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:	Teach Tobhair
Name of provider:	Kingsriver Community Holdings Company Limited by Guarantee
Address of centre:	Kilkenny
Type of inspection:	Unannounced
Date of inspection:	19 May 2026
Centre ID:	OSV-0009103
Fieldwork ID:	MON-0050416

About the designated centre

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

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	2

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 19 May 2026	10:20hrs to 19:00hrs	Lisa Walsh	Lead

What residents told us and what inspectors observed

This centre was newly registered in November 2025 and this was its first inspection. This risk-based unannounced inspection was undertaken following receipt of unsolicited information of concern which raised concerns about the provider's governance and management arrangements and possible impact on the quality and safety of care provided. The inspection was completed by one inspector over the course of one day. The inspector found that there were high levels of non-compliance with the regulations reviewed on the day of inspection. Significant gaps in oversight and risk management were identified which impacted on the governance systems in place and the quality and safety of care provided to residents.

On arrival to the centre, the inspector was greeted by the person in charge who was working in the centre that day due to unplanned staff absence. Both residents who resided in the house had already left the centre for the day. One resident attended a day service five days a week. The other resident did not attend a formal day service and was supported by staff to engage in activities in the community. The inspector was informed that their presence in the house as an unfamiliar person may upset one of the residents and that this posed a risk. However, there were no sufficient risk assessments or plans in place to manage this risk and staff did not know what guidance to give to ensure visitors were protected and residents' were supported in this situation.

This centre was registered to accommodate two residents and had no vacancies on the day of inspection. Both residents moved into the centre when it opened from different centres. The inspector was informed that they get along well, however they engage in separate activities and generally only spend time together to have meals.

After an introduction meeting with the person in charge, the inspector was brought on a walk through the centre. The centre is a three-bedroom semi-detached house based in Kilkenny. Residents had access to a vehicle, which also supported them to attend their day service and was used to take trips. The centre consisted of two residents' bedrooms, a staff bedroom/office, a sitting room, a bathroom, a toilet and an open plan kitchen/dining room, which lead out into a private back garden. Minimal environmental restrictions were in use; however these had not been notified to the Chief Inspector of Social Services as required.

The inspector found that the centre was clean, bright and comfortable. The centre was in a good state of repair and well-maintained both internally and externally. Each resident's bedroom was decorated to their taste and with items of interest or activities they enjoyed. While the centre was clean some attention to infection control procedures was required. For example, in the bathroom there was several

bottles of toiletries and toothbrushes all stored together with no way to identify which resident they belonged too.

Residents were engaging in activities in the community and observed to have active lives. The inspector had the opportunity to meet with one resident when they returned to the centre. The inspector used observations and discussions with staff and management, alongside a review of documentation to inform judgments on the residents' quality of life. The resident required support to communicate. When the resident communicated their needs, it was clearly understood by staff, with staff responding immediately to their requests. The resident was supported to have cup of tea with the inspector and was using their electronic tablet to watch videos. The other resident declined to meet with the inspector. The inspector left the centre to finish reviewing documentation at another location.

The next two sections of the report present the findings of this inspection in relation to the governance and management arrangements in place in the centre, and how these arrangements impacted on the quality and safety of the service being.

Capacity and capability

Overall, the findings of this inspection were that the provider had failed to put effective management systems in place to ensure that the service provided was safe and that appropriate plans were in place to manage risk within the centre. Some significant incidents had occurred, and these had not been recognised as a safeguarding concern. Some incident records reviewed were incomplete and inaccurate and there had been no review of these incidents by senior management. The inspector reviewed an incident that had occurred which posed a safeguarding risk, however the provider was not aware of the incident and no safeguarding plans had been put in place to manage this risk.

Unsolicited information had been received for the centre, following which the provider completed an internal audit and identified some areas that required action. While they had an action tracker in place, several actions were not completed within the set timeframe. In addition, the audit was not effective in identifying all of the key areas of concern that were highlighted on this inspection.

Regulation 15: Staffing

There were no staff vacancies on the staff team at the point of inspection. The provider did not use agency staff and planned and unplanned leave was covered by core staff working additional hours or using the provider's relief staffing panel.

The inspector reviewed rosters for March and April 2026. There were three staff on duty during the day and two staff at night to meet the support needs of residents. The staff skill mix consisted of social care workers and healthcare assistants. The person in charge was not part of the roster and worked from an office in the provider's head office. However, there was evidence that they attended the centre.

A sample of staff files were reviewed and all schedule 2 information was available. Staff spoken with were found to be kind, respectful and well known to the residents.

Judgment: Compliant

Regulation 16: Training and staff development

The person in charge maintained a training matrix for all staff working within the centre, including regular relief staff. Records showed that all staff had completed mandatory training in safeguarding, Children's First, fire safety, manual and people handling and safe administration of medicines. Some other mandatory training was not yet completed by staff. For example, three staff had not yet completed training in positive behaviour support training. Two staff had also not completed first aid training, the person in charge had scheduled online training in the interim while awaiting in person training for this.

While staff were receiving supervision this was not being conducted in line with the provider's own policy. From a review of a sample of staff files, supervision was not being provided at an appropriate frequency and as deemed required in supervision records. On review of staff meetings, they had also raised concerns of the lack of management presence, support and guidance when the centre was opening with a new team in place.

Judgment: Substantially compliant

Regulation 23: Governance and management

Overall, the inspector found that the provider had failed to effectively implement monitoring tools and management systems to ensure that the service was effectively managed and that residents were being provided with a safe and quality service. The inspector also identified several concerns in relation to risk management within the centre, which is detailed under the relevant regulation.

Before the inspection, the provider had informed the inspector that following receipt of unsolicited information they had completed an internal audit of their governance and management systems. This audit by the provider identified some areas of non-compliance with governance and management, training and staff development and

risk management. There was an action plan in place with all actions to be completed by 14 May 2026. However, on the day of inspection 14 of the 21 actions had not been completed. This included the five highest red-rated actions for risk management. The inspector was informed that a decision was made to extend the timeframe for these to be completed by the 29 May 2026. Meetings were held to discuss progress of actions and what was outstanding to be completed, however there was no records of these meetings maintained.

As well as the audit referenced above, the inspector was informed that the first six-monthly unannounced audit had been completed the day previous to the inspection. While these audits had been completed, they were ineffective in capturing and actioning key areas of concern in the centre as highlighted during inspection. For example, they had failed to identify that incidents had occurred which posed a safeguarding risk or that incidents were not recognised as safeguarding concerns. In addition, they had failed to identify that some incident records were incomplete, inaccurate and had not been reviewed by management. For one significant safeguarding incident that had occurred, the provider was not aware of it and this had not been identified through the audits completed. Following a review of resident's records who had been impacted by the incident, it had not been recorded and their daily log reflected inaccurate information. This meant that there were no appropriate support measures in place and no risk assessments had been completed to identify any further actions that may be required.

The inspector was informed that there were monthly staff meetings, however, only meeting minutes for January, February and April 2026 were provided for review, which were facilitated by the person in charge. The inspector requested copies of additional meeting minutes since the centre was open, however the inspector was informed that these were not held in the centre and were not available for the inspector to review despite requesting access to these.

While the provider had sufficient staffing arrangements in place, the systems in place did not address the excess of hours some staff were working each month. They also did not identify when staff were working a considerable amount of time without sufficient breaks in between. The inspector identified examples of some staff working more than 190 hours in the month. In addition to this some staff were working up to nine days in a row without a break. Some staff were also completing a sleepover shift and then completing another 12-hour day shift the same day they finished their sleepover shift. As well as impacting staff welfare this posed a risk to the service being provided to residents.

Judgment: Not compliant

Regulation 31: Notification of incidents

From a review of incidents and adverse events occurring in the centre in recent months. A number of these events had not been notified to the Chief Inspector. These were reported retrospectively following the inspection.

In addition, some restrictive practices were used within the centre. However, these had not been identified as a restrictive practice and had not been reported in quarterly returns. These were reported retrospectively following the inspection.

Judgment: Not compliant

Quality and safety

Overall, the inspection findings identified substantial concerns regarding the centre's risk management processes. The inspector observed kind staff who were working towards providing care to residents to meet their assessed needs. However, the inspector found that significant improvement was required to areas of care and support for residents, including protection, positive behaviour support and individual assessment and personal plans. Some improvement was also required for infection protection and control.

Residents were supported to have a healthy lifestyle and access healthcare support as required.

Regulation 26: Risk management procedures

The inspector identified serious concerns in relation to risk management in the centre. There was no evidence of the management team reviewing incidents to ensure there were appropriate measures in place to mitigate risks and guide staff practice. In one example, the inspector reviewed a safeguarding incident which had occurred, with significant risks identified on review of documents and in discussion with staff by the inspector. When the inspector sought assurances about how this risk was managed, they were informed that the provider was not aware of the detail of the incident, meaning there was no plans in place to mitigate these risks. In addition, the incident report was not completed and partial information on the incident was recorded on a word document. Some accounts of the incident varied in the records reviewed, some had inaccurate information and other accounts had not been completely recorded so full details of the incident was not available.

For another incident that had occurred no incident report had been completed. Information that was recorded about the incident was incomplete. On review of the residents' daily records An Garda Síochána had been contacted and attended the

centre. However, management did not know any details about why they were contacted, when they were contacted and which staff contacted them.

There was a risk register and centre risk assessments in place. However, they were not centre specific. For example, the centre risk assessments in place were dated July 2025 despite the centre not having been registered to operate until November 2025. These were also generic and did not identify the current risks within the centre or offer guidance to staff on how to manage these. The inspector was informed of additional risks that had been identified both within the centre and outside of the centre. There were no risk assessments in place and no measures implemented to ensure the safety of residents, staff and others. For example, as mentioned the inspector or an unfamiliar persons presence in the home may upset one of the residents and this posed a risk of potential harm. However, there were no risk assessments or plans in place to manage this risk to visitors.

For residents' individual risk assessments in place the inspector found that risk ratings were not revised following the implementation of control measures. This meant that it was not clearly documented whether the risk had been reduced or mitigated following the implementation of control measures and whether these were effective. These risk assessments also did not identify the current safeguarding risks within the centre.

Judgment: Not compliant

Regulation 27: Protection against infection

The centre was generally very clean and tidy. The premises was well-maintained and decorated to a high standard. However, the storage practices of toiletries and toothbrushes placed residents at risk of cross-contamination and healthcare associated infections. For example, there were multiple bottles of toiletries in the shared bathroom and several toothbrushes stored together in one container. Staff could not identify who the toiletries and toothbrushes were belonging to.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

While residents had been assessed prior to admission, they had not been re-assessed as required, to reflect changes in their needs and circumstances. For example, one resident had been assessed as needing two male staff to support them and could not be supported by female staff. They were currently being supported by male and female staff. The inspector was informed that this guidance had changed and they could be supported by some female staff. However, there

was no evidence that the resident's needs and associated risks had been reassessed to guide this decision. One of the resident's personal goals in place had been reviewed and continued to state that two male staff were required at all times.

Residents had personal plans in place. Residents also took part in keyworking sessions each month to discuss their goals and progress towards these. While these plans were in place they were not aligned with some resident preferences. The plans were reviewed to say that these were not possible to complete at present due to presenting risk and would be reviewed. However, these were not dated, and it was unclear how long this had been in place nor when the review was due to take place. In addition, there was no specific risk assessments completed for each gaol the resident wanted to work towards to guide staff practice.

Judgment: Not compliant

Regulation 6: Health care

Residents were supported to live a healthy lifestyle. The health and wellbeing of each resident was promoted and supported in a variety of ways, including through diet, nutrition, recreation, exercise and physical activities.

Management and staff were referring residents to healthcare professionals, as and when required. Where residents were assessed with health care needs, the provider had arrangements in place to ensure they received the care and support that they required. This was done in a rights-based approach to ensure person-centred care was delivered where decisions were made with the resident. There were health and social care professionals available to this service to review residents' health care arrangements.

Judgment: Compliant

Regulation 7: Positive behavioural support

Several significant incidents had occurred in the centre. While there was a dedicated staff team in place the provider had not ensured that all staff had the knowledge and skills needed to respond to behaviour that is challenging or to support the residents to manage their behaviour. There was a lack of management oversight and incident records were not being completed, which is further detailed under Regulation 26: Risk management procedures. This meant that these were not being reviewed to ensure that residents were being supported to meet their needs.

While there was an assessment for positive behaviour support in place for a resident, this had not been reviewed following several significant incidents and did

not reflect their current needs. The inspector requested the up-to-date assessment; however, the management present was not clear if there was an updated assessment and this was not provided to the inspector. There was a positive behaviour support plan in place, however there were two separate documents which could lead to confusion, and they both varied in guidance provided to staff. Neither plan in place would effectively guide staff practice to ensure that the resident was supported to manage their behaviour.

On a review of training records, three staff had not yet completed training in positive behaviour support and were not scheduled to complete this until the end of November 2026. Given the level of serious adverse incidents that had occurred in the centre, the inspector was not assured that all staff had access to appropriate training as required.

There were a small number of environmental restrictive practices in use within the centre. However, these had not been identified as restrictive practices meaning that they were not applied in accordance with the national policy.

Judgment: Not compliant

Regulation 8: Protection

The provider had failed to recognise and respond to significant safeguarding concerns within the designated centre. The provider had an up-to-date safeguarding policy that reflected current national guidance. While this policy provided directions to staff on how to identify, report, and respond to safeguarding concerns and staff had been in receipt of training, practice in the centre was not reflective of the guidance within the policy nor staff knowledge.

The inspector was not assured that the staff team or the person in charge had recognised or reported all safeguarding concerns. From review of incident and accident records and daily logs, some serious incidents between residents had not been identified as safeguarding concerns and had not been reported to the relevant authorities in line with national policy. This also meant that there were no safeguarding plans in place following serious incidents. For instance one incident reviewed had resulted in a resident having to lock themselves inside a room in their home to stay safe during an incident of escalated behaviour and the inspector was not assured that the resident was being protected from all forms of abuse.

Some other recorded adverse events had been identified as safeguarding incidents. However, the detail of these incidents did not constitute a safeguarding concern.

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	Not compliant
Quality and safety	
Regulation 26: Risk management procedures	Not compliant
Regulation 27: Protection against infection	Substantially 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	Not compliant

Compliance Plan for Teach Tobhair OSV-0009103

Inspection ID: MON-0050416

Date of inspection: 19/05/2026

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 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • The organisation has commenced the implementation of CPI Safety Intervention to replace Studio III. Four staff have been trained as CPI Safety Interventions Instructors, this will strengthen the organisation's approach to positive behaviour support and ensuring staff are equipped with contemporary, evidence-informed practices. • In addition, a CPI Safety Interventions Instructor is based in this designated to provide additional support and guidance to staff • Since the inspection all staff have completed two days training in CPI Safety Interventions first training. • All staff are trained in first aid with the exception of one staff, they are on planning schedule to have completed by 31 July 2026 • Since Inspection all staff received supervision from PIC and are in line with policy • The Person in Charge has drafted a team meeting scheduled till year end and added it to team meeting blue folder No.5. In the future if the PIC is absent from designated Centre one of the Community Practitioners will support team and facilitate team meetings	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management:	

• Enhanced Executive Management Team oversight has been introduced, supported by themed governance meetings focusing on key areas of regulatory compliance, including governance and management, safeguarding, risk management, medication management, staffing, restrictive practices and person-centred care.
• At local level, Quality and Safety meetings are held within each designated centre. The outcomes and actions from these meetings feed into the organisation's Quality and Safety Committee, which reports directly to the Board of Directors. This structure ensures that quality and safety matters are escalated appropriately and that the Board maintains oversight of regulatory compliance and service quality across all designated centres.
• All actions from the providers audit were closed out on end June, CEO has discussed the extension of timelines with the management team and all are very clear now that deadlines were to be adhered to and only the CEO could extend
• A Quality Enhancement Plan has been introduced across all designated centres to strengthen provider assurance, monitor regulatory compliance, track improvement actions and provide evidence of sustained compliance through enhanced executive oversight
• A standardised, colour-coded documentation and governance filing system has been introduced across all designated centres to improve accessibility, consistency and oversight of regulatory documentation
• The Provider has completed a robust review on the governance and management structure across the service and within each designated centre, the outcome of the review was communicated to the management team on 08 June 2026
• A Senior Operations Manager has been appointed and will commence on 10 August 2026.
• A quality and compliance officer was appointed on 23 March 2026 to assess quality and compliance for the service.
• A health and wellbeing lead/RNID was appointed on 12 May 2026 to oversee personal development, health and well-being of people supported.
• All managers completed training in risk management on 26 May 2026.
• All managers completed refresher training in Regulations on 12 May 2026.
• A retrospective review of person supported records and incidents was completed by the provider on 2 June 2026.
• A review of the audit system was completed by the Innovation & Communication and the Compliance & Quality Officer on 05 June 2026
• The content of audits and audit schedule will be reviewed and amended by the Innovation & Communication Manager & Compliance & Quality Officer by 17 July 2026
• The Quality & Compliance Officer will carry out six month unannounced inspection by 31 July 2026
• An independent review was commissioned to verify roster data; formal written confirmation is expected from the roster service provider by 19 July 2026.
• Innovation & Communication Manager developed guidance and updated minute template on Team Meetings, same sent to Person in Charge on 26 May 2026.
• PIC will use new team meeting guidance and template at June team meetings and Quality & Compliance Officer will review quality and sign off same by 10 July 2026
• PIC will add schedule of team meetings to year end in team meeting folder and inform all staff by 12 June 2026. In the absence of PIC one of the Community Practitioners will facilitate team meeting.

• The Quality and Compliance Officer & Innovation & Communication Manager reviewed folder system in Designated Centre's and made recommendations of improvement to the CEO, these were approved and a new person supported and house folder system will be set up in each Designated Centre by 12 June 2026.
• Community Practitioner programme commenced on 15 June 2026, which will focus on health and well-being, governance, quality and compliance and best practice. This group of practitioners will be led by the Innovation and Experience Manager and overseen at CEO level.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
• The Registered Provider acknowledges the requirement to ensure that notifiable incidents are identified, escalated and notified to the Chief Inspector in line with regulatory requirements. Notification processes are being reviewed, staff and management guidance is being strengthened, and incident review arrangements will include explicit checks that notification requirements have been considered and completed where required.
• This will form part of the review being undertaken with the CHO5 Safeguarding Team, who have been invited to review safeguarding arrangements within the service and meet with the Provider to offer additional guidance and support
• The Person in Charge will review the daily notes each day to ensure effective oversight of the service. The review will enable the identification of any incidents, adverse events or safeguarding concerns and ensure they are managed promptly in accordance with the incident management and safeguarding procedure.
• A new process has been implemented effective from June'26 team meeting.PIC to complete analysis of incident and discuss learning at monthly team. Evidence can be viewed in minutes of team meetings (blue folder No 5) and evidence of incident document completed can be viewed in yellow folder No 13 risk management.
• PIC will provide a report to the Quality & Safety Committee at monthly meetings, this will be overseen by Senior Operations Manager.
• PIC completed restrictive practices assessment in the designated Centre, has identified restrictive practices and developed risk assessment by 06 July 2026
• The PIC will report all restrictive practices to HIQA through quarterly notifications.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
• The Registered Provider acknowledges the requirement to ensure all risks are identified, assessed, controlled, reviewed and escalated appropriately. The centre risk register has been reviewed and immediate risks identified in the warning letter have been prioritised. High-rated risks will be subject to provider-level review and escalation.
• An external review of the organisation's Risk Management Policy and Framework has been commissioned to ensure the policy is robust, aligned with regulatory requirements and reflective of best practice. The revised Risk Management Policy and associated management training will be completed on or before 10 September 2026. The findings and recommendations from this review will be implemented across all designated centres.
• All managers completed risk management training on 26 May 2026
• The PIC will review the centre risk assessments will be completed by 06 July 2026
• All staff will be required to read and sign updated risk assessments by 31 August 2026.
• Risk assessments will be a standing item at team meeting.

Regulation 27: Protection against infection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
• A review of the bathroom environment was completed following inspection and individual baskets have been implemented.

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 Registered Provider acknowledges the requirement to ensure that each resident has an up-to-date assessment and personal plan that reflects their assessed needs, preferences, risks, supports and goals. Resident assessments and personal plans are being reviewed to ensure they are current, person-centred, informed by relevant multidisciplinary input and implemented in practice. This review and associated actions will be completed by 31 July 2026.
• A full review of each person supported personal plan will be completed by 10 August 2026 this will include reviewing the assessed needs, support plans and risk assessments
• The PIC will oversee the review of the personal plan to ensure the appropriate supports are in place.
• The PIC will discuss personal plans at July team meeting to ensure staff team are aware of person supported preferences and connectivity with the key working conversations.
• New guidance document on key working was issued across the service on 26 June 2026
• The Community Practitioners will introduce a new Policy in regards to the Personal Plan Framework by 31 July 2026
• In-person training on personal plan framework will be added to training plan for all staff to receive by 30 October 2026

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
• The organisation has commenced the implementation of CPI Safety Intervention to replace Studio III. Four staff have been trained as CPI Safety Interventions Instructors, this will strengthen the organisation's approach to positive behaviour support and ensuring staff are equipped with contemporary, evidence-informed practices. In addition, a CPI Safety Interventions Instructor is based in this designated to provide additional support and guidance to staff
• The Registered Provider acknowledges that people supported who present with behaviours of concern must be supported through evidence-informed, person-centred and least restrictive approaches. Positive behaviour support arrangements are being reviewed, including behaviour support plans, restrictive practice oversight, staff guidance, training and escalation arrangements. Implementation of CPI Safety Intervention is being progressed organisation-wide. In addition, a CPI Safety Interventions Instructor is based in this designated to provide additional support and guidance to staff.
• Since the inspection all staff have completed two days training in CPI Safety Interventions.
• Four staff have been trained as CPI Safety Techniques Instructors
• The PIC will complete restrictive practices assessment, identify the restrictions and

develop relevant risk assessments by 06 July 2026
• The PIC will report all restrictive practices through the quarterly notifications

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
• The Registered Provider acknowledges the requirement to protect residents from abuse and to ensure safeguarding concerns are identified, reported, investigated and managed appropriately. Safeguarding arrangements have been reviewed, and staff will receive continued safeguarding guidance and training. Safeguarding concerns will be monitored through centre and provider-level governance arrangements.
• All members of the management team will complete Designated Officer training by 30 September 2026. A dedicated safeguarding training day for the management team will be scheduled to support this.
• The Registered Provider has requested that the CHO5 Safeguarding Team undertake a review of all safeguarding arrangements within the service and meet with the Provider to offer additional guidance and support in strengthening safeguarding practice, this meeting is due to take place by 31 August 2026.
• All members of the management team will complete Designated Officer training by 30 September 2026. A dedicated safeguarding training day for the management team will be scheduled to support this.
• All staff completed HSELand Safeguarding Vulnerable Adult by 30 June 2026.The PIC will complete training for Designated Officer, this will better equip him to guide and direct staff

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	31/07/2026
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	30/06/2026
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.	Not Compliant	Orange	17/07/2026
Regulation 23(1)(c)	The registered provider shall ensure that	Not Compliant	Orange	31/07/2026

	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.			
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 support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.	Substantially Compliant	Yellow	25/07/2026
Regulation 23(3)(b)	The registered provider shall ensure that effective arrangements are in place to facilitate staff to raise concerns about the quality and safety of the care and support provided to residents.	Not Compliant	Orange	31/07/2026

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.	Not Compliant	Orange	31/07/2026
Regulation 26(1)(e)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: arrangements to ensure that risk control measures are proportional to the risk identified, and that any adverse impact such measures might have on the resident's quality of life have been considered.	Not Compliant	Orange	31/07/2026
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	Not Compliant	Orange	31/07/2026

	system for responding to emergencies.			
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.	Substantially Compliant	Yellow	29/05/2026
Regulation 31(1)(f)	The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: any allegation, suspected or confirmed, of abuse of any resident.	Not Compliant	Orange	30/06/2026
Regulation 31(3)(a)	The person in charge shall ensure that a written report is provided to the chief inspector at the end of each quarter of each calendar year in relation to and of the following	Not Compliant	Orange	31/07/2026

	incidents occurring in the designated centre: any occasion on which a restrictive procedure including physical, chemical or environmental restraint was used.			
Regulation 05(1)(b)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out subsequently as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.	Not Compliant	Orange	30/08/2026
Regulation 05(4)(a)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which reflects the resident's needs, as assessed in accordance with paragraph (1).	Not Compliant	Orange	30/07/2026
Regulation 05(4)(b)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre,	Not Compliant	Orange	30/06/2026

	prepare a personal plan for the resident which outlines the supports required to maximise the resident's personal development in accordance with his or her wishes.			
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	07/07/2026
Regulation 07(2)	The person in charge shall ensure that staff receive training in the management of behaviour that is challenging including de-escalation and intervention techniques.	Not Compliant	Orange	07/07/2026
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.	Not Compliant	Orange	06/07/2026

Regulation 08(1)	The registered provider shall ensure that each resident is assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection.	Not Compliant	Orange	10/07/2026
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	30/09/2026