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:	Acorn Respite & Residential Services
Name of provider:	Western Care Association
Address of centre:	Mayo
Type of inspection:	Unannounced
Date of inspection:	27 May 2025
Centre ID:	OSV-0003914
Fieldwork ID:	MON-0047017

About the designated centre

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

Acorn Residential Services is a centre operated by Western Care Association. The centre provides residential care for up to ten male and female residents, who are over the age of 18 years and who have an intellectual disability. The centre comprises of two houses located on the outskirts of a town in Co. Mayo, situated within close proximity to each other. Residents have their own bedroom, en-suite facilities, shared bathrooms, kitchen and dining areas, sitting rooms, staff office, utility and garden area. Staff are on duty both day and night to support the residents who live here.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	7

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
Tuesday 27 May 2025	10:00hrs to 15:20hrs	Catherine Glynn	Lead
Tuesday 27 May 2025	09:00hrs to 17:00hrs	Marie Byrne	Lead

What residents told us and what inspectors observed

This inspection was unannounced and was conducted due to the Chief Inspector of Social Services receiving information of concern relating to the provider's governance and oversight of designated centres. Overall, inspectors found that significant improvements were required in six regulations reviewed, and minor actions in two regulations of the eight reviewed, showing that there was ineffective governance and oversight arrangements in place in this centre.

Inspectors also noted from conversation, observation and review of documentation that the provider had poor systems in place relating to the monitoring of the quality of the service and that audits were completed that identified all areas for improvement rather than showed completion. Significant improvements were required in six of the eight regulations reviewed, and two were identified as substantially compliant.

The designated centre consisted of two houses on the outskirts of a large town in Co. Mayo. Each resident had their bedroom and access to suitable bathroom facilities. There was also suitable communal space throughout each house, including a kitchen, dining area, laundry facilities, sitting rooms, and a staff office with sleepover facilities. Both houses had suitable garden areas to the front and rear of the centres. At the time of this inspection, inspectors saw improvements as works were completed since the last inspection in August 2024. This included remedial works required in the kitchen bathroom and general maintenance that was identified in a two-storey house.

Inspectors arrived at the centre and were met by the one staff on duty, who was alone and supporting two residents. Inspectors were asked to wait outside to enable residents to transition appropriately onto their bus for attendance at their day programme. Inspectors respected this request and observed from a close location. Inspectors returned to the centre after observing the residents had transferred to their bus. One resident immediately met the inspectors and completed their method of saying hello by tapping hands with the inspectors and another resident smiled and waved at the inspectors before setting off. Inspectors were then informed that one resident was currently in hospital whilst awaiting test results recently completed. This resident was supported by one staff in the hospital as per their assessed needs.

Inspectors noted that issues with compatibility of residents at the centre had resulted in incidents of peer-on-peer aggression which although the provider was aware had not lead to an action plan to address. Furthermore, ongoing incompatibility issues negatively impacted on the promotion of residents' rights, curtailing their freedom and range of movement in the centre. While the provider was aware no actions had been implemented at the time of the inspection. These issues will be further elaborated in regulations 23, 7,8, and 26.

Residents were supported in one house to engage in activities of their choosing outside of the centre, and the centre's staff team supported residents in activities of their choosing. However, activities were not evident in the main house where compatibility was such an issue that two residents were facilitated with transfers to the respite house, impacting the availability for respite facilities. Inspectors noted that the provider had failed to plan ahead for the aging profile in the residential house and had not maintained record effectively. An occupation therapist had completed an assessment in one house and had advised the management team that this the two storey house would bot be suitable in five years for the residents, however a copy of the assessment was not available in the centre.

Inspectors were met by the person in charge who had returned from extended leave since early March 2025, and two staff who were completing their morning shifts and administration on the day of inspection. Since the last inspection in August 2024 inspectors found that there had been little improvements due to the ongoing compatibility issues present on one house. Inspectors visited both houses and spent time reviewing documentation and meeting with staff present during the inspection.

A walkaround was completed in both houses and each house was found clean and tidy, however it was very evident that the two storey house was not suitable to meet the needs of four residents due to the lack of future proofing, which had been discussed on two previous inspections completed in February and August 2024. On each inspection, inspectors were advised of plans to reconfigure one house however no quality improvement plan was available on the day of this inspection. One house was not fully accessible should residents have a change in needs. The two-storey house was assessed by a Health Service Executive occupational therapist in 2022 but no report was received at the time of this inspection. This report suggested that this house would not be suitable in five years due to the aging profile of residents.

In summary, while residents were being supported in one house with their assessed needs and provided with suitable activities and access to the local community, significant improvements were required in the two-storey house due to the limitations on residents due to, incompatibility, premises, and rights. This situation had resulted in incidents to repeated safeguarding incidents, restrictions on their movements, accessibility and safeguarding in one house in Acorn respite and residential centre.

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

Capacity and capability

Inspectors were not assured that the provider's oversight and governance of this service was effective.

One house required significant review due to the providers failure to respond to repeated actions evident in the centre. These included safeguarding, positive behaviour support and appropriate risk management which will be discussed in detail under each associated regulation.

The provider did not ensure that improvements were identified in the centre through their auditing processes, for example, through the provider six monthly unannounced visits and in the annual review of quality and safety.

Improvements were also required to the recording of and responding to incidents. Inspectors found that an incident that had occurred at the centre, had not been reported within three days to the Chief Inspector as required under the regulations.

A complaints system was in place to manage complaints received. A record of complaints was maintained and managed in line with the provider's policy.

Regulation 15: Staffing

From conversations with staff members, it was clear to inspectors that consistency of care and support was paramount for residents living in this centre. Inspectors noted that a high level of care and support was required in this centre.

The inspectors saw that staff meetings had occurred in 2024 and were in line with the local policy which specified that staff meetings should occur at a minimum of four times a year. The inspectors reviewed rosters from November 2024 to May 2025. This showed consistent and core staffing on duty to support residents in line with their assessed needs. The provider had ensured that sufficient staffing was in place in this centre at all times.

Inspectors reviewed staffing rosters from January 2025 to the day of the inspection. They were well maintained and showed an accurate reflection of the staff on duty at the time of the inspection. Improvements had occurred since the last inspection, such as additional staffing in one house due to compatibility issues.

Judgment: Compliant

Regulation 23: Governance and management

The provider did not have effective governance and management systems in place in this centre as found on the day of the inspection.

Significant improvements were required in governance and management, safeguarding, individual assessment and personal planning, risk management, positive behaviour support, and notifications. Minor improvements were also

required in complaints within the centre, which are discussed in each regulation.

Inspectors reviewed the audit schedule for the centre and noted that improvements were required. The annual review of care and support was completed in January 2025. This failed to identify concerns in relation to safeguarding issues in one house, risk management, social care needs and access to positive behaviour support in the centre. These issues were again not identified in the most recent unannounced visit completed in April 2025, it was noted by inspectors that three actions were listed for review but did not include the areas of improvement found on this inspection.

In addition, further improvements as outlined below would enhance regulatory compliance further.

- Resident's individual assessment and quality of their personal planning information required review, to ensure residents were gaining access to activities that were meaningful, relevant and that they enjoyed in their day to day lives. This also included activity sampling and ensuring that all records were reviewed and monitored appropriately to ensure effectiveness.
- Positive behaviour support systems required review to ensure that all residents were accessing and receiving this support, with clear guidelines and guidance for staff on supporting residents appropriately, in a proactive and consistent manner.
- The arrangements for risk management required improvement as not all control measures were shown on resident's personal risk management plan (PRMP)
- The statement of purpose did not accurately describe the services in place in each house in the centre as found on the day of the inspection.
- Inspectors noted that recognition of repeated safeguarding incidents were not escalated effectively and were not responded to in a comprehensive manner to identify, address and improve the living environment for all residents.
- The provider had failed to complete a comprehensive assessment of residents' assessed needs in one house in line with their aging, health and social needs, reflecting all relevant multidisciplinary assessments, and recommendations.

Judgment: Not compliant

Regulation 31: Notification of incidents

The provider had failed to submit a necessary notification to the Chief Inspector in line with the requirements of the regulations.

Inspectors noted that staff had sought medical attention for a resident, after consultation with their general practitioner (GP), who referred the resident to a local minor injury centre. This incident had occurred on 10/02/2025 and was not

submitted within three days as specified in the regulations.

Judgment: Not compliant

Regulation 34: Complaints procedure

The provider had a complaints policy and procedure in place in the centre however, an improvement was required to ensure the relevant persons identified on the complaints procedure available in a service user-friendly format (Booklet) was accurate and reflected the correct management as seen on the day of inspection.

The provider had a complaints policy and procedure in place in the centre, which provided guidance to staff on complaints management in the centre.

There was a log of complaints maintained in the centre with actions evident of the response to the complainant, and the outcome of the complaint as required by the regulations. Inspectors found there was no active ongoing complaints on the day of the inspection. The provider had information displayed should a resident or relative become unhappy with the outcome of the complaint, showing the appeals process available and other support persons available if needed.

Judgment: Substantially compliant

Quality and safety

Overall, inspectors found residents had opportunities to take part in activities and were supported to make decisions about their care and support. They were supported to develop and maintain relationships and to spend time with their family. They lived in a warm, clean and comfortable home. However, inspectors found that improvements were required in relation to ensuring that one of the premises was suitable to meet residents' changing needs and their aging profile. Improvements were also required in relation to safeguarding, residents' assessments and plans, positive behavioural support and risk management.

Inspectors reviewed a sample of four resident's assessments and personal plans. They found that these documents positively described their needs, likes, dislikes and preferences. They had their healthcare needs assessed. However, improvements were required in a number of areas and these will be discussed further under Regulation 5: Individualised Assessment and Personal Plan, and Regulation 7: Positive Behavioral Support.

Residents staff and visitors were protected by the risk management procedures and practices in the centre. However, the provider's policy did not contain the

information required by the regulations and this will be discussed further under Regulation 26: Risk Management Procedures. There was a system for responding to emergencies and to ensure the vehicle was serviced and maintained.

Inspectors found that residents were not fully protected by the safeguarding and procedures and practices in the centre. Staff had completed training and discussions were regularly held at staff meetings about safeguarding and protection.

Regulation 26: Risk management procedures

The provider had not ensured that effective systems were in place for effective risk management in the designated centre.

Inspectors noted that the provider had some systems in place for the identification, assessment and management of risks in the centre, including a system of responding to emergencies, significant improvements were required. Inspectors viewed the the risk register, a sample of residents and general risk assessments and a record of incidents and accidents in the centre in 2025. Combined, these demonstrated that improvements were required across a number of areas such as;

- The risk register available in a folder in the centre and the online version were different,
- Neither risk register was not found to reflect the potential or actual risks in this centre, particular relating to safeguarding and behaviours of concern,
- Two residents' personal risk management plans were not found to fully reflect the presenting risks or control measures particularly relating to safeguarding,
- Some risks were not found to be appropriately risk rated, such as behaviours towards others for one resident.

From a review of a sample of records relating to accidents and incidents in 2025, it was not evident, as described above that these were leading to the review and update of the risk register or risk assessments.

The provider's risk management policy did not contain some of the information required to meet regulatory requirements. This included;

- The measures and actions in place to control the following specified risks: the unexpected absence of any resident, accidental injury to residents, visitors or staff, aggression and violence, and self-harm.
- The arrangements for the identification, recording and investigation of, and learning from, serious incidents or adverse events involving residents.

There were systems in place to ensure the vehicle was roadworthy and suitably equipped. The provider had an emergency plan in place.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

Overall, inspectors found that improvements were required to the assessment of residents' social care needs in the centre, in line with the provider's policy and procedures.

Inspectors reviewed a sample of four the residents' assessment of need and personal plans and found that improvements were required in relation to a number of areas such as:

- One residents assessment of need had not been updated despite their changing needs, particularly relating to their health in the months prior to inspection,
- One resident was due to have an annual review of their personal plan in January 2025 and this had not occurred,
  The staffing supports in the centre differed in three residents' plans,
- One resident who was being weighed twice weekly and was assessed as having a number of health concerns and risks relating to their diet and weight; however, there was no dietician referral completed,
- One resident had a referral to a speech and language therapist relating to their communication support needs completed in July 2024 and there was nothing on file to show progress or follow up on this referral,
- There were limited goals in place for residents, and for those that were in place, some were unclear and lacked detail on how or when they would like achieve them. For example, for one resident a goal was to "develop personal and social skills". There was a document available to track progress of their goals, steps taken to achieve their goals but this was blank.
- Keyworker meetings/reports were not being completed monthly, as planned. For example, one resident had nine completed in 2024 and none to date in 2025.

Overall inspectors found that there were inconsistencies across a number of documents, the most up-to-date guidance was not in place for some residents and in some areas there was not sufficient information to guide staff practice to support them in line with their wishes and preference and assessed needs.

Judgment: Not compliant

Regulation 7: Positive behavioural support

Inspectors found that responsive behaviours were not managed in a way which kept everybody safe, as risks relating to safeguarding and protection continued to

present. This will be discussed further under Regulation 8: Protection.

Inspectors reviewed a sample of three residents' assessments of need which identified they had moderate to severe behaviour support needs which require high levels of support. Inspectors were informed that they were in receipt of support from the behaviour specialist; however, when inspectors requested documentary evidence to demonstrate this (e.g. behaviour support plan, review minutes) they were informed that this was not in place, for example behaviour support plans and minutes of review meetings.

There were a number of restrictions in the centre such as lap belts or motion sensors. A restrictive practice register was developed by staff in the centre and this was being regularly reviewed; however, inspectors were informed these had not been reviewed by the provider's restrictive practice/rights committee in 2024 or 2025 as required under their own policy.

There were rights checklists for the use of restrictive practices on file for two residents which were developed in 2012 and these were found not to be reflective of current restrictions notified to the Chief Inspector ; which were lap belts, motion sensors and an epilepsy monitor. The contrary the rights checklists in the centre reflected practices linked to road safety, the house being single staffed, its impact on the residents' ability to access their community and the locking of the front door. In addition, the rights checklists were not subject to regular review with one being last reviewed in 2014 and the other in 2022.

Judgment: Not compliant

Regulation 8: Protection

The provider had failed to respond and address repeated safeguarding issues in the centre.

Inspectors found that although the provider had done actions, safeguarding concerns still remained in one house in this centre. Furthermore, planned actions to address the reason for the safeguarding concerns had not occurred such as MDT property meeting and compatibility assessments.

The provider had taken a number of responsive steps to support some residents to move from one houses in the centre to the other and this had removed some presenting risks relating to safeguarding and protection, however significant safeguarding risks still occurred at the centre. For example, there had been a 13 allegations of abuse reported to the Chief Inspector of Social Services identifying the same person allegedly causing concern in the 12 months prior to the inspection.

Inspectors reviewed an open safeguarding plan and found that the provider was implementing some of additional control measures; however, the plan was not fully effective at the time of the inspection and some of the recommended controls had

not been implemented. For example, compatibility studies which were due to be completed by the oversight review committee by 22 January 2025 had not occurred and a multi-disciplinary team meetings which was due in January 2025 to discuss property/service options for residents had also not occurred.
Judgment: Not 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	Not compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 26: Risk management procedures	Not compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Not compliant

Compliance Plan for Acorn Respite & Residential Services OSV-0003914

Inspection ID: MON-0047017

Date of inspection: 27/05/2025

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	Not Compliant

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

The Person in Charge (PIC) will review and update all persons supported Individual Plans (IP's), to ensure they represent the resident's needs and preferences. This will include the review and update of Personal Risk Management plans ensuring they capture all control measures. 29/08/2025

The PIC will update the Statement of Purpose to incorporate an accurate description of the services in place in each house in the centre. 16/06/2025

The Person in Charge will liaise with the Behavioural Support Specialist to ensure that all Behavioural Support guidance is provided for staff that is appropriate and consistent in response. Commenced 30/06/2025

There is no active Safeguarding plan in place in the designated centre.

The Provider has re-established a Governance and Oversight Forum that will be chaired by one of the Senior Management team. The forum will ensure all actions agreed are implemented and progressed in a timely and effective manner, in addition the forum will support the service to provide quality services to the people supported. Membership will include relevant personnel from support departments. The most recent meeting occurred on 15/07/2025.

The provider has rolled out training for all Person in Charge on the New Risk Management system. The PIC completed this event on 10/07/2025 a follow up event will be scheduled at Area Team meeting to provide further training to Persons in Charge.

The PIC will complete comprehensive needs assessments for all residents in one house in

the designated centre, ensuring they reflect all needs. 01/09/2025

The Registered Provider will establish a Compliance Oversight Group, to meet quarterly, to monitor progress of all actions towards compliance set out in the Compliance Tracker and to address/problem solve issues identified. (18/08/2025)

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:

The Person in Charge will complete a retrospective NF03 30/06/2025 to notify the authority of a missed 3-day notification.

All notifications to the authority will be reviewed at the business meetings between PIC and PPIM. 28/08/2025

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:

The Person in Charge will review and update the center's complaints policy to ensure it represents the relevant personnel 07/07/2025

The provider will ensure that All staff and people supported to be made aware of the Complaints policy. A communication will be sent out requesting the policy is shared with all staff at their team meeting to enable people supported to raise complaints. (28/08/2025)
The provider will ensure that the Easy Read Complaints Policy to ensure that the Governance information is correct for each Area. (08/10/2025)

Regulation 26: Risk management procedures	Not Compliant

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

The provider has rolled out training for all Person in Charge on the New Risk Management system. The PIC completed this event on 10/07/2025. A follow up event will be scheduled at Area Team meeting to provide further training to Persons in Charge. The centre's Risk register is now updated on Vi clarity system 15/08/2025

The Person in Charge will complete a quarterly review of incident injury reports and incorporate any new risk into the centre risk register. Completed Q2

As part of the updating of the centre risk register the PIC will review and update all Person Risk management plans to ensure they reflect the risks and controls for each

resident. 18/07/2025

The Registered Provider has reviewed and updated the Risk Management Policy to include guidance on, and signposting for, all of 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 of 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.

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

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:

The Person in Charge will review and update each residents Assessment of Need to ensure they are reflective of the needs of the residents. 16/06/2025

The PIC along with the medical professional (GP) will assess the need for one resident to access a dietician. 08/07/2025

The PIC will communicate with SLT for a status update regarding a referral relating to one residents communication support needs which was completed in July 2024.

The named staff will liaise with link staff, along with each resident to review and update all Individual Plans (IP's), ensuring they represent the resident's needs and preferences. In addition, all Circle of support meetings will be scheduled to agree the goals and priorities going forward- 29/09/2025.
The PIC will monitor progress in the individual plans via the quarterly updates completed by Named staff; this will be reviewed by the PPIM at the Business meetings with the PIC

Regulation 7: Positive behavioural support	Not Compliant

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

Although not available on the date of the inspection the provider had completed a compatibility assessment for all residents in the designated centre on 22/08/2024. This

assessment was completed by a Behaviour Support Specialist who had a good knowledge of residents. The BSS will review the compatibility assessments to ensure the information captured in the assessment is current. 27/08/2025

There is no Safeguarding Plan in the designated at present.

The Person in Charge will review and update all the Rights Checklists by 22/08/2025. Where there are identified restrictions in place the PIC will forward the Checklists to the Rights Review Committee for their attention. Checklists will be forwarded to RRC by the 22/08/2025. Review date 03/09/2025.

The RRC will review all Rights Checklist submitted on 03/09/2025.

The provider will review the structures of the Rights Review Committee to improve scope, structure and expectations of the Rights Review Committee responses to ensure that Rights Checklists are timely and clearly understood by all. The Rights Review Committee is due to meet on 03/09/2025 where the checklist will be reviewed by the committee.

The PIC will ensure that all records of engagement with Behavioural support personnel will be recorded and filed in the resident's Individual plan folder.

Regulation 8: Protection	Not Compliant

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

There is no current Safeguarding plan in the designated centre.

The Provider has reestablished the Governance oversight forum, chaired by member of SMT with Multi-Disciplinary and Senior Management (Properties and Facilities manager; Area Manager; Operations Manager; QSSI; Social Work; day service manager; PIC) membership in attendance. 15/07/2025 most recent meeting took place.

Although not available on the date of the inspection the provider had secured a compatibility assessment for all residents in the designated centre on 22/08/2024. This assessment was completed by a Behaviour Support Specialist who had a good knowledge of residents. This will be reviewed by the author to ensure it represents the current compatibility 27/08/2025.
The provider will request a review by the author of the assessments to ensure this information remains current. BSS specialist who carried out the initial compatibility study will join the next staff meeting on the 27th of August. And will review the compatibility study with management and staff and ensure it is current and relevant.

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.	Not Compliant	Orange	01/09/2025
Regulation 26(1)(c)(i)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: the measures and actions in place to control the following specified risks: the unexpected absence of any resident.	Substantially Compliant	Yellow	01/09/2025
Regulation	The registered	Substantially	Yellow	01/09/2025

26(1)(c)(ii)	provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: the measures and actions in place to control the following specified risks: accidental injury to residents, visitors or staff.	Compliant		
Regulation 26(1)(c)(iii)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: the measures and actions in place to control the following specified risks: aggression and violence.	Substantially Compliant	Yellow	01/09/2025
Regulation 26(1)(c)(iv)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: the measures and actions in place to control the following specified risks: self-harm.	Substantially Compliant	Yellow	01/09/2025
Regulation 26(1)(d)	The registered provider shall ensure that the risk management policy, referred to	Substantially Compliant	Yellow	01/09/2025

	in paragraph 16 of Schedule 5, includes the following: arrangements for the identification, recording and investigation of, and learning from, serious incidents or adverse events involving residents.			
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	01/09/2025
Regulation 31(1)(d)	The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: any serious injury to a resident which requires immediate medical or hospital treatment.	Not Compliant	Orange	30/06/2025
Regulation 34(1)(b)	The registered provider shall provide an effective complaints procedure for residents which is in an accessible	Substantially Compliant	Yellow	08/10/2025

	and age-appropriate format and includes an appeals procedure, and shall make each resident and their family aware of the complaints procedure as soon as is practicable after admission.			
Regulation 05(1)(b)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out subsequently as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.	Substantially Compliant	Yellow	29/09/2025
Regulation 05(6)(a)	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 be multidisciplinary.	Not Compliant	Orange	29/09/2025
Regulation 05(6)(b)	The person in charge shall ensure that the personal plan is the subject of a	Not Compliant	Orange	29/09/2025

	review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall be conducted in a manner that ensures the maximum participation of each resident, and where appropriate his or her representative, in accordance with the resident's wishes, age and the nature of his or her disability.			
Regulation 05(6)(c)	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 assess the effectiveness of the plan.	Not Compliant	Orange	28/09/2025
Regulation 05(6)(d)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall take into account	Not Compliant	Orange	28/09/2025

	changes in circumstances and new developments.			
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.	Not Compliant	Orange	18/07/2025
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.	Not Compliant	Orange	18/07/2025
Regulation 07(5)(b)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation all alternative measures are considered before a restrictive procedure is used.	Substantially Compliant	Yellow	18/07/2025
Regulation 07(5)(c)	The person in charge shall ensure that, where a resident's	Substantially Compliant	Yellow	30/09/2025

	behaviour necessitates intervention under this Regulation the least restrictive procedure, for the shortest duration necessary, is used.			
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	22/08/2025