



Report of an inspection of a Designated Centre for Disabilities (Adults).

Issued by the Chief Inspector

Name of designated centre:	The Stables
Name of provider:	Talbot Care Unlimited Company
Address of centre:	Louth
Type of inspection:	Unannounced
Date of inspection:	16 June 2025
Centre ID:	OSV-0008602
Fieldwork ID:	MON-0047404

About the designated centre

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

This centre provides residential services to male and female adults, and is located on the outskirts of a town. The centre can accommodate up to six adults, and residents are supported by a team of social care workers and support workers. The centre is managed by a full time person in charge who is supported in their role by a house manager. Residents can access the services of a general practitioner, as well as range of healthcare personnel within the service.

The centre is a large two storey house with an adjoining apartment, and individual bedrooms are provided for residents. The residents can access a range of amenities in the local town, and a car is provided to facilitate residents to access community activities in both the local and nearby towns.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	6
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How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Monday 16 June 2025	15:45hrs to 19:00hrs	Caroline Meehan	Lead
Tuesday 17 June 2025	12:05hrs to 19:45hrs	Caroline Meehan	Lead

What residents told us and what inspectors observed

This inspection was carried out over two days, and the inspector had the opportunity to meet all residents living in the centre, observe what life was like for residents, speak to the team, and review a number of assessments and plans of care.

From speaking with a resident, and from observing other residents as they went about their day, it was evident that staff were endeavouring to provide the support residents needed. However, this was not always possible due to the ongoing risks and compatibility concerns in the centre.

The inspector spoke to a resident in the garden on the first evening of the inspection, and they told the inspector about some of the things they liked to do. This included setting plants, going to a day service three days a week, cooking and baking for themselves, and shopping. The resident spoke very positively about how they now looked after their own money, and how they were planning an upcoming party for their birthday. However, the resident did tell the inspector they do not get on with everyone they lived with, and described how an incident the previous week had upset them.

Residents were observed to use the front garden throughout the day, and there was a trampoline, a swing, and garden seating provided. However, the inspector observed that an adverse incident did occur in the garden, and while other residents did not witness this, the safeguarding measures to protect the resident's dignity and privacy was not effective.

The centre was bright and spacious and had been equipped with a range of equipment and furniture specific to the interests of residents. For example, some residents liked to use the indoor trampoline and large physio ball in the sittingroom and one resident had a desk and chair also in this room, for doing jigsaws. It was observed that there had been some minor damage to the premises, and a set of curtains and some photographs were therefore not hung on the day.

It was important that residents knew what was happening for the day, and each resident had a visual board, or a written plan on a whiteboard in their room. A staff member explained how this was prepared with residents individually every morning. The person in charge talked about some of the community activities residents liked for example, going to carnivals, swimming, horseriding, and walks, and it was evident throughout the inspection that residents were going on various community activities both days.

The person in charge knew residents very well, and described a range of communication, healthcare and social supports in place for them. They were also very knowledgeable on the emotional and sensory needs of each resident, and how best to support residents to minimise adverse incidents, as well as keep them safe.

However, the sensory and behavioural needs of residents could not be effectively supported at all times, due to exposure to known triggers, and a difficulty in providing a low stimulus environment for all residents concerned. Consequently, residents had been negatively impacted on a number of occasions.

Staff were observed to interact with residents in a calm, kind and considerate way, and this was in keeping with their sensory and communication needs. For example, the person in charge was helping a resident with their plan for the day, and used lots of positive reinforcement and clear instructions to help the resident in managing their morning routine, and later plans for a visit from their family.

Residents were supported to keep in contact with their families and families visited the centre often, or residents went home for visits. Families were kept up-to-date on their loved ones wellbeing, including their personal plans, or any change in circumstance.

It was acknowledged by the inspector that the person in charge and the staff team were endeavouring to keep residents safe, by providing a range of activities, and trying, as best as possible, to offer different activities outside of the centre, to limit interactions between some residents. However, these measures were found to be reactive to adverse incidents that had occurred in the centre over the past number of weeks, and information was available that the admission of a resident may pose a significant level of risk to all residents.

The next two sections of the report outline the governance and management arrangements, and how these arrangements negatively impacted on the quality and safety of care and support residents received in the centre.

Capacity and capability

This inspection was carried out following receipt of solicited information regarding ongoing compatibility issues, and safeguarding concerns in the centre. The inspection took place over one evening and the following day. Three regulations were found to be non-compliant including protection, admissions and the contract for provision of services, and governance and management. Two substantial compliances were identified in risk management and in positive behavioural support.

There were sufficient staff and an appropriate skill mix in the centre, and staff were respectful and kind in their interactions with residents. However, admission procedures in the centre were failing to take account of known risks, in order to protect both residents living in the centre and prospective residents. Vital information gathered at the pre-admission stage was evidently not used to inform the decision in the admission of a resident to the centre, and this had significant negative impacts on the wellbeing, safety, and dignity of residents.

While there were arrangements for monitoring the centre, issues identified on this inspection were either not identified, or acknowledged as concerns in the provider reviews, and therefore opportunities for learning, improving the service, as well as taking actions to ensure the service was safe were not availed of.

Regulation 15: Staffing

There were sufficient numbers of staff employed in the centre, and staff had the skills and knowledge to support residents in the centre. The centre was staffed by a person in charge, two team leads, and direct support workers. There were five staff on duty during the day and two staff at night time. During the day four staff worked from 8.00 – 20.00 hours and one staff from 10.00 to 22.00 hours. Both night staff worked from 20.00 to 08.00 hours. The person in charge was responsible for this and one other centre and divided their time equally between the two centres.

On the day of inspection there were five staff on duty. The inspector reviewed a sample of rosters over a three month period, consistent staff had been provided, and staffing levels were in line with the stated needs of residents. This meant residents were provided with continuity of care, and there was sufficient staff levels to support their needs

The inspector observed from training records that staff had been provided with mandatory training in safeguarding, positive behavioural support, and positive management of complex behaviours. This meant that staff had the necessary skills and knowledge to support residents. The inspector met with a staff member and they were knowledgeable on how to support residents with their choices, and how to respond to safeguarding concerns. Staff were also observed to approach residents in a calm and respectful manner, in line with their identified needs of using a low arousal approach.

Overall the inspector found the staffing arrangement was in line with the needs of residents, and there were sufficient numbers of staff employed in the centre.

Judgment: Compliant

Regulation 23: Governance and management

While there were systems in place for monitoring the centre, escalating risks, and highlighting concerns regarding admissions to the centre, these systems were not effectively used to identify issues, or take proactive measures to keep residents safe, and provide for effective support. The provider had failed to respond appropriately to known risks to residents, or learn from previous issues that had arisen in the centre, and as a result residents' safety and wellbeing had been impacted. The systems in place to monitor the centre, and provide assurances to the

provider on the quality and safety of care and support residents received were not effective.

While resources were provided in the centre, including staffing, suitable accommodation, and transport, the provider had not effectively implemented their own policies on risk management and admissions, to ensure the safety of residents. This included reviewing serious incidents in the centre at a provider level, and using recommendations from assessments to inform an admission. As a result there had been a number of safeguarding issues arise over a five week period, and the quality of experiences for residents in the centre had been adversely affected.

There were systems in place for monitoring the service provided to residents; however, these were not identifying key issues, and therefore there were no actions or evidence of learning relevant to the issues highlighted during this inspection.

For example, an annual review of the quality and safety of care and support was completed in December 2025. At the time of this review there had been a number of significant adverse incidents involving some residents who required hospitalisation or medical attention, as well as safeguarding incidents. While the review outlined a resident would be transitioning out of the centre, and noted the number of safeguarding notifications, it had not considered the impact of this resident's presentation on other residents, the unsuitability of the centre to meet the needs of the resident at the time, and therefore had not outlined how this could be improved upon to prevent a similar situation arising again.

Similarly, a six monthly unannounced visit to the centre completed in early April 2025, found admissions and safeguarding compliant, and there was no reference made to the serious incidents that had occurred in the centre between October and December 2024.

The provider, in their risk management policy, outlined that senior management were responsible for overseeing corrective actions were completed arising from annual reviews and six monthly assessments. Given the failure in identifying these issues and effectively taking action to rectify concerns in provider reviews, the inspector found there was ineffective oversight of the services provided to residents.

Judgment: Not compliant

Regulation 24: Admissions and contract for the provision of services

While there was a clear procedure in place for admissions to the centre, the admission practices were not transparent, and were not taking into account the needs of the prospective residents in order to meet their needs, and to protect all residents from abuse. At the time of the inspection ten residents had been admitted to the centre. Of these, one resident had been discharged, three residents had transitioned to other centres due to the unsuitability of the placement, and one

resident was due to transition out of the centre the following day, due to compatibility concerns.

The inspector reviewed the written admissions policies and procedures document that had been reviewed by the provider in October 2024. The policy outlined the procedure for assessing prospective residents for admissions, and a management referral team was in place to review all referrals to the service. This included establishing an internal assessment team to complete an assessment of all referrals to the service, consider the type of service that best matches the prospective resident's known needs, and identifying any areas of compatibility risks at the initial stage of assessment. According to the policy this collated information was used by the management referral team to arrive at a decision around an offer of service, and this decision must include compatibility, as well as the statement of purpose for each centre within the provider's remit.

However, the inspector found the assessment information around the needs and risks gathered in late 2024, regarding a resident who was admitted to the centre in April 2025, was not evidently used to inform an appropriate admission for this resident. For example, the initial assessment completed in September 2024, clearly outlined the resident needed to live with one to two residents only, required a low stimulus environment, and identified a number of compatibility risks at that stage. A subsequent assessment carried out three weeks later also recommend the resident live in a quiet environment; however, the need for the resident to live with one to two other residents was not identified, nor were compatibility risks.

The inspector reviewed extracts of minutes of six management referral team meetings concerning the most recent admission of a resident to the centre. There was no evidence to confirm that the specific accommodation needs of the prospective resident, the identified compatibility risks, as well as the recommended low stimulus environment was discussed at these meetings.

A decision to offer a residential placement in this centre for the resident was made in February 2025. However, given the identified needs of the resident, to live with one to two residents, and the environmental considerations, this centre could not safely and effectively meet this resident's needs.

The inspector met the person in charge and assistant director of services on the first day of inspection and reviewed a detailed compatibility assessment completed in March 2025, in relation to the admission of a resident to the centre. At the time of this assessment serious compatibility concerns were identified, and included risks to both the prospective resident, and the residents currently living in the centre. This meant that the safety and wellbeing of all residents concerned were identified as at risk by the planned admission. While suggested control measures were outlined, and safeguarding measures were implemented recently, the assistant director confirmed these had not worked.

The detailed compatibility assessment completed by the person in charge and the assistant director of services was also not evidently considered in management referral meetings. For example, the decision to admit the resident occurred prior to

this compatibility assessment being completed, and there was no reference to this assessment or referring multidisciplinary assessments in minutes of referral meetings, subsequent to the decision in February 2025. This meant that this resident, as well as all other residents living in the centre, were put at risk by the admission practices employed by the provider, which had resulted negative impacts on residents living in the centre

The inspector also reviewed documents on the admission and transition of one resident who moved out of the centre late in 2024. At that time of admission while there were some known behaviours of concern, additional risks had emerged a number of months after admission, due to the changing needs of the resident. The resident subsequently transitioned to more suitable accommodation, and the inspector observed a transition plan had been developed at the time to support this move for the resident.

Judgment: Not compliant

Quality and safety

Residents' quality of care and support had been impacted by safeguarding issues in the centre, including the effective provision of behavioural support, the management of risks, and ensuring residents were protected from abuse.

While residents' emotional needs had been assessed, behaviour support plans could not be effectively implemented due to compatibility concerns in the centre. These concerns had also resulted in a number of safeguarding incidents happening in the centre. The provider had not effectively reviewed risks around admissions, or a series of significant incidents in the centre, to ensure the safety of residents in this centre would not be further compromised. As a result all residents living in this centre had been negatively impacted.

Regulation 26: Risk management procedures

The provider had not effectively implemented arrangements for the identification of risks and learning from a series of significant incidents involving residents, and therefore had put residents at risk of harm.

There was an organisational policy on risk management that had been reviewed in October 2022. The policy stated that organisational learning was supported through a review of serious adverse events by the corporate management team, and monitoring and review of incident trends, complaints, and allegations by the risk management team.

However, the inspector spoke to the person participating in management on the second day of inspection, and they stated there had been no review at provider level, following a series of serious incidents involving residents in late 2024, specifically safeguarding of residents, and admission of residents to the centre. This meant that the provider had not implemented their own procedures to inform required changes of practice and to keep residents safe in the centre. Similarly, an admission of a resident to the centre recently had highlighted a number of significant risks; however, the person in charge told the inspector while safeguarding was on the risk register, admissions to the centre were not.

Incidents were documented and reviewed by the person in charge and the assistant director of services, and were also discussed at team meetings. For example, in January 2025, minutes of the staff meeting noted, residents were readjusting following the transition of a resident to another centre, and residents were being supported by the multidisciplinary team to help them settle following a stressful period.

Similarly, more recent safeguarding incidents were reviewed at team meetings and noted to have been escalated to senior management, as per minutes of team meetings in May 2025. However, given the known risks prior to the admission of a resident to the centre, the known impact that residents had experienced due to another resident's behaviour, and the specific known needs to support residents with their emotional wellbeing, the provider had, in conflict to all this evidence, put residents at risk through admission procedures in the centre, and this had resulted in harm to residents in the centre.

The inspector acknowledged that, a serious incident review had been completed by senior management following an incident in which a resident was hospitalised, and the inspector observed that all harmful substances were locked away on the day of inspection as per the recommendations made following this review

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

While residents' behavioural needs had been assessed and there were behavioural support plans in place, their emotional wellbeing could not be effectively supported in the centre.

Residents had been assessed by a behavioural therapist, and there were behaviour support plans in place. The inspector reviewed two behaviour support plans, and behaviours of concern were clearly outlined, as well as known circumstances that may trigger behaviours of concerns. The inspector found plans could not be effectively implemented as residents had ongoing exposure to known triggers, for example, loud noises, sensory overload, and negative interactions with others. Some proactive measures were in place including skills teaching, planning daily activities,

and communication strategies; however, strategies such as a low stimulus environment, and accommodating the sensory needs of all residents could not be provided for. In addition, an environmental restriction had been introduced to reduce the likelihood of negative interactions between two residents, however, this was found not to be effective.

Judgment: Substantially compliant

Regulation 8: Protection

While safeguarding incidents in the centre were reported, appropriate measures were not in place to protect residents, and as a result, impacted negatively on residents' wellbeing.

The Office of the Chief Inspector had been notified of 21 allegations of abuse since the last inspection in March 2024, as well as 11 serious injuries requiring medical treatment or hospitalisation. At the time of a series of notifications from October 2024, assurances were sought from the provider, on the measures the provider was taking to ensure residents were protected, and the provider outlined a resident would be transitioning to a single occupancy centre. This was due to the fact that the resident's needs could not be met in the centre, and the impact of the resident's behaviour on other residents living in the centre.

As mentioned, a subsequent admission of a resident had identified the significant extent of impacts on both the resident being admitted to the centre, and the residents already living in the centre at the time of admission in 2025. This included distress for all residents, emotional dysregulation, physical aggression and property destruction. Despite the known compatibility and safeguarding risks, the decision was made to admit the resident, and nine notifications reporting allegations of abuse were reported to the Office of the Chief Inspector between April and June 2025. In this regard, the provider had failed to protect residents from abuse.

At the time of notifications in April to June 2025, the person in charge had outlined the safeguarding measures being implemented to ensure residents were protected.

However, on the first day of inspection the inspector observed staff attempting to implement a safeguarding measures that was not effective, and the dignity and privacy of one resident was impacted. The inspector discussed safeguarding measures with the assistant director and the person in charge, following recent notifications, and they stated that safeguarding measures were not effective.

The inspector met the person participating in management on the second day of inspection, and they outlined within approximately two weeks of the resident being admitted to the centre in late April 2025, it was acknowledged by the provider that this admission was not working out. The person participating in management

outlined the plan for the resident to transition out of the centre on the day following the inspection.

Given the known safeguarding risks prior to the admission of a resident to the centre recently, and the known previous impact of a resident's behaviour on other residents living in the centre, decisions had been made that had impacted on the wellbeing, safety and dignity of residents, and had failed to protect all residents concerned.

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 23: Governance and management	Not compliant
Regulation 24: Admissions and contract for the provision of services	Not compliant
Quality and safety	
Regulation 26: Risk management procedures	Substantially compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Not compliant

Compliance Plan for The Stables OSV-0008602

Inspection ID: MON-0047404

Date of inspection: 17/06/2025

Introduction and instruction

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

This document is divided into two sections:

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

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

A finding of:

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The Provider has reviewed the systems and processes in place to ensure effective governance and management of the centre is maintained. A full review of the Admissions process has been conducted to enhance the admissions process and the effectiveness of compatibility assessments. This is fully described under Regulation 24. The Risk Management Policy has been revised to add further guidance on the review of safeguarding issues and notifications. A Bi-Weekly meeting with the Director of Quality and Safety, Directors of Service and Senior MDT is in place. These meetings will focus on trending of incidents and reviewing any escalation within a Designated Centre which cannot be effectively managed with the current control measures. The preparation of the 6 monthly Providers Led unannounced audits has been reviewed to ensure that all information sources are used to develop lines of enquire for the audit. This will include the use of trending reports and reviewing the implementation of learning from serious incidents. Furthermore, any learning identified during serious incident reviews or aggregate reviews, will be reflected in the Annual Review of Quality and Safety of Care within the centre. All actions arising from provide level reviews, will be carefully monitored for implementation during monthly Governance Meetings. The occupancy of this centre will be reduced to accommodate 5 residents. This has supported the implementation of a low stimulus environment within the centre, which has supported the quality of life of the residents.	

Regulation 24: Admissions and contract for the provision of services	Not Compliant
Outline how you are going to come into compliance with Regulation 24: Admissions and contract for the provision of services: A full review of the Admissions process has been completed. This review resulted in the following changes, which will increase the transparency of decision making around any future prospective admissions. 1. The assessment recommendation forms used will clearly indicate what support a resident requires, including the specific accommodation needs of the prospective resident, as well as if a low stimulus environment is required. 2. A new compatibility assessment has been devised and is being trialed, to ensure that the needs of the prospective residents can be met and to protect all current residents from being adversely impacted by a new admission. This compatibility assessment will be completed by the identified Centre's Person in Charge and Assistant Director of Service. The compatibility assessment will be shared with the assigned Director of service, for their review. 3. The outcome of all compatibility assessments will be brought to the weekly referrals meeting and presented by the assigned Director of Service, to the referrals committee. This will ensure all referral team members are clear on any potential compatibility issues. Final decisions on any admission to the centre will rest with the referrals committee. 4. The referrals and transitions meetings notes will clearly record what step in the process the prospective admission is at and when a final decision is made on whether admission to the centre is appropriate. These notes will also note any discussion regarding compatibility. This new process is being piloted and will be reviewed within 6 weeks, where the effectiveness of the system will be reviewed. All modifications to the process will be reflected in the Admissions policies and procedures.	
Regulation 26: Risk management procedures	Substantially Compliant
Outline how you are going to come into compliance with Regulation 26: Risk management procedures:	

A review of the organisational risk management process has been completed following the outcome of this inspection. The following changes are being implemented to enhance the risk management arrangements in place.

1. The risk management policy has been revised to add further guidance on the review of safeguarding issues and notifications.
2. A weekly operational trending report of all notifications and incidents is now in place. With trends to be escalated via weekly via the Governance system that's in place, PIC to ADOS to DOS. These cumulative reports are sent to the COO on a weekly basis.
3. At a provider level, a weekly trending report is generated by the MIS Manager. This report is reviewed at a weekly meeting by the Director of Quality and Safety, Senior MDT members and Director of Services, to ensure that any emerging trends can be reviewed and addressed in a timely manner. A further meeting is held weekly to review any escalation within a Designated Centre which cannot be effectively managed with the current control measures.
4. The Incident Management Policy (TG058) will be expanded to ensure that Level 3 incidents receive a category 3 aggregate review. This will formalise and embed a systems facilitate incident reviews, such as post discharge impact assessments.

Regulation 7: Positive behavioural support

Substantially Compliant

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

The provider had identified the need to support a resident with a transition from the centre and this took place on 18.06.2025. This has now ensured that a low arousal environment is maintained. A review of the Behaviour Supports within the centre has been conducted. All residents requiring a Positive Behaviour Support Plan, have an appropriate plan in place with specific guidance to inform staff practice.

Engagement has taken place with each resident through an appropriate and accessible means to obtain feedback on their experience. This has been conducted through observation and trending of incidents. This will be an ongoing process, to ensure the welfare of the residents is continually monitored.

Residents' overall assessment of need is reviewed at least annually with the Talbot Group MDT. All residents have access to the Talbot Group MDT as required and appropriate referrals can be made for additional MDT input should the need arise. Residents' Positive Behaviour Support plans in place are now effectively implemented and the resident's' emotional needs are being supported in line with their individualised needs.

Regulation 8: Protection	Not Compliant
Outline how you are going to come into compliance with Regulation 8: Protection: A review of the arrangements in place to ensure all residents within the centre are protected from all forms of abuse has been completed. After the transition of a resident from the centre was completed on the 18.06.2025, residents appear to be more comfortable and content. The following measures have been put in place to reduce the likelihood of any further protection issues within the centre. 1. The overall occupancy of the centre has been reduced to 5 adults. An application to vary the registration of the centre to reduce the maximum occupancy of the centre to 5 will be submitted. This will contribute towards sustaining a low arousal environment within the centre. 2. Where peer to peer incidents occur, safeguarding arrangements will be kept under review for effectiveness. 3. A full review of the admissions process has been completed, with a enhancement of the admissions process and compatibility assessment process being implemented. 4. An update to the Risk Management Policy has been completed to add further guidance on the review of safeguarding issues and notifications. 5. At a provider level, a weekly trending report is generated by the MIS Manager. This report is reviewed at a weekly meeting by the Director of Quality and Safety, Senior MDT members and Director of Services, to ensure that any emerging trends can be reviewed and addressed in a timely manner. A further meeting is held weekly to review any escalation within a Designated Centre which cannot be effectively managed with the current control measures. The Incident Management Policy (TG058) will be expanded to ensure that Level 3 incidents receive a category 3 aggregate review. This will formalise and embed a system to facilitate incident reviews, such as post discharge impact assessments.	

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	30/09/2025
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of care and	Not Compliant	Orange	30/09/2025

	support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.			
Regulation 24(1)(b)	The registered provider shall ensure that admission policies and practices take account of the need to protect residents from abuse by their peers.	Not Compliant	Orange	30/09/2025
Regulation 26(1)(d)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: arrangements for the identification, recording and investigation of, and learning from, serious incidents or adverse events involving residents.	Substantially Compliant	Yellow	30/09/2025
Regulation 7(5)(a)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation every effort is made to identify and alleviate the cause of the resident's challenging behaviour.	Substantially Compliant	Yellow	20/08/2025

Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	20/08/2025
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