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: | Belltree |
| Name of provider: | Resilience Healthcare Limited |
| Address of centre: | Clare |
| Type of inspection: | Unannounced |
| Date of inspection: | 15 April 2025 |
| Centre ID: | OSV-0005635 |
| Fieldwork ID: | MON-0045923 |

## About the designated centre

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

This designated centre is located in a mature residential area on the outskirts of the city. The premises is a two-storey detached house where residents have access to a choice of sitting rooms, a kitchen and dining area, utility room and, their own bedroom. Two of these bedrooms have en-suite facilities. There is a pleasant garden and paved area to the rear of the property. A residential service is provided and residents have access to an external day service or, receive an integrated type service from their home. A maximum of four residents can be accommodated. The designated centre is open seven days a week and the model of support is social. The house is always staffed and there are a minimum of two staff members on duty at all times. The management and oversight of the service is delegated to the person in charge supported by a team leader.

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

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| Number of residents on the date of inspection: | 4 |

## 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 15 April 2025 | 09:45hrs to 16:45hrs | Mary Moore | Lead |

## What residents told us and what inspectors observed

This inspection was unannounced and was completed to assess the providers' compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with disabilities 2013 and, the National Standards for Adult Safeguarding (2019). While some action was needed for the provider to demonstrate full compliance, the inspector found that safeguarding residents from harm and abuse was consistently and effectively embedded into the operation, governance and management of this designated centre.

This designated centre is located in a mature residential area on the outskirts of the city. Public transport can be accessed nearby but transport suited to the needs of the residents is also available. The house is a spacious detached two-storey premises on its own site. Each resident is provided with their own bedroom and two of these bedrooms have ensuite facilities. Two residents and the staff team share the main bathroom. To better support the needs and preferences of the residents, the provider made some modifications to the house. These modifications separated shared communal spaces so that residents could have their own space as needed. The residents share the kitchen-dining area and can access as they wish the pleasant garden to the rear of the house. The provider has a programme of maintenance with works ongoing and planned at the time of this inspection.

When the inspector arrived the person in charge, the team leader and two staff members were on duty. One resident had left to attend an off-site day service and one resident had left with a staff member to participate in a community walk. Two residents were in the house one of whom greeted the inspector and asked the inspector their name. The resident obviously recognised the inspectors name as did the other three residents when spoken with later in the day. The role of the Health Information and Quality Authority (HIQA) and the work of the inspector, including visiting the house, was one of the many topics regularly discussed with the residents.

This inspection was facilitated by the person in charge who could clearly describe and demonstrate to the inspector the arrangements in place to promote the individuality, rights and choices of the residents while protecting them from harm and abuse. The inspector also met with the regional manager who came on site to meet the inspector, answer any queries that arose and to provide support if needed to the person in charge.

Safeguarding was embedded in this service in response to the individual and collective needs of the residents. The residents did not always live well together in what is effectively a shared living arrangement. This absence of compatibility had impacted on the quality and safety of the service. Incrementally, as evidenced over the course of inspections completed by HIQA, the provider had developed and improved its systems for protecting residents from safeguarding risks including the risk of harm from a peer. Those improved systems included enhanced staffing

levels, ensuring continuity of staffing, focused training for the staff team, input from the multi-disciplinary team, good systems for identifying and managing risks and, ongoing consultation with the residents themselves.

These improved systems, their effectiveness and how that effectiveness was monitored was readily evidenced from the records reviewed by the inspector. For example, safeguarding residents was consistently referenced in the assessment of needs, personal plans, positive behaviour support plans, staff meetings, meetings with residents and in the risk register. While residents were good verbal communicators, communication and the role it might play in triggering behaviour or the use by residents of behaviour to communicate their needs was well recognised and integrated into the providers safeguarding arrangements.

The residents living in this designated centre are of a younger age profile. The house was energetic and happy with residents coming and going with staff throughout the day. Each of the four residents chatted easily with the inspector and shared their day-to-day life with the inspector. There was discussion of the daily routines and activities that residents enjoyed, of family and the plans in place for an upcoming group holiday. All of the residents were looking forward to the holiday and in particular the opportunities they might have for some musical entertainment. Music appeared to be a shared love as one resident showed the inspector their karaoke machine and discussed their hope of making their own compact disc. Another resident said that they loved going to a local music class and showed the inspector the book of songs that they used. One resident was looking forward to going home to family at the weekend and showed the inspector the present that they had bought for a family member. A resident had enjoyed a recent birthday while another resident discussed the plans they had for celebrating their upcoming birthday with staff, peers and friends. Residents spoke of the opportunities that they had to volunteer and to enjoy the experience of work in local shops and services with the support of the staff team. The opportunities that residents had reflected their interests, choices and abilities. For example, a resident had completed a creative writing class while two residents volunteered and inputted into the "meals on wheels" programme at a local community based day service.

Three residents invited the inspector to view their bedrooms, said that they liked their rooms and that they had picked the paint colours for their rooms. In their bedroom, one resident had and showed the inspector their own nicely framed personal strategies for helping them to regulate how they were feeling at certain times. Another resident had been provided with their own self-contained area of the house and told the inspector that they liked having their own space while they did, as they wished, join their peers in the main section of the house.

While busy there was an easy atmosphere in the house and respectful banter between the residents and staff. One resident compared the work of the inspector to the providers own quality and risk personnel who was evidently known to the resident. The inspector saw that the person in charge was accessible to the residents who readily approached and addressed the person in charge by name. Residents could contact the person in charge by phone if the person in charge was not in the house. The inspector saw that the staff team maintained the staffing

presence and supervision needed to prevent and respond to peer to peer incidents that could occur.

The residents had known each other prior to moving to this designated centre and had formed friendships with each other. The reality was however, as in any shared living arrangement, some residents lived better together than others. This absence of compatibility was actively managed by the provider. The residents did not raise any concerns about their living arrangements with the inspector. The inspector noted that the feedback residents had provided as part of the providers annual service review was overall very positive. However, the inspector saw two residents had not named each other when asked if they got along with the people that they shared the house with it. A third resident said that everything in the house was much better while another resident said everything was fine as long as everyone followed the agreed house rules. It was evident that residents could and did amicably spend supervised time together such as the planned holiday but staff had to be consistently vigilant for the risk of opportunistic peer to peer incidents that could occur. The inspector was satisfied that the arrangements put in place by the provider had significantly reduced the number of incidents that did occur.

However, based on the findings of this inspection there were needs that a resident could perceive as unmet needs and who then expressed this through behaviour that could impact on their peers. The provider had identified a need for and was seeking additional supports for the resident. In addition, while there were very good local management systems that provided safeguarding assurance, the provider could not evidence that it had, in 2024, completed the quality and safety reviews required by the regulations at least on a six-monthly basis.

The next two sections of this report will describe the leadership, governance and management arrangements in place and how they protected residents from harm while promoting their individuality, their rights and their quality of life.

## Capacity and capability

The inspector found suitable systems of governance and management. Responsibilities and reporting relationships were clear and understood. There was clear accountability for the safety of the service provided to residents. While improvement was needed in the provider's quality assurance system, the provider was using the information gathered locally about the service to reduce the risk of harm to residents and to promote the rights and wellbeing of each resident.

The day-to-day management and oversight of the service was delegated to the person in charge. The person in charge had management responsibility of another designated centre and was satisfied that they had the capacity and the support they needed to manage both centres effectively. The person in charge had practical support from a team leader. The team leader was new to this role and the person in

charge described how they inducted, supported and guided the team leader.

There was a planned and actual staff duty rota and based on what the inspector observed and read the provider planned and managed its staffing resources to reduce the risk of harm to residents and to promote the rights and individuality of the residents. For example, there was a minimum of three staff members on duty each day up to 21:00hrs. The provider had addressed issues of continuity and consistency that had previously arisen in this designated centre.

The inspector reviewed the staff training matrix and saw that good oversight was maintained of staff attendance at training. Any refresher training that was due was booked or highlighted so that it would be completed.

There was a schedule in place for the completion of formal staff supervisions in addition to the informal support and supervision provided by the person in charge. The person in charge convened monthly staff meetings and there were no reported obstacles to staff raising any queries or concerns they might have. The inspector reviewed the team meetings minutes folder, saw that there was good staff attendance at the meetings and, safeguarding risks and plans were discussed at these meetings.

There was a written code of conduct that was provided to all staff. A set of values to be adopted by staff was prominently displayed in the staff office. The inspector saw that staff had access to copies of relevant policies and guidance including the providers own safeguarding policy and procedure and guidance published by the Authority such as recognising indicators of abuse.

The inspector saw that how the provider safeguarded residents from harm and abuse was consistently reviewed. For example, the person in charge maintained data on incidents that occurred and the safeguarding considerations of those incidents. Data was collected each day and analysed each quarter on how each resident was feeling and what made them happy or unhappy. The person in charge had completed the 2024 annual review of the quality and safety of the service and had sought feedback from residents as part of the review. A six-monthly review of the quality and safety of the service had also been completed in February 2025. That review also looked at how residents were protected from harm and abuse. However, the provider could not evidence for the inspector that a quality and safety review had been completed in the six-months prior to this February 2025 review.

## Regulation 15: Staffing

The inspector found that the provider was effectively planning, organising and managing the workforce to meet the safeguarding needs of the residents including the supervision needed to prevent peer-to-peer incidents. There was a folder available to the inspector of planned and actual staff duty rotas. The rotas were well maintained and showed each staff member on duty and the hours that they worked. The staff duty rota reflected the staffing levels and arrangements described to and

observed by the inspector.

The provider had improved the continuity of the staffing arrangements in the centre and this continuity supported the consistency of support that residents needed. For example, the consistent implementation of behaviour support plans and safeguarding measures. The person in charge reported that there was currently no requirement for contingencies such as agency staff. One regular experienced relief staff member was listed on the staff duty rota. However, staffing will be discussed again in the context of protection as the provider was monitoring how it protected residents and was, in that regard, seeking additional resources to enhance the safeguarding measures in the designated centre.

The recruitment of staff was centralised. While the inspector did not review individual staff files the inspector requested and saw that the provider had recruitment measures that supported the safeguarding of residents. A vetting disclosure was in place for each staff member employed.

Judgment: Compliant

## Regulation 16: Training and staff development

There was a staff supervision process in place that ensured staff were in receipt of regular formal support and supervision. The person in charge maintained a record of the supervisions they had completed with the staff team and this indicated regular (at least six) supervisions for each staff member in 2024 to date in 2025. The person in charge and the team leader described how the provision of safe quality supports was a core theme explored during formal and informal supervision. The inspector was advised that there was no requirement for enhanced supervision and no concerns arising from the supervisions completed.

The minutes of the staff meetings indicated that the meetings were occurring on a monthly basis. The agenda and the items discussed were found to be resident focused. Safeguarding and protection plans were discussed such as the importance of not placing demands on residents and how to complete and record the "check-ins" completed each day with each resident.

Staff had access to a programme of training and good oversight was maintained of staff training requirements. The inspector reviewed the staff training matrix and saw that a training record was in place for each staff member listed on the staff duty rota. All staff had completed baseline training in child and adult safeguarding, in responding to behaviour that challenged including de-escalation and intervention techniques, gender awareness and, promoting a human rights-based approach to health and social care. Training bespoke to the needs of the residents was also delivered to the staff team by the multi-disciplinary team. This training aimed to support staff to recognise and understand the impact of life experiences on how residents might present.

Judgment: Compliant

## Regulation 23: Governance and management

There were systems of governance and management in place that underpinned the delivery of a safe and quality service to residents. Roles and responsibilities were clear including designated safeguarding roles and responsibilities. The service was led by a capable person in charge who was appropriately supported in their role by the provider. The person in charge confirmed they had access as needed to their line manager and practical management support from the team leader. The inspector found that the person in charge was effectively implementing the provider's systems to ensure that residents were protected from harm and abuse. For example, the support, supervision and training provided to the staff team.

The provider had systems of quality assurance that focused on providing assurance that residents were protected from harm and abuse. Safeguarding and protection, positive behaviour support, the use of restrictive practices and incidents were, based on records seen, consistently reviewed. The person in charge regularly used an accredited self-audit tool to audit the safeguarding arrangements in the centre. Incrementally, the provider had improved the quality and safety of the service based on the information that it collated itself and information such as from previous HIQA inspections. For example, the provider could demonstrate how it had responded to the last HIQA compliance plan such as re-engaging with a complainant who had reported some ongoing dissatisfaction. As part of the provider's quality assurance systems, residents were consistently spoken with in relation to their needs, support and care.

The annual review for 2024 had been completed and had considered how residents' rights, choices and individuality were respected and safeguarded in the designated centre. A quality and safety review was also completed in February 2025. However, the provider could not evidence that a quality and safety review had been completed in the six months prior to this February 2025 review.

Judgment: Substantially compliant

## Quality and safety

This was a very person centred service where residents were supported to express their individuality, their choices and preferences. In the context of that individuality and as referred to in the opening section of this report, the residents, while happy to live in the centre, did not always live well together. The provider had significantly improved how it supported residents to live well together. Safeguarding residents

was embedded into the planning, delivery and oversight of the care and support provided to residents. Much improvement was evidenced in the quality and safety of the service. However, the provider had itself identified that additional support for one resident had the potential to further reduce the risk for peer-to-peer incidents.

Each resident participated in the process of personal planning. The inspector followed one particular safeguarding line of enquiry and reviewed one resident's personal plan. The inspector saw that safeguarding was assessed as part of the resident's comprehensive assessment of need, safeguarding needs and risks were identified and safeguarding plans were put in place to protect the resident from harm and abuse.

The resident was spoken with about these risks and any controls needed to keep the resident safe. For example, controls so that the resident could safely access and use social media sites and messaging platforms. Controls were in place that were applicable to more than one resident. The provider could demonstrate and justify why these restrictions were in place, how they were discussed with residents and managed so that they were not overly restrictive of resident choice and preferences. The inspector saw that educating residents about risks and how to stay safe was ongoing in this designated centre.

The inspector saw that there was a good link between assessing safeguarding risks, the review of the restrictions in place, the review of incidents or near misses that had occurred and, oversight of the risk register.

The identification and assessment of risk, including safeguarding risks, sought to promote and support resident choice and preference whilst also keeping residents safe. For example, staff supported residents to safely use their personal devices and to access a broad range of community amenities and services. Each resident had a busy daily and weekly schedule including the opportunity, if they wished, to engage in further education. There were minimal restrictions within the house itself. One resident was waiting for a door-opening device that they could use themselves as they were dependent on staff to open and close the door to their section of the house.

As stated in the opening section of this report the provider was actively managing each day a safeguarding risk between residents. Incremental actions taken by the provider such as ensuring continuity of staffing and a consistent staff approach had significantly reduced the number of incidents that had occurred. This was reflected in the notifications submitted to the Chief Inspector of Social Services. The inspector reviewed the log maintained by the person in charge of incidents that had occurred including potential safeguarding incidents and was satisfied the improvement reported was correct.

The personal plan reviewed by the inspector included a detailed but practical positive behaviour support plan that clearly detailed behaviour that could occur, why it occurred and the nuances and subtlety of the behaviour that staff had to be aware of as it could trigger responsive behaviour from a peer. For example, a particular way of looking at a peer could trigger responsive behaviour. It was clear from the

plan that the resident could at times perceive that they had needs that were not being met and expressed their perceived unmet needs through behaviour. For example, if staff attention or a particular event was focused on another resident. As evidenced in the reduction of incidents this risk was managed well. However, the provider had itself identified that the allocation of additional one-to-one time for the resident had the potential to better support the resident and reduce the risk for behaviour of concern.

The location, design and layout of the house was suited to the needs of the residents. Residents could access a broad range of services and amenities from the house. The house was found to be safe, warm and visibly clean during this unannounced inspection. The provider had a programme of property maintenance. For example, works had recently been completed in the main bathroom and it was planned to replace flooring in the house while residents were on holiday. The residents were aware of these planned works

## Regulation 10: Communication

While each of the four residents had good verbal communication skills, plans and strategies to support good and effective communication, understanding, retention of information and, positive expression were in place. A total communication approach was in use. For example, the inspector saw in one residents communication plan that there were times when it was best for staff to provide the resident with written explanations and times when the resident preferred to give staff written requests. Staff used a range of accessible documents to discuss different subjects with residents and the residents themselves were very much part of the providers safeguarding systems.

It was recognised in practice and in the positive behaviour support plan that behaviour was at times a form of communication or a response to communication. For example, how a resident might respond to a particular look or gesture from a peer and, why the peer may have communicated with their peer in that way.

Judgment: Compliant

## Regulation 17: Premises

The provider recognised that the design and layout of the house could impact on residents' quality of life. Therefore, the provider had made changes so that the house better supported residents' emotional, physical and overall wellbeing. For example, one resident had private communal space adjacent to their bedroom and told the inspector that they loved having this space. The provider had segregated the two main communal rooms so that they were spaces that could be used by

different residents or for differing activities.

Residents had access to and used the pleasant garden to the rear of the house.

The provider had an ongoing programme of maintenance and refurbishment that residents were consulted about and had input into.

The residents were reported to be well-known in the estate. The location of the house meant that the residents could access a range of amenities and services.

Judgment: Compliant

## Regulation 26: Risk management procedures

The inspector discussed with the person in charge how risk in the designated centre including safeguarding risks were identified, assessed and managed. The inspector saw that each resident had a risk management plan and risks such as for the absence of compatibility between the needs of the residents and for behaviour of concern to occur were identified and assessed. Risks and how they were controlled were reviewed on an ongoing basis by the person in charge and these reviews were linked to any incidents or near misses that had occurred. The measures in place to control safeguarding risks were resident and centre specific and included the designated centres staffing levels and arrangements.

Judgment: Compliant

## Regulation 5: Individual assessment and personal plan

Each resident participated in the process of personal planning. The support and care provided aimed to keep residents healthy and well, safe from harm while also ensuring they had good choice and reasonable control over their support. Safeguarding needs were part of the comprehensive assessment of needs and the support plan. How potential safeguarding risks were managed was part of the ongoing assessment and review of the personal plan. The personal plan recognised and sought to ensure that the individual needs, abilities and preferences of the resident were met and their personal goals were achieved, whilst keeping the resident safe from harm. There was evidence of appropriate multi-disciplinary input into the plan and the annual review of the plan was imminent.

Judgment: Compliant

## Regulation 7: Positive behavioural support

Residents could present with behaviours of concern. At times this behaviour could be directed at a peer. The management and responses to behaviours of concern sought to understand why the behaviour was exhibited and to support the resident while recognising and protecting the safeguarding needs of the other residents. Residents has access to and support from the positive behaviour support team. Assessments had been completed to determine if support from psychiatry was needed. The person in charge maintained good oversight of incidents that occurred so as to monitor the effectiveness of the plans in place and the consistency of the support provided.

Restrictions were in place to safeguard residents from harm and abuse. For example, consistent staff supervision, restricted access to certain personal care items and restricted or supervised access to devices and social media platforms. The provider could justify the need for these restrictions and the restrictions were managed so that residents had safe access as opposed to no access. There was a system in place for reviewing the use and ongoing need for each restriction. Residents were spoken with as to why these restrictions were in place.

Judgment: Compliant

## Regulation 8: Protection

The provider had safeguarding policy and procedures. The person in charge was found to be very knowledgeable in relation to their role and responsibility to protect residents from all forms of harm and abuse. How that responsibility was exercised was very evident in records seen. For example, the providers revised safeguarding policy and procedures was brought to the attention of and discussed with the staff team. The person in charge assessed staff knowledge of safeguarding by the use at regular intervals of different safeguarding scenarios.

The designated safeguarding officer was contacted for advice and guidance. Safeguarding, recognising, reporting and responding to safeguarding risks and concerns including the risk of harm by a peer was strongly referenced in the arrangements in the designated centre. For example, the inspector saw that the person in charge followed up on situations where a risk to resident safety could have arisen such as when attending community based classes.

Plans were in place detailing how residents were to be supported with their personal and intimate care needs.

Residents were consistently spoken with in relation to the risks that presented to their safety and, where they were necessary, the restrictions that were in place to

keep them safe.

Based on the findings of this inspection safeguarding risks in this designated centre were well managed. However, the provider had identified that additional one-to-one staff support for a resident had the potential to enhance the support the resident did receive and hence reduce the risk for behaviour of concern and peer-to-peer incidents. The provider had made initial requests to its funding body seeking the resources needed to enhance this safeguarding control.

Judgment: Substantially compliant

## Regulation 9: Residents' rights

While keeping residents safe, the individuality, rights, choices and preferences of residents were respected and promoted. This meant that different safeguarding arrangements were in place for different residents as a person-centred approach was used in developing safeguarding arrangements. For example, in relation to how residents accessed and used their personal monies, attended to their personal care or the opportunities residents had to leave the house without staff support. Residents were spoken with on an individual basis each day such as the explicit "daily check-ins" completed with each resident to establish how each resident was feeling, what had gone well for them that day and what might not have gone so well. Collectively each week the general routines of the house were discussed between the residents and the staff team.

Residents were spoken with and had input into decisions about their support and care as the provider sought to support residents to understand the risk that might be associated with choices and decisions that they might make. The residents themselves had agreed a set of house rules that each resident was expected to respect and follow so that the house was a pleasant place for all residents to live in. The rules were set out in plain language that the residents understood and identified with such as the way they looked at each other and their tone of voice.

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 15: Staffing | Compliant |
| Regulation 16: Training and staff development | Compliant |
| Regulation 23: Governance and management | Substantially compliant |
| **Quality and safety** | |
| Regulation 10: Communication | Compliant |
| Regulation 17: Premises | Compliant |
| Regulation 26: Risk management procedures | Compliant |
| Regulation 5: Individual assessment and personal plan | Compliant |
| Regulation 7: Positive behavioural support | Compliant |
| Regulation 8: Protection | Substantially compliant |
| Regulation 9: Residents' rights | Compliant |

# Compliance Plan for Belltree OSV-0005635

## Inspection ID: MON-0045923

## Date of inspection: 15/04/2025

**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:<br><br>We will develop an internal recording system by the end of May 2025 to ensure that Internal Quality and Safety Reviews are completed on a 6 monthly basis.<br><br>As a provider all Internal Quality and Safety Review processes will be reviewed to ensure compliance with Policy and Procedure by the end of May 2025. | |
| Regulation 8: Protection | Substantially Compliant |
| Outline how you are going to come into compliance with Regulation 8: Protection:<br><br>We will develop a specific monitoring tool by the end of May 2025 that will be used by support staff and management to identify triggers or factors that may lead to an individual having a perception of unmet needs.<br><br>We will present this monitoring tool and findings to our funders in a planned meeting scheduled for August 25 to evidence the need for additional funding to enhance safeguarding controls.<br><br>As a provider we will continue to advocate on behalf of service users to their allocated commissioners. | |

## 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(2)(b) | The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall maintain a copy of the report made under subparagraph (a) and make it available on request to residents and their representatives and the chief inspector. | Substantially Compliant | Yellow | 31/05/2025 |
| Regulation 08(2) | The registered provider shall protect residents from all forms of abuse. | Substantially Compliant | Yellow | 31/08/2025 |