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:	Mill House
Name of provider:	Lightsky Ireland
Address of centre:	Offaly
Type of inspection:	Unannounced
Date of inspection:	10 February 2026
Centre ID:	OSV-0005742
Fieldwork ID:	MON-0045476

About the designated centre

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

Mill House is a designated centre operated by Lightsky Ireland. The centre can provide residential care for up to five male and female residents, who are over the age of 18 years and who have an intellectual disability. The centre is located on a rural area of farm land, located in Co. Offaly, comprising of five individual apartments, various communal areas and staff offices. Staff are on duty both day and night to support the residents who live here.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	3

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 10 February 2026	09:30hrs to 15:45hrs	Anne Marie Byrne	Lead

What residents told us and what inspectors observed

This was an unannounced inspection that was carried out to assess the provider's compliance with the regulations. In the absence of the person in charge, the day was facilitated by the deputy person in charge. The inspector also got to meet briefly with a staff member that was on duty, and with two of the residents. Overall, although there were examples found of where care and support was provided to a good standard, there were several aspects of this service that required significant improvement. Some of which resulted in an immediate, and an urgent action being given to the provider to address two separate areas of particular concern, which will be discussed in more detail later on in this report.

The centre comprised of various different buildings located on the same grounds. One building contained four one-bedroom apartments on the ground and first floor level, comprising of en-suite bedrooms, kitchen and living spaces. These apartments were fully equipped with kitchen facilities, which allowed residents to store, prepare and cook their own meals, if they wished to do so. The main building also comprised of another upstairs apartment, with the ground floor containing a communal kitchen and dining area, two sitting rooms, a quiet room, toilet, and storage area. This building was largely used by residents if they wished to spend recreational time away from their own apartment, and had televisions, comfortable seating and furnishings, and enough space to allow residents to spend time alone or together, if they wanted. Some of them enjoyed having their meals together in the communal dining area, and there were clean and suitable kitchen facilities to allow for meal preparation and dining. There was also a separate building for laundry, and another building that comprised of two staff offices, a medication room, and staff toilet. A nicely maintained courtyard linked all of these various buildings, with a staff and visitor car park adjacently located. Grounds that surrounded these buildings provided residents with different walk-ways and garden spaces that they could make use of in the good weather. Over the course of this inspection, the inspector visited two of these apartments, which were very much decorated and designed in accordance with residents' own personal tastes and interests. One resident had displayed an entire shelf of figures that they had collected, and had displayed many of their DVDs both in the living area and within their bedroom. Although for the most part, this centre was nicely presented and gave residents a comfortable and homely living environment, arrangements for deep cleaning did require the attention of the provider. In addition, issues were identified in relation to fire containment, with multiple fire doors found to be not closing properly, which will be discussed again later.

There were three residents living in this centre, with two vacancies at the time of this inspection. They had lived together for a period of time and generally got on well as a peer group, with the layout of the centre giving them the option to spend time together in communal areas, while also giving them space to spend time independent of one another, if they so wished. They primarily required care and

support in response to their assessed positive behaviour support needs, social care, some had identified risks that required on-going supervision and monitoring, and one had specific communication needs. Two staff were on duty each day, with one resident requiring a one-to-one staff support ratio during waking hours. At night, there was one waking staff on duty. There were no safeguarding concerns in this centre at the time of this inspection, all residents were presenting well, and were engaging positively daily with their activity planner with the support of staff.

Upon the inspector's arrival to the centre, two residents were present, while the third had already left to attend a college course in art and design that they were undertaking. After speaking for a time with the deputy person in charge about the care and support needs of these three residents, the inspector took a walk-around of the premises and got to meet with one of these residents before they headed out to a medical appointment. This resident remembered meeting the inspector on previous inspections, said that they were doing well, and proudly showed off their apartment. Since the last inspection, this resident had re-located to a different apartment, and now lived above the main building. They loved clothes and make-up, and had an area set up in their hallway for these belongings. On the wall of this hallway, they had many photographs displayed of family, and of them attending car shows, which they had a particular interest in. They then brought the inspector into their kitchen, living area, and bedroom, which had been fitted with an upstairs fire escape since the last inspection. They had a white board displayed in their living area, which they used to log notes of upcoming events and appointments. They spoke of how they were happy in their new apartment, and of how staff had celebrated their birthday with them quite recently. They had a guitar and karoke microphones in their apartment, and spoke of their interest in music and desire to pursue this further. They shortly left with their supporting staff to attend an appointment, and were hoping to go shopping also while they were out. The inspector later got to meet with the second resident for a short period. They typically liked to sleep in until the afternoon, and had various routines around the grounds of the centre that they liked to do after they got up. They had an assessed communication need, and used sign language to communicate with staff. They briefly came to the door of the office to speak with the deputy person in charge, which they routinely did every day, with the deputy person in charge observed to be able to interpret and understand what this resident wanted to express. Over the course of this inspection, interactions between these residents and staff were observed to be warm, respect, and kind.

These residents had many interests and got out and about very regularly to engage in activities of their choice. Some enjoyed shopping, going for walks, often went out on drives, dined out, some had started playing pool, and others often visited family and friends. Along with adequate staffing arrangements, there were two vehicles allocated to this centre, allowing residents to get out as often as they wanted. There was also good encouragement around residents' personal goals, many of whom had chosen goals around further education and money management skills. For one resident, they didn't like to be as socially active as their peers, and generally liked to spend alot of their time at the centre. The deputy person in charge spoke of how there was a piece of work being completed with this resident to try and support

them to engage in routine social activities, and were actively monitoring the resident's progress and supports required in relation to this.

Although there were many positive findings from this inspection, aspects of the provider's own risk and governance and management arrangements required considerable improvement. Failing were found in the provider's own recognition, and response to, some incidents which had recently occurred, whereby, they failed to take appropriate action to review the safety needs of one particular resident. Deficits were also found in relation to some aspects of the provider's own oversight arrangements, which required review to ensure their overall effectiveness in monitoring for the quality and safety of care in this service.

The specific findings of this inspection, will now be discussed in the next two sections of this report.

Capacity and capability

Since the last inspection of this centre, there was a decline in compliance found in relation to aspects of the premises, risk management, fire safety, and the provider's own oversight and management arrangements for the service.

At the time of this inspection, the local management team comprised of the person in charge and deputy person in charge, who were supported by an operations manager. Subsequent to this inspection, the provider submitted a notification to the Chief Inspector, informing of some changes that were being made to this local management structure. The staffing arrangement for this centre was subject to on-going review, with two staff members on duty during the day, and one waking staff at night. There was a familiar staff team working in this centre, who were supported by a local management team. Where additional staffing resources were required from time-to-time, there were relief staff able to provide this. At the time of this inspection, on-going recruitment was underway, to fulfill staff vacancies which had recently arisen.

Staff team meetings were often occurring, which gave staff the opportunity to meet with local management to discuss residents' care and support arrangements, and any other business. Local management maintained good contact with the operations manager, and attended regular online meetings with them. Staff training was maintained under constant review, and refresher training was scheduled for all staff, as and when required. Although for the most part, this centre was well-resourced to meet the assessed needs of residents, the resources required to meet the operational needs of this service, particularly in relation to maintenance management, did require better arrangements to be put in place.

Over the course of this inspection, there were a number of areas requiring significant review by this provider. Despite local audits occurring, provider-led visits,

and various other routine daily and weekly checks of different aspects of this service, some of the more concerning issues raised upon this inspection, had not been detected by the provider through their own internal monitoring systems. Furthermore, one issue in particular which required the immediate attention of the provider to address, still took a number of days for the provider to avail of the resources they needed so as establish the root cause of the issue, in order for it to be rectified. In addition to this, there were multiple deficits to the provider's own internal systems for alerting themselves to risk in this centre, which greatly impacted their priority of review, response, and monitoring of the quality and safety of care in this centre at senior management level.

Regulation 15: Staffing

The provider had ensured that this centre's staffing arrangement was subject to on-going review. There was good staff retention in this centre, which provided consistency of care to residents. Where additional staffing resources were required from time-to-time, the provider had regular relief staff identified to provide this cover. At the time of this inspection, recruitment was on-going, and the provider was also in the process of reviewing day and night-time staffing level arrangements to identify if any changes were required to be made to these. There was a planned and actual roster maintained at the centre, which included staff names, and their start and finish times worked.

Judgment: Compliant

Regulation 16: Training and staff development

The provider had ensured all staff had received the training they required to carry out their duties. Where refresher training was required, this was scheduled accordingly by local management. Staff were also subject to on-going supervision from their line manager.

Judgment: Compliant

Regulation 23: Governance and management

The oversight and governance of this centre required significant review and improvement, particularly in relation to some operational resources, and also with regards to the provider's own monitoring systems for overseeing the quality and safety of care.

Despite an immediate action being given to this provider in relation to an issue identified with fire containment in this centre, this issue wasn't resolved in a prompt manner. Although assurances were sought and received around the provider's interim fire safety arrangements until such a point as this issue was resolved, a review of maintenance resources was required to ensure that should specific issues arise in this centre, that suitable such resources were established and in place, for these to be rectified in a timely manner.

Despite the multiple oversight and governance systems in place in this centre to oversee the quality and safety of care, these required significant review to ensure their effectiveness. As covered under regulation 26 below, there were multiple deficits found in the provider's risk management system. These deficits had a negative impact on the provider's ability to recognise and identify for themselves, the incidents that required their urgent and immediate attention. This had resulted in significant time frames occurring as to when senior management linked back in with local management with their response to incidents which had been escalated to them. Of concern to the inspector was that despite two particular incidents having recently been escalated to the provider, they had not appropriately responded to these, resulting in an urgent action being issued on this inspection. Up until then, the provider had not alerted themselves, or recognised that these incidents needed their urgent attention to ensure any potential harm to residents was appropriately reviewed, responded to, managed, overseen, and monitored. Furthermore, there was also significant delays observed on the part of the provider to oversee and ensure that control measures, which they recognised for themselves as being necessary, were implemented on foot of another serious incident which occurred in December 2025, which at the time of this inspection, still had not been put in place.

Although this centre was subject to regular internal auditing and six monthly provider-led visits, the methodology in which these were being carried out also required review. For example, the last six monthly provider-led visit in October 2025, was expansive in nature and didn't allow for specific aspects of the care and support relevant to that being delivered to residents in this centre, to be more robustly reviewed. Although this visit did identify where some improvements were required, the focus of this visit was largely based on the review of documentation and and would have benefited from an increased focus on the review of care delivery. In addition, the provider had not completed an annual review of this service, which was required by the regulations.

Judgment: Not compliant

Regulation 31: Notification of incidents

There was a system in place to ensure all incidents were notified to the Chief Inspector of Social Services, as and when required by the regulations.

Judgment: Compliant

Quality and safety

Residents' social engagement and personal development was very much advocated in this centre, with residents having multiple opportunities to get out and about, and also to engage in various educational courses that they had particular interest in. There were adequate staffing and transport arrangements in place to support residents to be as socially active as they wished to be, and there was always a variety of different activities that these residents could choose from. As well as this, the particular layout and design of this centre allowed for residents to have various areas to relax in, be it in their own apartment, or within the communal areas of the main building. Residents got on well living together as a peer group, with safeguarding arrangements ensuring the safety and welfare of all three residents. Good practices were found in relation to residents' re-assessment, personal planning, and health care arrangements, with residents being encouraged to be involved in these aspects of their care. However, this inspection did identify several aspects of the provider's risk management system that required significant review, improvements were needed to deep cleaning arrangements, to fire safety arrangements, with more minor improvement required to behavioural support.

Fire drills were often occurring, with the records of these assuring staff could support these residents to evacuate the centre in a timely manner. Residents had a good understanding of what to do if the fire alarm sounded, and each required very minimal support to evacuate. There were fire detection systems throughout the centre, staff had up-to-date training in fire safety, and all fire exits were maintained clear. Since the last inspection, the provider installed an upstairs fire escape to an upstairs apartment, providing an additional escape route to the resident that lived there. However, the route of exit from the bottom of this fire escape required attention, as various trip hazards were observed from debris which hadn't been cleared. Of concern to the inspector, was the number of fire doors in the main building which were not closing properly, which had not been detected through regular fire safety checks that were being carried out.

There were a low number of incidents reported in this centre; however, of those that had happened, the context and nature of some of them posed significant risks to residents' safety, had been challenging for staff to respond to. The provider did not have a system for these incidents to be risk-rated, which negatively impacted the prioritisation of their review, response, management and oversight. Furthermore, following a serious incident in December 2025, there was also a significant delay found in the implementation of a fundamental control measure, which the provider themselves had deemed necessary to mitigate against re-occurrence. Improvements were also found in relation to how the trending of these

incidents was being carried out, and also in ensuring that appropriate risk assessments were in place for all identified residents' risks.

Many of these residents liked to maintain their own apartment, with some independently taking responsibility for general day-to-day cleaning and up-keep, while others were supported to do so with the help of staff. In addition to this, deep cleaning was scheduled to be completed weekly by staff. However, the effectiveness of this overall arrangement required the significant attention of the provider, to ensure better standard of deep cleaning was being maintained.

Positive behavioural support was very much promoted, and residents' behaviours and triggers were well-known to staff. There was also good staff knowledge in relation to how behavioural incidents were to be responded to, with various incident reports demonstrating how staff had effectively supported residents back to baseline. However, the provider had not ensured that behaviour support plan was in place for a resident who required this support.

Regulation 13: General welfare and development

The provider had ensured that each resident had the opportunity to regularly engage in activities that were meaningful to them, with adequate staffing and transport in place to enable this. In addition, residents' educational goals were very much recognised and encouraged by staff. One of these residents was supported to attend a local college where they were undertaking an art and design course. This resident also had a keen interest in creative writing, and had an area in their apartment set up to allow them to do this. Another resident who expressed an interest in hairdressing, was also facilitated to attend a course in this area. This centre was also respectful of the young adult age of some of these residents, and supported them to pick and choose activities and outings that reflected the stage of life that they were at. Another resident who preferred to spend alot of their time at the centre, was being supported by staff to identify small trips each week so as to broaden their social activities. This was a work in progress, and was being maintained under very regular review by local management.

Judgment: Compliant

Regulation 17: Premises

The centre comprised of multiple buildings on the one grounds, containing five separate apartments, a laundry and storage area, offices, and a main building. Although for the most part, the centre was well-maintained and comfortably furnished, there were a number of areas that required the attention of the provider, particularly in relation to deep cleaning arrangements, to include:

- The bathrooms of two apartments visited by the inspector were not cleaned to a high standard, and didn't have sufficient storage arrangements within the shower area for resident's toiletries
- In one shower area, there was discolouration and build-up to the base of the shower wall and shower glass screen requiring attention
- Both apartments visited were not deep cleaned to a high standard, with high levels of dust found on multiple surfaces
- Aspects of the main building were also found not to be deep cleaned to a high standard, with dust build up on many skirting boards and around the fire place area

Two residents had tendency to collect and gather an excessive amount of personal items, which congested aspects of their apartment area. A review was of this was required, to ensure these residents were better supported to maintain clutter-free living environments.

In addition, there were also other aspects of this premises that required the attention of the provider:

- Multiple large gas cylinders were stored outside to the rear of the centre, and did not have suitable enclosed storage
- External gate to the side of the main building was broken
- Maglock gate to the front of the property was not closing properly
- Multiple areas around the centre would have benefited from joinery gaps being filled and some redecoration works

Judgment: Not compliant

Regulation 26: Risk management procedures

Although the provider did have risk management systems in place, multiple aspects of this required significant review and improvement.

Upon review of incidents that had occurred in the centre, two incidents of concern were identified by the inspector which had recently occurred in relation to one particular resident. These incidents posed a potential threat to the safety of this resident, one of which had resulted in a minor injury to the resident, and took staff an hour and a half to manage and support this resident back to baseline. The first incident occurred in January 2026 and was escalated to senior management the day after it happened. However, this did not result in any immediate review being carried out of this resident's safety arrangements at that time. A few days prior to this inspection, a second similar incident occurred involving the same resident, which also posed a potential threat to their safety and welfare. Although immediate steps were taken locally to ensure no harm came to this resident after this second incident, the provider had not taken appropriate action to formally review the first incident that was escalated to them, so as to mitigate against any potential harm to

this resident, and reduce the likelihood of this second incident reoccurring. An urgent action was given to the provider to carry out a multi-disciplinary review of these incidents, and to implement any necessary control measures required. A response to this urgent action was subsequently submitted to the Chief Inspector, assuring that this had been addressed.

Of the incidents reports reviewed by the inspector, none had a risk-rating calculated to indicate the level of risk posed by their occurrence. The inspector observed some of these to have been very challenging in nature for staff to respond to, where one resident in particular had placed themselves at considerable risk of harm on more than one occasion, some of which took over an hour for staff to manage and respond to. Despite all incidents being routinely submitted for senior management review, in the absence of risk-rating, this meant that no severity rating was afforded to any of these incidents, so as to determine the priority of review required, based on the level of risk posed. Furthermore, this also meant that there was no indication of a threshold timeframe as to when senior management needed to respond to incidents. For example, following an incident that occurred on the 29th January 2026, where an resident had engaged in a significant behaviour of concern, no risk rating for this incident was calculated. This incident was escalated via the provider's pathway the day after it occurred, and a response to this wasn't received from senior management until the day before this inspection.

There were also considerable time delays found in the provider's implementation of their own identified control measures. Following a serious incident in December 2025, whereby, a resident had absconded from the centre via a fire exit in their bedroom, the provider identified the requirement for a mag-lock to be installed to this door, so as to prevent re-occurrence. However, at the time of this inspection, this mag-lcok was still not fitted to this door. As an interim measure, local management had adjusted night time staffing arrangements to increase the supervision of this resident, so as to mitigate against re-occurrence of a similar incident. However, at the time of this inspection there was still no time frame identified for when the installation of this mag-lock was going to be completed.

The purpose and function of monthly incident trending also required review, so as to ensure this process was effective in identifying specific risks. For example, the January 2026 incident trending report identified that one incident had occurred during that period, documenting that this incident was in relation to a minor injury sustained by a resident. However, upon review of that incident, the inspector observed considerable more risks posed by this incident, which the current trending process did not focus upon.

Although there were a number of risk assessments in this centre, a review of this assessment process was required to ensure any identified resident risk had a supporting risk assessment. For example, for one resident, they had individual risks associated with self-harm, hoarding, low mood, and physical aggression. However, these individual risks were not supported by an appropriate risk assessment. Furthermore, in response to some incidents that had previously occurred in relation

to absconsion, the provider had not put protocols in place to guide staff on what to do, should a similar incident involving this resident occur.

Judgment: Not compliant

Regulation 28: Fire precautions

Upon a walk-around of the centre, significant concerns were raised in relation to fire containment arrangements. In the main building alone, which contained a resident's apartment, none of the six fire doors in this premises were closing properly. In addition, one fire door in the kitchen area of this building had been wedged open. An immediate action was issued on the day of this inspection for these issues to be addressed. Despite regular fire safety checks being carried out by staff, these had failed to identify the issues identified with multiple fire doors, requiring the attention of the provider to review the overall effectiveness of these fire safety checks.

Since the last inspection, an upstairs fire escape had been installed into one of these apartments. However, the pathways leading from the bottom of this exit to the fire assembly and another exit points required attention. These pathways had debris, ground conditions around this exit route were poorly maintained, and were not clear from falls hazards, posing a potential risk to anyone exiting via this route.

In addition, the location of a fire blanket in the kitchen of one apartment required review, as its current location made it difficult for this to be accessed, should it be needed in the event of a fire.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

Residents' needs were subject to on-going review, and there were personal plans developed to guide staff on how to support residents with their assessed needs. Residents were supported to be part of this process, if they wanted, and were kept informed of any changes that were impacting their care and support arrangements. Personal goal planning was an important aspect of the care provided to these residents, with many having chosen goals that they were working towards in relation to money management, creative writing, learning to play pool, and taking up part-time courses in areas of interest to them.

Judgment: Compliant

Regulation 6: Health care

Although residents in this centre had minimal assessed health care needs, this was still an aspect of their care and support that was maintained under very regular review. Residents were supported to attend medical and dental appointments, and the service was supported by multi-disciplinary input, as and as when required. Residents were very much involved in the planning of their own health care arrangements, and were supported by staff to ask any questions and voice any concerns they had in relation to this aspect of their care.

Judgment: Compliant

Regulation 7: Positive behavioural support

The provider had ensured that where residents required positive behaviour support, that suitable arrangements were in place for this. Residents were supported by a staff team that were aware of their specific behaviours that they required support with, and also around the various positive behaviour support interventions that were required to support them back to baseline. However, for one resident who did require daily support in relation to this aspect of their care, they did not have a positive behaviour support plan outlining the specific behaviours they often displayed, the known triggers in relation to these, or the reactive and proactive strategies required to be implemented in response to these.

Judgment: Substantially compliant

Regulation 8: Protection

The provider had ensured systems were in place for the identification, response, management and on-going monitoring of any concerns relating to the safeguarding of these residents. These procedures were well-known to staff, and residents were aware that they could come to staff if they had any concerns of their own. All staff had received up-to-date training in safeguarding, and at the time of this inspection, there were no active safeguarding plans required in this centre.

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	Not compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Compliant

Compliance Plan for Mill House OSV-0005742

Inspection ID: MON-0045476

Date of inspection: 10/02/2026

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:

The registered provider has strengthened governance and oversight arrangements to ensure the designated centre is effectively monitored, appropriately resourced, and that care and support are delivered safely and in line with regulatory requirements.

1. Provider Oversight and Monitoring

The Operations Manager will conduct formal governance visits to the centre at a minimum of every six months, with at least one visit unannounced, in line with regulatory requirements. These visits will include:

• A comprehensive audit of care and support practices
• Review of health and safety systems
• Review of incident management and safeguarding practices
• Oversight of documentation and regulatory compliance

A written report will be completed following each six-monthly visit, outlining findings, identified deficits, and a time-bound action plan specifying responsible persons and completion dates. Progress against actions will be reviewed at subsequent governance meetings.

2. Annual Review of Quality and Safety

An annual review of the quality and safety of care and support will be completed in consultation with residents, families, staff, and relevant external professionals. This review will evaluate service effectiveness, identify areas for improvement, and inform the development of a Quality Improvement Plan. The plan will include measurable objectives and clear timeframes to ensure continuous service improvement.

3. Incident Management and Escalation Pathway

A strengthened incident management pathway has been implemented. All incidents are reported promptly to the Person in Charge and escalated to the Operations Manager and Operations Director as required. Incidents are risk rated to ensure proportional and timely response.

Where applicable, multidisciplinary input, including behavioural specialist support, is sought to review incidents and update risk assessments or support plans. Safeguarding

concerns are reported in line with national policy and notified to the Chief Inspector where required.
4. Weekly Governance Meetings
Weekly operational governance meetings are held between the Person in Charge (or Deputy Manager) and the Operations Manager. These meetings review:
• Incidents and safeguarding concerns
• Risk management and control measures
• Staffing levels and resource allocation
• Maintenance and environmental safety
• Progress on compliance actions
Minutes are maintained, and actions are tracked to completion.
5. Clear Deputising and Accountability Structure
Clear lines of authority and accountability are established. The Deputy Manager assumes responsibility in the absence of the Person in Charge, and the Operations Director assumes oversight responsibilities in the absence of the Operations Manager. This ensures continuity of governance and leadership at all times.
6. Strengthened Audit Systems
The centre's audit programme has been reviewed and expanded to ensure full regulatory coverage, with increased emphasis on:
• Direct observation of care delivery
• Verification of 1:1 staffing hours
• Person-centred care planning
• Risk assessment review and follow-up
Audit findings are incorporated into structured action plans with clearly defined responsibilities and deadlines.
Summary of Governance Improvements:
• Six-monthly provider-led visits with written reports
• Annual quality and safety review with stakeholder consultation
• Weekly governance meetings with recorded actions
• Risk-rated incident management system
• Strengthened audit and monitoring framework
• Clear deputising arrangements ensuring continuity of leadership
These measures ensure strengthened oversight, clear accountability, improved monitoring systems, and a sustained focus on delivering safe, high-quality, person-centred care in compliance with Regulation 23.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
The registered provider has implemented strengthened systems to ensure the premises is clean, suitably decorated, well maintained, safe, and appropriate to residents' needs.
1. Environmental Oversight and Monitoring
• The Person in Charge conducts documented weekly environmental audits and daily

walkabouts to identify hazards or maintenance concerns.
• Findings are recorded and reviewed by the Operations Manager.
• Identified issues are risk rated, prioritised, and assigned to a responsible person with clear completion dates.
• Progress is reviewed at weekly operational meetings until resolved.
2. Planned and Reactive Maintenance
• A scheduled maintenance programme was completed in February following review of internal maintenance logs and inspection findings.
• All identified structural issues, including gates, maglocks, joinery gaps, and gas cylinder protection, have been addressed.
• All ongoing maintenance issues are logged through the centre's reporting system and tracked to completion.
• Recruitment of a full-time maintenance staff member is in progress to ensure consistent on-site oversight and timely response to repairs.
3. Cleaning and Hygiene Standards
• A full deep clean of the premises has been completed.
• Revised daily and nightly cleaning schedules are in place, clearly outlining responsibilities and designated deep-cleaning tasks.
• Staff complete daily sign-off records to confirm cleaning tasks are completed to the required standard.
• The Person in Charge monitors compliance through spot checks and documented audits.
4. Clutter Management and Safe Storage
• Individual risk assessments have been completed where accumulation of personal belongings presented potential risk.
• Residents are supported, in a person-centred manner, to maintain safe and clutter-free living spaces.
• Designated storage solutions have been implemented where required.

These measures ensure the premises is continuously monitored, maintained to a high standard, and remains safe, accessible, and appropriate to residents' assessed needs. Ongoing review through governance meetings and audit processes will ensure sustained compliance.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
Incident Logging and Risk Rating
All incidents are recorded immediately upon occurrence and assigned a risk rating of Low, Medium, or High. This ensures appropriate prioritisation, timely management response, and proportionate follow-up actions. Incidents are reviewed as part of

governance oversight to identify trends and implement additional control measures where required.

Multidisciplinary (MDT) Support

A Behaviour Therapist has been engaged to provide specialist input. This includes supporting residents directly, reviewing incidents, and guiding staff in the development and review of risk assessments and behaviour support strategies.

Positive Behaviour Support (PBS) Plan

A comprehensive Positive Behaviour Support Plan has been developed for the resident identified as requiring daily structured support. The plan clearly outlines:

• Behaviours that may present
• Identified triggers
• Proactive strategies to reduce escalation
• Reactive strategies to safely support the resident to return to baseline

All staff supporting the resident have been formally briefed on the updated PBS plan and have signed acknowledgement to confirm understanding. The plan is reviewed regularly in line with best practice and updated as required to reflect any changes in presentation or support needs. Implementation is reinforced through daily handovers and ongoing supervision to ensure consistency of practice.

Refresher Training

All staff have completed refresher training in Managing Behaviours to ensure they possess up-to-date knowledge and skills to respond appropriately and safely.

Individual Risk Assessments

Comprehensive, person-centred risk assessments have been reviewed and updated for all residents. Staff have been briefed on these assessments and have acknowledged their understanding to ensure consistent implementation of control measures.

Environmental Safety Checks

Daily environmental checks are conducted in all communal areas and residents' apartments to ensure ongoing safety. Findings are documented in the communication book, residents' notes, and maintenance log. Identified risks are addressed promptly and tracked to resolution.

Risk Management Training

Staff have received additional training in risk identification, assessment, and control measures to strengthen safe practice across care delivery and premises management.

Summary

The service has strengthened its systems for incident management, behaviour support, and environmental safety. Incidents are logged and risk rated promptly, with MDT oversight supporting informed decision-making. Individual risk assessments and PBS plans are current, clearly documented, and consistently implemented. Staff training and governance monitoring ensure a proactive, structured approach to risk management, supporting residents' safety, wellbeing, and quality of care.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:

• Fire Doors
All fire doors have been inspected to ensure they are fully operational and close effectively. Necessary repairs have been completed to ensure compliance. Staff have been formally reminded of the requirement to keep fire doors closed at all times, to ensure that doors are never wedged open, and to verify that doors close fully and function correctly.
• Staff Fire Safety Training
All staff have been debriefed on fire safety precautions. Mandatory fire safety refresher training has been completed to ensure staff maintain up-to-date knowledge of fire prevention measures, emergency response procedures, and safe evacuation protocols.
• Exit Routes and Door Management
All exit routes, including upstairs fire escape pathways, have been cleared of debris and potential hazards to ensure safe and unobstructed evacuation. Daily management walkabouts now include checks to confirm that fire doors are closed, functioning correctly, and free from obstruction.
• Fire Escape Access – Apartment 5
The fire escape area in Apartment 5 has been addressed. Rubber safety matting has been installed, and a clearly defined, unobstructed walkway has been established from the fire escape to the designated external assembly point to ensure safe and efficient evacuation.
• Fire Safety Equipment
All fire safety equipment, including fire blankets, fire extinguishers, and alarm systems, is checked weekly. Fire blankets have been repositioned to ensure improved visibility and accessibility. Any defective equipment identified is repaired or replaced without delay.
• Routine Checks and Documentation
Weekly documented checks of fire doors, escape routes, and fire safety equipment are conducted and retained for governance oversight and inspection review.
• Resident Fire Safety Awareness
Key working sessions have been completed with residents to promote understanding of fire safety procedures and evacuation arrangements. Residents have been supported to understand their individual evacuation plans.
• Fire Drill
A recent fire drill was conducted, with all residents and staff successfully evacuating to the designated assembly point. A post-drill debrief was completed to review performance, identify any learning points, and reinforce safe evacuation practices.

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
Development of Positive Behaviour Support (PBS) Plan
A comprehensive Positive Behaviour Support plan has been developed for the resident

requiring daily structured support. The plan clearly outlines:
• Specific behaviours that may present
• Known triggers for these behaviours
• Proactive strategies to prevent escalation
• Reactive strategies to safely return the resident to baseline

Staff Awareness and Training

All staff supporting the resident have been briefed on the PBS plan and have signed acknowledgment forms to confirm their understanding of behaviours, triggers, and required strategies. Staff have also completed refresher training in Managing Behaviours to reinforce skills and ensure consistent implementation.

Monitoring and Review

The PBS plan is regularly reviewed in line with best practice to reflect any changes in the resident's behaviour or support needs. Daily handovers include discussion of behaviours and application of PBS strategies to ensure continuity and consistency of care.

Documentation and Compliance

The PBS plan is documented in the resident's care file and is accessible to all relevant staff. Compliance with the plan is monitored through supervision, audits, and ongoing team meetings.

These measures ensure that behavioural support is delivered consistently, safely, and in a person-centred manner, strengthening both the quality and safety of care for the resident.

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 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Not Compliant	Orange	01/05/2026
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.	Substantially Compliant	Yellow	01/05/2026
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent	Not Compliant	Orange	01/05/2026

	and effectively monitored.			
Regulation 23(1)(d)	The registered provider shall ensure that there is an annual review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards.	Substantially Compliant	Yellow	01/05/2026
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.	Not Compliant	Orange	16/02/2026
Regulation 28(2)(b)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Substantially Compliant	Yellow	01/03/2026
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	10/02/2026
Regulation 07(1)	The person in charge shall ensure that staff have up to date knowledge and	Substantially Compliant	Yellow	01/05/2026

	skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.			