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:	Ladywell Lodge
Name of provider:	St John of God Community Services CLG
Address of centre:	Louth
Type of inspection:	Unannounced
Date of inspection:	20 October 2025
Centre ID:	OSV-0003025
Fieldwork ID:	MON-0046378

About the designated centre

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

Ladywell Lodge is a centre situated on a campus based setting in Co. Louth. It is registered to support 24hr residential care for up to eight male and female adults some of whom have complex medical needs. The centre is divided into two separate units which are joined by a communal reception area. Each unit comprises of a large dining/sitting room, additional small communal rooms, adequate bathing facilities, laundry facilities and an office. Residents have their own bedrooms. There is a large kitchen shared by both units where staff prepare meals and residents can be involved in meal prep and baking if they wish. Both units have access to a shared garden area where furniture is provided for residents use. The centre is nurse-led meaning that a nurse is on duty 24 hours a day. Health care assistants also play a pivotal role in providing care to residents. The person in charge is employed on a fulltime basis and is only responsible for this centre. Residents are supported to access meaningful day activities by the staff in the centre. There are two buses available in the centre so as residents can access community facilities.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	5

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Monday 20 October 2025	13:20hrs to 19:20hrs	Anna Doyle	Lead
Tuesday 21 October 2025	09:00hrs to 11:50hrs	Anna Doyle	Lead
Monday 20 October 2025	13:20hrs to 19:20hrs	Sarah Guing	Support
Tuesday 21 October 2025	09:00hrs to 11:50hrs	Sarah Guing	Support

What residents told us and what inspectors observed

This inspection was unannounced and was carried out with a specific focus on safeguarding, to ensure that residents felt safe in the centre, and that supported decision making arrangements were in place that incorporated the will and preference of the residents.

The centre currently supports five residents. The registered provider is not admitting any new residents to this centre even though it is registered to support eight residents.

Overall, the inspectors found that there were adequate resources in place to provide person-centred care to the residents living here. This meant that the residents got to choose what their day looked like and what activities they would like to do each day. However, there were some improvements required in personal plans, risk management, a communication plan for one resident, audits and the timely progress of one residents transition to an individualised community setting.

Prior to the inspection some allegations of safeguarding concerns had been notified to the Office of the Chief Inspector over the previous year. These concerns were followed up as part of this inspection to ensure that the person in charge and registered provider had systems in place to manage and review these concerns; and prevent or minimise these events recurring. Inspectors were assured from reviewing records that the registered provider had taken actions to address the safeguarding concerns reported.

Over the course of the inspection, the inspectors got to meet all of the residents, spoke to staff and the person in charge. They also reviewed records pertaining to the care of residents, and observed some practices.

This centre is located on a large campus. This centre is due to close at is currently part of a congregated setting. The registered provider was in the process of seeking contractors to complete a purpose built community dwelling so as residents could move there. In 2022 this was estimated to take approximately five years. One resident was also due to move to an individualised setting in the community where they would have their own home. This resident had moved to this centre on a temporary basis in 2022. At the time of this inspection this resident was still living here and a business case had been sent to seek funding for a bespoke community home for the resident. This had not been approved at the time of this inspection and therefore did not provide assurances to inspectors that this residents transition was being addressed in a timely manner.

The centre was divided into two separate living units which were spacious, well decorated and clean. Four residents lived in one of the units and the remaining resident lived in the other unit alone. Each resident had their own bedroom which was personalised, warm and nicely decorated. A review of audits conducted in the

centre had highlighted that some areas of the centre required repainting. The inspectors however were assured that this was being addressed at the time of this inspection. For example; some residents had recently had their room repainted and one residents bedroom was still undergoing some upgrades at the time of this inspection. The inspectors observed photographs of this resident out shopping with staff for paint colours and other items to redecorate and upgrade their bedroom.

Over the course of the inspection, residents were observed to be involved in several activities and were making day to day decisions about what they wanted to do. One resident for example; was tired and requested to go to bed in the afternoon for a rest. Residents could get up in the morning time whenever they chose to, and some of the residents got up at night time to watch television or have a cup of tea with staff on night duty when they chose to.

On arrival to the centre inspectors found that two residents had already left for a planned outing. One of the residents had remained out for most of the day, as they had went to a shopping village where they enjoyed sitting out having crepes and coffee. This resident loved driving to different places and one of their goals was to visit every county in Ireland. A review of this residents plan showed that the resident had already been to numerous counties, like Galway, Dublin and Kildare where they had enjoyed various activities. Another resident went out for a drive in the afternoon, and two other residents went out for something to eat and a 'pint' in the evening time.

Inspectors observed from interactions with staff and residents that the residents got to choose what they wanted to do. Staff were observed supporting all of the residents in a kind, patient and jovial manner, while respecting the residents' rights to make their own decisions. For example; one resident was deciding whether to go for a drink and an evening meal on the day of the inspection. The resident was observed telling the staff where they wanted to go for the drink but wasn't sure whether they wanted to have their meal out. The second day of the inspection the resident was up early having breakfast but decided to go back to bed because they were tired after the evening out the night before. These observations informed inspectors that residents were not required to stick to rigid routines and could choose what they wanted to do.

The inspectors were also informed that one of the residents was the 'events manager' and had organised all the Halloween decorations. The residents were going to celebrate Halloween by having a party and some of them were going out on the second day of the inspection to purchase some costumes for this party.

Residents were also included in bigger decisions about their lives and where required support was provided to them. As an example; an assisted decision making co-ordinator was employed in the wider organisation to provide support and guidance to residents and staff about the residents right to be included in decisions about their lives.

Family and friends could visit the centre, and one of the residents spoke about their family visiting the centre the day before the inspection. Staff members also informed

inspectors of other visits that residents received from family and how they supported one resident to meet up with family in the community and attend important family celebrations.

Due to the assessed needs of the residents, there was a large amount of equipment stored in the centre to support their needs. This included, clinical equipment such as oxygen and a defibrillator to ensure timely access to medical interventions for the residents should the need arise. Inspectors reviewed the maintenance records of this equipment and found that all equipment had been serviced. However, a review of residents plans, staff meetings and other records in this centre showed that some residents were either awaiting new equipment or an assessment to see if new equipment was warranted regarding their mobility needs.

For example; one resident had recently had a fall and the inspectors found that the staff team had recommended in the residents plan to have an environmental assessment of their bedroom to ensure that it was suitable. This had not been completed at the time of this inspection. In another assessment a resident who required a splint for their arm, was waiting for this to be fitted and this had not been completed either.

Inspectors also found that some audits conducted in the centre, had also highlighted that residents were awaiting the delivery of some equipment. One resident for example; was waiting for a comfort chair to be delivered and there was no confirmation of when this would be delivered. This had been highlighted in an audit conducted in May 2025.

Overall, inspectors found that residents looked well cared for, were included in decisions about their lives and appeared happy living in their home. Notwithstanding improvements were required in some of the regulations reviewed on this inspection.

The next two section of the report present the findings of this inspection in relation to the governance and management arrangements and how these arrangements impacted the quality of care and support being provided to residents.

Capacity and capability

Overall, there was a defined management structure in this centre, outlining clear lines of accountability. The centre was also adequately resourced. Three improvements were required under governance and management, personal plans and communication.

The centre had a defined management structure in place which consisted of a person in charge who worked on a full-time basis in this centre. The person in charge reported to the director of care and support. The director of care and support met with the person in charge on a regular basis to review the care being provided in the centre. The centre was being monitored and audited as required by

the regulations and the registered provider completed a number of other audits to ensure that the service provided was to a good standard. Where areas of improvement had been identified there was a plan in place to address these. However, despite the fact that a resident had been identified in 2022 that they were to move to a community based setting, this had not progressed at the time of this inspection as the provider was still awaiting approval from the funding agency to progress this.

There was sufficient staff on duty to meet the needs of the residents. At the time of the inspection there were two staff vacancies. To ensure consistency of care, a regular on call relief panel were available to cover vacancies.

Staff had been provided with mandatory training and other training in order to meet the needs of the residents and support residents in a safe manner. For example; all staff had completed safeguarding vulnerable adults to ensure that residents were safeguarded and had completed training in human rights, assisted decision making and the national consent policy to support residents to make their own decisions.

Regulation 15: Staffing

The provider has ensured that there was a sufficient number of staff at the appropriate levels and with the necessary skills and experience working in the service to meet the needs of all residents. The person in charge maintained a planned and actual rota. The staff skill mix included, nurses a social care worker and health care assistants. The staff numbers included five staff on days and three staff on night duty. One resident required one to one staffing, or two staff for various personal care, and when going out on outings. Inspectors observed that these staffing levels were maintained over the course of the inspection.

There were systems in place to report safeguarding concerns should they arise. There were senior managers on call during the day and at night a senior nurse was on call for further advice. The inspectors spoke to three staff formally and spoke to others over the course of the inspection informally. Four staff reported that they had no concerns about the quality of care provided and those staff reported that they felt very supported by the person in charge.

The staff spoken to also had a good knowledge of the resident's needs and were observed to be kind and supportive to the residents over the course of the inspection. Of the staff met, they said they felt very supported in their role and were able to raise concerns, if needed, to the person in charge and senior managers who were on call on a daily basis and out of hours to include weekends and at night.

Judgment: Compliant

Regulation 16: Training and staff development

Staff had been provided with training, in safeguarding vulnerable adults and human rights. The staff were knowledgeable about the care and support needs of each resident, and of the reporting procedures in place should a safeguarding concern arise in the centre. A sample of other training provided included;

- Fire Safety
- Positive Behaviour Support
- Children' First
- Manual Handling
- Basic Life Support
- Dementia Training
- Infection Prevention and Control, (some of which included hand hygiene and personal protective equipment).
- Feeding, Eating, Drinking and Swallow Difficulties.
- National Consent Policy Training
- Total Communication (which was also planned for a further six staff in November 2025).

Monthly staff meetings were held in the centre and a sample of the minutes of these meetings showed that safeguarding was a standing agenda item at these minutes. At these meetings a review of the residents care and support needs was also discussed which included any items that needed to be followed up for residents.

Judgment: Compliant

Regulation 23: Governance and management

There was a clearly defined management structure in the centre which outlined clear lines of authority and accountability in this centre. The person in charge was employed on a full time basis in the centre. However, two improvements were required in audits and the transition of one resident to a bespoke community setting.

The person in charge reported directly to a director of care. They had a very good knowledge of the assessed needs of the residents living in this centre and residents were observed to be relaxed and comfortable in the presence of the person in charge.

There was a clear reporting procedure to report safeguarding concerns in the centre. There had been some safeguarding concerns reported in this centre, some of which related to the impact of one residents behaviours of concerns on other residents. The registered provider had taken steps to address this. For example; as

already stated in section 1 of this report, the registered provider had submitted a business case to seek funding for an individualised placement in a community setting for one resident. This had not been approved at the time of this inspection. As a result, the registered provider had moved the resident concerned to live on their own in one unit in the centre. The other four residents then lived in the other side of the centre. This addressed the immediate safeguarding concerns, notwithstanding, this was a temporary solution, and this unit was not suitable as a long term home for the resident concerned.

The designated centre was being audited as required by the regulations and an annual review of the service had been complete for 2024 along with a six monthly unannounced visit to the centre. These audits were to ensure the service was meeting the requirements of the regulations, was safe and appropriate in meeting the needs of the residents. Other audits conducted included infection prevention and control, and residents finances. On completion of the audits, actions were being identified along with a plan to address them. The inspectors observed that some improvements identified in these audits were addressed for the most part. However, some of them concerned the purchase of new equipment highlighted from an audit conducted in May 2025. While the person in charge was taken actions to try and address these at the time of the inspection, these issues and other issues relating to equipment as discussed under regulation 5 of this report were not for example; escalated to senior management in the organisation to ensure timely actions were taken.

The registered provider had a number of committees in the organisation to review restrictive practices and human rights. The registered provider also had a staff member employed in the wider organisation who provided support to residents and staff about supported decision making that ensured consideration of the will and preferences of the residents.

Regular staff meetings were held where staff could raise concerns and where issues like safeguarding and learning from incidents that related to risks in the centre were discussed and reviewed.

Judgment: Substantially compliant

Quality and safety

Overall, the residents in this centre, were for the most part provided with a safe quality service. The residents living here were included in decisions around their care and got to make decisions about their day to day activities. Where safeguarding incidents occurred in the centre, the registered provider and person in charge were reporting them to relevant authorities and implementing measures to safeguard the residents. However, improvements were required in communication plans to assist a resident with making choices and personal plans.

Each person has a personal plan. A sample viewed showed that residents had an up to date assessment that detailed their needs and there were comprehensive support plans in place to support their development and healthcare. However, inspectors found several examples where recommendations included in residents care plans and assessments, had not been followed up in a timely manner. These included access to a dentist and recommendations around the residents mobility needs.

The residents had access to the Internet and telephones, and most of their communication needs were provided for. However, one residents communication plans required review.

The registered provider had a policy in place to guide practice and report any safeguarding concerns in the centre.

Regulation 10: Communication

Management and staff recognised that behaviour can be a form of communication, and were aware that some behaviours of concern may arise due to an unmet physical, psychological or emotional need that cannot be verbally expressed by the resident. The inspectors observed for example that communication needs were outlined in one residents behaviour support plan. They also observed that the resident had a communication plan in place outlining some of the ways in which they were communicating. As an example; the resident used four signs that communicated some of their choices.

However, the inspectors found from talking to staff and observing other records pertaining to this residents support plans, that more detail was required in the residents communication plan. As an example; when the inspectors were talking to staff they explained other gestures that the resident used to communicate a choice. This required improvement as this resident required a consistent approach from a staff team that knew the resident well. The communication plan also needed to be improved to show how this resident was offered choices. For example; it was noted in this residents plan that they took pride in their appearance, however the communication plan did not outline how the resident was supported to make choices in regard to this.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

The registered provider had a policy on risk management. This included systems to alert significant risks to senior personnel in the centre. The person in charge reviewed all incidents that occurred in the centre to assure that risks were

mitigated, these incidents were also discussed at staff meetings to ensure shared learning following these incidents.

Residents had individual risk assessments in place that outlined control measures that were in place to mitigate these risks and safeguard residents. As an example; the control measures in place for residents who were at risk of choking, included having staff trained to respond to an incident of choking and residents who required it were supervised during meal times. Inspectors also observed residents being supervised at meal times over the course of the inspection. Another resident who was at risk of falls, had handrails installed on a corridor to prevent further falls.

Two buses were also provided in the centre. Inspectors reviewed the records pertaining to these buses and found records showing that they were maintained in good working order and were insured at the time of this inspection.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

Each person has a personal plan. A sample viewed showed that residents had an up to date assessment that detailed their needs and there were comprehensive support plans in place they to support their development and healthcare. However, inspectors found several examples where recommendations included in residents care plans and assessments, had not been addressed in a timely manner. Notwithstanding that the person in charge had been trying to follow up on them. This was concerning as all of the residents had mobility needs in this centre and these recommendations needed to be implemented in a timely manner to safeguard the residents concerned.

These recommendations included:

- a report following a sensory assessment for a resident was not available for this resident even though it indicated that the assessment had been conducted in 2021
- a resident who had a decrease in mobility had been prescribed hand/arm splints, while these had been purchased they had not being fitted
- two residents who had recent falls had been referred to have an assessment completed on their bed, and their bedroom. This had not been completed at the time of this inspection
- one resident who had mobility needs was waiting for a new wheelchair. There had been no update about the delivery of this chair
- one resident had been assessed as requiring a new comfort chair, however there was no evidence of when this would be delivered

- one resident had been waiting to see a dentist for a prolonged period of time. This had not been addressed to a satisfactory level at the time of this inspection.

Judgment: Not compliant

Regulation 7: Positive behavioural support

Residents were supported by a range of allied health support professionals and staff to support their emotional needs. Behaviour support plans were in place to guide staff practice. The positive behaviour support plan was detailed and there was a detailed written structured routine for one resident who required this. Two staff members went through how one resident liked to be supported and it was evident that they knew staff the resident very well.

A clinic nurse specialist in behaviour support reviewed the support plans in place for the residents. There was evidence that information was been gathered in relation to some behaviours of concern to try and establish the reason for a residents' behaviours in order to better support them. There had also been a number of medical investigations conducted to try and establish the reason for one residents behaviours of concern to rule out medical reasons. However, as actioned under communication and personal plans there were some improvements required to this residents personal plans.

There were a number of restrictive practices being reported to the Chief Inspector every three months. They included mechanical restraints such as bed rails, lap belts and chairs which were in place to support the residents mobility needs and some sensor alarms to alert staff that a resident may require assistance. The staff team were reviewing these to ensure that they were the least restrictive measure. The registered provider had oversight arrangements for restrictive practices in this designated centre. There were two committees in the wider organisation who reviewed restrictive practices and human rights issues in the centre. The 'Governance of Restrictive Interventions Committee (GRIC)' reviewed and approved restrictive practices used in this centre every three months. The 'Human Rights Committee' also reviewed other rights restrictions and wrote a letter to each resident following their review to explain decisions made at these review meetings.

A restrictive practice register was also maintained indicating when the restraints were put in place. A review of this register showed that some minor improvements were required to the times included on this register. The person in charge agreed to follow this up and assured inspectors that they would speak to all staff about it.

Judgment: Compliant

Regulation 8: Protection

The registered provider had adopted the Health Service Executive (HSE) national policy on safeguarding vulnerable adults to guide staff practice in the centre. A separate standard operating procedure was in place which outlined the reporting procedures to be followed in the event of an allegation of abuse in the organisation. The inspectors reviewed this standing operating procedure and found that it had been reviewed in September 2025.

All staff had been trained in safeguarding vulnerable adults and staff spoken to were aware of the procedures to follow in such an event and the types of abuse. Four staff reported to the inspectors that they had not concerns about the quality and safety of care of the residents. At the time of the inspection there had also been no recent complaints raised in the centre by staff, residents or family members.

Safeguarding concerns were being identified and managed, and actions had been taken to minimise the likelihood of peer to peer safeguarding concerns. As an example; one resident displayed some behaviours of concern when they were anxious. This was impacting on other residents in the centre. The registered provider had taken a number of actions to ensure that these other residents were not impacted. For example; the registered provider had submitted a business case to seek funding for an individualised placement in a community setting. This had not been approved at the time of this inspection. As a result, the registered provider had moved the resident concerned to live on their own in one unit in the centre. The other four residents then lived in the other side of the centre. While this was a temporary solution, this unit was not suitable as a long term home for the resident concerned. This was actioned under regulation 23 governance and management of this report.

Judgment: Compliant

Regulation 9: Residents' rights

The residents had access to an assisted decision-support coordinator in the service who was available to attend the centre, to offer support and guidance to both the residents and staff.

Support plans in place for each resident gave an outline of how a resident was indicating that they consented to practices. It also included details of what kind of environment they would prefer, or staff, in order to feel comfortable and ready to consent to some interventions.

At residents meetings, easy-to-read information was made available to residents about their right to feel safe. They were also kept informed at these meetings about things that were happening in the wider organisation or important rights issues that

were happening in the wider community. As an example; all residents had been informed about the upcoming presidential election.
Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
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	Compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Ladywell Lodge OSV-0003025

Inspection ID: MON-0046378

Date of inspection: 21/10/2025

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: Regional Director of Services discussed the Business case relating to a resident of Ladywell Lodge with the HSE at their monthly joint meeting on the 12/11/25. The Regional Director of services requested an update on the status of the Business plan on 24/11/25. Replacement shower trollies were delivered to the Designated Centre on 05.11.25	
Regulation 10: Communication	Substantially Compliant
Outline how you are going to come into compliance with Regulation 10: Communication: Outstanding additional information as recommended has been added to the critical information template and the communication plans describing how residents are supported to make choices.	
Regulation 5: Individual assessment and personal plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
Sensory Assessment was reviewed by the occupational therapist, management and staff and completed 04.11.25.

Arm splints assessed and fitted by the occupational therapist on 24.10.25

Bedroom assessments completed by the occupational therapist on 28.10.25.

External service assessed furniture on 29.10.25 which recommended adding padding to the edge of a bedside locker and chest of drawers expected delivery 20/12/25.

2 replacement chairs delivered on 24.10.25 and 06.11.25.

Dentist appointment booked for the resident concerned on 04.12.25

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(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	01/12/2025
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	05/11/2025
Regulation 05(2)	The registered provider shall ensure, insofar as is reasonably practicable, that arrangements are	Not Compliant	Orange	20/12/2025

	in place to meet the needs of each resident, as assessed in accordance with paragraph (1).			
Regulation 05(7)(c)	The recommendations arising out of a review carried out pursuant to paragraph (6) shall be recorded and shall include the names of those responsible for pursuing objectives in the plan within agreed timescales.	Substantially Compliant	Yellow	04/12/2025