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:	Cois na Gheata
Name of provider:	Inspire Wellbeing CLG
Address of centre:	Kildare
Type of inspection:	Unannounced
Date of inspection:	19 March 2025
Centre ID:	OSV-0007755
Fieldwork ID:	MON-0043351

About the designated centre

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

The centre is registered to provide residential care and support for up to 12 adults diagnosed as being on the autistic spectrum. The centre is located in a rural setting on a large campus in County Meath. The centre comprises of three houses and two single studio apartments, supporting both male and female adult residents. Residents all have their own bedrooms and each house while configured differently, contains a kitchen, sitting room and adequate numbers of bathrooms. The campus has a large grounds, with sensory gardens, mini farm area, orchard, a poly tunnel where some residents engage in horticultural activities and a number of other designated areas for activities such as arts and crafts, cooking and massage. The centre is staffed by a mixture of social care staff, care workers and has nursing support available.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	10

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 19 March 2025	10:00hrs to 17:00hrs	Maureen Burns Rees	Lead
Wednesday 19 March 2025	10:00hrs to 17:00hrs	Tanya Brady	Support

What residents told us and what inspectors observed

The inspectors found that there were governance systems and processes in place to oversee the care and support being provided for residents. However, these systems had failed to identify some of the key areas of non compliance as identified on this inspection. This meant that the provider could not be assured that the management and oversight arrangements in place could ensure that the service provided was safe, appropriate to residents' needs, consistent and effectively monitored. Although some residents were engaged in activities on the campus and within the local community, for other residents, the inspectors found minimal evidence that these residents were engaged in activities that enhanced their lives and provided them with a meaningful day and life experiences. In addition the rights of a small number of residents were not being upheld in terms of their privacy and dignity. The inspectors were not assured that the residents were being provided with appropriate emotional and behavioural support. In addition, some of the precautions that had been put in place against the risk of fire were not adequate.

Improvements were required regarding the up keep and maintenance of the property, including the cleaning arrangements. In particular, the inspectors were concerned regarding the individual living space for one of the residents. The inspectors observed that this resident's bedroom and adjoining smaller tiled room, was unclean, with visible dirt on the floor, walls, skirting boards and windowsills. A collection of used and unclean mugs and utensils were noted to be stored on shelves. Open food items were observed to be inappropriately stored. Wardrobe drawers were found to be broken and observed to be unclean and to contain sharp items. In addition, an external building used solely by the identified resident was observed to be unclean with visible dirt on floor, sofa, walls and skirting boards. Broken pieces of wood and sharp objects were observed on the floor. The inspectors issued an urgent action plan for these specific issues to be addressed and the provider submitted assurances, including pictorial evidence that actions had been taken to address the cleanliness and maintenance of the area on the day following the inspection.

Since the last inspection, the kitchens, including flooring and the majority of bathrooms in each of the houses had been replaced and redecorated. However, the carpet and flooring in a number of other areas appeared worn and stained and there was chipped and worn paint on the walls and woodwork in a number of areas. The second bathroom in one of the houses was observed to have some worn surfaces and stained and worn tile grouting and broken surface on some tiles. The surface of the arm chairs in two of the kitchens had worn and broken surfaces. The inspectors found that cleaning records were not being appropriately maintained and observed that a number of areas had not been effectively cleaned as a layer of dust was observed on a number of surfaces.

A small number of residents' rights were not being promoted by the care and support provided in the centre. The rights of two residents were found not to be

upheld in terms of their privacy and dignity. For one resident, their bedroom door included two see through glass panels with a direct view of the residents bed and main area of their bedroom from outside the door. Staff reported that two hourly checks were completed for this resident using these see through panels. However, the need to complete these checks was not clear. For another resident, the window on the room containing their bath had see through glass and the garden area outside was a communal area. This meant that there was a potential that others could observe the resident when bathing. It was reported that the resident did not routinely use the bath but did choose to use it on occasions.

The centre is located on a large campus in a rural setting. One other designated centre shared the same campus. The centre comprises of three houses and two studio apartments which are each assigned to one of the three houses. The centre was registered to accommodate up to 12 residents. However, there were two vacancies at the time of inspection hence there were 10 residents living in the centre. There were three residents living in two of the houses, two residents in one of the houses and one resident living in each of the apartments. The residents living in the single apartments did not have certain facilities in their home and availed of the facilities in the houses that they were adjacent to. These included, kitchen, dining, utility, living room and laundry areas. The majority of residents had limited verbal communication. Residents living in the centre ranged in age from 45 to 59 years and had been living in the centre for an extended period.

The inspectors visited each of the three houses and the two studio apartments. One or both of the inspectors met with eight of the 10 residents living in the centre. Two of the residents were out on planned activities within the community on the day of inspection so the inspectors did not have an opportunity to meet them. The majority of the residents met with were unable to verbally tell the inspectors their views of the service but appeared in good form and comfortable in the company of staff. A number of the residents indicated to one or both inspectors that they were comfortable and content living in the centre. Over the course of the day, individual residents were observed attending organised activities on-site, such as arts and crafts. Other on-site activities that residents could attend included baking or horticultural activities. Other residents went out for drives, walks and shopping in the local community and town.

Each of the houses had adequate space for residents with good sized communal areas. Each of the residents had their own bedroom which had been personalised to their own taste. This promoted residents' independence and dignity, and recognised their individuality and personal preferences. There was external space to the rear of each of the houses which had seating and tables for outdoor dining and some planting. The residents also had access to a number of large communal garden areas. Within the wider campus, residents had access to a poly tunnel, an arts and crafts room, coffee dock, a massage area, an orchard with apple trees, a forested area with a walking route, a sensory garden and a farm area with 2 donkeys, a goat, hens and ducks. A pet cat was also seen wandering between houses and the main office building. A staff member told one of the inspectors that a number of the residents enjoyed planting and consuming some of the vegetables grown in the poly

tunnel and fruits from the orchard area.

There was an atmosphere of friendliness in each of the homes visited. Inspectors observed elements of residents daily lives including meal times and activities. Staff were observed conversing with residents and responding appropriately to their verbal and non verbal cues. Residents appeared relaxed, happy and content in the company of staff and their fellow residents. Numerous photos of residents were on display. There was easy to read information on human rights in each of the houses.

Residents were actively supported and encouraged to maintain connections with their friends and families through a variety of communication resources, including visits, video and voice calls. There was a visiting policy in place and no restrictions on visits. There was evidence that residents and their representatives were consulted with and communicated with, about decisions regarding their care and the running of their home. From a sample of records reviewed, it was found that these residents had regular one-to-one meetings with their assigned key workers. The inspectors did not have an opportunity to meet with the relatives or representatives of any of the residents but it was reported that they were happy with the care and support that the residents were receiving.

Residents were supported to engage in a number of activities in the centre and within the local community. However, it was identified by the inspectors, that some residents were not engaging in activities in the community and there was limited evidence that these residents were being supported to have a meaningful day. This is discussed further under Regulation 5. Residents were engaged in routine individualised programmes coordinated within the centre. The provider had a day service coordinator and activity trainers who worked with residents across the campus on a sessional basis. In addition, a horticulturist was part of the staff team and supported residents to grow a range of fruit and vegetables in the poly-tunnel and large communal gardens. A small number of the residents had membership of the gym and swimming pool in a local hotel. Examples of activities that residents engaged in included, walks and cycles within the campus and to local scenic areas, drives, arts and crafts, pottery, baking and cooking, literacy skills, music therapy, eating out in local restaurants, swimming, attending football matches, overnight hotel stays, board games, jigsaws, massage, water and sensory games and gardening. A number of residents were using pedometers to monitor their daily steps which was being encouraged by the staff team. There were however, only two vehicles for use by the staff to support all residents to access activities within the community.

The next two sections of this report present the inspection findings in relation to governance and management in the centre, and how governance and management affects the quality and safety of the service being delivered.

Capacity and capability

There were management systems and processes in place to promote the service provided to be safe, consistent and appropriate to residents' needs. However, improvements were required in relation to the day to day oversight and monitoring of the centre to ensure that that residents were in receipt of good quality care and support which was safe, consistent and promoted their rights. In particular issues were identified in relation to the premises maintenance and upkeep, staff training, residents rights, fire safety arrangements, behavioural support arrangements and provisions to ensure that all residents had meaningful days so as to enhance their quality of life.

The centre was managed by a suitably qualified and experienced person in charge. The person in charge had taken up the position in April 2024. They were in a full time position but were also responsible for one other centre in the community which was located a short distance away by car. They were supported by two team leaders. Each of the team leaders had protected hours for their management roles. One team leader was responsible for two houses and one apartment while the other team leader was responsible for one house and an apartment. A team leader met with the inspectors and was found to have a good knowledge of the requirements of the regulations. The person in charge reported that they felt supported in their role and had regular formal and informal contact with their manager. The person in charge was found to be consistently involved in the governance and management of the centre.

There was a clearly defined management structure in place that identified lines of accountability and responsibility. This meant that all staff were aware of their responsibilities and who they were accountable to. The person in charge reported to the director of services who in turn reported to the chief executive officer. The person in charge and director of services held formal meetings on a regular basis. In addition, the person in charge had regular formal meetings with the team leaders which promoted effective communication across the centre.

Regulation 15: Staffing

The staff team were found to have the right skills and experience to meet the assessed needs of the residents. At the time of inspection, there were two staff vacancies. The person in charge reported that recruitment was in the final stages for these vacancies. The positions were being covered by a regular small number of agency staff. This provided consistency of care for the residents. Staff members spoken with reported that they felt supported in their role. The actual and planned duty rosters were found to be maintained to a satisfactory level.

The majority of the staff team had been working in the centre for an extended

period. This enabled relationships between residents and staff to be maintained. The inspectors noted that staff met with and the person in charge were familiar with residents' needs and preferences.

Judgment: Compliant

Regulation 16: Training and staff development

Training had been provided to staff to support them in their role and to improve outcomes for the residents. However, records available showed that a number of staff were overdue to attend mandatory refresher training in fire safety and manual handling. A training matrix in place to monitor same was not effectively maintained which meant that the person in charge did not have oversight of training provided for staff and training requirements for individual staff members.

Suitable staff supervision arrangements were in place. The inspectors reviewed a sample of supervision records for staff working in the centre. This was considered to support staff to perform their duties.

Judgment: Substantially compliant

Regulation 23: Governance and management

There were management systems and processes in place to promote the service provided to be safe, consistent and appropriate to residents' needs. However , these systems had failed to identify some of the key areas of non compliance as identified on this inspection. In addition some of the systems such as cleaning schedules were incomplete which did not allow for effective monitoring, for instance not all rooms being identified on the schedule. Other reviews or audits completed had failed to identify where information was not current or was inaccurate as outlined under Regulation 7:Positive Behaviour Support, for instance. This meant that the provider could not be assured that the management and oversight arrangements in place could ensure that the service provided was safe, appropriate to residents' needs, consistent and effectively monitored.

The provider had completed an annual review of the quality and safety of the service and unannounced visits, to review the safety of care, on a six monthly basis as required by the regulations and other monitoring visits and other audits and checks in areas such as finance, medication and health and safety. However, a number of these reviews had not been effective, in that they failed to identify maintenance issues relating to the premises, fire safety issues, infringements to residents rights and the lack of arrangements to ensure a meaningful day for a

number of the residents.

Judgment: Not compliant

Regulation 31: Notification of incidents

Notifications of incidents were reported to the office of the chief inspector in line with the requirements of the regulations. Over all, there were a low number of incidents reported in this centre.

Judgment: Compliant

Quality and safety

From what the inspectors observed, there was evidence that the residents in each of the three houses and two apartments had their care and support needs supported. However, the maintenance and upkeep of the premises required attention, a number of residents rights were not being upheld, behavioural support arrangements in place had not been reviewed for an extended period and significant improvements were required to ensure that all residents experienced meaningful days to enhance their life experiences.

Assessment documentation and support plans reflected the assessed needs of individual residents and outlined supports required to maximise their personal development in accordance with their individual health, personal and social care needs. The reflection of resident choices and wishes required further review. There was evidence that some residents were supported to engage in one-to-one or group activities both on and off site. However, inspectors found that other residents did not have regular opportunities to engage in meaningful activities outside of their home and off the campus. This impacted residents general well being and development as it restricted their ability to fully participate in and benefit from meaningful or community based activities.

Overall, the health and safety of the residents, visitors and staff were promoted. However, on the day of the inspection an inspector observed that cleaning materials which had been risk assessed as requiring to be locked away were being stored in a communal area. In addition window blind cords were not fixed nor shortened as required and this was pointed out to the person in charge on the day. An external building used by one resident, but freely accessible to all individuals was observed to have broken pieces of wood, scrap materials such as batteries and sharp objects on the floor. There was a risk register in place and individual and environmental risk assessments had been completed and were subject to regular review. Risk

management and minimisation plans were in place which had been informed by the risk assessments. There was an incident reporting system in place with arrangements in place for investigating and learning from incidents and adverse events involving the residents.

Regulation 17: Premises

Under this regulation the provider was required to submit an urgent compliance plan to address an urgent risk. The provider's response did provide assurance that the risk was adequately addressed. The provider submitted written and photographic evidence on the day following the inspection to support their assurances. The urgent actions related to observations, in one of the houses, of one resident's bedroom and adjoining smaller tiled room. These were found to be visibly unclean, with dirt on floor, walls, skirting boards and windowsills. A collection of used and unclean crockery and utensils were placed on shelves. Open food items were being inappropriately stored and it was apparent that the room had not been effectively cleaned. Wardrobe drawers were observed to be broken, dirty and to contain sharp items. An external building, which the person in charge reported was only used by one resident was also observed to be dirty with visible dirt on floor, sofa, walls and skirting boards. Broken items, batteries and sharp objects were observed on the floor.

On arrival to one of the houses inspectors observed two tents that inspectors were told belonged to a resident. These were filled with broken electrical items, wrappers and discarded materials. The person in charge stated that these were important to the identified resident however, it was not clear what measures were in place to protect all residents from the risk of injury or the risk of pests as these were located outside adjacent to the front door.

Each of the houses and the studio apartments visited, were found to be homely and comfortable. However, the carpet and flooring in a number of areas appeared worn and stained and there was chipped and worn paint on the walls and woodwork in a number of areas. The second bathroom in one of the houses was observed to have some worn surfaces and stained and worn tile grouting and broken surface on some tiles. The surface of the arm chairs in two of the kitchens had worn and broken surfaces.

Cleaning records were not being appropriately maintained. The inspectors reviewed cleaning records in each area which recorded staff sign off for cleaning in various areas. However, these records were not adequately maintained. For example in one of the houses, a resident's bedroom and personal areas was not included in the schedule. In some cases, there were gaps in the records for when cleaning had occurred. In other cases, records indicated that areas had been cleaned. However, it was evident on observation that a number of areas had not been effectively cleaned as a layer of dust was observed on a number of surfaces.

Judgment: Not compliant

Regulation 28: Fire precautions

Precautions were in place against the risk of fire. However, a fire door in one of the houses was observed to be damaged, three fire doors in one of the houses were observed to be wedged open on the morning of the inspection and a fire door to a small laundry area in two of the houses was observed to not have a self closing device linked to the fire alarm system in place. This meant that in the event of fire, these fire doors might not be effective in containing a fire. It was noted in the records of checks for one of the houses that records were not being appropriately maintained.

There was documentary evidence that fire fighting equipment, emergency lighting and the fire alarm system were serviced at regular intervals by an external company. A procedure for the safe evacuation of residents in the event of fire was prominently displayed in each house. Each of the residents had a personal emergency evacuation plan which adequately accounted for the mobility and cognitive understanding of the individual resident. Fire drills involving the residents had been undertaken at regular intervals and it was noted that the centre was evacuated in a timely manner.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

The inspectors found that there were appropriate and suitable practices in place relating to the ordering, receipt, prescribing, storage, disposal and administration of medicines in each of the houses. All medication was found to be stored securely in each of the houses. A sample of medication records reviewed by inspectors in each of the houses found that medications were being administered as prescribed with suitable records maintained.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

Although it was acknowledged that residents' well being and welfare was maintained by a good standard of evidence-based care and support, the inspectors found that a number of residents were not being actively supported to have meaningful days, so

as to enhance their quality of life experience.

There were some institutionalised type practices in terms of set routines for some residents but there was limited evidence that these routines had been reviewed to ensure that residents were provided with opportunities to engage in a variety of activities of their choosing. There were limited opportunities for education, training and employment for some residents. The inspectors reviewed a sample of personal plans and found that there was no robust system in place to establish residents educational, employment or training goals. It was acknowledged that one resident had recently begun attending a social farm weekly and this was a positive change.

While there was evidence that a number of the residents engaged regularly in activities on the campus and within the community, there was limited evidence of this for other residents. For example, a sample of records reviewed for three residents reflected that the three residents had engaged in minimal activities over a preceding four week period and there was no evidence recorded that they had left the campus during this period. Records stated that they had 'followed their own routine' and activities recorded included, 'watching television' and 'relaxed in room and lounge'. Goals identified for a number of the residents were not specific, person centred or measurable. For example, a goal for one resident was ' to engage in community activity' and for another 'to develop social goals and activities'. There was limited evidence that progress in achieving the goals set were being monitored. An annual personal plan review for each of the residents whose file were reviewed had been completed. These reviews involved consultation with family members.

Judgment: Not compliant

Regulation 6: Health care

Residents' healthcare needs appeared to be met by the care provided in the centre. Individual health assessments and plans were in place. There was evidence that residents had regular visits to their general practitioners (GPs). Residents had access to a registered nurse who was based on the campus in a full time position from Monday to Friday. There was evidence that dietary guidance for individual residents was being adhered to. A number of residents were being encouraged to monitor their daily steps using a tracker device.

Judgment: Compliant

Regulation 7: Positive behavioural support

The inspectors were not assured that the residents were being provided with appropriate emotional and behavioural support. It was identified that positive

behaviour support plans were in place for residents identified to require same. However, these plans had not been effectively reviewed in an extended period. While inspectors were told that there was now some access to a behaviour support therapist for the centre this was limited and had not yet extended to all residents who required support.

It was noted that the person in charge had signed a number of plans as having been reviewed by them but information within these plans was not current. A restrictive practices register was in place and subject to regular review. However, it was identified that a restriction in one of the houses which impacted each of the residents living there was only being recorded as a restriction for one of the residents. It was noted that there had been a reduction in some restrictions in the preceding period.

Judgment: Not compliant

Regulation 8: Protection

There were measures in place to protect residents from being harmed or suffering from abuse. Allegations or suspicions of abuse had been appropriately reported and responded to. Intimate and personal care plans were in place for residents identified to require same. These provided a good level of detail to support staff in meeting individual resident's intimate care needs. Safeguarding information was on display and included information on the nominated safeguarding officer.

Judgment: Compliant

Regulation 9: Residents' rights

A number of residents' rights were not being promoted by the care and support provided in the centre. The rights of two residents were found not to be upheld in terms of their privacy and dignity. For one resident, their bedroom door included two see through glass panels with a direct view of the residents bed and main area of their bedroom from outside the door. Staff reported that two hourly checks were completed for this resident using these see through panels. However, the need to complete these checks was not clear. For another resident the window on the room containing their bath had a see through glass window and the garden area outside was a communal area. This meant that there was a potential that others could observe the resident when bathing. It was reported that the resident did not routinely use the bath but did choose to use it on occasions.

As discussed under Regulation 5, improvements were required in relation to some residents access to activities in line with their interests and wishes, particularly in

relation to accessing their local community

In one of the houses, personal and confidential health information for one of the residents was on display on the fridge. An inspector observed that this information was removed by the person in charge on the day of inspection.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Cois na Gheata OSV-0007755

Inspection ID: MON-0043351

Date of inspection: 19/03/2025

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: - 4 staff have been scheduled to complete their refresher training in Fire Safety & Manual Handling by 27/05/2025 - The PIC has established a recurring monthly training compliance meeting with the local management team across the campus commencing 31/05/2025 to update the training compliance matrix, to identify gaps and to ensure accuracy.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: - Monitoring: o The Provider has carried out refresher training on Effective Auditing Skills on 15/04/2025 for staff undertaking Reg 23 reviews, internal audits and other monitoring checks to address deficits and enhance the effectiveness of our monitoring processes. o The Provider has devised an annual Quality Check of Reg 23 reports through the Quality & Compliance dept to identify areas for improvement in our own systems, including skills development among those that conduct monitoring in services commencing 30/05/2025 - Governance: all actions arising from this inspection will be monitored by the Assistant Director/Director through a Service Improvement Plan - updated through monthly Supervision sessions to reflect progress, address barriers and to identify any further actions required.	

Regulation 17: Premises	Not Compliant

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

- Urgent remedial actions were implemented by the Provider on 20/03/2025 to address risks identified during the inspection.

Further corrective action is planned as follows:
- Cleaning Schedules:
o Schedules for all houses have been reviewed and updated by the PIC to ensure all spaces and rooms are captured by 31/03/2025.
o The PIC will carry out a rolling programme of Hygiene and Upkeep Spot Checks commencing on 31/03/2025 to monitor compliance and standards, and to address issues as they arise.
o The PIC has introduced a new weekly Team Leader quality check of cleaning records (& fire checks & data privacy) commencing on 05/05/2025
o A standardised Shift Handover Sheet implemented across the campus on 05/05/2025 by the PIC to ensure actions and records are completed or handed over to oncoming shift.

- The Provider has identified a schedule of premises upgrades with preliminary final completion date is 31/12/2025, pending appointment of subcontractors. To include:
o Replacement for worn carpets & flooring
o Upgrade bathroom tiling and surfaces in second bathroom
o Repainting walls and woodwork in aged areas
o Replacement of damaged kitchen chairs and armchairs

Regulation 28: Fire precautions	Not Compliant

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

- The PIC emailed all staff on 20/03/2025 to remind everyone of the fire regulations, and not to wedge fire doors open, and keep all fire exits clear.
- Replacement fire doors, including self-closing devices where missing, were ordered by the Provider from the Contractor on 20/03/2025, and will be measured, delivered & fitted as soon as possible (the Contractor advised there is potentially a lead time of 7-8 weeks on some doors)
- A standardised Shift Handover Sheet implemented across the campus on 05/05/2025 by the PIC to ensure actions and records are completed or handed over to oncoming shift, including Fire Checks.
- The PIC has introduced a new weekly Team Leader quality check of fire records (& cleaning & data privacy) commencing on 05/05/2025

Regulation 5: Individual assessment and personal plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:

The PIC has identified actions to improve the approach to individualised person-centred, rights-based support:
- The staff team in bungalow 1 will undertake Social Role Valorisation training on 01/05/2025 to support the team in the delivery of meaningful community engagement & person-centred support.
- The PIC and Team Leaders are reviewing personal plans with residents using social stories & pictorial tools to help them identify meaningful goals and choices of day-to-day activities, to be in place by 31/05/2025.
- The PIC and the staff team are sourcing a range of community-based activities to provide options & choice to the residents in line with their personal preferences, likes and interests; This will be used to inform the individual "Planned and Actual" Activity Schedules by 16/05/2025

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:

- The Restrictive Practice Register was reviewed and updated by the PIC on 09/04/2025 to reflect the impact of some restrictions on other residents;
- The staff team have developed Social Stories to support communication and consent with residents on the nature of restrictive practices, by 01/05/2025
- The PIC will bring the updated RP Register to the provider's 'Restrictive Practices Review Committee' meeting on 17/06/2025 for endorsement or further suggested changes if required; In the interim, this will be reviewed/endorsed by the Assistant Director/Director to provide oversight and guidance.
- The PIC has updated the easy read booklet on human rights and advocacy services for residents, which will be reviewed on a person to person basis by 31/05/2025 and thereafter as need arises;
- The Behaviour Consultant will further review the Behaviour Support Plans, by 28/04/2025 and may give further guidance for review at that stage which will be added to the Service Improvement Plan for this inspection.
- The PIC reviews restrictive practices at least every 6 months (or a more frequently as necessary) and it stands as a rolling item on the staff meeting agenda, to consider whether they continue to be valid and as an opportunity to reduce or eliminate their use or to trial alternatives.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:

Reg 9(1)
- In a meeting on the 03/04/2025 staff were reminded to ensure confidential personal information relating to residents is stored securely at all times; This was reiterated to all staff by the PIC by email on the 28/04/2025.
- The PIC has introduced a new weekly Team Leader quality check of data privacy (& cleaning & fire) records commencing on 05/05/2025
- Transparent glass panels in one bedroom door set have been covered over for privacy

on 20/03/25, with new doors on order; and a translucent glass privacy cover has been placed on the window of one bathroom by the Provider on 18/4/25.

Reg 9(2)(b)
- The PIC & Team Leaders will commence 'Active Support' workshops with the staff team on 01/05/25 to support the delivery of meaningful community engagement & person-centred support across the service.
- The PIC has reinstated a "Planned and Actual" Activity Schedule for each resident by 16/05/2025 which will support individuals to identify their preferences and choices for day to day activity, training, employment and/or volunteering opportunities, and will demonstrate any changes they choose to make in line with their will and preference.
- The Provider will have a targeted focus on the actions relating to residents' rights in the forthcoming Regulation 23 reviews to inform future plans and continuous improvement.

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 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	31/05/2025
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Not Compliant	Red	20/03/2025
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is	Not Compliant	Orange	30/05/2025

	safe, appropriate to residents' needs, consistent and effectively monitored.			
Regulation 28(2)(a)	The registered provider shall take adequate precautions against the risk of fire in the designated centre, and, in that regard, provide suitable fire fighting equipment, building services, bedding and furnishings.	Not Compliant	Orange	05/05/2025
Regulation 05(2)	The registered provider shall ensure, insofar as is reasonably practicable, that arrangements are in place to meet the needs of each resident, as assessed in accordance with paragraph (1).	Not Compliant	Orange	31/05/2025
Regulation 07(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.	Not Compliant	Orange	17/06/2025
Regulation 09(1)	The registered provider shall ensure that the designated centre	Not Compliant	Orange	05/05/2025

	is operated in a manner that respects the age, gender, sexual orientation, disability, family status, civil status, race, religious beliefs and ethnic and cultural background of each resident.			
Regulation 09(2)(b)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability has the freedom to exercise choice and control in his or her daily life.	Substantially Compliant	Yellow	16/05/2025