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:	Wood View Residential Service
Name of provider:	Western Care Association
Address of centre:	Mayo
Type of inspection:	Unannounced
Date of inspection:	23 May 2025
Centre ID:	OSV-0001789
Fieldwork ID:	MON-0047059

About the designated centre

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

Wood View provides a residential service to four residents who have a mild to moderate intellectual disability. The service can also accommodate residents who have autism and who attend the services of a mental health team. The centre is a two storey building which is located on the outskirts of a medium sized town where public transport links such as trains, buses and taxis are available. The residents also have transport available which is used to access their day service and local community. Each resident has their own bedroom and there is also sufficient kitchen and dining facilities in place. A social model of care is delivered in the centre and residents are supported at all times by a combination of social care workers and social care assistants. There is also a sleep in arrangement to support residents during night-time hours.

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
Friday 23 May 2025	08:55hrs to 16:00hrs	Mary McCann	Lead
Friday 23 May 2025	08:55hrs to 16:00hrs	Kieran McCullagh	Support

What residents told us and what inspectors observed

Overall, residents reported that they were well cared for by a committed consistent skilled staff team. However, improvements were required in risk management, governance and management and safeguarding.

This unannounced inspection was undertaken by two inspectors on the 23nd of May 2025 due to the Chief Inspector of Social Services (The Chief Inspector) receiving information of concern relating to the registered provider's governance and oversight of designated centres. The provider is the Western Care Association (WCA). WCA is a voluntary body who are governed by a board of management in Co Mayo. Inspections form part of the assessment of on-going assessment of the quality and safety of the service provided to residents to ensure residents enjoy a good quality of life where their rights are protected and their voice is listened to.

This inspection report details the findings by the inspectors on the day of inspection relating to the quality and safety of the service provided by the registered provider and the capacity and capability of the registered provider and staff working in the designated centres to deliver a safe, quality-rights based service to make sure residents have a good quality of life that they enjoy.

There was one member of staff on duty when inspectors arrived at the centre and they welcomed the inspectors in to the centre and introduced the residents to inspectors. There were three residents in the centre. One resident was at home in the care of their family and was due to be collected by the centre staff in the afternoon. One resident was sitting in the kitchen/dining room and was just after finishing their breakfast. Another resident was in the sitting room doing some colouring and writing and the third resident was being assisted by staff with their personal care. This resident came to the sitting room and started listening to music which they said they enjoyed on their IPAD.

Inspectors spoke with all three residents who confirmed that they had their breakfast and enjoyed living in the centre and going to day services. One of the residents had 1:1 support at day services and spoke about how they liked attending day services and going for coffee. All residents confirmed and this was supported in the documentation reviewed that they accessed the community regularly, utilising the services of the local town and going to scenic areas. Staff were observed to engage warmly and respectfully with residents and chatted with them about their day and how they felt. They displayed a very good knowledge of residents' needs and had worked in the centre for a considerable period of time. Staff explained that they enjoyed working with the residents and wanted to make sure that residents were happy and had a good quality of life. All residents looked well dressed and appeared happy and content in the company of staff and inspectors. As it was a sunny day staff were observed to be applying sun protection on all three residents in preparation for attending their day centres.

Two members of day service staff came to the centre to bring the residents to the day centre and residents appeared happy going. The centre transport was used to bring residents to and from the day centre and was available to the centre in the evenings and at weekends. The person in charge arrived at the centre at approximately 09:30 am. Inspectors met two staff, one briefly in the afternoon and the other for a considerable period of time along with the person in charge. Staff were knowledgeable on the needs of residents, particularly in relation to behaviour support, nutritional care and safeguarding. One staff described how staff enact the behaviour support plan for one resident and this was discussed at staff meetings and the importance of consistency and action on any triggers to the behaviour of concern to ensure residents were protected. This was supported in discussion with the person in charge and from minutes of staff meetings reviewed by inspectors. Staff knew what steps to follow should a safeguarding incident occur. They spoke about information sharing in the centre through handover meetings between staff on a daily basis and regular staff team meetings. Staff also spoke about the supports they offered residents in the centre and in the wider community.

Wood view is a four bedded two storey house located 10 minutes' walk from a scenic town in the west of Ireland and is registered to provide care to four adults. The house has a small garden to the front and an enclosed back garden to the rear of the premises which provided privacy to residents to relax outdoors weather permitting. Both of these areas required maintenance to ensure they provided a pleasant area for residents to utilise. Each resident had their own personalised bedroom. The premises was warm, homely, and clean and personalised with photos and personal items of resident's choice. Communal areas including a kitchen/dining room, a sitting room, a utility room with a shower and toilet downstairs and a bathroom upstairs. An office which doubled as a sleep over room for staff was also available.

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

Capacity and capability

This section of the report sets out the findings of the inspection in relation to the leadership and management of the service, and how effective it was in ensuring that a good quality and safe service was being provided.

In summary, governance and management systems required improvement in this centre. This related primarily to ensuring actions from the compliance plan submitted post the previous inspection were completed in line with the timescales agreed with the Chief Inspector and where this was unattainable the provider renegotiated the time lines in discussion with the Chief Inspector. Additionally, there was poor governance in relation to the overarching review of risk management and

this is further under Regulation 26.

There was a clearly defined management structure in place and staff were aware of their roles and responsibilities in relation to the day-to-day running of the centre. The day to day running of the service was led by the person in charge, supported by a consistent staff team, who was knowledgeable about the support needs of the residents living in the centre. Staff were very knowledgeable of the needs of the residents and had a very good rapport with them. The staffing levels in place in the centre were suitable to meet the assessed needs and number of residents living in the centre.

The person in charge was aware of their regulatory responsibility to ensure notifications were submitted to the Chief Inspector, in line with the regulations.The provider had ensured that there was an effective complaints procedure for residents to utilise. The procedure had been prepared in an easy-to-read format to aid residents' understanding. All staff on the day of the inspection were provided with the appropriate skills and resources to deal with a complaint and had a full understanding of the complaints policy.

The next section of the report will reflect how the management systems in place were contributing to the quality and safety of the service being provided in this designated centre.

Regulation 15: Staffing

The provider had ensured there was enough staff with the right skills, qualifications and experience to meet the assessed needs of the residents at all times in line with the statement of purpose and size and layout of the designated centre on the day of inspection

The person in charge maintained a planned and actual staff roster. Inspectors reviewed both rosters from the 12th to the 26th May 2025 and found that regular staff were employed and accurately reflected the staffing arrangements in the centre, including the full names of staff on duty during both day and night shifts.

There was a consistent team of staff in the centre. This meant the team was familiar to the residents and knew their communication strategies and the way they liked their care to be delivered. Staff were kind and caring in their interactions with residents. Staff confirmed that the person in charge was freely available and very supportive.

An assistant manager had been appointed into post to assist the person in charge and was due to commence working in the centre soon. Where staff were on leave, regular staff provided cover for extra shifts. There was a management person on-call out of hours and contact details of this were available in the centre. The person

in charge told the inspectors that they also covered shifts on the floor to support staff and to ensure a good quality rights based service was delivered to residents.

Judgment: Compliant

Regulation 23: Governance and management

The governance and oversight arrangements in this centre ensured that in the main residents received a good service, however some improvements were required.

There was a defined management structure in place with clear lines of authority and accountability. The provider had ensured that there was adequate staff on duty to meet the needs of residents. Staff reported to the person in charge and the person in charge reported to the area manager and met with them regularly. One inspector reviewed the most recent annual review for 2024. This had been completed by the person in charge on the quality and safety of care and support in the designated centre. The inspector found that this was a comprehensive review and included the views of the residents and their families.

Six monthly unannounced visits were also completed by a senior staff member independent of the centre and inspectors reviewed the most recent six monthly report dated 21 February 25. One action identified from this had not been addressed. This related to updating the personal risk management plans for some residents. Regular team meetings were occurring and there was good attendance by staff at these meetings. Detailed minutes were available for staff who were unable to attend. Inspectors reviewed the minutes from the 21 May 2025 and 09 April 2025. These minutes evidenced that incidents, fire evacuation procedures, and the assistive decision making service were all discussed.

The inspectors reviewed the audits folder and seen that audits completed included infection prevention and control, medication management, and finances were regularly completed. Where deficits were identified they were actioned by the person in charge and were further discussed with the area manager.

Inspectors reviewed risk management arrangements at the centre and found that they required improvement, this is discussed in detail under Regulation 26.

An out of hour's management on call staff roster was in place. The person in charge confirmed that this had recently been reviewed and was agreed at local level but staff had not been sanctioned as yet at organisational level. Details of the confidential recipient were available to staff should they wish to raise concerns about care and support provided to residents. A staff member who was on duty confirmed to inspectors that the person in charge was approachable and freely available and there was no barrier to raising concerns regarding residents care with them

The person in charge had a good understanding of the Trust in Care Policy and

when requested a copy of the provider's policy and procedure was made available to inspectors for review. Staff and the person in charge were also aware of the HSE National Policy on Trust in Care. The person in charge informed inspectors that since they commenced their post they never had any occasion to utilise the policy. There had been no complaints regarding safeguarding where a staff member was implicated.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

Inspectors reviewed the accident and incident records and found that all incidents that warranted submission to the Chief Inspector had been completed. Inspectors also noted that accidents and incidents were well recorded and there was good detail of what had occurred.

There had been no incidents where a trust in care investigation was required since the person in charge commenced in post in this centre in 2019. The person in charge was aware of their obligation to submit a notification if there was any allegation of a safeguarding incident. They displayed a good knowledge of when a staff member was involved in a trust in care investigation was warranted.

All accident and incidents were recorded on a digital system and the area manager received an alert when an in incident was recorded. The person in charge had completed a course run by the registered provider on incident recording.

Judgment: Compliant

Regulation 34: Complaints procedure

The provider had established and implemented effective complaint handling processes. For example, there was a complaints policy in place. Throughout the duration of the inspection inspectors observed that staff were provided with the appropriate skills and resources to deal with a complaint and demonstrated that they had a full understanding of the policy in place.

An easy to read complaints guide was in place and this was freely available in the centre. Residents indicated to the inspectors that if they had a complaint they could speak to any of the staff and felt their complaint would be investigated.

One inspector reviewed the complaints log maintained by the person in charge in the designated centre. On the day of the inspection there were no open complaints. This was confirmed by the person in charge. All residents were complimentary towards the staff team. There was an appeal procedure included in the complaints

policy. This meant that if the complaint initiator was not satisfied they could appeal their complaint to a person independent of the centre.

Judgment: Compliant

Quality and safety

This section of the report details the quality and safety of the service for the residents who lived in the designated centre.

Inspectors determined that the care provided to residents was good and residents were complimentary of the service provided to them by staff. However, areas that required review included review of the suitability of the premises for current residents, ensuring risks were identified, assessed and controls put in place to mitigate those risks, and regular monitoring of the effectiveness of these control measures occur. This is discussed further under Regulation 26: Risk management procedures.

The person in charge had ensured that residents' health, personal and social care needs had been assessed. The assessments reflected the relevant multidisciplinary team input, and informed the development of care plans, which outlined the associated supports and interventions residents required.

The provider and person in charge ensured that the service continually promoted residents' rights to independence and a restraint-free environment. For example, restrictive practices in use were clearly documented and were subject to review by appropriate professionals. Staff spoken with were knowledgeable of positive behaviour support plans in place and inspectors observed positive communications and interactions throughout the inspection between residents and staff. However, improvements were required to ensure all residents with an assessed positive behaviour support need had a support plan on file that included proactive and preventative strategies in order to reduce the risk of behaviours that challenge from occurring.

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. The inspector 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.

Regulation 26: Risk management procedures

The provider had not ensured that risk management procedures in the centre were effective and protected the rights of residents. While there was a risk risk management policy in place which was last updated in January 2023, the inspector noted that the provider had not ensured that the policy included all required information in accordance with regulatory requirements. For instance, it did not contain or signpost staff to information pertaining to the unexpected absence of a resident, accidental injury to residents, visitors, and staff, aggression and violence or self-harm. This required review by the provider.

Inspectors observed that the centre was not meeting the changing needs of residents and housing arrangements for all residents required review. There was evidence on file that the person in charge had requested an overall assessment of the premises to include the stairs, the bathroom, downstairs shower, and toilet. However, no evidence was made available to inspectors on the day of this inspection of an update to this request.

One resident was accommodated downstairs and the shower and toilet facilities available to them included a small shower, toilet and wash hand basin. This resident had surgery in February 2025. An Occupational Therapist (OT) had assessed the shower prior to the resident returning to the centre and hand rails were installed. The OT recommended a further assessment to be completed with the resident when they returned to the centre from acute services. There was no evidence made available to the inspectors on the day of inspection that this had occurred.The resident returned to the centre on 24 February 2025. The person in charge confirmed that an OT service was available within the organisation but this resident had not been prioritised for review by this service.

There was documentation in place from a care plan prior to the surgery that the resident could shower independently. The resident had expressed the view that they were very private regarding their personal care. However, post-surgery staff told inspectors and this was recorded in their care plan, that the resident required verbal and physical prompts from staff to shower. Additionally the personal risk management assessment had not been reviewed on the suitability of the use of this shower for the resident to accommodate a staff member to assist due to it's size. This issue was raised at the last inspection in October 2024 and the provider's compliance plan response stated 'The Person in charge will liaise with the maintenance team to review the downstairs shower facilities with a view to adding an additional en-suite in the downstairs bedroom". This was to be completed by the 31/12/24. This had not occurred.

Additionally, three residents were accommodated upstairs. At the time of the last inspection the inspector documented that these residents who were accommodated upstairs had access to one bathroom which contained a bath with a shower over it and a toilet. Consequently residents had to navigate entry to the bath to have a bath or shower. A grab rail was available to assist residents. The stairs from the ground floor to the first floor were steep. A risk assessment was available relating to residents accessing the bath/shower and using the stairs. In the action plan post the last inspection the registered provider's response stated "Accommodation that meets the needs of the residents providing adequate space for their sensory and social

needs is being sought. This housing will have a positive effect on individuals' behavioural requirements. For changes that may occur to people's living environment, the person in charge will work with the Behaviour Support Specialist to ensure a comprehensive transition plan is in place where necessary, ensuring the most positive experience when moving to a new home with a completion date of the 03/03/25". This had not occurred.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

Corresponding person centred care plans were in place with regard to the assessed needs of residents. This meant that the care plans informed staff as to how residents liked their care to be delivered.

Inspectors reviewed two residents care plans with their consent and found that residents had good individual assessments and personal plans in place which were person centred and met the assessed needs of the residents. These were up to date and reviewed at quarterly intervals. Personal plans were reviewed annually and goals were identified. For example, goals included spending time at home, having a massage fortnightly, having a weekly pedicure, and having coffee out regularly.

A key worker system was in place and there was good evidence of the voice of the resident in the planning goals. Where goals were identified these were progressed and there was good evidence that these were achieved. There was involvement of family members in the care and support of residents. One resident was in the care of their family on the day of inspection. Another resident went home regularly at weekends. Some residents' family members attended the circle of support annual review meetings related to the care planning process.

All residents attended day services Monday to Friday and the centre staff provided access to meaningful activities in the evenings and at weekends. Residents had access to advocacy. One resident had recently seen an independent advocate and plans were in place for the resident to have a follow up meeting with this advocate. The Person in charge explained that one person's family were actively engaged in the care and support of the resident and they acted as the residents advocate. There was evidence of involvement of health and social care specialist staff in the care and in the review of residents' care plans.

Judgment: Compliant

Regulation 7: Positive behavioural support

Inspectors reviewed the restrictive practices log and found that restrictive practices were regularly reviewed by the person in charge. Restrictions in place at the time of this inspection included a door chime to ensure staff were aware if a resident were to leave the centre unattended. The chime gave staff the opportunity to support the resident to go outside safely or come back into the centre. A door lock was also in place so a resident did not leave the centre unattended. From a review of the notifications submitted for Quarter 1 2025 the inspector found this the door was locked on eight occasions. A seat belt clip was in place for one resident as a safety measure as they may stand up and take their seat belt off whilst the vehicle is moving.

Medication for three individuals was stored in a press in the kitchen of the centre, to enable staff have access the residents medication whilst remaining in the kitchen to ensure safety regarding modified diet requirements. All restrictive practices were included on the individual residents' rights checklist and had been reviewed by the provider's rights review committee. A daily log was kept of their enactment. The restrictive practices in use were reviewed regularly by the person in charge to ensure they were the least restrictive option given the current assessed needs of residents. A personal risk assessment plan was in place for these restrictions.

There was one behaviour support plan in place and this was reviewed by the inspectors. This was comprehensive and showed good evidence that it was discussed with the resident. This plan had been completed in collaboration with specialist behaviour support staff. Staff spoken with all confirmed that they were aware of the behaviour support plan and that it was discussed at staff meetings. Staff spoke of the importance of consistency in approach by staff enacting the plan.

Inspectors noted on reviewing the accident and incident log that one resident recently had three episodes of self-injurious behaviour. However, no behaviour support or care plan had been developed to guide staff as to how to manage this behaviour. This meant there was a risk that staff would not consistently mange this behaviour. Additionally, there was no process in place to record antecedent behaviour so that staff could swiftly enact a strategy that may prevent the self-injurious behaviour.

Staff had undertaken training in management of behaviour of concerns. This meant that staff were aware of established evidence based practices to respond to responsive behaviour and how best to manage the behaviours of concern. The provider also had a policy on behaviour support which was entitled 'The Listening and Responding Policy' and the staff spoken with confirmed they were aware of this policy.

The person in charge confirmed that where incidents of responsive behaviour occurred these were reported to the area manager and specialist behaviour support staff and psychology through meetings and the incident recording digital system. They also confirmed that they spoke regularly to the area manager regarding these incidents and minutes of these discussions were available and reviewed by the inspectors. Quarterly reviews of accident and incidents were occurring and inspectors discussed the outcome of these with the person in charge. They

confirmed that peer to peer negative incidents had decreased since the time of the last inspection. There had been two incidents since October 2024, which included one in December 2024 and one in May 2025. The person in charge contributed this to better specialist behaviour specialist behaviour support, staff being more aware of antecedent behaviour and enacting the behaviour support plan more swiftly and consistently, and assistance from mental health services regarding an as required protocol for use of medication.

Judgment: Substantially compliant

Regulation 8: Protection

Inspectors found that this centre had procedures in place to safeguard residents which included good recording of accident and incidents, appropriate reporting to the Chief Inspector regarding safeguarding issues and staff training.

Inspectors reviewed the notifications regarding safeguarding that were submitted to the Chief Inspector since October 2024. From a review of these, the inspectors found that there had been a decrease in peer to peer safeguarding incidents since 2024. Additionally, a review of other relevant documents which are referenced throughout this report and talking with the person in charge and staff, inspectors found that for the most part this centre protected the safeguarding of residents.

Inspectors noted that there was no up to date intimate care plan in place for one resident following a surgical procedure completed in February 2025. This meant that staff were not aware of the current person centred views of the resident and how they wished their intimate care to be delivered.

Residents could engage in independent activities due to the numbers of staff on duty. There were two staff on duty which provided adequate staff to be available to listen and support residents when residents needed staff assistance. Other systems in place to safeguard residents that were in place included a consistent competent staff team who were observed to be caring and kind to residents and residents indicated to inspectors that they were happy living in the centre.

A policy on safeguarding residents was also available and staff spoken with were aware of the contact details of designated officers which were also displayed in the centre. The provider had also ensured that all staff had current Garda Vetting in place prior to commencement of employment.

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 15: Staffing	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 26: Risk management procedures	Not compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Substantially compliant

Compliance Plan for Wood View Residential Service OSV-0001789

Inspection ID: MON-0047059

Date of inspection: 23/05/2025

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: All actions identified in the six-monthly report dated 21/02/2025 have been fully implemented by the Person in Charge (PIC), with attention given to the ratings outlined in the Personal Risk Management Plans. These actions are now complete. A local on-call system is currently operational, providing 24-hour out-of-hours support. An organisational on-call system has been developed in agreement with the Board of Directors and representative unions and staff. The Provider has scheduled this to be operational in September 2025.	
Regulation 26: Risk management procedures	Not Compliant
Outline how you are going to come into compliance with Regulation 26: Risk management procedures: The Registered Provider has reviewed and updated the Risk Management Policy to include guidance on, and signposting for, all the specific risks identified in Regulation 26, to include control measures and mitigating actions in place, including the following risks: • Unexpected absence of any resident • Accidental injury to residents, visitors or staff, • Behaviours of concern (to include aggression and violence) • Self-harm. The Registered Provider has provided training in the understanding of Risk Management to 7 Areas. In addition, all those Areas have live risk registers. Further engagement and support to understand the concept and system of Risk Management will be delivered to Area Teams over the coming months. The next phase includes community supports and	

Senior Management / Department Heads to develop Risk Registers for each department and the Corporate Risk Register. 19/08/25.

The revised Risk Management Policy will be issued 01/09/2025.

To adjust to the changing needs of the residents the PIC arranged a review of the internal living space, this was completed in February 2025, the maintenance personnel inspected the downstairs bedroom with a view to adding an en-suite.

The OT visited the Designated Centre on 27/05/25, and again on 01/06/25. Following on from this a further comprehensive Environmental Assessment, including all bathrooms within the Designated Centre took place on 05/06/25 where the O.T. visited with maintenance personnel. Recommendations from this are detailed in the O.T. report and will be over two phases; phase one consisting of steps that can be completed over a short to medium term to improve the quality of living space. This includes:

• Creating a solid -rear yard to ensure safe and even ground that can be enjoyed by all living in the house, with the addition of external handrails in identified areas for safety.
• Constructing a covered useable external area on the rear of the property for people to further utilise outside space.
• Add additional lighting to the newly enhanced exterior area to ensure safety.
• Add a small garden shed to the rear of the property.
• The addition of handrails to the side of the upstairs toilet.
• The addition of a handrail to be added to wall of upstairs bathroom.

These works will be completed by 01/12/25. Phase two of the planned improvement will be review by a qualified architect to review what is feasible in terms of enhancing the current living area of the premises. The review will be complete by 01/12/2025

The O.T. will remain engaged in the service whilst these works continue and as there is need, further bathing and showering assessments will take place for two individuals commencing on 04/07/25.

Should a resident move out of the Designated Centre the PIC and BSS will ensure a transition plan is in place, after discussion with the BSS it is agreed that a transition plan will be in place within six weeks of the intended move.

Regulation 7: Positive behavioural support	Substantially Compliant

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

The Person in Charge (PIC) will ensure that, for each entry in the Incident Injury database—particularly those related to self-injurious behaviour—the antecedent behaviour will be clearly documented. Additionally, the PIC will ensure that a clear and detailed support plan within the personal risk management plan is in place for each individual and that this plan is reviewed and monitored in collaboration with the Behaviour Support Specialist. The completing of incident injury reports will be addressed at staff team meeting by August 2025

Regulation 8: Protection	Substantially Compliant
Outline how you are going to come into compliance with Regulation 8: Protection: The Personal and Intimate Care Plan for one individual has been updated by the PIC to reflect their changed support needs in relation to showering. The revised plan was shared with all members of the staff team on 01/06/2025 to ensure consistent implementation of care.	

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Substantially Compliant	Yellow	15/09/2025
Regulation 26(1)(a)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: hazard identification and assessment of risks throughout the designated centre.	Not Compliant	Orange	19/08/2025
Regulation 26(1)(e)	The registered provider shall ensure that the risk management	Not Compliant	Orange	01/12/2025

	policy, referred to in paragraph 16 of Schedule 5, includes the following: arrangements to ensure that risk control measures are proportional to the risk identified, and that any adverse impact such measures might have on the resident's quality of life have been considered.			
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.	Not Compliant	Orange	19/08/2025
Regulation 7(5)(a)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation every effort is made to identify and alleviate the cause of the resident's challenging behaviour.	Substantially Compliant	Yellow	01/08/2025
Regulation 08(6)	The person in charge shall have safeguarding	Substantially Compliant	Yellow	01/06/2025

	measures in place to ensure that staff providing personal intimate care to residents who require such assistance do so in line with the resident's personal plan and in a manner that respects the resident's dignity and bodily integrity.			