistently available to residents and are used effectively by all staff within the Designated Centre to promote meaningful communication and resident participation in daily life.
The Provider has installed Wi-Fi infrastructure throughout the Designated Centre, enabling residents to access Wi-Fi services on their mobile phones and iPads.

Regulation 13: General welfare and development	Not Compliant

Outline how you are going to come into compliance with Regulation 13: General welfare and development:
The Provider has delivered educational sessions to staff to enhance knowledge and skills in supporting residents to identify, develop, and achieve personal goals. These sessions will be incorporated into the induction programme for all new staff to ensure a consistent, person-centred approach to supporting residents' development, independence, and quality of life.
The Provider will ensure that documentation within residents' Personal Plans and daily records is sufficiently detailed and outcome-focused. Records will clearly describe the activities undertaken by the resident, the duration and purpose of the activity, the resident's level of participation and engagement, and the extent to which the activity was meaningful and enjoyable for the resident. Keyworkers will provide regular updates at team meetings to ensure staff are informed of residents' progress and changing support needs.
The Provider will ensure that, following review of residents' Personal Plans, daily living routines are person-centred, meaningful, and reflective of each resident's assessed needs, preferences, interests, and goals. Plans will incorporate opportunities for skill development, recreation, social inclusion, and participation in community-based activities. Where a resident chooses not to participate in an activity, staff will record the reason for non-participation, while respecting the resident's rights, preferences, will and preference, and capacity to make decisions.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
The Provider has installed new garden furniture, which is available for residents' use and enjoyment. Residents will be actively involved and supported in further enhancing the garden area through the selection of additional features and items of their choosing.
The Provider has confirmed that the main bath remains fully functional and continues to be used on a daily basis. Any required repairs are being managed through the maintenance department to ensure its ongoing availability and safe operation.
The Provider has engaged with the Estates Department regarding the requested upgrades to both bathrooms. The proposed works are currently being costed and will be considered for inclusion in the 2027 Minor Capital Programme.

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:

The Provider has installed new garden furniture, which is available for residents' use and enjoyment. Residents will be actively involved and supported in further enhancing the garden area through the selection of additional features and items of their choosing.

The Provider has confirmed that the main bath remains fully functional and continues to be used on a daily basis. Any required repairs are being managed through the maintenance department to ensure its ongoing availability and safe operation.

The Provider has engaged with the Estates Department regarding the requested upgrades to both bathrooms. The proposed works are currently being costed and will be considered for inclusion in the 2027 Minor Capital Programme.

The Provider will ensure Positive Behaviour Support Plans are reviewed following relevant incidents and discussed at team meetings to ensure ongoing effectiveness. Where required, multidisciplinary reviews will be convened in a timely manner, plans will be updated without delay, and all changes will be communicated effectively to staff to ensure a consistent approach to support.

The Provider, supported by the Quality Patient Safety Advisor, will undertake a review of residents' Proactive Risk Assessments in collaboration with the Person in Charge and keyworkers. Risk assessments will be reviewed to ensure they accurately reflect residents' current support needs and staffing requirements, particularly in relation to participation in paired or group-based social activities, while promoting positive risk-taking and community participation.

The Person in Charge has submitted referrals to the Speech and Language Therapy Department to review residents' Communication Passports and communication support plans. These reviews will ensure that residents' communication needs are comprehensively assessed, with consideration given to historical CATTS communication assessments where available, and will support the development and implementation of personalised communication systems tailored to each resident's individual needs.

The Provider will ensure that all recommended communication supports, including pictures, objects of reference, and other communication systems, are consistently available to residents and utilised by staff to promote effective communication, participation in decision-making, and meaningful engagement in daily life.

The Person in Charge, in consultation with keyworkers and relevant multidisciplinary team members, will review communication guidance to ensure that any changes in residents' communication needs are identified promptly, accurately documented, reflected in care planning documentation, and communicated effectively to all staff to support a consistent and person-centred approach.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
The Provider will ensure all resident incidents continue to be reviewed by the Advanced Nurse Practitioner prior to escalation on the National Incident Management System. All injuries of unknown origin will be reported in accordance with the National Incident Management System to ensure they are captured within the existing monthly Senior Management Incident Review process.

The Provider has arranged for a Safeguarding Officer to visit the Designated Centre and hold a Safeguarding Workshop with staff. This workshop will focus on the Safeguarding Vulnerable Adults at Risk of Abuse Policy, recognition of incidents or events that are considered safeguarding concerns and discussion of practical case examples.

The Provider will implement the 'Adult Safeguarding Practice Guidance on Injuries of unknown origin', published by the National Safeguarding Office which comes into effect 01/07/2026.
The Provider has revised the resident body chart to facilitate the accurate documentation of individual injuries and to support the recording and tracking of the subsequent investigation process.
The Provider and Advanced Nurse Practitioner will deliver workshops for staff on incident recognition, categorisation, documentation and reporting. These workshops will include improving staff awareness of the impact of Residents' behaviours on peers and ensuring this is accurately reflected in documentation and will inform interventions.

The Provider, in collaboration with the Rights Review Committee will review the restrictive practice register to ensure all restrictive practices are appropriately documented, proportionate, regularly reviewed and remain the least restrictive option for the shortest possible duration

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
The Provider is establishing a Residential Planning and Placement Committee to strengthen oversight of admissions, transitions, and service planning within the Designated Centre. The Committee will comprise the Area Director of Nursing, Assistant Director of Nursing, Clinical Nurse Manager 3, Advanced Nurse Practitioner in Positive Behaviour Support, Advanced Nurse Practitioner in Chronic Disease Management, Clinical Nurse Manager 2 for Day Services, and an independent external representative.
The Person in Charge will attend meetings and make representations, as appropriate, to ensure that residents' assessed needs, preferences, and compatibility considerations are fully considered in decision-making processes. The Committee will provide oversight of

residential planning and placement decisions, ensure that identified actions are progressed in a timely manner, and support the delivery of person-centred services that are responsive to residents' changing needs and promote positive outcomes.
The number of residents living in the Centre will reduce in the coming weeks from five to four. The Provider has reviewed the current restrictions in use in the centre, and in view of the pending reduction in number of residents has devised a proposal with the aim of eliminating and reducing a number of environmental restrictions in use currently and referred this to the Rights Review Committee for consideration.

A comprehensive review of the existing Compatibility Assessment Tool is being completed to strengthen the evidence base, improve transparency in decision-making, and clearly define responsibility and accountability. This process will inform the planned revision of the current compatibility assessment form, which will be underpinned by a formal policy on compatibility assessment. The policy will be supported by up-to-date evidence from relevant research literature. Oversight of this work will be provided by the Residential Planning and Placement Committee.
The Provider has conducted a comprehensive review of the existing Compatibility Assessment Tool to strengthen the evidence base, improve transparency in decision-making, and clearly define responsibility and accountability. This review has resulted in revision of the current compatibility assessment form, which is now underpinned by a formal policy. The policy is supported by up-to-date evidence from relevant research literature. Oversight of Compatibility Assessments reviews will be provided by the Residential Planning and Placement Committee.

The number of residents living in the Centre will reduce in the coming weeks from five to four. Subsequently the Provider has reviewed the current restrictions in use in the centre, placing particular focus on identifying opportunities to reduce or remove environmental restrictions that impact on residents' rights, independence, and freedom of choice.
In light of the findings, the Provider has written a proposal for reductions and removals of restrictions and referred this to the Rights Review Committee for consideration.

The Provider in collaboration with the Rights Review Committee will undertake a comprehensive review of all restrictive practices in place within the Designated Centre to ensure they are implemented in accordance with national policy and best practice. Particular focus will be placed on identifying opportunities to reduce or remove environmental restrictions that may impact on residents' rights, independence, and freedom of choice.

The review will ensure that any restrictive practice is individually assessed, proportionate to the assessed need, the least restrictive option available, and subject to regular multidisciplinary review. Findings from the review will inform actions to promote residents' rights and enhance their quality of life.

In relation to the Resident referenced in the report the Person in Charge will continue to engage with the Decision Support Service to progress the referral for the appointment of a Decision-Making Representative and will monitor the progression of the application to ensure timely follow-up and support.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 10(1)	The registered provider shall ensure that each resident is assisted and supported at all times to communicate in accordance with the residents' needs and wishes.	Not Compliant	Orange	31/08/2026
Regulation 10(2)	The person in charge shall ensure that staff are aware of any particular or individual communication supports required by each resident as outlined in his or her personal plan.	Substantially Compliant	Yellow	31/08/2026
Regulation 10(3)(a)	The registered provider shall ensure that each resident has access to a telephone and appropriate media, such as television, radio, newspapers and internet.	Not Compliant	Orange	23/06/2026

Regulation 13(2)(b)	The registered provider shall provide the following for residents; opportunities to participate in activities in accordance with their interests, capacities and developmental needs.	Not Compliant	Orange	31/08/2026
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Substantially Compliant	Yellow	31/08/2026
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Substantially Compliant	Yellow	31/08/2026
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	31/08/2026
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six	Substantially Compliant	Yellow	10/07/2026

	months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.			
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 abuse of any resident.	Not Compliant	Orange	15/07/2026
Regulation 31(3)(a)	The person in charge shall ensure that a written report is provided to the chief inspector at the end of each quarter of each calendar year in relation to and of the following incidents occurring in the designated centre: any occasion on which a restrictive procedure including physical, chemical or	Not Compliant	Orange	10/07/2026

	environmental restraint was used.			
Regulation 05(1)(b)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out subsequently as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.	Substantially Compliant	Yellow	31/08/2026
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	31/08/2026
Regulation 05(6)(c)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall	Not Compliant	Orange	31/08/2026

	assess the effectiveness of the plan.			
Regulation 05(8)	The person in charge shall ensure that the personal plan is amended in accordance with any changes recommended following a review carried out pursuant to paragraph (6).	Substantially Compliant	Yellow	31/08/2026
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Substantially Compliant	Yellow	15/07/2026
Regulation 08(3)	The person in charge shall 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.	Not Compliant	Orange	01/07/2026
Regulation 08(7)	The person in charge shall ensure that all staff receive appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse.	Not Compliant	Orange	15/07/2026
Regulation 09(2)(b)	The registered provider shall ensure that each resident, in accordance with	Not Compliant	Orange	31/08/2026

	his or her wishes, age and the nature of his or her disability has the freedom to exercise choice and control in his or her daily life.			
Regulation 09(2)(d)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability has access to advocacy services and information about his or her rights.	Not Compliant	Orange	31/08/2026
Regulation 09(3)	The registered provider shall ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.	Not Compliant	Orange	31/08/2026