



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

## Issued by the Chief Inspector

Name of designated centre:	Prosper Fingal Residential Service 1
Name of provider:	Prosper Fingal Company Limited by Guarantee
Address of centre:	Co. Dublin
Type of inspection:	Unannounced
Date of inspection:	12 January 2026
Centre ID:	OSV-0003398
Fieldwork ID:	MON-0049126

## About the designated centre

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

Prosper Fingal Residential Service 1 is a designated centre consisting of three properties in North County Dublin. The centre can accommodate up to 15 residents both male and female with a mild to moderate intellectual disability. Some residents may also have a secondary disability such as a physical disability, sensory disability or a mental health need. The service operates 7 days a week for 52 weeks of the year. The staff team consists of a person in charge, social care workers, nursing staff and care assistants. The service operates on the principles of person-centredness, respect and inclusion. Staff aim is to provide a safe and comfortable home within a community environment which supports and promotes independence and well being.

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

Number of residents on the date of inspection:	5
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This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

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

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

### **1. Capacity and capability of the service:**

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

### **2. Quality and safety of the service:**

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

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

**This inspection was carried out during the following times:**

Date	Times of Inspection	Inspector	Role
Monday 12 January 2026	09:30hrs to 18:00hrs	Brendan Kelly	Lead

## What residents told us and what inspectors observed

This unannounced inspection of Prosper Fingal Residential Service 1 was carried out to inform a recommendation on the provider's application for renewal of registration of the centre. The inspection also reviewed the provider's ongoing progress related to their compliance plan, submitted following an inspection in October 2025. This inspection was carried out solely in one of the locations in the designated centre due to the concerns identified specific to this location during the previous inspection. Overall, this inspection identified improvements across the regulations reviewed. Continued improvements are required however, from the provider, to ensure ongoing compliance with the Regulations.

On the day of inspection the inspector met and spoke to four of the five people using the service, the person in charge, and two of the staff on duty for the inspection. Later in the day at a feedback meeting the inspector was also able to meet and speak with four of the provider's senior management team.

On arrival at the location the inspector was met by a member of the front line staff team. The inspector was informed that there was a staff training and a staff meeting on that morning. The training provided was in mental health and Lámh training which was facilitated by the provider's Psychologist and Speech and Language therapist.

The residents had already left for their various day services when the inspector arrived and it was later in the day when the inspector had the opportunity to speak to residents. The first resident who the inspector had the chance to speak to was a resident who had raised their own concerns during the previous inspection. The resident informed the inspector that life was now "kind of" better since the previous inspection. The resident outlined that new transport arrangements were in place which they were very happy with and were working well. The resident also spoke positively about an increase in staffing that had been implemented since the previous inspection and that this was helping residents with engaging in activities of their choosing. The resident also informed the inspector that they saw a housemate was better in the last few weeks but was concerned that they did not know if an incident was going to occur. The inspector observed that the resident appeared happier in their home based off their presentation during the October 2025 inspection.

The inspector then met with a second resident in the staff office. The inspector had met with this resident during the previous inspection. The resident again appeared content and happy in their home. The resident informed the inspector that they had a good day and had gone out for lunch with their day service.

The inspector met with a resident who had moved into the location shortly before the October 2025 inspection. The resident informed the inspector that they like their

home. The resident discussed positive examples such as the staff team, enjoying the food that is cooked, going for dinner, going bowling and maintaining contact with family. The resident informed the inspector that they get on well with their housemates and that they would not change anything about their home.

The inspector also met with a fourth resident briefly in the staff office. The resident had in the previous inspection report of October 2025 been engaging in significant behaviours of concern. The resident appeared happy to meet with the inspector for a short time. They informed the inspector that they had a good day and were happy with their home. The resident went to the kitchen for some snacks and the inspector observed the resident interacting in a positive manner with staff and other housemates for the remaining duration of the inspection. The inspector observed that the resident appeared more relaxed and was not seeking the same level of reassurance from staff as in the previous inspection.

The inspector also had the opportunity to meet with and speak to the provider's speech and language therapist and psychologist who were providing training on the day of inspection. In conversation with the provider's speech and language therapist they outlined how they felt supports in place for one resident now, have made a positive impact. One support outlined was the introduction of medication to help with the resident's anxiety levels. The inspector observed throughout the inspection a positive reaction from all persons regarding the introduction of pharmaceutical supports for the resident.

The provider's psychologist discussed the changes made to behaviour support plans since the previous inspection. Improvements were made in terms of a more consistent and collaborative multi-disciplinary approach. Also discussed was the importance of additional guidance for staff in updated plans. Members of the provider's clinical team had also met with health and social care professionals in the community to advocate for additional supports.

Both members of the clinical team who met with the inspector indicated that the resident was now in a better position to engage in care plans as a result of enhanced supports.

The next two sections of this report will outline in greater detail the governance arrangements of the provider and how these governance systems have impacted on the quality and safety of the lived experience of the people using the service.

## Capacity and capability

This inspection was completed to assess the implementation of actions contained in the compliance plan submitted by the provider following an escalated inspection in October 2025. In addition, outcomes from this inspection informed a decision on

renewal of the centre registration. The inspector was assured that all of the actions outlined in the compliance plan were being undertaken and were in progress.

While some actions continued to require ongoing input and action from the provider, the inspector was assured the provider had committed to a thorough review of the systems failures outlined in the October 2025 report.

The inspector observed evidence of a multi-layered response from across the provider's multi-disciplinary teams and members of the senior management team.

The provider had a definite plan in place regarding the additional staffing hours outlined in the October 2025 report. Residents and staff who spoke with the inspector agreed the changes were having a positive impact.

The provider had ensured additional external mental health training had been rolled out to all staff working in the designated centre. On the day of inspection further mental health training led by the provider was taking place. Lámh training was also taking place on the day of inspection.

The inspector was assured of the improved governance systems in place since the last inspection. The inspector observed increased oversight of the ongoing issues from the provider's senior management team. As a result additional measures were in place that were beginning to have positive impacts.

#### Registration Regulation 5: Application for registration or renewal of registration

The provider had submitted all required documentation for the application to renew the registration of the centre. This included the correct and completed application form. The provider had also submitted floor plans that were reviewed on inspection.

Key documents such as the centre statement of purpose and resident's guide were reviewed prior to the inspection. Both documents contained relevant information for residents and their representatives.

The provider had also submitted information regarding the management team of the centre including qualifications, relevant background information and photographic identification.

Judgment: Compliant

#### Registration Regulation 9: Annual fee to be paid by the registered provider of a designated centre for persons with disabilities

The inspector observed evidence that the provider had paid the relevant fees in line with the regulation.

Judgment: Compliant

### Regulation 15: Staffing

The provider had no vacancies on the day of inspection in the location. The person in charge maintained a planned and actual roster on site in the location. On the day of inspection the inspector reviewed roster for December 2025 and the planned roster for January 2026. There was no agency usage with the contingency plan for planned and unplanned leave, consisting of a familiar panel of relief staff or the permanent team working additional hours.

The roster showed dates for mental health and behaviour support training and also upcoming team meeting dates.

The provider's compliance plan from the inspection in October 2025 outlined a roster review for additional staff assigned to the location. The inspector observed that the roster review had been completed and a long term plan was now in place for these additional hours. The sleepover shift that had been added to the roster in October 2025 now commenced earlier in the day. This ensured that residents had a greater opportunity for social activities in the evening. It also allowed for residents to engage with staff 1:1 if required.

The earlier start time of the sleepover staff also allowed staff to ensure increased attention to the safeguarding measures in place.

The inspector met with two staff on the day of inspection. Both staff were complimentary of the changes made since the last inspection. Both staff discussed the changes to the roster as one of the main improvements. The staff members also spoke positively about the changes made to resident plans which now provided a greater emphasis on guiding staff practice.

The staff members also spoke of the increased presence of the senior management team which led to staff feeling more supported.

Judgment: Compliant

### Regulation 16: Training and staff development

The provider's compliance plan outlined additional training that would be rolled out to all staff in the designated centre. On the day of this inspection the inspector reviewed and observed evidence of the additional training. Following a review of the

review of the evidence, the inspector was assured the provider was implementing the measures outlined in their compliance plan.

An external trainer had been sourced by the provider. The training provided was in relation to specific mental health diagnosis of residents in each location in the centre. The inspector observed evidence that all staff in each of the locations had completed the training.

On the day of inspection the provider was rolling out additional training for the staff that was specific to the residents in this location. The training was being facilitated by the provider's psychologist. Following completion of the mental health training, the provider's speech and language therapist was also on site to provide Lámh training to the staff team. Lámh was a preferred method of communication of one resident.

The inspector also observed evidence that the provider intended in the week after the inspection to provide behaviour support training to the staff team in this location.

Staff who met with and spoke to the inspector spoke positively regarding the additional training that had been provided. Staff outlined that the training had provided additional knowledge in regard to the mental health conditions they were supporting residents through.

Judgment: Compliant

## Regulation 23: Governance and management

In their compliance plan submitted to the Chief Inspector of Social Services the provider had committed to the establishment of a working group to ensure actions as outlined were progressed. Incident management and safeguarding processes were also to be subject to review.

On the day of inspection the inspector reviewed minutes of governance meetings that had occurred since the previous inspection. The inspector was assured that the provider had increased their presence in the location. The inspector observed evidence of actions implemented by the provider that had started to make a positive difference to the people using the service.

The inspector reviewed the working group meeting minutes from November and December 2025. The meetings were attended by members of the provider's senior management team as well as various members of the provider's clinical team. Agenda items for these meetings included safeguarding, staff training, staff engagement, engagement with community based mental health providers, health and safety, behaviour support, finance, whole time equivalent, audits, local leadership and personal plans.

The inspector also reviewed minutes of a meeting with a community mental health provider in December 2025. The meeting was attended by members of the senior management team, clinical and local teams. The inspector observed that the meeting had a positive outcome with a new intervention in place for one of the residents. It was clear to the inspector both in conversation with various stakeholders and documentation review that the intervention had shown early signs of success.

The inspector observed evidence of increased communication between the provider's residential and day service locations. The inspector reviewed information for staff that outlined the resident presentation in day service. This presentation was in contrast to behaviours that were observed in the resident's home. There was evidence that the provider was trying to implement similar patterns and routines for residents in both locations.

The provider had also committed to ensuring to meet with a resident who had raised concerns during the previous inspection. The inspector observed evidence through a review of meeting minutes of regular meetings with this resident. Meetings had occurred each month since October 2025 with the next meeting planned for the day after this inspection. The inspector also observed evidence of a meeting that was attended by family members of the resident. In conversation with the resident, they outlined these meetings were helpful and they were happy attending.

In the submitted compliance plan from the previous inspection the provider had committed to review of team meetings in particular agenda items such as safeguarding and incident reviews. The inspector reviewed the team meeting minutes from November and December 2025. The inspector observed that the meetings were attended by members of the provider's senior management team including the area manager, clinical manager and safeguarding officer. Agenda items for the meetings included resident updates, clinical updates, person centered plans, medications, health and safety and quality and standards.

In the December 2025 meeting the provider's safeguarding officer used various scenarios from incidents that had occurred in the location to provide additional guidance for the staff team.

The staff who met with the inspector were complimentary of the increased management presence in the location, staff discussed the additional information there were now getting from team meetings as another positive.

The inspector also observed evidence of meetings taking place with representatives of the residents since the last inspection. A collaborative approach was observed from a review of the minutes. Plans were established in terms of attempting to create consistent routines. There was also evidence of a collaborative approach in times were the residents may be experiencing distress.

Judgment: Compliant

## Quality and safety

This section of the report outlines how the provider is ensuring the residents are in receipt of and are experiencing a safe service. While the provider had made progress in terms of providing a safe service for the residents, improvements were further required in the areas of risk management, individual assessments, behaviour support and protection.

The inspector was not fully assured of the effectiveness of key documents such as risk assessments and behaviour support plans. Key areas that were impacting residents had not been identified in either.

While safeguarding systems in place showed significant improvement further improvements were needed. One resident's safeguarding plan required updating and compatibility remained a concern.

While the inspector observed Incident numbers decreasing since the last inspection, the possibility and impact of peer-to-peer incidents remains an ongoing concern. One significant incident had occurred that required calls to emergency services late at night.

## Regulation 26: Risk management procedures

The provider uses an online system to identify, rate and review risk. The person in charge maintains the local risk assessments as part of their oversight roles and responsibilities. The inspector reviewed the risk assessment updates completed since the last inspection as well as the provider's stated actions in their compliance plan response in relation to risk management.

In the submitted compliance plan from the previous inspection, the provider committed to reviewing the processes for identification, scoring and review of risk assessments. The inspector observed evidence of improvements in these processes, however, further improvements were needed. The inspector acknowledges that the provider's compliance plan actions, identified under Regulation 26: Risk management procedures were not fully due for completion until early February 2026.

The inspector was assured the quality and information provided to staff in risk assessments had increased since the last inspection. Risk is an area that was now subject to appropriate escalation within the provider's management structure.

Increased risk assessments were in place for the issues identified in the previous inspection, however, not all areas had been effectively risk assessed.

For example, on review of one resident's risk assessments not all key areas of risk had been identified for the resident. There was significant evidence demonstrating the impact of incidents on service transport, impact of peer-to-peer to incidents and the resident's on-going mental health challenges were key areas of risk to address. However, none of these areas had been subject to a risk assessment.

On review of another resident's risk assessments, the inspector observed evidence of the need for increased information to evidence effective scoring of risk assessments. One assessment was in place for behaviours of concern. This risk without control measures was rated as at 16, however, with the introduction of just four control measures the risk rating had reduced to a nine.

The provider had risk assessments in place for safeguarding and the impact of one residents behaviour on peers. In the cases of both assessments the initial rating without control measures was 16 and the rating with effective control measures reduced to 12. However, there was no evidence of how the provider intends to continue to reduce this further or when these next steps will be completed.

Risk assessment review dates and evidence of risk being linked to behaviour support and safeguarding also needed improvement. In each of the risk assessments reviewed by the inspector there was no evidence of when the assessments would be reviewed to ensure they continued to be effective. The risk assessments also were not using the information available from incident reports, behaviour support plans or safeguarding plans to inform scoring or control measures.

Judgment: Substantially compliant

## Regulation 5: Individual assessment and personal plan

The provider uses an online system to maintain resident individual assessments and plans. These plans are updated by key workers. The person in charge has oversight of the plans to ensure they are reviewed in line with policy and regulatory requirements.

The inspector reviewed two resident care plans and the actions identified in the providers compliance plan since the last inspection. The inspector observed evidence of improvements made to resident care plans, however further improvements are required.

On review of one resident's care plan the inspector observed plans in place for mental health and well-being, intimate care, behaviour support, safety and risk and goals. The inspector reviewed the mental health and well-being section of the care plan in greater detail. The inspector observed greater communication between the residential service and the day service. This led to improved strategies for example,

as a result of transitions being a challenge for the resident, there is now a dedicated 1:1 day service staff in the morning available for 30 minutes. This allows the resident to settle into their day and reduces the likelihood of incidents.

The inspector observed evidence of effective communication between both locations. Any changes that were needed were clearly communicated and this meant that the staff in either day service or the resident's home could then make alterations to the resident's visual schedule allowing them to be prepared for what was to happen.

The provider's compliance plan outlined improvements that were to occur to the resident's mental health and well-being plans. The inspector observed evidence that positive changes were evident but not in all mental health plans reviewed.

The mental health and well-being plan is broken into clear sections that identify an area of concern for the resident and then outlines strategies for staff to help support the resident.

The inspector reviewed the resident's intimate care plan. In the past the resident had engaged in incidents with sharp objects. The resident's intimate care plan outlined situations where staff are to take over when providing intimate care support. This section required more detail in particular, in what scenario are staff to commence personal care and step-by-step instructions for staff. The risk assessment for this scenario also required greater links to the information in the care plan.

On review of a second resident's care plan the inspector again observed improvements had been made to the information provided to staff but that further improvements were required. For example, the resident had a mental health and well-being care plan in place, however, despite ongoing evidence that one of greatest impacts on the residents mental health was the impact of peer-to-peer incidents, this was not acknowledged in the care plan.

Judgment: Substantially compliant

## Regulation 7: Positive behavioural support

The provider had behaviour support plans that were in place where required for the residents. The plans were completed and reviewed by the provider's psychologist with input from the provider's mutli-disciplinary team.

The provider also had an online system in place that allowed for the reporting and review of all incidents that occurred in this location.

The inspector reviewed two of the behaviour support plans in this location, the provider's compliance plan from the previous inspection and the incident reviews since the previous inspection. The inspector observed improvements had been made

in regard to both behaviour support plans, however, continued improvements were required.

The inspector observed evidence that the provider had implemented plans and actions in regard to their compliance plan and that all incidents that had occurred had been subject to review.

The inspector reviewed two behaviour support plans and observed increased guidance for staff. The plans contained guidance on behaviours of concern presentation, early indicators of stress, setting events, triggers, proactive and reactive strategies. The plan for one resident clearly outlined the various behaviours of concern that may occur and what the resident's presentation may look like in each of the scenarios.

Key information was available to staff in terms of what may cause a resident stress. For example consistency was discussed as essential for one resident and any changes that may occur need to be communicated. The plan also outlined guidance for staff in terms of the resident's ability to tolerate stress. This resident's plan made reference to other sources of information such as mental health and well-being plans and communication plans. Proactive and reactive strategies gave staff clear guidance such as verbal reassurances and the importance of making changes to timetables without having to cancel favourite activities.

The resident's behaviour support plan also outlined staff intervening in aspects of the resident's personal care. As outlined in another section of the report, this needs further clarification to and more detailed information to ensure both staff and resident safety.

The inspector reviewed a second behaviour support plan. The behaviour support plan outlined key guidance for staff on behaviours of concern presentation, triggers and managing behaviours. One area where there is clear evidence of causing behaviours of concern for this resident is that of the impact of negative interactions with a peer. This is an area that is not discussed within the behaviour support plan nor provides any guidance for staff in managing the impacts of negative interactions. This is despite the provider implementing significant changes to, for instance bus routines and increasing the staffing numbers.

The inspector reviewed all incident reports since the previous inspection in October 2025. There had been eight incidents since the previous inspection. The provider had not had any incident reported since mid-December 2025. The inspector observed evidence that incident reviews had been discussed at team meetings. In December 2025 the providers safeguarding officer attended the team meeting and reviewed incidents with the team.

One serious incident had occurred in the centre in November 2025. The inspector observed the incident had been subject to a serious incident review that included various stakeholders including family representatives of the resident and the provider's clinical teams. The inspector observed evidence of plans in place in the event a similar incident occurred in the future.

Judgment: Substantially compliant

## Regulation 8: Protection

The inspector reviewed the safeguarding systems in place since the previous inspection. The inspector was assured that improvements had been made, but as with other areas of the report, continued improvements were required.

The provider's designated officer attended team meetings in November and December 2025. During the December 2025 meeting, the inspector observed evidence of safeguarding scenarios being discussed with the team and outlining what the appropriate response to each scenario should be.

The provider had ensured to notify the national safeguarding team via their online portal of safeguarding incidents. Notifications that were submitted to the online portal were agreed and closed in the main, with a formal safeguarding plan requested for one resident.

However, the inspector reviewed two incidents, one in November 2025 and one in December 2025 that appeared to be safeguarding in nature. The person in charge indicated to the inspector that on review of the incidents it was decided that as there were no peers in the immediate view of the resident it was deemed not to proceed with safeguarding processes. When the inspector asked if there was an objective decision making tool used to differentiate between similar incidents in terms of safeguarding reporting they were informed there was not.

Closed and open safeguarding plans were reviewed by the inspector. The inspector also reviewed a safeguarding plan in place for one resident who had been the person allegedly causing concern in the safeguarding plans submitted. This plan was developed as a separate document by the providers designated officer.

Safeguarding plans either interim or formal submitted via the portal were comprehensive in nature. They outlined the intended purpose of the plan, how the actions could keep residents safe, who would complete the actions and by when. A formal safeguarding plan was requested by the Health Service Executive, national safeguarding team and this had been submitted.

A safeguarding plan in place that had been developed locally and not submitted via the portal required review. The information contained did not provide as much guidance for staff. Areas identified were to reduce behaviours causing distress, for everyone to feel happy and safe and preventing safeguarding concerns. However, the actions aimed at addressing the identified concerns required further review.

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
<b>Capacity and capability</b>	
Registration Regulation 5: Application for registration or renewal of registration	Compliant
Registration Regulation 9: Annual fee to be paid by the registered provider of a designated centre for persons with disabilities	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Compliant
<b>Quality and safety</b>	
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

# Compliance Plan for Prosper Fingal Residential Service 1 OSV-0003398

Inspection ID: MON-0049126

Date of inspection: 12/01/2026

## Introduction and instruction

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

This document is divided into two sections:

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

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

A finding of:

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

## Section 1

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

### Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 26: Risk management procedures	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 26: Risk management procedures:</p> <ol style="list-style-type: none"><li>(1) The seven actions committed to under this Regulation in the Compliance Plan arising from inspection October 2025 will be completed.</li><li>(2) The provider will source additional external training in individual risk management for identified stakeholders with responsibility for risk sign off.</li><li>(3) Incident reports and support plans (including at a minimum positive behaviour support plans, mental health &amp; wellbeing support plans and safeguarding plans), related to each resident, will be analysed to inform each resident's individual risk management plan (IRMP) scoring and control measures.</li><li>(4) A more through review of IRMPs for all residents will be undertaken with reference to information gathered through action 3.</li><li>(5) A schedule of IRMP review dates will be prepared for each resident.</li><li>(6) IRMPs will be reviewed in accordance with agreed review schedule.</li><li>(7) Risks scored medium or above, after controls are put in place, will have a target risk rating agreed and further controls identified to try and further reduce the likelihood or impact of the risk, within agreed timeframes.</li><li>(8) Individual Risk will be made a standing item in governance meetings between the PIC and Area Manager.</li><li>(9) Discussions about individual risk during governance meetings between PIC and Area Manager will be shared with staff at team meetings.</li><li>(10) Reporting on individual risk to the SMT will be enhanced.</li><li>(11) Actions here resulting in an enhanced approach to individual risk management will be reflected in company policy.</li></ol>	

Regulation 5: Individual assessment and personal plan	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:</p> <p>(1) The four actions committed to under this Regulation in the Compliance Plan arising from inspection October 2025 will be completed.</p> <p>(2) A more thorough review of mental health &amp; wellbeing support plans for all residents will be undertaken with reference to inspection findings and updated IRMPs.</p> <p>(3) The mental health &amp; wellbeing support plan of one resident in Knock Cross will be updated to include the impact of peer-to-peer interactions on the resident's wellbeing.</p> <p>(4) The personal and intimate care support plan of one resident in Knock Cross will be updated to contain more detail on how staff can support the resident in specific circumstances and with reference to the resident's IRMP.</p>	
Regulation 7: Positive behavioural support	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:</p> <p>(1) The seven actions committed to under this Regulation in the Compliance Plan arising from inspection October 2025 will be completed.</p> <p>(2) The positive behaviour support plan of one resident in Knock Cross will be updated to include the impact that negative interactions with a peer can have on this resident's behaviour.</p> <p>(3) Frontline staff will be more integrally involved in the development and review of positive behaviour support plans.</p> <p>(4) Reporting on behaviours of concern and positive behaviour support to the SMT will be enhanced.</p>	
Regulation 8: Protection	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 8: Protection:</p> <p>(1) The nine actions committed to under this Regulation in the Compliance Plan arising from inspection October 2025 will be completed.</p> <p>(2) An objective decision-making tool will be prepared to guide staff when screening</p>	

safeguarding incidents for reporting and escalation.

(3) The provider will not develop local safeguarding plans for residents alleged to have caused harm. Instead supports to residents alleged to have caused harm will be recorded in relevant sections of their individual support plans e.g. positive behaviour support plan.

(4) Reporting on safeguarding incidents to the SMT will be enhanced

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## 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 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	30/04/2026
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	31/03/2026

Regulation 05(7)(a)	The recommendations arising out of a review carried out pursuant to paragraph (6) shall be recorded and shall include any proposed changes to the personal plan.	Substantially Compliant	Yellow	31/03/2026
Regulation 05(7)(b)	The recommendations arising out of a review carried out pursuant to paragraph (6) shall be recorded and shall include the rationale for any such proposed changes.	Substantially Compliant	Yellow	31/03/2026
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	31/03/2026
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Substantially Compliant	Yellow	31/03/2026
Regulation 08(6)	The person in charge shall have safeguarding measures in place to ensure that staff providing personal intimate care to residents who require such	Substantially Compliant	Yellow	31/03/2026

	assistance do so in line with the resident's personal plan and in a manner that respects the resident's dignity and bodily integrity.			
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