



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

## Issued by the Chief Inspector

Name of designated centre:	Appleview
Name of provider:	Sunbeam House Services CLG
Address of centre:	Wicklow
Type of inspection:	Unannounced
Date of inspection:	08 January 2026
Centre ID:	OSV-0001702
Fieldwork ID:	MON-0044680

## About the designated centre

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

Applevue is a designated centre operated by Sunbeam House Services CLG, located in an urban area of County Wicklow. The designated centre offers residential services to four adults with intellectual disabilities. The designated centre consists of a detached house which is located in a housing estate and consists of a sitting room, dining room, kitchen, utility room, four individual bedrooms, a staff sleepover room, an office and a number of shared bathrooms. The house provides residents with a garden space to the rear of the property. The centre is staffed by a person in charge and social care workers. The person in charge works in a full-time capacity and they are also responsible for a separate designated centre.

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

Number of residents on the date of inspection:	4
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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
Thursday 8 January 2026	08:45hrs to 16:00hrs	Kieran McCullagh	Lead

## What residents told us and what inspectors observed

The purpose of this unannounced inspection was to monitor the care and welfare, and support arrangements for residents living in the centre and assess compliance with the regulations.

In February 2025, the Health Information and Quality Authority (HIQA) published an overview report of governance and safeguarding in designated centres operated by the provider. The report incorporated the findings of 34 inspections carried out in 2024 and focused on five regulations (Regulation 5: Individualised assessment and personal plans, Regulation 7: Positive behaviour support, Regulation 8: Protection, Regulation 15: Staffing, and Regulation 23: Governance and Management). The provider was found to be not-compliant under those regulations.

The report contained a compliance plan from the provider, which detailed a number of actions intended to address the identified concerns and achieve compliance. This inspection was a component of the Chief Inspector of Social Service's comprehensive evaluation of the provider's plan and its effectiveness in driving improvements.

The inspection was carried out over a single day and was facilitated by the person in charge. During the inspection, the inspector also met with the operations manager, and three staff members on duty. To assess the quality of life for residents the inspector relied on a combination of observations, discussions with residents, a review of relevant documentation, and conversations with key staff members.

The designated centre is situated in a coastal town and seaside resort in County Wicklow. The house comprised of five bedrooms, including one staff sleepover room, a kitchen, a dining room, a sitting room, a utility room, and three bathrooms. The centre is registered to accommodate four adult residents, and the inspector had the opportunity to meet all four residents over the course of the inspection.

Upon arrival the inspector was greeted by a staff member who was supporting a resident with their morning routine. The inspector completed a walk through of the designated centre. The inspector observed that the designated centre was clean, warm, and welcoming. Residents' bedrooms were laid out in a way that was personal to them and included items that was of interest to them. There was a private garden/driveway area to the front of the property and a large garden area to the rear. The gardens were well maintained and provided a tranquil space for residents to enjoy in times of good weather.

While the designated centre was generally well-maintained, the inspector identified potential fire safety risks specifically related to the utility room, which was to the rear of the designated centre. For instance, the inspector noted that the utility room was not of fire resisting construction, was not fitted with a self-closing fire door, and

automatic fire detection was not provided in this room. These risks had not been identified as part of the provider's own internal auditing systems and were not recorded as part of the provider's most recent health and safety audit completed in February 2025. Furthermore, the inspector also noted that emergency lighting to the front of the designated centre was not operational on the day of inspection and required servicing. This is further discussed under Regulation 28: Fire Precautions.

The inspector had the opportunity to meet and talk to all four residents over the course of this inspection. One resident sat and talked with the inspector at the dining room table. The resident remembered the inspector from previous inspections and told them they were very happy living in their home, and felt safe. They spoke about changes in staff and told the inspector that they did not like this. The resident had an active and busy life and could access the community independently. They liked to visit the local shops, and coffee shops and were well known in their locality. They informed the inspector they had a volunteer job, which they attended twice per week. The resident told the inspector they did not feel like going into their job today as they were worried about a recent incident that had occurred. Later in the day, the inspector observed the resident being supported in relation to this by the person in charge.

In the afternoon the inspector observed another resident who required emotional support and comfort from the person in charge. The resident was upset regarding potential plan changes and voiced concerns over not being able to go out for coffee with their fellow housemate. They had also voiced concerns around another resident who owed them money. It was apparent to the inspector that residents living in this designated centre required high level support, and concerns were raised at the end of this inspection in relation to lone working staffing arrangements that were in place at the time. This is discussed further under Regulation 15: Staffing.

Two other residents briefly engaged with the inspector on a number of occasions throughout the course of the inspection. They told the inspector they were happy living in their home, felt safe, and had no complaints. It was evident to the inspector that all four residents enjoyed being in each others company and had built up strong connections with each other. For example, residents spent time together chatting in the kitchen, and went out on community activities together.

The inspector spent time speaking with the person in charge and operations manager. The person in charge informed the inspector that the highest rated risk in the designated centre pertained to feeding, eating, drinking, and swallowing (FEDS). Specifically, two residents required staff supervision due to high risk of choking and the requirement for their meals to be prepared and served in a specific manner to mitigate the risk of choking. Concerns were raised regarding high frequency use of agency staff and lack of appropriate FEDS training. In addition, agency staff did not complete mandatory positive behavioural support training, which was concerning as all residents had identified behaviours that challenge.

Since the previous inspection, there had been multiple changes to the management structure of this designated centre. A review of the provider's own six monthly reports, health and safety report, and local audits evidenced that a high number of

identified actions had been completed. For instance, the most recent six monthly report completed in August 2025 found the provider to be 31% not compliant and 50% sub compliant with the regulations. On the day of this inspection there was no specific, or time bound plan in place to bring the centre back into compliance with the regulations.

In summary, the provider had failed to ensure their management systems were providing a service that was safe, appropriate to residents' needs, consistent, and effectively monitored at all times. Strategies to support residents were not effective and there remained an ongoing risk to residents wellbeing and safety.

In response to the high levels of non-compliance found on inspection, the Office of the Chief Inspector of Social Services invited the provider to attend an escalation meeting requiring the provider to bring the centre back into compliance.

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 delivered to each resident living in the centre.

## Capacity and capability

This section of the report presents the inspection findings regarding the leadership and management of the service, and evaluates how effectively it ensured the provision of a high-quality and safe service. Overall, it was determined that the provider had failed to ensure that management systems in place in the designated centre were effective in providing a service that was safe, appropriate to residents' needs, consistent, and effectively monitored at all times.

The provider had not ensured that the centre was adequately resourced to ensure the effective delivery of care and support. The provider failed to put in place appropriate contingency arrangements to respond to residents' assessed needs, behavioural support needs, and known fire safety concerns. The heavy reliance on agency staff meant there was no continuity of staffing which supported the building of relationships between staff and the residents who relied on staff support.

The provider and the person in charge did not have effective systems in place to assure them that all agency staff employed to work in the designated centre had the required mandatory or service specific training in order to fully support residents living in this designated centre. Agency staff members' training was not recorded or incorporated into the designated centre's staff training records. The absence of documentation further highlighted the inadequate oversight and review of staff training by the provider and the person in charge. This was particularly concerning

considering the known feeding, eating, drinking, and swallowing (FEDS) risks, and positive behavioural support needs of residents.

The provider had not ensured appropriate oversight and monitoring of the designated centre. Frequent changes to the management structure has led to a lack of continuity and stability since the previous inspection. The inspector noted that staff team meetings were consistently missed, and critical actions as a result of internal audits had not been actioned or completed. This led to a number of non compliance judgements and resulted in urgent actions been issued to the provider following inspection.

Overall, the provider's governance and management of the designated centre had failed to account for both known and potential risks, and they did not ensure that the designated centre was appropriately resourced and monitored to provide consistent, effective care and support for residents at all times.

Additionally, there were serious risks identified in respect of staff training and development, and the fire safety management systems. For this reason, on the day of the inspection, the inspector took the unusual action of issuing the provider with two urgent actions requiring the provider to put in place arrangements to mitigate and manage identified risks in these areas.

Following the inspection, the provider submitted an urgent action compliance plan response in relation to risks identified by the inspector. The provider set out actions they would take in order to bring the centre back into compliance.

The plan was reviewed by the inspector and gave assurances that the provider would take necessary actions to mitigate against risks identified. This is discussed further under Regulation 16: Staff training and development, and Regulation 28: Fire precautions.

## Regulation 15: Staffing

Overall, improvements were required to the oversight of staff rosters, and staffing arrangements to ensure continuity of care for all residents residing in the designated centre.

The inspector completed a thorough review of staff rosters for the months of November 2025, December 2025, and January 2026. Although the provider was endeavouring to back fill vacant shifts, it was found that there was an over reliance on agency staff to cover vacant shifts. For instance, the inspector found that:

- Nine shifts were covered by a number of different agency staff across the month of November 2025. The exact number of agency staff could not be determined on the day of inspection as gaps in roster management meant that the names of agency staff members had been recorded appropriately

- 30 shifts were covered by six different agency staff across the month of December 2025
- 15 shifts were covered or were planned to be covered by seven different agency staff across the month of January 2026.

The provider had not ensured that suitable contingency arrangements were in place to ensure continuity of care for residents. This was of concern given the high risk assessed needs of some residents, which included choking concerns, and identified positive behavioural support needs, and required comprehensive review by the provider.

Improvements were required to the recording of agency used to back fill vacant shifts. For example, there were numerous occasions in which the full name of the agency staff or the agency used was not recorded. This required enhancement to ensure the provider and person in charge had easy access to accurate and up-to-date staff rosters.

Furthermore, the staffing arrangements in the designated centre required consideration and review. Specifically, the lone working arrangements in place from 5pm. Residents living in this designated centre had high support needs, including positive behavioural needs which required ongoing staff support and encouragement. Current staffing arrangements in place were not in line with residents' assessed needs and required improvement.

Judgment: Not compliant

## Regulation 16: Training and staff development

During the course of this inspection a number of concerns were identified which posed a risk to the safety of the residents. Due to these risks, an urgent action was issued to the provider which required them to submit an urgent compliance plan detailing the response they would take to address these risks in a timely manner.

Systems for recording and monitoring staff training were in place, ensuring that core staff had completed all mandatory training. However, improvements were required to ensure that all agency staff were well-equipped to provide quality care, and had completed all necessary mandatory training and service specific training.

Examination of the staff training matrix evidenced that all all core staff members had completed a diverse range of training courses, enhancing their ability to best support the residents. This included mandatory training in fire safety, and safeguarding of vulnerable adults.

However, there was no recorded evidence on file that agency staff members had completed mandatory positive behavioural supports training or service specific training pertaining to feeding, eating, drinking, and swallowing (FEDS). The deficits

in staff training posed a risk to the quality and safety of the care and support provided to residents and their wellbeing.

Following the inspection the provider submitted an urgent compliance plan, which outlined the actions they would take. The inspector reviewed the response and was assured that the provider would put in place necessary actions to bring the centre into compliance.

For example, the provider outlined the following in their plan:

- Going forward, confirmation of minimum qualifications and location-specific training records for all agency staff will be maintained on site. The person in charge / deputy client service manager will request this documentation from agencies each time a staff member is booked to work in the location or retrospectively if booked outside person in charge / deputy client service manager working hours
- In addition to core mandatory training, agency staff where lone working in the designated centre are required to complete FEDS training. Where this has not been completed prior to commencement of a shift, it will be completed as part of the staff member's initial shift in the location. This will be outlined in the induction folder
- Any agency staff working on a regular basis in the designated centre will be booked onto the Positive Behaviour Support training provided by Sunbeam House Services
- The person in charge will arrange location-specific choking training for the staff team within the centre. Regular agency staff will be invited to attend to support consistency of practice.

The person in charge was responsible for the provision of supervision and support to all staff members within the designated centre. According to the provider's policy, staff were to receive three formal supervision / appraisal sessions per year. However, following a review of the supervision schedule it was evident that staff were not in receipt of supervision as per the provider's established policy. Without documented consistent staff supervisions, it was not evidenced that staff were adequately supervised in respect of their work and their defined responsibilities. This required considerable review and improvement by the provider and person in charge.

Judgment: Not compliant

## Regulation 23: Governance and management

Improvements were required to ensure the provider and person in charge had suitable oversight of the centre and that effective governance arrangements were in place to ensure the service was safely and effectively managed.

Since the last inspection in June 2024 there had been multiple changes in the management of the designated centre. Specifically, the designated centre had seen four different individuals assume the role of the person in charge and two different operations managers. The inspector noted that this frequent turnover in leadership had a detrimental effect in the designated centre. For example, this inspection found high levels of non compliance across a number of regulations, likely due to regulatory drift and the absence of a core and stable management team.

The inspector observed a large number of actions identified as part of the provider's own internal audit system had not been progressed or completed. Specifically, actions regarding team meetings, supervision meetings, residents' personal plans and goals, key working meetings, daily and monthly audits, and fire safety risks had not been assigned to a person responsible, and remained incomplete on the day of this inspection.

The inspector found that increased oversight arrangements between the operations manager, person in charge, and deputy client service manager was required in order to establish delegated responsibilities, identify timelines for actions to be complete, and ensure that appropriate regulatory oversight was maintained for the designated centre.

Judgment: Not compliant

## Quality and safety

The provider did not demonstrate the capacity or capability to operate the service in compliance with the regulations and in a manner which ensured safe and quality care to all residents. Overall, strategies in place to support residents' assessed positive behavioural support needs were not effective, and there remained an ongoing risk to residents' safety due to risks related to fire safety.

There were a number of fire safety risks identified on this inspection. In particular, actions identified as part of a property and environmental assessment completed a number of years ago had not been actioned or progressed in a timely manner. Risks related to internal fire doors, fire identification labels, fire signage, smoke seals, and gaps between fire doors all remained outstanding on the day of this inspection. Additionally, further fire risks were observed by the inspector pertaining to high risk rooms. Specifically, it was observed that some emergency lighting was not operational, and the utility room was not of fire resisting construction, was not fitted with a self-closing fire door, and automatic fire detection was not provided in this room.

The provider had failed to ensure that there were appropriate positive behavioural supports available to residents who required such supports. Residents were presenting with behaviours that were of risk to their own and others safety.

In addition, agency staff had not been provided with mandatory training to ensure they had up-to-date knowledge and skills in the area of positive behavioural support to enable them to respond consistently to the support needs of residents. Furthermore, staff were not provided with adequate guidance or strategies to enable them support residents manage their behaviours. Overall, the inspector found that there was insufficient behavioural supports in place for residents to support them in developing skills that would improve their quality of life and reduce the behaviours that were impacting negatively on their own and other residents' lives.

Good practices were in place in relation to safeguarding. Any incidents or allegations of a safeguarding nature were investigated in line with national policy and best practice. Inspectors found that appropriate procedures were in place, which included safeguarding training for all staff, the development of personal and intimate care plans to guide staff and the support of a designated safeguarding officer within the organisation.

Overall, strategies in place to reduce behavioural incidents occurring were not effective, and there remained an ongoing safety risk to residents living in this designated centre.

## Regulation 28: Fire precautions

There were a number of fire safety risks identified on this inspection which posed a risk to the safety of the residents. Due to these risks, an urgent action was issued to the provider which required them to submit an urgent compliance plan detailing the response they would take to address these risks in a timely manner.

Some of the risks were known to the provider, however the inspector found that these had not been addressed in a timely manner.

For instance, the provider's six monthly audits completed in February 2025 and August 2025, and the provider's health and safety audit completed in February 2025 identified a number of concerns and risks pertaining to fire safety. Specifically, risks related to internal fire doors, fire identification labels, fire signage, smoke seals, and gaps between fire doors had all been identified as part of the provider's own internal audits. However, on the day of this inspection appropriate actions had not been implemented by the provider to address known fire safety risks and concerns.

The inspector also observed additional fire safety risks during the walk around of the designated centre. For instance, it was observed that some emergency lighting was not operational, and the utility room was not of fire resisting construction, was not

fitted with a self-closing fire door, and automatic fire detection was not provided in this room.

Following the inspection the provider submitted an urgent compliance plan, which outlined the actions they would take. The inspector reviewed the response and was assured that the provider would put in place necessary actions to bring the centre into compliance.

For example, the provider outlined the following in their plan:

- A fire safety risk assessment was conducted on the building in 22/02/22. Risks were categorised using a traffic light system with no high red risk identified at that time. A fire engineer attended the designated centre on 12/01/2026 to complete an updated fire assessment, including a review of the 2022 report. The updated report will be provided to the Chief Inspector of Social Services and any actions identified will be reviewed and progressed by the Operations Manager and person in charge.

- Facilities have confirmed that the fire rating labels for two recently replaced fire doors (hallway door and dining room door) are not in place. Facilities are following this up directly with the contractor to obtain certification. Person in charge will continue to follow this up as part of their monthly governance checks.

- A provider health and safety audit will be completed on 22/01/2026. The person in charge will review the audit findings on receipt and will liaise with facilities and maintenance teams to address any fire-related actions identified. Progress will be monitored through governance oversight structures

- A new weekly fire safety checklist has been introduced and is maintained within the fire and general register folder

- Up-to-date fire evacuation plans, revised on 12/01/2026, are displayed at the front door of the building and are available to staff and visitors

- Fire equipment servicing and maintenance records are managed by facilities, and copies of all current records are now held on file within the designated centre for local reference and inspection purposes.

Judgment: Not compliant

## Regulation 7: Positive behavioural support

The inspector reviewed the arrangements in place to support residents' positive behaviour support needs and found that the provider had failed to provide all residents with timely and effective positive behavioural support in line with their assessed needs.

One resident who had assessed positive behavioural support needs did not have a positive behaviour support plan on file on the day of this inspection. The inspector was informed that this was as a result of the resident's refusal to engage with the positive behaviour support specialist. However, the inspector saw evidence on file that the resident had a risk assessment pertaining to positive behavioural support, had a history of making allegations against staff members, and that changes to their routine could lead to incidents of behaviours that challenge. Furthermore, medical advice following two recent incidents in which the resident presented to hospital, was that there was no known medical reason and that the resident was presenting with behavioural issues.

On the day of inspection agency staff had not received mandatory training regarding positive behavioural supports. This was of concern given the lone working arrangements within the designated centre, and agency staff did not have the necessary knowledge, skills, and competencies to effectively implement positive behavioural supports or respond appropriately to behaviours that challenge.

This was particularly concerning and demonstrated the provider's written commitments and assurances provided to the Chief Inspector were not accurate as found on this inspection.

Judgment: Not compliant

## Regulation 8: Protection

The registered provider and person in charge had implemented systems to safeguard residents from abuse. For example, there was a clear policy in place with supporting procedures. This had been reviewed and updated in October 2024, and it clearly directed staff on what to do in the event of a safeguarding concern.

All staff working in this designated centre had completed mandatory safeguarding training to support them in the prevention, detection, and response to safeguarding concerns. Staff spoken with throughout this inspection were knowledgeable about their safeguarding remit and regulatory responsibilities. For example, all safeguarding concerns had been reported to the Chief Inspector in line with the regulations.

At the time of this inspection there were no safeguarding concerns open. The inspector reviewed the records of previous safeguarding incidents identified during the previous inspection in June 2024, and one safeguarding incident which had been notified to the Chief Inspector in 2022. The provider and person in charge had ensured that these had been appropriately investigated and reported. Furthermore, and to mitigate the risk of recurrence a number of actions were implemented. For example, all residents had updated money management assessments completed, residents' finances were regularly audited, the provider's social worker was actively

supporting one resident regarding their finances, and an external financial specialist was commissioned to complete a full and thorough audit of residents' finances.

All residents spoken with on the day of this inspection informed the inspector they felt safe and happy living in their home.

Following a review of two residents' care plans the inspector observed that safeguarding measures were in place to ensure that staff provided personal intimate care to residents who required such assistance in line with their personal plans and in a dignified manner.

Judgment: Compliant

## Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
<b>Capacity and capability</b>	
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
<b>Quality and safety</b>	
Regulation 28: Fire precautions	Not compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Compliant

# Compliance Plan for Appreview OSV-0001702

Inspection ID: MON-0044680

Date of inspection: 08/01/2026

## 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 15: Staffing	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 15: Staffing:</p> <ol style="list-style-type: none"> <li>1. An immediate review of staffing arrangements has been completed. The centre now operates with two staff on duty for 12 hours per day. There are currently no lone working arrangements in place. Night-time staffing has been enhanced to include a sleepover staff member and a temporary waking night staff member to address residents' assessed needs, including fire safety, positive behavioural support, and evacuation requirements. Completion date: 05/02/2026</li> <li>2. A wider consultation with the staff team is commencing in relation to current rosters and the longer term needs assessed of the location. This consultation will inform future staffing arrangements and will be overseen by the Person in Charge with support from the PPIM. Completion date: 31/05/2026</li> <li>3. The roster has been reviewed and will continue to receive monthly review by the Person in Charge and Deputy Service Manage to ensure adequate staffing levels and continuity of care are maintained. Vacancies and outstanding shifts are now covered by the same regular agency staff, where possible, promoting consistency within the team. Completion date: 03/02/26 and ongoing</li> <li>4. The Person in Charge has ensured that all staff rosters now clearly record full names, agency/relief staff, and the agency providing the staff member. This ensures transparency and easy access to up-to-date staffing records. Completion date: 12/01/2026</li> <li>5. All new staff and agency staff read, understand, and sign the location induction folder prior to commencing duties. Where staff commence outside of core PIC or Deputy hours, induction is facilitated by experienced staff. The PIC or DSM reviews and signs off on the induction folder as evidence of completion. Completion date: 05/02/2026 and ongoing</li> <li>6. Localised safeguarding plans are being put in place. These plans will detail choking</li> </ol>	

risks, positive behavioural support needs and other high-risk factors, ensuring all staff, including agency staff are informed aware of known risks.

Completion date: 28/02/2026

7. There is currently 1 vacant post. Recruitment for this post is ongoing and will be regularly followed up by the PIC to ensure shortlisting and interviews. Completion date: 30/04/2026

8. A clear protocol for sourcing staff cover has been implemented. Cover is sought initially from the existing team, then from SHS internal resources, then regular agency staff and only as a last resort, alternative agency staff. This protocol is documented in the induction folder and communicated to all staff.

Completion date: 28/01/2026

9. Residents' needs assessments are being updated to reflect current risks and support requirements. These assessments, including choking risks and PBS needs, will inform staffing levels and skill mix, ensuring safe and appropriate care at all times. Oversight of updates and implementation will be maintained by the PIC and Deputy Service Manager.

Completion date: 30/04/2026

Regulation 16: Training and staff development	Not Compliant
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Outline how you are going to come into compliance with Regulation 16: Training and staff development:

1. All regular, agency, and relief staff have completed FEDS training to ensure safe feeding, eating, drinking, and swallowing practices.

Completion date: 05/02/2026 & ongoing

2. All staff are scheduled to receive appraisal and supervision sessions in line with provider policy. A schedule for the remainder of the year has been set up and will be carried out by the Person in Charge or Deputy Service Manager.

Completion date: 05/02/2025 and ongoing

3. Confirmation of minimum qualifications and location-specific training records for all agency staff will be maintained on site. The Person in Charge or Deputy Service Manager will request this documentation from agencies each time a staff member is booked to work, or retrospectively if booked outside PIC/DSM working hours.

Completion date: 05/02/2026 and ongoing

4. In addition to core mandatory training, agency staff working in the designated centre are required to complete FEDS training. Where this has not been completed prior to commencement of a shift, it will be completed during the initial shift. This requirement is included in the induction folder to ensure compliance.

Completion date: 05/02/2026 and ongoing

5. The majority of additional shifts are now covered by regular agency staff, supporting continuity of care and allowing for effective ongoing monitoring of training compliance.

The Person in Charge reviews monthly to monitor agency staff training and identify any gaps. Completion date: 31/01/2026 and ongoing

6. The Person in Charge conducts a monthly review of all training, including agency and relief staff, to ensure ongoing compliance with mandatory and location-specific requirements. Any gaps identified will be addressed promptly and findings are documented as part of governance oversight. Commencement date: 31/01/2026 and ongoing

7. Location-specific choking training has been arranged for the staff team within the centre. Regular agency staff will be invited to attend to support consistency of practice and attendance is documented in training records.  
Completion date: 20/03/2026

Regulation 23: Governance and management

Not Compliant

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

1. A Service Improvement Plan (SIP) is in place to address identified actions and monitor progress. The Person in Charge oversees this process in conjunction with the PPIM.  
Completion date: 05/02/2026 and ongoing

2. The PPIM will conduct one governance and management meeting with the PIC each quarter to review, assign and document actions arising from audits. In addition to this the PPIM and PIC have one 1;1 meeting per quarter. Additionally, at least one unannounced visit to the location will occur quarterly also.  
Completion date: Commencing 12/01/2026 and ongoing

3. A full-time permanent Person in Charge commenced in the location on 03/02/2025 and has responsibility for one additional designated centre. The PIC ensures oversight of staffing, training, and implementation of the SIP to maintain continuity and quality of care.  
Completion date: 05/02/2026

4. A full-time Deputy commenced in the location on 22/12/2025. They will also have responsibility for one additional designated centre. The Deputy supports the PIC in oversight, supervision and governance processes to maintain safe and effective service delivery. Completion date: 05/02/2026

5. A full handover and induction have been commenced with both the new PIC and Deputy overseen by PPIM. 31/03/26. Completion date: 05/02/2026

6. The SIP identifies the actions highlighted as part of the provider's internal audit system. The SIP is updated weekly, and all outstanding audits, actions, and recommendations are monitored and actioned. This includes audits of staffing, documentation, personal plans, keyworking, safeguarding, restrictions and fire safety.  
Completion date: 05/02/2026 and ongoing

7. Team meetings are scheduled for the next six months and include agenda items such as safeguarding, residents' rights, induction, training, and quality of care. These meetings will be documented and monitored through the SIP. These occur bi-monthly.  
Completion date: 05/02/2026 and ongoing

8. All staff are scheduled to receive appraisals. The schedule for the remainder of the year has been set up and will be carried out by the PIC or Deputy, ensuring accountability and support for staff in their roles.  
Completion date: 05/02/2026 and ongoing

9. Residents goals are being reviewed and updated as part of the SIP process. Progress against goals and identified actions is monitored by the PIC and Deputy.  
Completion date: 31/03/2026 and ongoing

10. Monthly keyworker updates will be reviewed by the PIC to ensure accuracy, consistency and evidence of care delivery. Oversight includes monthly review of notes to monitor quality and compliance. Completion date: 05/02/2026 and ongoing

11. Governance oversight is now embedded through regular PIC/Deputy supervision, PPIM meetings and reporting to the Operations Manager. This ensures accountability for delegated actions, regular completion of audits and ongoing

Regulation 28: Fire precautions	Not Compliant
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Outline how you are going to come into compliance with Regulation 28: Fire precautions:

1. Fire upgrade works were completed in the centre in 2025. This included two recently replaced fire doors (hallway door and dining room door). Smoke seals were reviewed, and any gaps or deficiencies were addressed as part of these remedial works. Verification for these works carried out remains outstanding. Facilities are following this up directly with the contractor to obtain certification. The Person in Charge will continue to monitor this and ensure completion of follow-up as part of monthly governance checks.  
Completion date: 10/04/2026

2. The utility room has been reviewed as part of the health and safety audit (internal) and fire safety audit (external). A fire detection device will be installed to enhance safety. The rear of the building also has a secondary door for evacuation in the event of a fire.  
Completion date: 28/02/2026

3. Any fire-related actions identified in the provider's health and safety audit will be overseen by the PIC in collaboration with facilities and maintenance teams. Progress will be monitored through governance structures.  
Completion date: 05/02/2026 & ongoing

4. A new weekly fire safety checklist has been introduced and is maintained within the fire and general register folder. The Health and safety rep and PIC will ensure completion and review monthly.  
Completion date: 05/02/2026 & ongoing

5. Daily checks of all means of escape are completed by staff in Applevue to ensure exits remain unobstructed and safe for use. These checks are monitored by the Person in Charge and Deputy Manager as part of routine oversight. Completion date: 12/01/2026 and ongoing

6. Up-to-date fire evacuation plans, revised on 12/01/2026, are displayed at the front door of the building and are available to staff and visitors. Completion date: 31/01/2026

7. All emergency lighting is serviced regularly and records are maintained. The most recent service was in December 2025 and no faults were identified. Fire equipment servicing and maintenance records are managed by Facilities and copies are accessible to the PIC. The next review will occur in February 2026. Completion date: 28/02/2026.

8. All provider staff have completed mandatory fire safety training. The Person in Charge has reviewed the training records for Applevue and confirmed that all staff are in date. Ongoing monitoring of training compliance will continue. Completion date: 12/01/2026

9. All agency staff receive an induction on commencement of each shift, which includes a fire safety walkthrough of the building and clarification of evacuation procedures and exit routes. Compliance is overseen by the Person in Charge and Deputy Manager. Completion date: 12/01/2026 and ongoing

10. The fire safety risk assessment conducted on 22/02/2022 was reviewed by a fire engineer on 12/01/2026. Their report will be provided to the Chief Inspector and a copy sent to provider Health and Safety Officer. Completion date 11/02/26.

11. The fire safety risk assessment conducted on 22/02/2022 was reviewed by a fire engineer on 12/01/2026 and identified a programme of works. An architect has been appointed to oversee the tender process for the work required in the centre. A non-invasive assessment is scheduled for 12/02/2026. The schedule of works is planned to go out to tender by 01/04/26, with contractors expected on site by late July 2026 and works taking 8–12 weeks. Should arrangements for any temporary resident accommodation during the works be identified, a robust plan will be put in place and communicated to residents and their families. Completion date: 31/10/2026

Regulation 7: Positive behavioural support	Not Compliant
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Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:

1. A referral has been made to the Positive Behaviour Support (PBS) team for the resident who previously did not have a plan on file. The resident has now indicated willingness to engage. In the event the resident chooses not to engage, the PBS team will provide guidance to staff on how to implement positive behavioural supports safely and effectively. The Person in Charge will oversee this process. Completion date: 30/04/2026

2. If the open vacancy remains unfilled and agency staff are required for more than six months; the provider will review Positive Behaviour Support (PBS) training for these personnel. The Person in Charge (PIC) will ensure, where possible, that no two-agency staff are scheduled together on the same shift to maintain consistency in implementing support plans. Completion date: 05/02/2026

3. A thorough review of the financial peer to peer concern was conducted internally and by external parties. This concluded towards the end of 2025 and a plan is being developed to address the outstanding issues. Completion date: 30/04/2026

4. The Person in Charge will ensure that any changes to residents' routines, or behaviours are documented in their individual risk assessments. This includes guidance for staff on interventions and de-escalation strategies.  
Completion date: 28/02/2026 & ongoing

5. The Person in Charge will monitor and review all PBS plans and associated risk assessments monthly to ensure effectiveness  
Commencement date: 28/02/2026 & ongoing

## 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 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Not Compliant	Orange	05/02/2026
Regulation 15(3)	The registered provider shall ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.	Not Compliant	Orange	31/05/2026
Regulation 15(4)	The person in charge shall ensure that there is a planned and actual staff rota,	Not Compliant	Orange	05/02/2026

	showing staff on duty during the day and night and that it is properly maintained.			
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.	Not Compliant	Red	12/01/2026
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	31/03/2026
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	31/05/2026
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	12/01/2026

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.	Not Compliant	Orange	12/01/2026
Regulation 28(1)	The registered provider shall ensure that effective fire safety management systems are in place.	Not Compliant	Red	05/02/2026
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	Red	31/10/2026
Regulation 07(1)	The person in charge shall	Not Compliant	Orange	31/03/2026

	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.			
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	31/03/2026