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

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|---|---|
| Name of designated centre: | Fiona House |
| Name of provider: | Praxis Care |
| Address of centre: | Donegal |
| Type of inspection: | Announced |
| Date of inspection: | 20 May 2025 |
| Centre ID: | OSV-0003924 |
| Fieldwork ID: | MON-0038666 |

## About the designated centre

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

Fiona House provides full-time residential care for six people with an intellectual disability who are over the age of 18 years. This centre is located in a residential area of a busy town and a range of community amenities are nearby. Residents are supported by a team of support workers during the day. Night-time support is provided by either one or two support workers through a combination of sleep over or waking night duties which is dependent on occupancy levels and residents' assessed needs.

**The following information outlines some additional data on this centre.**

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| Number of residents on the date of inspection: | 6 |

## How we inspect

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

As part of our inspection, where possible, we:

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

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

**1. Capacity and capability of the service:**

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

**2. Quality and safety of the service:**

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

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

**This inspection was carried out during the following times:**

| Date | Times of Inspection | Inspector | Role |
|---|---|---|---|
| Tuesday 20 May 2025 | 10:00hrs to 19:00hrs | Úna McDermott | Lead |

## What residents told us and what inspectors observed

This inspection was an announced inspection competed in May 2025. The purpose of this inspection was to monitor and review the arrangements that the provider had in place in order to ensure compliance with the Care and Support Regulations (2013) and to inform a registration renewal application. During the course of the inspection, the inspector met with all six residents living at Fiona House and spoke with five staff members. From time spent with residents and from what the inspector observed, it was clear that residents were happy in their home. However, the inspector was not assured by the oversight of the safeguarding and protection arrangements in place at the time of inspection. This will be expanded on under regulations 8, 23 and 31 below.

Six residents lived at this centre. The inspector found that the needs of the residents were changing as they aged. Some required additional care and support, while others were spending more time in the centre and less time at home with their families. Another resident was recovering from recent surgery. The inspector found that the provider had the capacity to meet with these new or changing needs. While there were concerns relating to safeguarding governance, overall, a good quality of care and support was provided. This will be expanded on throughout this report.

A tour of the premises found that it provided a comfortable living space. It was spacious and level access was provided throughout the building and into the garden. Each resident had their own bedroom and those visited were warm, comfortable and personally decorated. A range of communal areas were provided, which meant that residents could spend time alone or with others if they preferred. The kitchen was bright and cheerful and there was a plentiful supply of nutritious foods. Home cooked meals were prepared on the day of inspection and the pleasant aroma of food preparation added to the homely atmosphere.

The inspector held conversations with five residents on the day of inspection and spent time another in the sitting room. In addition, they reviewed five residents' questionnaires which were completed by residents with support prior to the inspection.

One resident told the inspector that they were happy, however, they felt a bit low at times when another resident became upset. They said that they liked the staff and they knew who to speak with if they were worried. Another resident agreed that the staff were kind and the food was nice. They told the inspector that they knew how to make a compliant and if there was a fire, they said that they would leave the house immediately, while pointing towards the assembly point. A resident recovering from a period of ill-health demonstrated a very good understanding of their health needs and the length of time during which they would have to rest. This showed that they were supported by the staff to understand the change in their needs at that time. Other residents spoke about their families and about activities that they enjoyed alone or as a group with their peers. During the course of the day, all

residents were observed moving around their home independently, chatting with staff, watching television and organising their personal items on return from their day service.

There were four staff on duty on the day of inspection. The inspector spoke with three of them, and also with the person in charge and the person participating in management. Staff told the inspector about changes in the leadership and management arrangements that occurred this year. They said that the team were settling into a new routine and that it was working well. One staff member was new to the service and competing their induction. They were aware of the nature of the induction process and when asked, had a good understanding of their role and of the importance of promoting and supporting the human rights of residents at Fiona House.

Overall, from observations made, conversations held and review of the documentation, the inspector found that the residents in this centre received a good quality, person-centred service. The atmosphere on the day of inspection was organised and calm. Staff knew what to do and the residents appeared happy and content participating in the daily activities of a typical household. However, there were changes in the governance and management of the centre, and while the new staff were settling into their roles, the inspector found that areas of regulatory drift on this inspection. This included non compliance with safeguarding requirements and non compliance in the submission of notifications for the attention of the Chief Inspector of Social Services. In addition, some improvements in the oversight of positive behaviour support were required.

The next two sections 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

The registered provider submitted an application for the renewal of registration of Fiona House, along with the prescribed information required. There were changes in the governance and management arrangements at this centre. The person in charge was new to the role and the provider submitted a statutory notification which was under review at the time of inspection. In addition, there was a new person participating in management, however, they were familiar with the service having worked their previously.

The centre was well resourced with sufficient numbers of staff, required equipment and dedicated transport. Staff employed were familiar with the assessed needs of the residents and were skilled and knowledgeable.

The provider had governance arrangements in place to ensure oversight of the service. Improvements were required and these are outlined throughout this report. In addition, a review of incidents at the centre found that not all were reported to the Chief Inspector as required.

The regulations below will provide further details on the finding of this inspection.

## Registration Regulation 5: Application for registration or renewal of registration

The registered provider submitted an application for renewal of registration to the Chief Inspector of Social Services in line with the requirements of this regulation.

Judgment: Compliant

## Regulation 15: Staffing

The registered provider had sufficient staff employed with appropriate skills and experience to meet with the assessed needs of the residents in line with the statement of purpose and the size and layout of the service.

The inspector reviewed a sample of planned and actual rosters from 1 April 2025 to 20 May 2025. They were well maintained and provided an accurate account of the staff on duty on the day of inspection. Where additional staff were required this was planned for. Staff were familiar with the residents which meant that consistency of care and support was provided.

Judgment: Compliant

## Regulation 16: Training and staff development

Staff had access to a programme of professional development through a schedule of mandatory and refresher training.

The inspector reviewed a sample of training modules for five staff members, including core and agency staff. Modules reviewed included human rights training, safeguarding and protection training, fire training, training in positive behaviour support and safe administration of medication training. This review found that all modules were up to date.

In addition, the inspector reviewed the arrangements in place for supervision and performance development of staff. This review found that a schedule of individual meeting was used and meetings were completed as planned.

Judgment: Compliant

## Regulation 22: Insurance

The registered provided has an insurance policy for the service which met with the requirements of this regulation.

Judgment: Compliant

## Regulation 23: Governance and management

As outlined, there were changes to the management and leadership team at this centre. A new person in charge commenced in December 2024 along with a change in the person participating in management, which also occurred at this time. While the provider had clear leadership arrangements in place, the inspector was not assured that the oversight of safeguarding and protection requirements was effective and this required review. This is expanded on under regulation 8, later in this report.

The provider had a team leader structure in place to support the roles of the person in charge. Each resident had an individual key worker and residents spoken with were aware of who their key worker was and how they supported them.

The service was well resourced with staffing, equipment and transport. Staff spoken with told the inspector that residents had access to all that they needed and if additional resources were required that these could be followed up on.

All residents had a comprehensive review of their care and support in a document called 'Every Day Living Plan'. The inspector reviewed the plans for four residents and found that they were reviewed in February and March 2025.

Where issues with interpersonal compatibility arose, the provider had a system to respond to this through regular compatibility assessments.

Residents' meetings were held on a weekly basis and the previous four meetings were reviewed by the inspector. This review found that easy to read minutes were available. In addition, the provider had a schedule of topics for discussion at each meeting and evidence was provided to show that this had occurred. For example,

how to make a compliant was discussed with residents' at the most recent meeting. Where residents choose not to attend, this was documented and respected.

A review of staff meetings held since January 2025 to the date of inspection found that they were taking place on a monthly basis and were well attended. The most recent meeting was held on 24 April 2025.

However,

- The inspector identified gaps in oversight of safeguarding and protection measures at the centre. This is outlined under regulation 8 below.
- In addition, while a review of the centre's audit schedule found that the annual review of care and support and the unannounced provider-led audit were in date, the safeguarding audits were not working well at the time of inspection. For example, two safeguarding matters which arose in March 2025 were not identified as such in safeguarding audits completed.

Judgment: Substantially compliant

## Regulation 24: Admissions and contract for the provision of services

The residents living at Fiona House were admitted to the centre prior to the changing over to the current provider. There were no new admissions since, and if this arose, the provider had an admissions process for use when required.

The inspector reviewed the admissions criteria for the centre and found that the criteria was clearly outlined and in accordance with the statement of purpose.

In addition, the inspector reviewed four of six admission contracts and terms of residency. This review found that a comprehensive system was in place, which included a residential agreement, a transport agreement and a bills agreement and guide to costs for each resident. However, there some were gaps in the documentation. These included signatures, dates and mileage amounts in some documents. This did not constitute a risk to residents and the gaps were amended on the day of inspection.

Judgment: Compliant

## Regulation 3: Statement of purpose

The provider had a statement of purpose that reflected the operation of the service. It was available in easy to read version for the residents and was subject to regular review.

While some amendments were required, these were completed on the day of inspection.

Judgment: Compliant

## Regulation 31: Notification of incidents

Statutory notifications were not submitted to the Chief Inspector of Social Services in line with the requirements of the regulation.

The inspector identified safeguarding issues that arose on two occasions as reported under regulation 8 below. These were not notified to the Chief Inspector of Social Services.

Judgment: Not compliant

## Regulation 4: Written policies and procedures

The provider had written policies and procedures which were available for review in the centre, implemented and updated in line with the regulations.

They were specific to the centre and provided clear guidance to staff.

Judgment: Compliant

## Quality and safety

The residents at Fiona House told the inspector that they liked their home and that they were happy. Overall, this was supported by the inspector's review of the documentation and from observations on the day of inspection. However, there were changes in the centre as previously outlined and this resulted in regulatory drift in the area of safeguarding and protection which was not compliant on this inspection. In addition, improvements in oversight of positive behaviour support were required.

In the main, the registered provider ensured that a person-centred service was provided in this centre. The residents' health, social and personal needs had been identified and assessed. The necessary supports to meet those needs had been put

in place. Staff were provided with good information in order to support residents' assessed needs.

The safety of residents was promoted in this service through good risk management systems. Risks to residents and the service as a whole had been identified and control measures put in place to reduce those risks.

A review of fire safety arrangements found that they were effective at the time of inspection.

Further findings relating to the regulations under this section of the report are provided below.

## Regulation 25: Temporary absence, transition and discharge of residents

The residents living at this designated centre were living there full-time, apart from time spent at home with their families.

There were no planned admissions or discharges at the time of inspection. Were this to occur, a review of the provider's policy documents found that there were arrangements in place to guide this process if required.

Judgment: Compliant

## Regulation 26: Risk management procedures

The registered provider had implemented good systems for the assessment, control and ongoing review of risk.

The inspector reviewed the centre's risk register and found the risks documented were in line with the needs of the residents and the service. It was subject to regular review.

Residents had individual risk assessments. The inspector reviewed three of these, all of which were in line with the provider's policy and provided clear guidance on how to control the risks identified. Observations made on the day of inspection found that control measures, such as going for a 1:1 walk with a resident after their return home, were happening in practice. Another risk management plan referred to a resident enjoying time with staff, and how this mitigated against the risk identified. This was also possible as there were plenty of staff on duty.

Where risks were identified through the centre's audit system, these were addressed or an action plan was in place.

Judgment: Compliant

## Regulation 28: Fire precautions

A review of the requirements under this regulation found that the inspector had effective fire arrangement in place, including systems for the detection, containment and extinguishing of fires.

The fire prevention policy was updated on 5 December 2024 and therefore in date. This outlined the requirements for weekly and monthly audits which were cross checked by the inspector for the period 3 March 2025 to 20 May 2025. This review found that checks were taking place in line with the provider's policy.

A review of fire fighting equipment found that the items provided were serviced regularly and in order. A review of a sample of fire containment doors along the main fire pathways found that they were closing correctly when activated.

Residents had individual personal emergency evacuation plans (PEEPS), and the inspector reviewed three of these documents. They provided clear information and guidance for staff and subject to regular review.

Judgment: Compliant

## Regulation 29: Medicines and pharmaceutical services

The provider had suitable arrangements for the prescribing, ordering, receipt, storing, administration and disposal of medicines. These medicines management practices were subject to regular review.

Each resident had access to a choice of pharmacist and records of medicines related interventions were well maintained and stored in a safe place.

Judgment: Compliant

## Regulation 5: Individual assessment and personal plan

Residents had individual folders with assessments of their health, social and personal care needs.

The inspector met with four residents and reviewed their assessments with their consent. This review found that they were well presented, well maintained, in date and subject to regular review.

Residents spoke with the inspector about their keyworkers and their goals for the year ahead. These included going swimming, going to musical theatre events, gardening, and beauty treatments.

Overall, the inspector found that staff were provided with clear information through support plans and activities of interest were arranged with the input of residents, their representative if appropriate and in line with their preferences.

Judgment: Compliant

## Regulation 6: Health care

The health and wellbeing needs of the residents living at Fiona House were changing at the time of inspection. From conversations held with staff and from a review of the documentation, the inspector found that the provider and the staff team were working closely with families in responses to changes at home and at the centre.

Residents had access to appropriate healthcare support which took their personal plan into account. Recommendations were documented on their health profile and each resident had a health passport for use if required.

All residents had a general practitioner (GP) and where medical treatment was recommended this was supported by the staff team.

The inspector spoke with a resident who was recovering from surgery. It was very clear that they were fully informed of their health needs. They spoke with the inspector about home visits from their physiotherapist and of how long they must rest for before their resumed their normal daily activities. This showed that residents were supported to understand their medical needs and this assisted their understanding and recovery.

In addition, residents had access to other allied health professionals such as occupational therapy, audiology, chiropody and dental appointments. Access to national screening programmes was provided if appropriate. Support from consultant-led care was provided. A resident who had a recent spell of poor mental health had a mental health appointment scheduled for the week of inspection.

Judgment: Compliant

## Regulation 7: Positive behavioural support

The residents living at this designated centre had a range of assessed needs and two residents required positive behaviour support. The inspector found that while the provider had positive behaviour support arrangements in place, that some of these required review to ensure that the information was in date and therefore effective.

The inspector held conversations with staff and it was clear that they had a good knowledge of how to support residents' with behaviours of concern and of what to do if required. The inspector reviewed both positive behaviour support plans. Both were reviewed on 9 May 2025. However, despite this, not all information was clear and relevant at the time of inspection. For example,

- the information provided was out of date. For one resident this related to trips home at the weekend. When the inspector reviewed this arrangement with the person in charge, they said that these trips had ceased in January 2025. In addition, staff spoken with told the inspector that guidance relating to the removal of hard and soft furnishings in the hallway was not in use at the time of inspection. This also required review.
- some information was not relevant. A review of the second support plan completed by the inspector found reference to the use of physical intervention. Staff spoken with told the inspector that this approach was not used at the centre and therefore not relevant to the resident named.

Some restrictive practices were used at the centre. These were subject to regular review by the provider's human rights review committee. While a restrictive practice register was in place, the information required review. This related to the reason for using a sensor mat beside a resident's bed. This was documented as due to a risk of lowering to the floor. However, from a review of risk assessments and from conversations with staff, it was clear that this was used to ensure that staff were alerted if the resident left their bed at night time in order to keep them and others safe. This was amended on the day of inspection.

Overall, while there were gaps in documentation, the inspector was assured by the supply of consistent, trained and experienced staff, who were aware of what to do if required. Enhanced oversight of the systems used would enhance compliance under this regulation.

Judgment: Substantially compliant

## Regulation 8: Protection

The provider had safeguarding and protection systems in place at this centre. However, from documentation reviewed and discussions with staff and residents,

the inspector was not assured that they were working effectively at the time of this inspection.

The inspector completed a review of incidents occurring from 1 March 2025 to the date of inspection. This review found that on two occasions, safeguarding matters arose at the centre which were not acknowledged as such. In addition, the actions required subsequent to allegations or suspicions of abuse, were not followed in line with local or national policy.

For example:

- An incident report on 4 March 2025 described a resident engaging in angry vocal gestures and assault of staff. It was documented that a resident was asked to move from the area and go to their room. The resident was then described a attempting to enter resident's bedrooms. The inspector spoke with a resident, who recalled the event. They told the inspector that they felt down at that time but that they felt better now.
- An incident report relating to an event on 10 March 2025 described a resident as screaming and shouting and trying to enter the bedrooms of other residents. It was documented that one resident was unable to go to their room and another was described as unable to sleep.
- In addition, a review of safeguarding documentation found that preliminary screening forms were not submitted to the national safeguarding and protection team and safeguarding plans were not reviewed or put in place in response to these matters which is contrary to the provider's policy.

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** | |
| Registration Regulation 5: Application for registration or renewal of registration | Compliant |
| Regulation 15: Staffing | Compliant |
| Regulation 16: Training and staff development | Compliant |
| Regulation 22: Insurance | Compliant |
| Regulation 23: Governance and management | Substantially compliant |
| Regulation 24: Admissions and contract for the provision of services | Compliant |
| Regulation 3: Statement of purpose | Compliant |
| Regulation 31: Notification of incidents | Not compliant |
| Regulation 4: Written policies and procedures | Compliant |
| **Quality and safety** | |
| Regulation 25: Temporary absence, transition and discharge of residents | Compliant |
| Regulation 26: Risk management procedures | Compliant |
| Regulation 28: Fire precautions | Compliant |
| Regulation 29: Medicines and pharmaceutical services | Compliant |
| Regulation 5: Individual assessment and personal plan | Compliant |
| Regulation 6: Health care | Compliant |
| Regulation 7: Positive behavioural support | Substantially compliant |
| Regulation 8: Protection | Not compliant |

# Compliance Plan for Fiona House OSV-0003924

## Inspection ID: MON-0038666

## Date of inspection: 20/05/2025

**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 registered provider will ensure that management systems are in place to ensure that the service provided is safe, appropriate to residents needs, consistent and effectively monitored through the following actions:

The Registered Provider has an internal Quality and Governance system where all incidents are logged. Head of Operations will monitor and review all incidents in monthly monitoring visit to ensure any concerns are reported appropriately.
Commenced 01.06.2025

The Head of Operations will be in the centre on a weekly for 3 months to ensure effective governance and oversight. Commenced 01.06.2025

The Registered Providers nominated person has met with all staff including management in centre to discuss the importance of reporting all incidents and safeguarding in the centre. Completed 26.06.2025

The registered provider will ensure all staff complete enhanced safeguarding training.
To be completed by 30.09.2025.

The registered provider's quality and governance department will complete safeguarding audit in the centre. To be completed by 30.09.2025

The registered provider will ensure compatibility risk assessments are continually reviewed through Head of Operations monthly monitoring visits.
Commenced 01.06.2025.

Safeguarding and incidents will be a standing agenda item at monthly staff meetings.
To commence 26.06.2025

The Head of Operations will monitor staff meeting minutes in monthly monitoring visits. To commence 01.06.2025.

| Regulation 31: Notification of incidents | Not Compliant |
|---|---|

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
The Person in charge and person participating in management have reviewed the two incidents which are noted within report. Following this review the person in charge has submitted notification as per regulation. Completed Date: 12/06/2025

The Person in Charge will ensure all incidents are notified as per regulations.
To commence 01.06.2025

The Registered Provider has an internal Quality and Governance system where all incidents are logged. Head of Operations will monitor and review all incidents in monthly monitoring visit to ensure statutory notifications are submitted within timeframes.
Commenced 01.06.2025

The Registered Providers nominated person has met with all staff including management in centre 26.06.2025 and discussed importance of reporting all incidents in the centre.
Completed 26.06.2025

The Person in charge will ensure incidents are a standing agenda item at staff meetings.
To commence 26.06.2025

| Regulation 7: Positive behavioural support | Substantially Compliant |
|---|---|

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
The Person in Charge will 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 through the following actions:

Positive Behavioural support consultant will attend the centre and review the positive behavior support plans to include most up to date information.
To be completed by 31/07/2025

The positive behavior support consultant will provide a bespoke workshop to all staff to include all updates to plans. To be completed by 30.09.2025.

The Person in Charge has scheduled a Multi-disciplinary meeting to review all restrictive practices in the centre. To be completed by 31.07.2025.

| Regulation 8: Protection | Not Compliant |
|---|---|

Outline how you are going to come into compliance with Regulation 8: Protection:
The Registered Provier shall protect residents from all forms of abuse through the following actions:

The person in charge has reviewed the two incidents which are noted within report. Following review notification has been submitted as per regulation.
Completed: 12.06.2025

The Person in Charge has notified the national safeguarding team of this safeguarding concern. Completed 12.06.2025

The Person in Charge and person participating in management will ensure all incidents and safeguarding are notified as per regulations. To commence 01.06.2025

The Registered Provider has an internal Quality and Governance system where all incidents are logged and safeguarding recorded. Head of Operations will monitor and review all incidents in monthly monitoring visit to ensure notifications are submitted as per regulations and within timeframes. Commenced 01.06.2025

The Registered Providers nominated person has met with all staff including management in centre and discussed importance of reporting all incidents and safeguarding in line with national policy. Completed 26.06.2025

The Registered provider will ensure all staff complete enhanced safeguarding training. To be completed by 30.09.2025.

The registered provider's quality and governance department will complete safeguarding audit in the centre. To be completed by 30.09.2025

The person in charge will ensure that safeguarding is a standing agenda item on monthly staff meetings. To commence 26.06.2025

## Section 2:

## Regulations to be complied with

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

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

| Regulation | Regulatory requirement | Judgment | Risk rating | Date to be complied with |
|---|---|---|---|---|
| Regulation 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 | 30/09/2025 |
| 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 | 30/06/2025 |
| Regulation 07(1) | The person in charge shall ensure that staff | Substantially Compliant | Yellow | 30/09/2025 |

| | | | | |
|---|---|---|---|---|
| | 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. | | | |
| Regulation 08(2) | The registered provider shall protect residents from all forms of abuse. | Not Compliant | Orange | 30/09/2025 |