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:	Meath Westmeath Centre 3
Name of provider:	Muiríosa Foundation
Address of centre:	Westmeath
Type of inspection:	Unannounced
Date of inspection:	10 June 2026
Centre ID:	OSV-0004590
Fieldwork ID:	MON-0050758

About the designated centre

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

The designated centre comprises three locations, all within close proximity to the nearest small town. There is a three storey house in a housing estate which provides a full time residential service with a social care staff to up to four adults with medium support needs. The house consists of an open plan kitchen/dining room and sitting area, utility room, sitting room, five bedrooms (three are ensuite), two bathrooms. There is a garden to the rear of the house. There is also a detached bungalow in another housing estate which provides a full time residential service with, social care workers and support workers to up to four adults with medium to high dependency support needs. The house consists of five bedrooms (one with an en-suite), one main bathroom, sitting room, kitchen/dining area and utility room. There is garden to the rear of the house. Lastly there is a detached bungalow which provides a full time residential service with social care staff to one resident with medium to high support needs. The house consists of an open plan kitchen/dining/living area, a separate living area, utility room, two bedrooms and a bathroom. There is a garden to the rear of the property. The organisation provides services to both male and female residents over the age of 18. All houses have 24 hour staff support with sleepover staff.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	8

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 10 June 2026	09:00hrs to 17:45hrs	Brendan Kelly	Lead
Thursday 11 June 2026	09:00hrs to 15:00hrs	Brendan Kelly	Lead

What residents told us and what inspectors observed

This two day unannounced risk inspection was carried out following the receipt of solicited information that was submitted by the provider to the Chief Inspector of Social Services as required under the relevant regulation. The information detailed a significant number of safeguarding and protection concerns that were occurring within the centre. The inspection highlighted serious concerns with the provider's admissions process which led to a series of non-compliance's in this report. Issues were identified in Regulation 15: Staffing, Regulation 23: Governance and management, Regulation 24: Admissions and contract for the provision of services, Regulation 8: Protection and, Regulation 26: Risk management.

The designated centre comprises three separate homes in three locations.Through the course of the two days the inspector spent time in all three locations. Overall, the inspection identified significant concerns within one of the locations of the centre. The findings highlighted in this report are mainly related to this one location. The residents in the other two locations were observed by the inspector to be happy and safe in their homes and were in receipt of good quality care and support.

Across both days of this inspection the inspector had the opportunity to observe, meet with and speak to all of the residents across the three centres, the person in charge, person participating in management and front line staff in each of the three centres. The inspector also observed the day-to-day interactions in each of the centres and reviewed key documents in each of the centres to inform judgements.

The centre is currently registered for eight residents. On the day of this inspection there were no resident vacancies. The inspector spent the first day of the inspection in one centre which was home to four residents. On arrival at this centre the inspector was met by a staff member who completed a walk around of the centre with the inspector. The centre comprised of a ground floor with one resident bedroom, living room, open plan kitchen/dining space, utility space and a bathroom. The first floor consisted of four bedrooms two of which were en-suite and a main bathroom. One of the bedrooms was a staff sleepover room and another used as a staff office. The centre had a second floor which consisted of one bedroom, one bathroom and a hot press.

The inspector met with one resident shortly after arriving in the centre. The resident had breakfast and chatted to the inspector about their home. The resident told the inspector that they liked the centre but wanted to live on their own. The resident told the inspector that they liked the staff and they liked their bedroom. Shortly after breakfast the resident came to the staff office and told the person in charge they wished to go out and the resident then left the centre with staff for the remainder of the day.

The inspector met with a second resident shortly before lunch time in the kitchen. The resident was happy to chat with the inspector regarding their plans for the day. They told the inspector that they hoped to go swimming later in the day. The resident told the inspector about their family.

The remaining two residents came home later in the afternoon. One resident came to speak to the inspector in the staff office. The resident told the inspector that when one resident is upset it makes them upset and afraid. The resident told the inspector that they want to go somewhere else when their housemate is upset.

From speaking with staff, some staff expressed how difficult it was to support the residents in this part of the centre effectively due to the ongoing safeguarding concerns despite their best efforts. The staff did express that they were well supported by the person in charge.

On the second day of the inspection the inspector visited the other two locations. On arrival at the first location the inspector met with the person in charge, residential leader and front line staff. The inspector completed a walk around of the centre with the front line staff. The centre was a bungalow that consisted of three resident bedrooms, a staff sleep over bedroom, a sensory room, two accessible bathrooms, a utility space, kitchen/dining area and a living room.

The inspector spoke with one resident in this centre shortly after arriving. The resident was in the sitting room reading a magazine and watching television. The resident had informed the staff that morning they were not feeling well and had chosen to spend the day at home instead of going to day service. The resident spoke positively to the inspector about their home, peers and the staff team.

The inspector observed that the centre was clean, spacious and laid out to meet the assessed needs of the residents. The inspector observed the remaining residents using their home as they wished and were supported by a knowledgeable staff team. The inspector observed residents using the sensory room with music, lights and a foot spa. Other residents were doing arts and crafts, relaxing watching television and playing with sensory toys.

In the afternoon of the second day the inspector moved to the third centre. This was a single occupancy premises with one resident. The inspector met with the resident and the front line staff working in the centre. The resident proudly showed the inspector around their home. The resident showed the inspector lots of photographs of them throughout their life which were proudly displayed on the walls. The resident was very happy and content in their home and spoke positively to the inspector about all aspects of their live in the centre.

The inspector completed a walk around of the centre with the resident. The centre consisted of two bedrooms, a bathroom, utility space, open plan kitchen/dining/living room area and a hot press. On a walk around of the gardens the inspector observed that an outside shed used by the resident was not fit for purpose. The shed had various holes and was also used jointly by the landlord of the property to store their personal items.

The inspector observed that each centre was well decorated, homely and that all residents had their own bedrooms. Resident bedrooms in each centre were all decorated individually and the inspector observed evidence in each bedroom of resident family photos and personal items.

In summary, the residents in two of the centres were being supported in a meaningful and person centred manner that ensured they were safe. However, residents in one centre were not experiencing the same quality of life due to their incompatibility. The providers oversight systems to ensure residents in one centre were safe and protected were also found to be ineffective.

The next two sections of this report will outline the governance and management systems in the centre and how these systems impacted on the quality and safety of the service provided.

Capacity and capability

This inspection showed that significant improvements were required on one part of the designated centre due to ensure residents' safety at all times.

Serious concerns were identified with the provider's admissions processes which had resulted in serious and ongoing incompatibility issues between some residents.

The provider had not resourced a centre adequately to ensure the assessed needs of the residents were being met. The inspection showed a reduction in staffing numbers at the weekend. This reduction in staffing hours continued to the day of this inspection despite evidence of behavioural incidents at times when staffing levels were reduced.

Overall the provider's systems had failed to ensure that admissions were occurring in a safe and planned manner.

Regulation 15: Staffing

The provider did not have the appropriate number of staff on duty at all times that ensured residents in the centre were safe and protected.

The provider had actual and planned rosters available in the centre. The roster were maintained by the person in charge as part of their oversight and responsibility. On the day of this inspection the inspector reviewed the rosters for the months of April and May 2026.

On reviewing the rosters the inspector observed that in one centre where compatibility issues arose the provider had reduced day shift hours at the weekend. The rosters showed that Monday to Friday day shifts were in place from 09:00-21:00, at weekends this changed to 11:00-18:00.

The inspector reviewed incident reports from May 2026 and observed that significant incidents had occurred in the centre at times where the staffing numbers had been reduced. Despite this evidence the provider had not reviewed the staffing levels in the centre in a timely and effective basis. For example, significant incidents had occurred on 06 May 2026 in one part of the centre. The provider only reviewed aspects of the staffing supports on the 21 May 2026. This was not a timely response considering the serious nature of the incidents.

Staff working in the centre expressed the difficulties they had in supporting the residents in an appropriate manner.

Overall, the staffing numbers in one centre had not been increased at times when significant incidents were occurring which was negatively impacting residents.

Judgment: Not compliant

Regulation 23: Governance and management

The inspection showed that the provider did not have effective systems in place to keep residents safe at all times. Overall, the provider had admitted a resident that was not in line with their own admission's policy which had resulted in significant safeguarding concerns occurring in the centre. The oversight and management of admissions, safeguarding and risk was poor. This was having a direct impact on the lived experience of residents in one part of the centre.

Ongoing incompatibility between residents within one part of the centre was not being managed to an effective degree. For example, the inspector reviewed multi-displinary team (MDT) notes that stated that one resident was not in receipt of a meaningful day which was directly correlating with increased incidents. At the time of inspection limited effective actions had been taken to address this and incidents in the centre had continued to increase in number and level of intensity. Overall, the effective management of safeguarding in the centre required significant improvements.

In addition, actions agreed in MDT meetings had not been implemented as required. For example, the inspector observed through a review of multi-disciplinary team meetings from May 2026, that a specific intervention in the form of visual supports was to be implemented for one resident. On the day of inspection this was not in place. This did not provide assurances that sufficient oversight was in place around specific actions from MDT recommendations.

Overall it was found that the centre was not adequately resourced to meet the needs of all residents within the centre. The inspector reviewed an emergency review by the provider's MDT following a significant incident in May 2026. In this review it was recommended that one resident had a dedicated vehicle. On the day of this inspection the centre did not have a dedicated second vehicle. Staff were required to borrow vehicles from day services or other centres. This was having a direct impact on all residents within one part of the centre. In addition, the staffing resources were not sufficient to meet the needs of all residents. Overall, the lack of resources meant that significant incidents were continuing to occur within the centre.

Judgment: Not compliant

Regulation 24: Admissions and contract for the provision of services

The provider had an admissions policy that outlined in detail the required steps to ensure a consistent approach when residents were transitioning into a centre. The findings of the current inspection indicated that the provider had not adhered to their own policies and procedures in relation to this process which was having a direct impact on residents' lived experience in one part of the centre.

On the day of this inspection the inspector reviewed the provider's policy on admissions, the transition plan of one resident and the minutes of a series of meetings prior to the resident's admission.

The provider's policy stated that compatibility assessments would be completed prior to the transition occurring. On the day of inspection the inspector requested to review compatibility assessments for all residents in the centre and was informed that none had taken place. In addition, in reviewing the resident's transition plan it was observed that the proposed resident had spent limited time with the current residents. The policy stated that a series of admissions meetings had to take place to determine the suitability of the placement. The inspector found that although 12 meetings had occurred the meetings did not take into account that the impact/compatibility concerns in relation to a new admission and the outcome of resident visits to the centre that had occurred to date. There was no evidence that this important aspect of care and support was appropriately assessed during the admission process.

On review of the provider's policy it stated that the centre does not accept emergency admissions. However, on review of the most recent admission of a resident to one part of the centre, it was evident that the time line indicated that the admission occurred on a very short time basis. The transition of this resident took a total of two weeks from provider being aware of the need for a residential placement for this resident to the resident moving into the centre. This did provide

assurances that the transition was suitably planned and in line with the provider's policy.

The resident's transition plan had been completed by the resident's previous day service provider. The inspector was not able to review any documents the provider had completed that outlined their plan to transition the resident to the centre. The transition plan the inspector did review recommended six visits to occur including one sleep over. In total the resident completed five visits and the sleep over did not occur. The inspector also observed the visits took place over a seven day period with the resident moving in on the seventh day. Again there was limited evidence that the transition occurred in line with the resident's assessed needs and there was a lack of appropriate documentation and review of the transition process

The admission's policy reviewed by the inspector also discussed the requirement for follow up reviews post the residents admission. Up to the day of inspection, no formal review of the resident's transition plan had occurred.

While it is acknowledged that in the days since the inspection one resident has had a more suitable location identified, the provider was required to ensure future admissions are subject to robust planning, careful consideration of compatibility and comprehensive review post admission.

In summary, due to the provider's significant failings in the pre-admission, transition and post transition process, all residents in one part of the centre were now experiencing significant and ongoing negative impacts in their day-to-day lives.

Judgment: Not compliant

Quality and safety

Risk management and protection systems in one part of the centre were of serious concern. Risk management systems had failed to adequately identify important areas of risk and where risks had been identified they were managed in an appropriate way.

Residents in one part of the centre were subject to ongoing and increasing incidents that were linked to a poorly planned admission to the centre in late 2025. Measures aimed at increasing resident protection could not be deemed as successful as incidents were continuing to occur.

While each premises in the centre was observed to be homely and bedrooms were decorated to each residents individual taste, some maintenance issues were required in two of locations.

Regulation 17: Premises

In the main all three locations in the centre were in a good state of repair and laid out to meet the assessed needs of the residents.

The inspector completed a walk around of all three locations across the two days of inspection. The premises were all well decorated and each part of the centre was clean and tidy.

Each resident had access to internet, smart technology such as television, tablets and mobile phones in line with their wishes.

The inspector observed some areas of maintenance that were required to be completed. For example, in one centre the inspector observed bathroom flooring that had started to separate from the walls. The inspector also observed in this centre some holes in walls that needed to be repaired.

As discussed earlier in the report, one location had a shed in the back garden that needed to be replaced. The shed was in a poor state of repair and was used to store items such as personal protective equipment for the centre. The inspector also observed that a section of the shed had been used by the landlord of the location to store their own items meaning the resident did not have use all of the shed.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

While the provider had systems in place such as a risk management policy and risk registers in place, not all risk in the centre had been appropriately assessed. This meant that effective control measures were not in place to mitigate actual ongoing risks in the centre.

On the day of this inspection the inspector reviewed a sample of residents' risk assessments. The inspector reviewed risk assessments in place regarding injury or harm from other residents. There were ongoing safeguarding risks occurring in the centre that were impacting some residents within the centre. On review of the the assessments they were not reflective of the actual risk in place and were scored as a green low risk. This was despite overwhelming evidence that incidents were having a significant impact on residents. The inspector also observed that the risk assessments were last reviewed in February 2026. The assessment had not been reviewed despite a large increase in incidents in both frequency and impact. This did not provide assurances that risk was being managed in line with best practice.

The inspector reviewed a risk assessment for one resident regarding distress behaviours. This assessment was last reviewed in March 2026 . Again, this

assessment had not been reviewed despite distress behaviours increasing since the beginning of May 2026. For example, a review of incident reports in the centre showed 19 distress behaviour incidents in 2026 with 16 of those in May 2026.

The inspector also observed in this risk assessment that not all control measures were being implemented. For example, one control measure was the use of a clear and consistent visual schedule. As discussed earlier in this report the visual schedule for the resident was not used on the day of this inspection.

In reviewing the risk assessments in place for one resident who had recently moved into the centre the inspector observed that the resident had only two risk assessments in place. One assessment for distress behaviours and one assessment for travelling in the centre transport. The inspector observed that the assessment for travelling in the car had only been in place since May 2026. Through a review of incident reports the inspector observed areas of concern that had not been subject to a comprehensive risk review. For example, the resident had displayed self-injurious behaviour, been physically aggressive towards staff and had not been sleeping at night.

In summary, risk management was not in line with best practice . There was a failure to identify ongoing risks in the centre and manage the risks to an effective degree. Risk ratings associated with some of the risk assessments were not proportionate to the actual risk and Important control measures were not being used effectively.

Judgment: Not compliant

Regulation 8: Protection

The provider had not ensured that all residents were protected and safe. On the day of this inspection the inspector found significant safeguarding concerns in one location in the designated centre.

The inspector reviewed the incident reports from this centre and the safeguarding plans in place. The inspector observed that all residents in this part of the centre were being impacted negatively.

The provider had implemented strategies that were not sustainable in the long term in an attempt to reduce the likelihood of incidents occurring. For example, one resident was now required to leave the centre each day and often multiple times a day to minimise the impact of safeguarding concerns.

In reviewing safeguarding plans the inspector observed actions which included increased staffing supervision. As outlined earlier in this report the provider had reduced staffing numbers at the weekend. This was despite evidence from incident reports that incidents were occurring at these times meaning residents were at an

increased risk of incidents with reduced staffing support. The provider had failed to put in measures to safely safeguard the residents.

It was also evident from a review of safeguarding plans that the strategies in place were not effective in reducing the likelihood of incidents. The inspector observed that through the months of May and June 2026 incidents had continued to occur.

While it is acknowledged again that the provider had begun the process of implementing the transition of one resident from a centre, at the time of inspection they were in the centre and safeguarding concerns were ongoing.

The residents in one centre were subject to repeated and ongoing compatibility issues that meant they were not protected in their home. Measures implemented by the provider had not been successful in reducing the frequency or impact of incidents nor where they sustainable in providing residents with a meaningful quality of life.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Admissions and contract for the provision of services	Not compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 8: Protection	Not compliant

Compliance Plan for Meath Westmeath Centre 3 OSV-0004590

Inspection ID: MON-0050758

Date of inspection: 11/06/2026

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • Additional staffing resources have been introduced to the centre by the registered provider as an emergency response to meet the assessed needs and to ensure the protection of all residents. • The PPIM and PIC meet on a weekly basis to review the staffing resource requirements and if and when increased staffing resources are required this is escalated to the senior management team	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • The CEO has commissioned a review of the admissions process undertaken in this centre at the end of 2025. • The Regional Director has scheduled a meeting on 18/08/2026 with all PPIMs to conduct a full review of the Admissions, Discharge and Transfer policy to assure adherence to all processes within the policy including multidisciplinary assessment, planned transition schedules and documented review of all visits and outcomes prior to placement • A comprehensive safeguarding and risk management review has been initiated for the	

affected area of the centre, with oversight from the Person in Charge (PIC), Area Director, and multidisciplinary team (MDT

• The Registered Provider has reviewed the Statement of Purpose and Function to ensure that emergency admissions cannot be facilitated at this Centre.

• Additional staffing and transport resources have been secured where necessary, and all safeguarding incidents are being reviewed to identify trends and implement preventative measures.

• All outstanding assessed clinical recommendations for residents, including the implementation of identified communication and visual supports, will be tracked through a newly established action monitoring system to ensure timely completion.

Regulation 24: Admissions and contract for the provision of services	Not Compliant

Outline how you are going to come into compliance with Regulation 24: Admissions and contract for the provision of services:
• The CEO has commissioned a review of the admissions process undertaken in this centre at the end of 2025.

• The Regional Director has scheduled a meeting on 18/08/2026 with all PPIMs to conduct a full review of the Admissions, Discharge and Transfer policy to assure adherence to all processes within the policy including multidisciplinary assessment, planned transition schedules and documented review of all visits and outcomes prior to placement.

• The registered provider is currently undertaking a full review of the admissions, transition, and post-admission processes to ensure compliance with Regulation 24 and adherence to the organisation's Admissions Policy

• Admission decisions will be supported by multidisciplinary assessment, planned transition schedules, and documented review of all visits and outcomes prior to placement.

• A standardised transition planning template has been introduced to ensure all stages of the admission process are recorded, monitored, and completed in line with assessed needs and organisational policy.

• Formal post-admission reviews will be completed within agreed timeframes to evaluate the success of the placement and identify any required supports.

• The Person in Charge, supported by the Area Director and Senior Management Team, will oversee compliance through regular audits of admission documentation and governance reviews to ensure all future admissions are robustly planned, appropriately assessed, and centred on the wellbeing, compatibility, and rights of both new and existing residents.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• Repairs have been scheduled to be completed to the bathroom flooring where separation from the wall has occurred, and all damaged wall surfaces will be repaired and repainted as required.
• Funding has been approved for a garden to be installed in one part of the designated centre that will allow the resident to safely store items.
• Progress on these actions will be monitored through the centre's maintenance request tracking system and reviewed by the Person in Charge to ensure completion within agreed timeframes.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
• The Person in Charge has completed a full review of all risk management plans and updated and implemented new risk management to reflect the current needs of all residents.

• Staff members have been briefed on updated risk management plans, safeguarding arrangements, and behavioural support strategies, including the consistent use of visual support and structured routines where required.

• Monthly reviews of incidents, safeguarding concerns, and emerging risks have been introduced to ensure that risk assessments are reviewed promptly following any significant incident, any increase in frequency or severity of behaviors of concern or change in residents' needs. This review is conducted by the PIC and PPIM and MDT support as required.
• Risk management and the centre's risk register is now a standing agenda item at the

monthly team meeting.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
• The registered provider has implemented an emergency response to ensure sufficient resources including staffing and transport are available to manage all safeguarding concerns in the designated centre, this include weekend rosters.

• Individual safeguarding plans and risk assessments will be updated to reflect revised control measures and will be subject to weekly management oversight to monitor effectiveness.

• The registered provider is working alongside its funder to progress a planned transition of the resident identified as contributing to ongoing compatibility concerns and will ensure that interim arrangements minimise the impact on all residents while preserving their rights, dignity, and quality of life.

• A multidisciplinary review lead by the Area Director and including the Person in Charge, Behaviour Support Team, Designated safeguarding Officer and relevant healthcare professionals was convened to review current safeguarding arrangements and implement enhanced control measures and support the transition of the resident to a new more compatible living arrangement.

• The Area Director and PIC meet regularly with the commissioner for services and other provider agency to progress the transition of the resident to a new more compatible living arrangement.

• The PPIM has planned a general welfare review for all residents in the Centre where safeguarding has been a concern, this will be undertaken by the provider's Clinical Psychologist and behaviour support team

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(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Not Compliant	Orange	04/06/2026
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Substantially Compliant	Yellow	30/11/2026
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the	Not Compliant	Orange	24/06/2026

	effective delivery of care and support in accordance with the statement of purpose.			
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	24/06/2026
Regulation 24(1)(a)	The registered provider shall ensure that each application for admission to the designated centre is determined on the basis of transparent criteria in accordance with the statement of purpose.	Not Compliant	Orange	18/08/2026
Regulation 24(1)(b)	The registered provider shall ensure that admission policies and practices take account of the need to protect residents from abuse by their peers.	Not Compliant	Orange	24/06/2026
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the	Not Compliant	Orange	24/06/2026

	assessment, management and ongoing review of risk, including a system for responding to emergencies.			
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	08/08/2026