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:	Alder Services
Name of provider:	Ability West
Address of centre:	Galway
Type of inspection:	Unannounced
Date of inspection:	24 March 2025
Centre ID:	OSV-0004060
Fieldwork ID:	MON-0046024

About the designated centre

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

Alder Services is a service run by Ability West. The centre provides residential and respite services for up to 10 male and female residents, who are over the age of 18 years and who have an intellectual disability. The centre comprises two detached two-storey houses located adjacent to one another in a residential area on the outskirts of Galway city, where residents have their own bedroom, some en-suite facilities, sitting rooms, kitchen and dining area, utility, staff offices and garden area. Staff are on duty both day and night to support the residents who avail of this service.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	7

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Monday 24 March 2025	09:30hrs to 16:30hrs	Mary Costelloe	Lead

What residents told us and what inspectors observed

This was an unannounced inspection, carried out to monitor compliance with the regulations and to follow up on non-compliance's identified at the last inspection. Alder Services comprises two detached two-storey houses which are located adjacent to one another in a residential area on the outskirts of the city. One house provides full-time residential services and the other house provides respite services. Each house can accommodate up to five residents. Both houses were visited as part of this inspection. At the time of inspection, there were five residents accommodated in the residential house. There was one resident being provided with a residential service on a temporary basis in the respite house. The provider had plans in place to provide a full-time residential home for this resident and the inspector was informed that the provision of a new purpose-built residential house was in progress. There were up to 24 service users availing of respite services on a rotational basis with three or four residents availing of the service each night. On the day of inspection, there were three residents living in the residential house, one resident was in hospital and one resident was at home with family members. There were three service users availing of the respite service.

The inspection was facilitated by the team leader and the inspector got to speak with three staff members. The inspector also met with four residents and briefly met with three respite service users. Overall, there were good practices observed in relation to residents' care and support. However, some improvements were required to staff roster records, to some aspects of risk management and to some specific health care documentation.

On arrival at the centre on the morning of inspection, the inspector met with a resident who welcomed them to the centre. They told the inspector how they normally worked three days a week and were enjoying the day off. They had plans to go out for the morning and were waiting to be collected. The resident advised that they were happy living in the centre, liked their work in a restaurant, and enjoyed doing activities of their choice at weekends. The resident spoke about recently enjoying a birthday celebration, eating out, attending music concerts and regularly attending the cinema. They mentioned that they were looking forward to going on an overnight stay away in a hotel and attending a concert. The resident spoke of enjoying their independence, having choice in their day, having their own key to the front door and own mobile telephone which they used to keep in contact with friends and family.

The inspector met with two residents later in the day on their return from day services as they relaxed in the sitting room in front of the open fire. Both residents advised that they were happy living in the centre, that the house was lovely and comfortable and how they all got on well together. They mentioned how they liked the open fire as it made the room cosy and warm. They spoke highly of staff, and stated that they were kind, helpful and understanding. They told the inspector how they could make choices in their daily lives and continued to enjoy regularly going

out and partaking in a range of activities. They spoke about how they attended weekly house meetings and decided on the weekly menu and preferred activities. One resident talked about how they were now attending a weekly Pilates class in the local community and also attended the local gymnasium. They spoke about looking forward to planned birthday celebrations and how they were going to celebrate together with afternoon tea in a local hotel. One spoke of having visited a former resident over the weekend who was now living in a nursing home. Residents were observed to be relaxed and comfortable as they interacted with staff and went about their own routines in the centre.

The inspector visited the respite house during the afternoon when the resident and three service users returned to the house from attending day services. All appeared to be happy as they returned to the house and greeted staff in a familiar way. Some respite users told the inspector how they enjoyed staying for respite breaks while others were unable to express their views due to their communication needs. Staff were observed to be very attentive to the needs of the resident and respite service users supporting them with personal care, offering choices with drinks and refreshments. The resident living in this house had complex support needs. Staffing arrangements were in place to support this resident in line with their assessed and complex support needs, they were provided with one to one staffing during the day and with an active staff member on duty at night time. Staff spoken with were familiar with and knowledgeable regarding the assessed needs of the resident and of service users as well as their individual likes, dislikes and interests. Staff reported that the resident had been out for a haircut over the weekend and had been out for lunch on Sunday in a local hotel with the respite service users.

Residents and service users were involved and had choice in selecting their preferred food and meal options. Residents discussed and selected their preferred meal options at the weekly house meetings. There were colorful pictorial menu options so that residents could easily see and select their preferred options. Some residents assisted with grocery shopping and meal preparation. Residents were also supported to eat out or get takeaways. Staff were knowledgeable regarding the nutritional needs of residents including those who required modified and specialised diets including the recommendations of the dietitian and speech and language.

Both houses were found to be generally well maintained and visibly clean throughout. However, some painting to bedrooms in the respite house which had been identified and requested through the provider's maintenance system in February 2025 had not yet been addressed. The houses were warm, comfortable, and furnished in a homely manner. Residents' artwork was framed and displayed throughout the houses. There were framed photographs of residents and photo albums showing residents enjoying a variety of activities and events. Each resident had their own bedroom which was personalised and decorated in line with their preferences. Some bedrooms had en suite shower and toilet facilities and there were an adequate number of shared bathrooms. Residents had access to a variety of communal day spaces including sitting rooms, kitchen and dining room in each house. There were garden areas located to the rear of each house and outdoor garden furniture provided for residents use. Residents and staff spoke of how they enjoyed spending time outside during the warm weather and how they hosted

summer BBQs and garden parties. The front entrance area to both houses had a variety of pots with colourful spring flowering plants.

Residents' rights were promoted and a range of easy-to-read documents and information was supplied to residents in a suitable format. For example, easy-to-read versions of important information such as the complaints process, safeguarding information, staffing information, menu options and information on upcoming events were displayed. Staff continued to ensure that residents' preferences were met through daily consultation, weekly house meetings, the personal planning process and ongoing communication with residents and their representatives. Topics including the complaints process and safeguarding had been discussed with residents at recent house meetings. The details and contact information for the designated officer and complaints officers were also displayed. Residents had access to information, television, radio, newspapers and the Internet. Some residents had their own mobile telephones and others their own iPads. Each resident had their own bedroom and the inspector observed that the privacy and dignity of residents was well respected by staff throughout the inspection. Staff interactions with residents and respite service users throughout the day were dignified, staff were observed speaking kindly and respectfully with residents, listening attentively and responding promptly to any requests for information or support.

Throughout the inspection, it was evident that staff continually strived to ensure that the care and support provided to residents was person-centred in nature and that they prioritised the wellbeing, autonomy and quality of life of residents. It was clear from observation in the centre, conversations with residents and staff, and information reviewed during the inspection, that residents had a good quality of life and had choices in their daily lives.

The next two sections of the report outline 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 residents lives.

Capacity and capability

The findings from this inspection indicated that the service was generally well managed and issues identified at the previous inspection in relation to complaints management had been addressed.

There was a clear management structure in place. The person in charge worked full-time and was responsible for day to day operation of the centre. They were supported in their role by a team leader, staff team and area manager. Nursing supports had been provided and there was now a nurse available in the organisation to assess residents and provide additional guidance for staff as required. There were on-call management arrangements in place for out-of-hours. The arrangements were clear and made available to staff who worked in the centre.

However, some improvements and further oversight was required to ensuring that staff rosters were accurate and reflected the hours worked by staff in the centre, to some aspects of risk management and to providing clarity around documented processes and evidenced based decision making in relation to end-of-life care. Improvements identified in relation to some maintenance issues in the respite house also needed to be progressed.

The provider had ensured that the staff numbers and skill-mix were in line with the assessed needs of the residents, statement of purpose and the size of the designated centre. The inspector was advised that there was one staff vacancy and recruitment for the post was currently in progress. The inspector noted that there were adequate staff on duty to support the residents and respite service users on the day of inspection. The staffing rosters reviewed for 17 March 2025 to 30 March 2025 indicated that a team of consistent staff was in place. However, improvements were required to the staff roster to accurately identify all staff on duty, to clearly set out the hours worked by staff and to identify abbreviations used in the roster.

Staff training records reviewed indicated that all staff had completed mandatory training. There were systems in place to maintain oversight of staff training and further training was scheduled. Additional training had also been provided to staff to support them in their roles.

The provider had systems in place to monitor and review the quality and safety of care in the centre. The provider had continued to complete six-monthly reviews of the service. The last review took place in December 2024. Actions as a result of this review relating to records of fire drills, restrictive practices, staff training and complaints had been addressed. The annual review of the service for 2024 had been completed. The review included consultation with residents and their representatives. The overall feedback received was complimentary of the service. Actions identified as a result of the review included monthly reviews of safeguarding incidents, the timely identification of any changing needs of residents given their aging profile and the implementation of a new system for weekly counting and recording of loose medications.

The local management team had also systems in place to ensure regular reviews of the quality and safety of care in the centre. There was an audit schedule in place and regular reviews had taken place in areas such as infection, prevention and control, incidents, key working files, service users files, medication management, fire safety, restrictive practices, safeguarding and residents finances. Issues identified as a result of audits had been discussed with staff at the monthly team meetings in order to share learning and bring about improvements to the service.

There were systems in place to record and investigate complaints. The inspector reviewed the records of three complaints made by residents and service users which showed clearly the actions and follow-up actions taken. All complaints had been resolved.

Regulation 14: Persons in charge

The registered provider had appointed a person in charge who worked full time in the centre. The person in charge was suitably qualified and experienced for the role. They normally worked Monday to Friday in the centre.

Judgment: Compliant

Regulation 15: Staffing

The provider had ensured that the staff numbers and skill-mix were in line with the assessed needs of the residents, statement of purpose and the size of the designated centre. However, improvements were required to the staff roster to accurately identify the staff on duty, to clearly set out the hours worked by staff and to identify abbreviations used in the roster. For example, a staff member currently redeployed was still identified as working on some days on the roster. There was no key to identify codes/abbreviations used on the roster. The hours worked by some staff were not always clear.

Judgment: Substantially compliant

Regulation 16: Training and staff development

The provider had ensured that all staff who worked in the centre had received mandatory training in areas such as fire safety, positive behaviour support, manual handling and safeguarding. Additional training was provided to staff to support them to safely meet the support needs of residents including various aspects of infection prevention and control, feeding eating and drinking guidance, administration of medications, epilepsy care and dementia care.

Judgment: Compliant

Regulation 23: Governance and management

The findings from this inspection indicated that the centre was generally being well managed. There was a clear management structure in place as well as an on-call management rota for out of hours and at weekends.The provider and local management team had systems in place to maintain oversight of the safety and quality of the service including six monthly reviews of the service, an annual review

of the service and a schedule of audits.

Improvements and further oversight were required to documented processes and evidenced based decision making in relation to end of life care in line with the providers own policies and procedures, to ensuring that staff rosters were accurate and reflected the hours worked by staff in the centre, to some aspects of risk management and to progressing identified maintenance issues in the respite house.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

There was a complaints policy in place and the complaints procedure was available in an appropriate format. Complaints were logged on the computerised system. Records reviewed provided assurances that complaints were reported, investigated and actions taken to resolve the issues. The complaints policy and procedure of how to make a complaints were discussed with residents.

Judgment: Compliant

Quality and safety

The provider had measures in place to ensure that the well being of residents was promoted. Residents were observed to be comfortable in their environment and with staff supporting them. The provider had adequate resources in place to ensure that residents got out and engaged in activities that they enjoyed on a regular basis and the staff team promoted and supported residents to exercise their rights and achieve their personal and individual goals. Residents spoken with indicated that they were happy living in the centre.

Staff spoken with were familiar with, and knowledgeable regarding residents' up-to-date health care needs. They discussed the complex care and support needs as well as the changing needs of some residents. They described regular input from a range of allied health services including physiotherapy, occupational health and speech and language therapy. They also spoke positively of the nursing supports now available in the organisation.

The inspector reviewed the files of two residents with complex care and support needs.The files were found to be informative and regularly reviewed. There were very comprehensive assessments of the personal, health and social care needs of each resident. There were a range of risk assessments completed including falls risk and manual handling risk. There were detailed care and support plans in place for all identified issues including specific health care needs. However, further oversight and

clarity was required in relation to a specific health care decision which was documented in a residents care plan.

Residents had access to general practitioners (GPs), out of hours GP service, consultants and a range of allied health services. Residents had also been supported to avail of vaccination and national screening programmes. Files reviewed showed that residents had an annual medical review. Each resident had an up-to-date hospital and communication passport which included important and useful information specific to each resident, in the event of they requiring hospital admission.

Personal plans had been developed in consultation with residents, family members and key working staff. The plans set out the services and supports provided for residents to achieve a good quality of life and realise their goals. Review meetings took place annually, at which, residents' personal goals and support needs for the coming year were discussed and progress reviewed. Each resident's personal outcomes for the year were documented in an easy-to-read picture format. It was clear that all residents were supported to progress and achieve their chosen goals. There were regular progress notes recorded and photographs demonstrating achievement of goals.

The management team had taken measures to safeguard residents from abuse. All staff had received specific training in the protection of vulnerable people. There were comprehensive and detailed personal and intimate care plans to guide staff. Safeguarding and abuse were recently discussed with residents at their weekly house meeting. The contact details of the designated officer were clearly displayed. Residents spoken with advised that they felt safe living in the centre. A number of safeguarding incidents had been reported to the Chief Inspector of Social Services over the past year, some of which related to negative peer-to-peer interactions between respite service users. The team leader outlined that educational key working sessions had been held with these individual service users to discuss safeguarding issues. The team leader advised that the compatibility of service users was taken into consideration when planning the respite schedule of stays and there had been no recent incidents reported. They advised while there were no active safeguarding concerns at the time of inspection, the local management team continued to advocate for a resident to have access to their own finances and accounts.

While there were systems in place for the identification, assessment, management and review of risk, improvements were required to some aspects of risk management. There was a risk register which had been reviewed in January 2025 and was found to be reflective of risk in the centre, however, control measures outlined for some identified risks and their risk ratings required review and updating. There were regular reviews of health and safety, medication management, infection, prevention and control and incidents completed by the local management team. The management and staff team continued to regularly review all restrictive practices and restrictions in use and there had been a further reduction in the use of a restriction while a resident was availing of transport. All residents, service users and staff had been involved in fire drills. Fire drills continued to be carried out on a

regular basis. The records of recent fire drills reviewed provided assurances that residents could be evacuated in a timely manner in the event of fire.

Regulation 17: Premises

Both houses in the centre were generally found to be be well maintained, comfortable, furnished and decorated in a homely style. However, some painting to bedrooms in the respite house which had been identified and requested through the provider's maintenance system in February 2025 needed to be progressed.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

Improvements were required to some aspects of risk management. There was a risk register which had been reviewed in January 2025 and was found to be reflective of risk in the centre, however, the control measures outlined for some identified risks required review and updating to reflect the additional control measures in place as described by the team leader. The risk ratings for some identified risks also required review to ensure accuracy and consistency. For example, the same identified risk had varying risk ratings documented.

While all residents had a PEEP (personal emergency evacuation plan), the inspector noted that one resident's plan reviewed required updating to accurately reflect their night-time evacuation needs. For example, staff outlined how the resident would be evacuated at night-time using their wheelchair, however, this was not reflected in their PEEP.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

While residents' health, personal and social care needs were assessed and care plans were developed where required, further oversight and clarity was required in relation to a specific health care decision which was documented in a residents care plan. This is discussed further under Regulation 6: Health care.

Care plans reviewed by the inspector were otherwise found to be individualised, clear and informative. Staff spoken with were familiar with, and knowledgeable regarding those residents with complex care and support needs. There were assessments of need completed, individual risk assessments, as well as, care and

support plans in place for all identified issues including specific health care needs. There was evidence that risk assessments and support plans were regularly reviewed.

Residents were supported to identify and achieve personal goals. Annual meetings were held with residents, their key workers and family representatives, and regular reviews took place to track progress of identified goals. Residents spoken with along with files and photographs reviewed indicated that residents had been supported to achieve their chosen goals during 2024. Residents also spoke of their planned goals for 2025 which were found to be clearly set out in the documentation reviewed.

Judgment: Compliant

Regulation 6: Health care

Staff continued to ensure that residents had access to the health-care that they needed and residents' with specific medical conditions continued to be closely monitored. However, improvements were required to documented processes and evidenced-based decision making in relation to end-of-life care both from a rights based prospective and in line with the providers own policies and procedures. For example, improvements were required to ensuring that instructions provided with regard to end-of-life care included, how decisions were made, the date of decisions, the rationale for it, and who was involved in discussing the decision.

Residents had regular and timely access to general practitioners (GPs), medical consultants and health and social care professionals. A review of a sample of two residents' files indicated that residents had been regularly reviewed by the psychologist, physiotherapist, occupational therapist, speech and language therapist, dentist, and chiropodist as well as recent reviews by ophthalmology, cardiac, rheumatology, gastroenterology and neurology specialists. Records reviewed showed that guidance from health care professionals was available to inform and guide staff in the designated centre. Staff had been provided with training for some specific health care needs, including, feeding eating and drinking guidance, epilepsy care, diabetes care and dementia care. Residents were supported to avail of vaccine programmes and national health screening programmes. Each resident had an up-to-date hospital passport which included important and useful information specific to each resident, in the event of they requiring hospital admission.

Judgment: Substantially compliant

Regulation 8: Protection

The provider had taken measures to safeguard residents from being harmed or

suffering abuse. All staff had received specific training in the protection of vulnerable people to ensure that they had the knowledge and the skills to treat each resident with respect and dignity and were able to recognise the signs of abuse and or neglect and the actions required to protect residents from harm. The inspector was satisfied that safeguarding incidents reported to the Chief Inspector had been managed in line with the safeguarding policy. The person in charge advised that there were no active safeguarding concerns at the time of inspection.
Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Substantially compliant
Regulation 8: Protection	Compliant

Compliance Plan for Alder Services OSV-0004060

Inspection ID: MON-0046024

Date of inspection: 24/03/2025

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 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: The Person in Charge has reviewed service rosters and amended to ensure that all pertinent and relevant information is captured, and that all information is clear and accurate in relation to service staff on duty and on rest time. - Completed on the 25th of March 2025. New legends have now been developed and included on the service rosters which clearly reflect the terminology, codes and abbreviations contained therein. - Completed on the 25th of March 2025. Changes to service roster schedules will be completed in a legible, explicit and up to date manner to accurately reflect actual staff on duty in each designated centre and in line with regulation 15. - Completed on the 25th of March 2025.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: actions required to effectively and comprehensively address any unmet healthcare needs by the 31st of May 2025. The Person in Charge will ensure that a comprehensive assessment is conducted in relation to the resident's decision making on End-of-Life care. This assessment will be fully inclusive of the resident, their choices and preferences and their family as appropriate. The assessment will identify the support and care required by the resident at end of life. This will be completed by the 31st of May 2025.	

The Person in Charge will ensure that key worker meetings and/or support meetings are held with each resident to ensure their voice, choice and preferences is upheld in relation to decisions making about any and all aspects of their healthcare. The Person in Charge will ensure that all changes in information given or received by residents is accurately reflected in their working files' documentation. This will be completed by the 31st of May 2025.

The Provider has provided the actions they have taken in relation to rosters under regulation 15, they intend to take in relation to risk management under regulation 26 and maintenance under regulation 17.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:

A monitoring meeting has been scheduled with the ancillary team, Person in Charge and Person Participating in Management for 19th May 2025. The purpose of this meeting is to review status of actions attached to the schedule of maintenance work. These meetings will continue on a quarterly basis to ensure regular review and oversight of maintenace issues for the centre.
The Person in Charge will follow up with the ancillary team to ensure that all works outstanding are completed as required. A system of regular review of FLEX submissions will be developed and reviewed weekly by the person in charge to include completion dates for works identified by the 30th of April 2025.

Regulation 26: Risk management procedures	Substantially Compliant

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

A review of the centre risk assessments and risk register was completed on the 27th March 2025. The risk register now clearly reflects identified risks, existing control measures to mitigate the risk and accurate risk rating. The Provider's Risk Management Policy clearly demonstrates the pathway for risk escalation.

As part of the review, all risk assessments will be updated to ensure all safety and protection controls are included in line with individual safeguarding plans. - To be completed by the 01st of April 2025.

Each resident's PEEP (personal emergency evacuation plan) was reviewed on the 25th of March 2025 to ensure all current support requirements are accurately reflected.

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:

As outline under regulation 23: Governance and Management

The Person in Charge will review all resident's individual healthcare needs and identify actions required to effectively and comprehensively address any unmet healthcare needs by the 31st of May 2025.

The Person in Charge will ensure that a comprehensive assessment is conducted in relation to the resident's decision making on End-of-Life care. This assessment will be fully inclusive of the resident, their choices and preferences, their family as appropriate and any Allied Healthcare professionals pertaining to the individual. The assessment will identify the support and care requested and required by the resident at end of life. This will be completed by the 31st of May 2025.

The Person in Charge will ensure that key worker meetings and/or support meetings are held with each resident to ensure their voice, choice and preferences is upheld in relation to decisions making about any and all aspects of their healthcare. The Person in Charge will ensure that all changes in information given or received by residents is accurately reflected in their working files' documentation. This will be completed by the 31st of May 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 15(4)	The person in charge shall ensure that there is a planned and actual staff rota, showing staff on duty during the day and night and that it is properly maintained.	Substantially Compliant	Yellow	25/03/2025
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Substantially Compliant	Yellow	31/05/2025
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	31/05/2025
Regulation	The registered	Substantially	Yellow	01/04/2025

26(1)(a)	provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: hazard identification and assessment of risks throughout the designated centre.	Compliant		
Regulation 26(1)(b)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: the measures and actions in place to control the risks identified.	Substantially Compliant	Yellow	01/04/2025
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Substantially Compliant	Yellow	01/04/2025
Regulation 06(3)	The person in charge shall ensure that residents receive support at times of illness and at the end of their lives which meets their physical,	Substantially Compliant	Yellow	31/05/2025

	emotional, social and spiritual needs and respects their dignity, autonomy, rights and wishes.			