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:	Parkview
Name of provider:	Sunbeam House Services CLG
Address of centre:	Co. Dublin
Type of inspection:	Unannounced
Date of inspection:	25 September 2025
Centre ID:	OSV-0001704
Fieldwork ID:	MON-0047184

About the designated centre

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

Parkview is a designated centre operated by Sunbeam House Services Company Limited by Guarantee. The centre is located on the outskirts of a town in Co. Dublin and can provide residential care for four female residents over the age of 18 years. The centre can cater for residents who have moderate to high support needs. The support provided varies depending on the individual residents' needs and requirements. Residents are supported to live as independently as possible in the centre, and are encouraged to actively engage with their community. The centre is a two-storey house which comprises of single residents' bedrooms, a sitting room, a kitchen and dining area, shared bathrooms and staff offices. The centre is close to transport services, shops and recreational services. Staff are present in the centre both day and night to support residents living here. The staff complement includes the person in charge, a deputy manager, social care workers, and healthcare assistants.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	4

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
Thursday 25 September 2025	09:30hrs to 17:35hrs	Michael Muldowney	Lead
Thursday 25 September 2025	09:30hrs to 17:35hrs	Orla McEvoy	Support

What residents told us and what inspectors observed

This unannounced inspection was carried out as part of the regulatory monitoring of the centre. It focused on how the provider safeguarded residents from abuse, promoted their human rights, and empowered them to exercise choice and have control in their lives.

Inspectors used observations, conversations with staff and residents, and a review of documentation to form judgments on compliance with the regulations inspected. They found that the centre was operating at a good level of compliance and that arrangements were in place to deliver safe and effective care and support. However, improvements were required under most of the regulations inspected to meet full compliance.

The centre accommodated four residents. Inspectors met all four residents throughout the inspection. Three residents were happy to speak with the inspectors, while one resident chose not to.

One resident told inspectors that they were happy and felt safe in the centre, and that they got on well with their housemates and staff. They said that there was nothing that they disliked about their home. The indicated that there was enough staff on duty to support their needs, and they showed the inspectors some of the mobility aids that they used. They said that they liked to go grocery shopping, art and using their smart tablet.

Another resident showed inspectors their bedroom, their art work in the hallway, and some of their personal possessions, including family photos and a new television and radio. They liked their bedroom, and said that they had the necessary mobility aids they required. There was an alarm in the resident's bedroom that was used to notify staff if the resident required assistance; the resident said that they did not like the loud noise that it made. They told inspectors about their hobbies and interests, including cooking, gardening, beauty treatments, and going out with staff, especially their key worker. They also said that they could use their right to vote, but did not plan on voting in the upcoming presidential elections.

One resident told inspectors that the centre was great, and that it was a nice house to live in. They said that they knew all of the staff working in the centre, and was happy with the support they provided. They also said that they could speak with the person in charge and staff if they were every unhappy, and that staff helped to resolve disagreements between residents. They had a paid job which they enjoyed, and also liked to use public transport, meet friends, cook, go to cafés and attend social clubs. They told inspectors about some of their personal goals that they were working on with their key worker, such as going on holidays.

Inspectors also read resident surveys that the provider used to inform their recent annual review of the centre. Two residents indicated that the house was not always

nice to live in because of the behaviours of other residents from time-to-time. However, overall, residents indicated that they felt safe, liked the food, could make their own choices and decisions, and were satisfied with the care and support they received from staff.

Inspectors spoke with different members of staff during the inspection, including the person in charge, a senior operations manager, two agency healthcare assistants, and the provider's safeguarding officer.

The person in charge and senior operations manager told inspectors that residents were happy and received person-centred care and support in the centre. They were satisfied with the access to multidisciplinary team services such as social work, mental health services, and occupational therapy.

Some residents' needs had recently increased and they required additional supports such as mobility aids and environmental adaptations. However, there were outstanding premise works that were needed to make the outdoor space more accessible and safer for residents to use. Additionally, inspectors were told that the staffing levels required clarification, and the person in charge was engaging with the provider on this matter.

The management team said that safeguarding concerns were appropriately managed and reported, and that associated actions were taken to safeguard residents. For example, incidents were reported to relevant external parties and the provider's safeguarding officer provided support and guidance to residents and staff.

The provider's safeguarding officer told inspectors that residents were safe living in the centre and lived as normal lives as possible. They said that residents were supported to take positive risks, gave good feedback on the care and support they received, and that their will and preferences were always taken into account. They spoke about some of the provider's safeguarding systems and how they were implemented. Safeguarding and protection is discussed further in the quality and safety section of the report.

Two agency healthcare assistants told inspectors that they had worked in the centre for approximately one month and had received an induction when they started. They spoke about some of the residents' needs and the associated interventions related to their mobility, communication, health, personal care and preferences. However, inspectors found that they could not access relevant safeguarding plans, and required more knowledge on reporting safeguarding concerns and using a specific manual handling device. Additionally, one healthcare assistant could not access the provider's online information system.

Overall, inspectors found that while compliance was found under some regulations inspected, improvements were required to meet full compliance to ensure that residents were in receipt of high quality and safe services.

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

Capacity and capability

In February 2025, 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 included an organisation improvement plan from the provider that outlined its actions to address the poor findings and to come into compliance. This inspection formed part of the Chief Inspector's overall assessment of the provider's implementation of the provider's plan and its effectiveness in driving improvements. There had been a number of quality improvements made in the centre which demonstrated some progress on the provider's implementation of the improvement plan and how it was impacting on the quality of life for residents living in this centre.

However, some further improvements were required to ensure that that the centre was resourced in line with the residents' assessed needs, and that actions and recommendations to enhance the quality and safety of the service provided to residents were addressed in a reasonable time frame.

The provider and person in charge had implemented management systems to monitor the quality and safety of service provided to residents. Annual reviews and unannounced six-monthly reports, as well as various audits had been carried out in the centre to identify areas for quality improvement. However, long-standing issues related to the premises had not been mitigated, and not all multidisciplinary team recommendations had been progressed.

The staff complement required clarification to determine if it was appropriate to the number and assessed needs of residents. Inspectors found that there was conflicting information on what arrangements should be in place. The person in charge had escalated this matter to the provider, and was awaiting a meeting on the matter.

Staff completed relevant training as part of their professional development and to support them in their delivery of appropriate care and support to residents. Key worker training had recently been rolled out by the provider as part of their improvement plan. However, only two staff in the centre had completed the training at the time of the inspection.

Regulation 16: Training and staff development

Staff were required to complete training as part of their professional development and to support them in the delivery of appropriate care and support to residents. Inspectors reviewed the most recent training logs with the person in charge. They found that the training logs required better maintenance and cohesion. For example, the person in charge said that staff had completed human rights training, but this was not included in the logs.

However, overall the training logs showed that staff had completed training in relevant areas, including safeguarding of residents, communication, manual handling, positive behaviour support, assisted decision-making, and dementia awareness.

Members of the provider's multidisciplinary team were also available to provide in-person training in the centre. For example, the provider's medication trainer attended a recent team meeting to provide epilepsy management training.

As noted under regulation 9, only two staff had completed key worker training so far, and the remainder were due to do it in November 2025.

This inspection did not review the arrangements for the supervision of staff.

Judgment: Compliant

Regulation 23: Governance and management

While there were good governance and management systems in place in the centre, including management structures and oversight arrangements, improvements were required to ensure that the centre was appropriately resourced and that improvement actions were carried out in a reasonable time frame.

The management structure included a full-time person in charge and senior operations manager. The person in charge had responsibility for two centres and was supported in their role by a deputy manager.

Generally, the centre was well resourced, but improvements were required to ensure that the centre was appropriately resourced in all necessary areas to deliver effective care and support. For example, the staffing arrangements required clarification from the provider to determine if they were suitable to meet the number and assessed needs of the residents. Additionally, more consideration was required from the provider on how rotas were planned to ensure that they were appropriate. For example, on the day of the inspection, the person in charge was due to attend

training off site, the deputy manager was on leave, and there were no permanent staff working with residents.

The provider and person in charge had implemented good systems to monitor and oversee the quality and safety of care and support provided to residents in the centre. Annual reviews (which consulted with residents), six-monthly unannounced visit reports, and audits were carried out. However, the provider's response to some improvement actions required improvement. Required works to the exterior of the premises had been noted in the last inspection report and were frequently highlighted in the provider's audits of the centre. The issues had also been escalated to the relevant parties by the person in charge; however, they remained outstanding and impacted on residents' ease and safety while accessing their home.

Improvements were also required to ensure that recommendations from multidisciplinary team services were followed up on. For example, in April 2025, an occupational therapy recommendation for a resident to trial using an aid for daily living had not been progressed.

On review of documentation and from speaking with the management team, the inspectors found that a number of the provider's plans for bringing Regulation 23: Governance and management, into compliance, across their centres, had been completed or partially completed in this centre with evidence of progress being made. For example:

- The senior operations manager was completing unannounced visits to the centre.
- The person in charge had completed training on using the national safeguarding portal.
- An induction folder was in place.

Judgment: Substantially compliant

Quality and safety

Overall, inspectors found that residents felt safe living in the centre, and they told inspectors about how they exercised their rights and had control in their lives. However, improvements were required under all of the quality and safety regulations inspected to meet full compliance and ensure that residents' assessed needs were being met, risks were assessed and managed, and that the provider's safeguarding systems were being consistently implemented.

Assessments had been completed to inform written care plans on residents' health, personal and social care needs. Some of the assessments and plans, including those on communication and positive behaviour support, required better evidence of

review to ensure that they were up to date and reflective of residents' changing needs.

There were arrangements to support residents to exercise choice and control in their lives. Some residents told inspectors that they liked planning personal goals with their key workers. The provider had rolled out key worker training to drive improvements in this area; however, at the time of the inspection only 20 percent of permanent staff working in the centre had completed this training. Additionally, inspectors found that residents' house meetings were not happening in line with the statement of purpose or residents' guide.

The provider had prepared a written risk management policy and it outlined the arrangements for identifying, assessing and escalating risks. However, improvements were required to ensure that all risks in the centre, including those specific to individual residents, were subject to a documented assessment to demonstrate that appropriate measures were in place.

Overall, there were good safeguarding policies and arrangements in the centre. Safeguarding concerns were appropriately reported, and effective measures were put in place to protect residents. For example, safeguarding plans were put in place, concerns were reported to external parties, and the provider's safeguarding officer was available to provide support and guidance. However, inspectors found that improvements were required to ensure that all staff working in the centre could access relevant information and were well-informed on reporting procedures.

Regulation 10: Communication

The residents communicated using different means including spoken words, body language and use of aids. Inspectors found that some improvements were required to ensure that residents were supported to communicate in accordance with their needs at all times.

The inspectors reviewed two residents' communication care plans and the associated supports. The plans reflected input from relevant multidisciplinary team services and were readily available for staff to refer to. However, a resident's communication passport required updating to reflect a resident's changing needs and the aids recommended to them, which staff on duty were not fully aware of.

The provider had also ensured that residents had access to media sources such as televisions, smart tablet devices, and the Internet.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

The provider had prepared a written risk management policy that outlined the arrangements for identifying, analysing and managing risks that may present in the centre and affect residents. The policy also incorporated positive risk taking, and noted residents' right to take risks, make decisions and have control in their lives.

Inspectors reviewed a sample of two resident's individual risk assessments. They pertained to a range of risks including behaviours of concern. However, there was an absence of a specific risk assessment for one resident related to a risk to their safety. The person in charge told inspector that a risk assessment would be prepared to ensure that the associated risk was assessed and documented.

Inspectors also found additional risks to residents' care during the inspection that required more consideration from the provider to ensure that they were mitigated. For example, agency staff working in the centre told inspectors that they did not know about a manual handling device that one resident required if they had a fall. Additionally, written information indicated that a resident required a low level of support to transfer; however, staff told inspectors that a higher level, including physical assistance, was required. This discrepancy posed a risk to the safety of the care and support provided to the resident. Inspectors escalated this matter to the person in charge during the inspection.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Residents' health, social and personal care needs had been assessed and associated care plans had been prepared to guide staff on the care and support they required. However, the review and upkeep of these documents required improvement to ensure that they up to date.

Inspectors reviewed two resident's assessments and care plans. The files reflected input from a wide range of multidisciplinary team services including dietitian, physiotherapy, occupational therapy, nursing specialists, speech and language, and mental health services. However, some of the care plans had not been reviewed to reflect changes in the residents' needs and presentations and the associated supports they required. For example, one resident's money management and safety plan did not reference recent supports that may require from staff.

Overall, improvements were required to ensure that residents' files were subject to robust review, particularly as their needs changed.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

Residents were supported to manage their behaviours of concern where required. Staff completed positive behaviour support training, and the provider's behavioural specialists developed written positive behaviour support plans. Inspectors reviewed three plans and found issues that compromised the effectiveness of the plans. For example:

- Not all staff working in the centre had signed the plans' signature sheets to indicate that they read and understood the plans. One plan was signed by only one staff member, and had not been signed by the resident concerned to indicate if they agreed to it.
- A specific intervention related to the use a visual activity planner was not in place. The resident concerned told inspectors that they would like if staff implemented the intervention.
- Information in one plan related to a resident's routine and abilities was not reflective of their current presentation.

Overall, improvements were required to ensure that the plans were up to date, read and understood by staff, and that all recommended interventions were in place.

Judgment: Substantially compliant

Regulation 8: Protection

Overall, the registered provider and person in charge had implemented good systems to safeguard residents from abuse. These systems were underpinned by the provider's safeguarding policy. However, improvements were required to ensure that staff working in the centre could access key information and were fully aware of the procedures for reporting safeguarding concerns.

Staff working in the centre were required to complete safeguarding training to support them in the prevention, detection, and response to safeguarding concerns. The person in charge had also attended additional training on reporting concerns to the national safeguarding office. The provider's safeguarding officer was also available to provide guidance to staff and residents on safeguarding matters.

Inspectors reviewed six reported allegations of abuse from 2023, 2024 and 2025. They found that the allegations were reported to the relevant parties as necessary, including the national safeguarding office. The allegations were also reviewed by the management team to identify actions to protect residents from potential abuse. Some residents told inspectors about the support and education they received for self protection. They said that they enjoyed working with the safeguarding officer, and found the support from the person in charge beneficial.

Safeguarding care plans had been prepared which outlined the associated interventions to be in place. However, inspectors found that two agency staff members did not know how to access one resident's safeguarding plan. This posed a risk to how effectively they may respond to the resident's needs. Furthermore, it was found that they required better knowledge on how to report safeguarding concerns.

Judgment: Substantially compliant

Regulation 9: Residents' rights

Generally, it was found that residents were supported to exercise their rights and have control and make choices in their lives. However, some minor improvements were required to strengthen the arrangements.

The statement of purpose and residents' guide referred to regular house meetings where common agenda items can be discussed. However, only two meetings had been recorded in 2025. The person in charge told inspectors that there could have been more meetings that were not recorded. This matter required better oversight to ensure that residents had the opportunity to attend and contribute to 'regular' house meetings if they wished to.

Residents had been allocated key workers who supported them to plan personal goals. For example, one resident had been supported to go on a hotel break in February 2025. One resident in particular spoke warmly about their key worker and told inspectors about how they helped them in their life. The provider had rolled out key worker training to strengthen the key working arrangements, but at the time of the inspection, only two of the 10 permanent staff working in the centre had completed the training. The remaining eight were scheduled to attend the training in November 2025.

The maintenance of residents' files required better oversight to ensure that information in their active file was accurate. In one resident's file, a plan referred to interventions that posed a risk to their privacy. The person in charge told inspectors that the plan was not being implemented and had only been active for a short time period. However, its presence in the resident's active file posed a risk that it may be followed by staff and thus impinge on the resident's right to privacy.

This was of particular importance due to the use of unfamiliar agency workers in the centre who would require clear guidelines on the most current and appropriate way to support residents in the centre.

Judgment: Substantially 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 16: Training and staff development	Compliant
Regulation 23: Governance and management	Substantially compliant
Quality and safety	
Regulation 10: Communication	Substantially compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Parkview OSV-0001704

Inspection ID: MON-0047184

Date of inspection: 25/09/2025

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 23: Governance and management	Substantially Compliant

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

• Staffing arrangements have been reviewed and established; workforce planner and Statement of Purpose have been updated by the PIC to reflect changes. Completed on 30/09/2025.

• 2 vacancy requests have been submitted to HR by the PIC to recruit based on staffing levels review. Completed on 20.10.2025

• The roster has been updated to reflect PI and DSM annual leave and training days. Roster and cover arrangements will be reflected on the roster and updated by the PIC/DSM as the need arises. Completed on 13/10/25

• The roster is structured to ensure that, wherever possible, the DSM and/or Person in Charge (PIC) are present on-site Monday to Friday. However, due to operational demands, there may be occasions when neither is present on location. In such cases, cover arrangements will be communicated to staff in advance whenever feasible. Additionally, the PPIM will be accessible by phone for support. A risk assessment addressing these scenarios and associated control measures has been implemented by the PIC. Completed 13/10/2025.

• A roster review has been completed to ensure that, where possible, at least one familiar staff is present on shift when agency staff is used. Completed 13/10/25

• Regular agency staff are used whenever possible. Completed 13/10/25.

• The PIC or DSM ensures that all new staff and agency staff read, understand, and sign the induction folder before commencing duties. If a new agency staff starts during the weekend or after PIC or DSM working hours, regular staff will provide induction, where possible, or arrangements will be in place to ensure the required action is completed.

The are also on call arrangements out of hours for support if required. The PIC or DSM reviews and signs off on the induction folder on their return as evidence of compliance. Completed 10/10/25.

• The weekly review of Client Information Data access for agency staff has been included in the PIC/DSM list of duties and a reminder set up in the respective online daily diaries. Completed 20/10/25

• OT recommendation: trial of aid for daily living for one resident has now been completed. Completed 15/10/25

• MDT recommendations are reviewed and delegated/actioned by the PIC/DSM as they arise, with outcomes documented in residents' support plans and communicated to staff. Completed 20/10/25

• Changes affecting residents or the operations of the designated centre are communicated to staff through emails and discussed at staff meetings to ensure staff are aware of the changes. Completed.

• Resident's changing needs are discussed with the PPIM at least quarterly at governance and management meetings. If a resident's needs change significantly or if additional support or guidance is required, these are also discussed at 1:1 support meetings with the PIC as needed. The PPIM is also available to staff outside of these meetings should urgent concerns or guidance be required. Outcomes and actions are documented in the resident's support plan and relevant assessments. Completed.

• To address premises required action in the designated centre: Planning permission is being pursued for a new access point through the boundary wall with the local county council. A validated planning application will be submitted by 21 November 2025 A provisional start date of 30 September 2025 has been set, subject to planning approval. Once permission is granted, completion of works is expected to begin within six months of approval.

• All safeguarding plans are now included in the induction folder, as well as the clients' folders, where required, which is accessible to all staff (including agency staff) on site. Completed.

• The PIC/DSM monitor staff's understanding of safeguarding procedures and reporting processes through informal supervision and team meetings, where safeguarding is a standing item on the agenda. Completed 20/10/25

• All staff are booked to complete key worker training, with all current staff expected to have completed the training by 30 November 2025. Any new staff members will be scheduled to complete key worker training as part of their induction when they commence their position.

• Client's files are reviewed monthly by keyworker/delegated staff and quarterly by PIC/DSM. Local management follows up on delegated actions to ensure completion within the agreed timeframe. Completed 20/10/25

• Changes that occur outside of the scheduled times are reviewed and delegated/actioned by the PIC/DSM as they arise, with outcomes documented in residents' support plans and communicated to staff. Changes affecting residents are communicated to staff through emails and discussed at staff meetings to ensure staff are aware of the changes. Completed.

• Support plans, assessments, and supporting documentation regarding communication and behaviour support identified as outstanding during the inspection are now reviewed and updated by the PIC. Completed 22/10/25

Regulation 10: Communication	Substantially Compliant

Outline how you are going to come into compliance with Regulation 10: Communication:
• Residents' house meetings will be held monthly, with agendas set according to residents' wishes. Residents will be provided with opportunities for individual participation if preferred, and all outcomes and participation will be appropriately recorded. Next meeting is scheduled for 03/11/2025.

• Communication passports have been updated to reflect the residents' changing needs, the use of communication aids where applicable. Completed 22/10/25

• Communication needs are reflected in the induction folder with reference to further reading in the clients' files. Completed.

• The PIC or DSM ensures that all new staff and agency staff read, understand, and sign the induction folder before commencing duties. If a new agency staff starts during the weekend or after PIC or DSM working hours, regular staff will provide induction, where possible, or arrangements will be in place to ensure the required action is completed. The are also on call arrangements out of hours for support if required. The PIC or DSM reviews and signs off on the induction folder on their return as evidence of compliance. Completed 10/10/25.

• Changes affecting residents are communicated to staff through emails and discussed at staff meetings to ensure staff are aware of the changes. Completed.

• A meeting has taken place between the PIC and SALT to discuss the communication needs of residents to ensure they are being effectively supported and documentation updated accordingly as an additional measure. A review of communication support plans lead by the SALT will be completed for three residents by the 12/12/2025.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:

• A review of residents' needs has now been completed by the PIC to ensure that all current risks are identified and that supporting documentation, such as support plans, is in place. This ensures that there are currently no discrepancies between residents' needs and documentation. Completed 22/10/25.

• A risk assessment has been completed for one resident to include the risk of vulnerability in the community. Completed 20/10/25

• All staff have received training on the correct use of the raiser chair and the associated manual handling procedures. This requirement has been incorporated into the induction folder checklist to ensure that all new and agency staff complete this training. Completed 10/10/20

• Any changes to risk assessments or support plans are communicated to all staff via emails, handovers, team meetings, and updates to the induction folder. Staff sign to confirm that they have read and understood the updated information. Completed 20/10/25

Regulation 5: Individual assessment and personal plan	Substantially Compliant

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

• Client's files are reviewed monthly by keyworker/delegated staff and quarterly by PIC/DSM. Local management follows up on delegated actions to ensure completion within the agreed timeframe. Completed 20/10/25

• Changes that occur outside of the scheduled times are reviewed and delegated/actioned by the PIC/DSM as they arise, with outcomes documented in residents' support plans and communicated to staff. Changes affecting residents are communicated to staff through emails and discussed at staff meetings to ensure staff are aware of the changes. Completed.

• Support plans, assessments, and supporting documentation regarding communication and behaviour support identified as outstanding during the inspection are now reviewed and updated by the PIC. Completed 22/10/25

• A review of residents' needs has now been completed by the PIC to ensure that all current risks are identified and that supporting documentation, such as support plans, is in place. This ensures that there are currently no discrepancies between residents' needs and documentation. Completed 22/10/25.

• Communication passports have been updated to reflect the residents' changing needs, the use of communication aids where applicable. Completed 22/10/25

• Communication needs are reflected in the induction folder with reference to further reading in the clients' files. Completed.

• The PIC or DSM ensures that all new staff and agency staff read, understand, and sign the induction folder before commencing duties. If a new agency staff starts during the weekend or after PIC or DSM working hours, regular staff will provide induction, where possible, or arrangements will be in place to ensure the required action is completed. The are also on call arrangements out of hours for support if required. The PIC or DSM reviews and signs off on the induction folder on their return as evidence of compliance. Completed 10/10/25.

• Changes affecting residents are communicated to staff through emails and discussed at staff meetings to ensure staff are aware of the changes. Completed.
• All safeguarding plans are now included in the induction folder, as well as the clients' folders, where required, which is accessible to all staff (including agency staff) on site. Completed.

• The PIC/DSM monitor staff's understanding of safeguarding procedures and reporting processes through informal supervision and team meetings, where safeguarding is a standing item on the agenda. Completed 20/10/25

• OT recommendation: trial of aid for daily living for one resident has now been completed. Completed 15/10/25

• MDT recommendations are reviewed and delegated/actioned by the PIC/DSM as they arise, with outcomes documented in residents' support plans and communicated to staff. Completed 20/10/25

• Resident's changing needs are discussed with the PPIM at least quarterly at governance and management meetings. If a resident's needs change significantly or if additional support or guidance is required, these are also discussed at 1:1 support meetings with the PIC as needed. The PPIM is also available to staff outside of these meetings should urgent concerns or guidance be required. Outcomes and actions are documented in the resident's support plan and relevant assessments. Completed.

Regulation 7: Positive behavioural support	Substantially Compliant

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

• All Positive Behaviour Support Plans are now reviewed to reflect recent changes and the recommendation of using visual aids with one a resident implemented. Completed 15/10/25

• PIC/DSM have now ensured that all staff read and sign the PBSP. There is a signature sheet attached to all the PBSP's to confirm staff understand and can follow the outlined interventions. When changes occur or new PBSPs are introduced, these will be followed up as required. Completed 20/10/25

• The PIC will ensure that all residents are given the opportunity to review and sign their Positive Behaviour Support Plans, where appropriate.
Staff will support this by:
o Explaining the plan in accessible language or using communication aids as needed.
o Documenting the resident's response (e.g. signed, verbally agreed, or declined).
Completed 20/10/25

• All recommended interventions have been implemented, including the visual activity planner requested by the resident. Completed 15/10/25

• Client's files are reviewed monthly by keyworker/delegated staff and quarterly by PIC/DSM. Local management follows up on delegated actions to ensure completion within the agreed timeframe. Completed 20/10/25

• Changes that occur outside of the scheduled times are reviewed and delegated/actioned by the PIC/DSM as they arise, with outcomes documented in residents' support plans and communicated to staff. Changes affecting residents are communicated to staff through emails and discussed at staff meetings to ensure staff are aware of the changes. Completed.

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:

• The weekly review of Client Information Data access for agency staff has been included in the PIC/DSM list of duties and a reminder set up in the respective online daily diaries. Completed 20/10/25

• All safeguarding plans are now included in the induction folder, as well as the clients' folders, where required, which is accessible to all staff (including agency staff) on site. Completed.

• The PIC/DSM monitor staff's understanding of safeguarding procedures and reporting processes through informal supervision and team meetings, where safeguarding is a standing item on the agenda. Completed 20/10/25

• The PIC or DSM ensures that all new staff and agency staff read, understand, and sign the induction folder before commencing duties. If a new agency staff starts during the weekend or after PIC or DSM working hours, regular staff will provide induction, where possible, or arrangements will be in place to ensure the required action is completed. The are also on call arrangements out of hours for support if required. The PIC or DSM reviews and signs off on the induction folder on their return as evidence of compliance. Completed 10/10/25.

• A roster review has been completed to ensure that, where possible, at least one familiar staff is present on shift when agency staff is used. Completed 13/10/25

• Regular agency staff are used whenever possible. Completed 13/10/25.

• The roster is structured to ensure that, wherever possible, the DSM and/or Person in Charge (PIC) are present on-site Monday to Friday. However, due to operational demands, there may be occasions when neither is present on location. In such cases, cover arrangements will be communicated to staff in advance whenever feasible. Additionally, the PPIM or Operations Manager will be accessible by phone for support. A risk assessment addressing these scenarios and associated control measures has been implemented by the PIC. Completed 13/10/2025.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• Action on seizure alarm settings: A review of the seizure alarm was completed on 22/10/2025. The alarm configuration was adjusted to ensure activation only in the event of a seizure, which has not occurred since 2021. No other alarm bells are present at the location.

• Residents' house meetings will be held monthly, with agendas set according to residents' wishes. Residents will be provided with opportunities for individual participation if preferred, and all outcomes and participation will be appropriately recorded. Next meeting is scheduled for 03/11/2025.

• Client's files are reviewed monthly by keyworker/delegated staff and quarterly by PIC/DSM. Local management follows up on delegated actions to ensure completion within the agreed timeframe. Completed 20/10/25

• Changes that occur outside of the scheduled times are reviewed and delegated/actioned by the PIC/DSM as they arise, with outcomes documented in residents' support plans and communicated to staff. Changes affecting residents are communicated to staff through emails and discussed at staff meetings to ensure staff are aware of the changes. Completed.

• Support plans, assessments, and supporting documentation regarding communication and behaviour support identified as outstanding during the inspection are now reviewed and updated by the PIC. Completed 22/10/25

• Client's files are reviewed monthly by keyworker/delegated staff and quarterly by PIC/DSM. Local management follows up on delegated actions to ensure completion within the agreed timeframe. Completed 20/10/25

• A review of residents' needs has now been completed by the PIC to ensure that all current risks are identified and that supporting documentation, such as support plans, is in place. This ensures that there are currently no discrepancies between residents' needs and documentation. Completed 22/10/25.

• Communication passports have been updated to reflect the residents' changing needs, the use of communication aids where applicable. Completed 22/10/25

• Communication needs are reflected in the induction folder with reference to further reading in the clients' files. Completed.

• The PIC or DSM ensures that all new staff and agency staff read, understand, and sign the induction folder before commencing duties. If a new agency staff starts during the weekend or after PIC or DSM working hours, regular staff will provide induction, where possible, or arrangements will be in place to ensure the required action is completed. The are also on call arrangements out of hours for support if required. The PIC or DSM reviews and signs off on the induction folder on their return as evidence of compliance. Completed 10/10/25.

• Changes affecting residents are communicated to staff through emails and discussed at staff meetings to ensure staff are aware of the changes. Completed.

• All safeguarding plans are now included in the induction folder, as well as the clients' folders, where required, which is accessible to all staff (including agency staff) on site. Completed.

• The PIC/DSM monitor staff's understanding of safeguarding procedures and reporting processes through informal supervision and team meetings, where safeguarding is a standing item on the agenda. Completed 20/10/25

• OT recommendation: trial of aid for daily living for one resident has now been completed. Completed 15/10/25

• MDT recommendations are reviewed and delegated/actioned by the PIC/DSM as they arise, with outcomes documented in residents' support plans and communicated to staff.

Completed 20/10/25

• Resident's changing needs are discussed with the PPIM at least quarterly at governance and management meetings. If a resident's needs change significantly or if additional support or guidance is required, these are also discussed at 1:1 support meetings with the PIC as needed. The PPIM is also available to staff outside of these meetings should urgent concerns or guidance be required. Outcomes and actions are documented in the resident's support plan and relevant assessments. Completed.

• Temporary hourly night checks for one resident have been reviewed and ceased as no longer required. Completed 10/10/25

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 10(1)	The registered provider shall ensure that each resident is assisted and supported at all times to communicate in accordance with the residents' needs and wishes.	Substantially Compliant	Yellow	12/12/2025
Regulation 10(2)	The person in charge shall ensure that staff are aware of any particular or individual communication supports required by each resident as outlined in his or her personal plan.	Substantially Compliant	Yellow	12/12/2025
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	Substantially Compliant	Yellow	30/09/2025

	the statement of purpose.			
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.	Substantially Compliant	Yellow	30/09/2025
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Substantially Compliant	Yellow	22/10/2025
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.	Substantially Compliant	Yellow	22/10/2025

Regulation 05(6)(d)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall take into account changes in circumstances and new developments.	Substantially Compliant	Yellow	22/10/2025
Regulation 07(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.	Substantially Compliant	Yellow	22/10/2025
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Substantially Compliant	Yellow	20/10/2025
Regulation 09(2)(e)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability is consulted and participates in the organisation of the designated centre.	Substantially Compliant	Yellow	22/10/2025

Regulation 09(3)	The registered provider shall ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.	Substantially Compliant	Yellow	22/10/2025