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:	Slieve Rua Residential & Respite Services
Name of provider:	Western Care Association
Address of centre:	Mayo
Type of inspection:	Unannounced
Date of inspection:	26 May 2025
Centre ID:	OSV-0003916
Fieldwork ID:	MON-0047073

About the designated centre

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

Slieve Rua provides a residential and respite service to 12 adults in three separate houses. This centre supports residents with low to high needs and can also facilitate residents with reduced mobility. One house is dedicated to respite and one resident uses this house for planned breaks. Two houses provide can residential care to up to five residents each. Each house in the centre is warm and comfortably furnished and residents' bedrooms are decorated with items of personal interest and photos of family and friends. The centre is located within walking distance of a small town in the West of Ireland. Some residents are offered an integrated service and some residents attend day services external to the centre. There is a staffing allocation to support residents during the day and there is a sleep in arrangement in place during night-time hours.

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
Monday 26 May 2025	10:50hrs to 17:00hrs	Angela McCormack	Lead
Monday 26 May 2025	10:50hrs to 17:00hrs	Florence Farrelly	Support

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. The inspection was completed by two inspectors.

Inspectors found that residents received person-centred care from a dedicated staff team who knew them well. However, inspectors found that risks were not effectively addressed since the last inspection, which meant that residents' needs at night were not met in one house. In addition, the centre continued to use restrictive practices without adequate review about how this impacted on residents. These matters will be discussed further later in the report.

The centre comprised three houses all located within a short distance from each other, and in easy access of a small town. Two houses (House 1 and House 2) could accommodate five residents each, and the third house (House 3) could accommodate up to two residents for respite; however only provided respite care to one resident at this time. House 3 was not open for respite on the day of inspection.

Inspectors met with seven residents throughout the inspection, four residents in House 1 and three residents in House 2. Sadly, two residents had recently died, one resident each from House 1 and House 2. Staff members and the person in charge spoke about these losses and about what measures were put in place to support the residents at the end of their life. They also spoke about how their families and the other residents were supported to deal with their loss. From these discussions it was very evident that end of life care was provided in a sensitive and inclusive manner and every effort was made to support all those effected.

Residents had various communication needs. Some residents briefly communicated with inspectors with the support from staff members. One resident, when asked, said that they liked living at the centre. Two residents from House 1 attended a day centre during the week. All other residents took part in activities from their home.

The inspectors noted that staffing levels in House 2 had improved since the last inspection, which meant that residents now had three staff each weekday for three hours. This supported them to do individual activities. In addition, the centre was resourced with vehicles to enable residents go on outings and partake in activities in the community. House 2 recently got a new bus which staff reported had a positive impact on residents.

Inspectors reviewed residents' care plans and spoke with staff members about residents' day-to-day routines. Residents were found to be supported to live their lives as they chose to. One resident spoke about going out for dinner that day. Other residents were observed watching music on a technological device and spending time in the sensory room. Residents were observed to be relaxed and

comfortable in their home and with each other. Residents were seen freely moving around their home. It was observed some residents had preferred areas in the house in which to relax, such as in a sensory room or on a chair looking out to the garden.

Five staff were spoken with throughout the day. Staff members talked about how the recent deaths affected residents and about how they were supported with their grief. They also spoke about the activities that residents enjoyed both in the house and outside. They said that with the staffing levels increased in both House 1 (due to commence in the evenings) and House 2 (during the day hours) that this would have a positive impact on residents and facilitate more opportunities for one-to-one activities. Residents had a range of leisure activities in the house that they enjoyed also. These included technological devices on which they could listen to music and play games, knitting, arts and crafts and watching television. There was also a nice accessible garden in House 1, and House 2 had plans to get their outdoor area re designed following damage from the storms earlier in the year.

Overall, the homes were designed to meet the needs of residents. There were a range of easy-to-read documents on display in the houses to support residents with their various communication needs. These included a picture roster, documents about advocacy, rights and safeguarding. Residents' bedrooms were individually decorated and clearly showed each resident's unique personality. However, in House 2 there were restrictive practices in some residents' bedrooms that were in place due to behaviours of another resident and this had not been appropriately reviewed as to the impact on the individual residents.

Inspectors reviewed five care plans and daily notes from two residents in House 2, which showed that some residents got up frequently during the night and led to 'disturbed sleep' for the sleepover staff. Since the last inspection by the Health Information and Quality Authority (HIQA), this was risk assessed and a decision made that this house required waking night staff to support residents. The person in charge and a person participating in the management (PPIM) of the centre had plans in place to address this and a staff meeting had been scheduled to discuss the plans. The person in charge had a roster devised to present at the meeting which would address the deficit. However at the time of the inspection this staff meeting had not taken place and no change had been made to the staffing levels in House 2. This meant that residents continued to be at risk during the night time in this location. In addition, inspectors found that protection concerns were not identified in this house. This will be elaborated on under Regulation 8: Protection

The next two sections outline the capacity and capability of the provider, and describes about how this impacts on the quality and safety of care provided.

Capacity and capability

This inspection found that there were significant improvements required to ensure a

timely response to address risks and to support residents effectively at night time. In addition, improvements were required in the identification, assessment and oversight of restrictive practices and in the identification of protection concerns.

The management structure included a full-time person in charge and residential service manager. The person in charge had responsibility for Slieve Rua only and they were based full-time at the centre.

The person in charge and some of the staff team had worked in the centre for many years and knew residents well. Staff members were supported through ongoing training and through individual and staff team meetings.

Audits were in place by both the provider and local management team. This included unannounced provider audits. However, these audits were not effective in identifying areas for improvement nor in effectively reviewing restrictive practices to ensure that they were proportionate to the risks identified.

Regulation 15: Staffing

The person in charge had completed a risk assessment about the changing needs of residents in House 2 since the last inspection of this centre in April 2024. This identified that a change in night time supports was required. However, the following was found;

- At the time of this inspection this had not been implemented. For example, on review of one resident's care notes from 01 May 2025 until the day of inspection (25 days), there was only one night where they did not get up throughout the night. Furthermore, records stated that they got up two/three times most nights. In addition, one resident who was the most recent admission to this house, also required night time supports at times. From discussions held on the day of inspection, inspectors could see that there were differing views between staff members and management about the need for this change from sleepover shifts to waking nights. This was reported to have resulted in a delay in addressing this.
- Inspectors also found that an additional restrictive practice had been implemented in this house to address protection concerns at night time following a safeguarding concern that occurred at night time in September 2024. The associated safeguarding plan included an action about reviewing the staff roster. This restrictive practice remained in place as there was no waking night staff in this house.

Notwithstanding that, inspectors reviewed the actual roster for House 2 between 06 January 2025 and 19 May 2025 where it could be seen that staffing levels during the day time hours had increased which had a positive impact on residents. Inspectors also found that the service responded to meet the needs of a resident who required hospital care and supported them at this time.

Judgment: Not compliant

Regulation 23: Governance and management

Inspectors found that in general local level issues were being addressed by the person in charge, such as identifying staffing needs, requesting reviews of restrictive practices by the oversight committee, however the provider was failing to address these matters in a timely manner. The following was found:

- House 2 was not resourced to meet the night time needs of all residents. For example; as mentioned earlier, there was only one night out of 25 that a resident was not up during the night. This meant that residents were at risk of falls and they were not being supported with continence needs. This also meant that restrictive practices were put in place for two residents to address protection concerns at night
- The provider and person in charge had implemented systems to monitor the quality and safety of service provided to residents in the centre. However, these were not effective in appropriately reviewing restrictive practices to ensure that they were used as a last resort and for the shortest duration. For example; inspectors reviewed the provider audit from December 2024, where there was a section to review restrictive practices. This template included guiding questions, including a prompt to review three restrictions checklists. However, the audit only noted the number of restrictions in the centre and did not review if these were proportionate to the risks and about what the impact on residents were
- Protection concerns affecting residents' right to privacy and security of personal possessions were not appropriately identified and reported. This is discussed in more detail under Regulation 8: Protection
- The provider and management team failed to identify all of the restrictive practices affecting residents. For example, in one resident's rights review checklist, there were gaps in the information meaning that not all restrictions in their life were recorded. This is discussed in more detail under Regulation 7: Positive Behaviour Support
- The provider's oversight committee for rights and restrictions had not reviewed one resident's restrictions, despite the person in charge submitting it for review in 2023. This related to a restriction in place for a number of years, which was put in place as a result of the behaviour of another resident
- In addition, the audits in place failed to identify the use of some restrictive practices, and also included the use of regular medication as a chemical restraint which was not in line with the provider's policy and guidance
- Training records for one staff who worked in House 3 were not available for review to ensure that they had the required training to support the resident with their needs while working alone. This was an action from the previous HIQA inspection in April 2024 and had not been addressed.

Judgment: Not compliant

Regulation 31: Notification of incidents

Inspectors found that a protection concern that occurred on 01 May 2025 had not been submitted to the Chief Inspector as required in the regulations. This was due to the concern not being appropriately identified as protection issue for one resident. This was submitted to the Chief Inspector post inspection. However, this required ongoing monitoring and understanding of possible protection concerns to ensure that all notifications are submitted as required and followed up in line with the provider's safeguarding policy.

Judgment: Compliant

Regulation 34: Complaints procedure

Inspectors were told that there were no open complaints at the time of inspection. Inspectors observed an audit template to record and review complaints, should there be any.

The provider had prepared a written complaints policy that was available in the centre. The policy included information on advocacy, the stages of managing a complaint, and staff responsibilities. The procedure had also been prepared in an easy-to-read format using pictures to make it easier to understand. This was observed to be readily available on notice-boards for residents in the centre.

Judgment: Compliant

Quality and safety

Overall inspectors found that improvements were required to ensure that all restrictive practices were appropriately identified and assessed as to the impact on individual residents.

In addition, a protection concern was not appropriately identified and responded to due to the incident not being recognised as impacting residents' rights to privacy and security.

Despite that residents were found to receive person-centred care and support from a knowledgeable staff team. Care plans were written in a person-centred way and

reflected residents' current health, social care and personal needs. Residents were supported to do activities that were meaningful to them and they had access to leisure and recreational activities that they enjoyed.

Regulation 26: Risk management procedures

The provider had a risk and incident management policy in place that outlined the procedures for identifying, assessing, and escalating risks and incidents. Inspectors reviewed the risk assessments in place and found that risks had been appropriately identified and assessed by the person in charge. For example; a risk assessment was in place to identify the changing needs for residents in one house and to identify what control measures were required to mitigate the risk, which included waking night cover. However, as mentioned previously, the provider's response to these risks in House 2 at night time, had not been completed in a timely manner to mitigate the risks to residents. This is covered under Regulation 23: Governance and Management, with regard to ensuring that the service is appropriate to residents' needs.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

Inspectors reviewed five residents' individual plans and found that person in charge had ensured that health, personal and social care needs had been assessed and were used to inform care plans.

The plans reviewed by inspectors included health care plans, communication plans and personal and intimate care plans. They were found to be up to date, under regular review, and were readily available to guide staff practice. The plans were written using person-centred language, and described residents' individual personalities, communication preferences, interests and health care needs. Residents were also supported to identify personal goals for the future.

Staff spoken with were familiar with residents' support needs and their individual likes and preferences. Staff members were observed communicating with residents in a kind and understanding manner that supported residents' individual communication preferences.

Judgment: Compliant

Regulation 7: Positive behavioural support

Inspectors found that the identification, assessment and ongoing oversight of restrictive practices impacting residents in House 2 required significant improvements. The following was found:

- Inspectors reviewed two residents' rights checklist that were prepared for review by the oversight committee, the rights review committee (RRC). One of these did not include all of the restrictions in the resident's life, such as a sensor mat at their bedroom door and a locked cupboard in their bedroom that they required staff to open for them. This restriction had not been recognised by the provider as a restriction through their reviews
- The provider unannounced visits did not effectively review the restrictive practices in place in the centre. For example; the last provider audit completed in December 2024 only noted the number of restrictions in the centre and did not review the rationale for these and if they were used as a last resort and for the shortest duration. This demonstrated that the provider did not have sufficient oversight of restrictions used in the centre. This posed a risk to the quality and safety of the service provided to residents.
- The oversight arrangements by the provider's RRC committee was not completed in a timely manner. For example, the person in charge submitted a request for review for one resident who had a restriction in their life for many years due to the behaviour of another resident. However, these had not been reviewed by the RRC at the time of inspection (or since 2019), despite this being an action from a previous HIQA inspection and a request for this review submitted by the person in charge in April 2023
- The provider had a restrictive practice policy that outlined that certain medicines were not classed as restrictive practices; however, inspectors found that within the centre, those medicines were being recorded as chemical restraint.

Judgment: Not compliant

Regulation 8: Protection

Inspectors found that staff and management awareness of protection concerns required improvements. The following was found:

- Inspectors found through a review of care notes, that a protection concern was not identified and followed up in line with the provider's safeguarding procedures. For example, on 01 May 2025 it was noted in the daily logs that one resident went into another resident's bedroom when they were not there, and took the resident's sweets from their cupboard. This was not identified as a protection concern with inspectors told that this was due to the resident affected not being there at the time.
- Furthermore, on discussion with the local management team about this, it was found that a lock was on this resident's personal cupboard due to risks of

another resident going in to take their items. The person in charge agreed to undertake a review of the resident's care notes for 2025 to establish if this protection concern occurred on other occasions.
- A notification about a protection concern was received to the Chief Inspector in September 2024. A provider assurance was requested to provide assurances that this protection concern was being managed appropriately. The actions taken included a review of the behaviour supports for one resident and the introduction of a sensor mat for another resident. While these actions supported the protection of the resident impacted, this required further review in terms of the impact of the restriction on their life.

The provider had policies and procedures in place for the protection of residents and for the provision of intimate and personal care plans. A protection concern that occurred in September 2024 was reviewed by inspectors, and found to have been appropriately followed up in line with the safeguarding procedures. The associated safeguarding plan was found to have been discussed at a staff meeting following the incident, to ensure that all staff were aware of the actions required. Staff spoken with were knowledgeable about the actions required to protect residents.

Five intimate care plans were reviewed and found that residents were protected through guidance for staff to meet their individual personal care need and preferences. Staff were required to complete relevant safeguarding training to inform their practices and to ensure that they were able to recognise, respond to and report any safeguarding concerns

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

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

Compliance Plan for Slieve Rua Residential & Respite Services OSV-0003916

Inspection ID: MON-0047073

Date of inspection: 26/05/2025

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 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: Night-time support protocols have been developed to ensure a responsive approach to individuals who are awake during the night while roster reconfiguration is finalised. The night-time support protocols outline how to safely and effectively meet the care needs of each individual during the night. It ensures continuity of support, promotes dignity and independence, and responds to any health, behavioural, or personal care needs that may arise during the night. These will be reviewed at staff team meetings to review their effectiveness. They will also be reviewed at the Business and Governance meetings between the Person in Charge and Area Manager. The Provider has conducted a roster review for House 2, incorporating the needs of those supported together with input from staff. The updated roster, which will include waking night duty, is scheduled for implementation on 31/10/25, subject to successful recruitment. Consultation is ongoing with staff affected by the proposed roster changes, in collaboration with union representatives. Should this collaborative process not result in a workable solution, the Area Manager will engage agency support services to ensure on-site coverage, until the vacant positions are filled on a permanent basis. A review of restrictive practices commenced on 28/07/25 to ensure all measures are appropriate, proportionate, and compliant with required standards. This was conducted by members of the Rights Review Committee. Following initial findings the Area Manager, in collaboration with the Person in Charge, and relevant MDT is reviewing relevant documentation and checklists. This will be completed by 26/09/25. Updates will be reviewed at the Governance & Oversight Forum, comprising of the Head of Operations, Head of Human Resources, QSSI, the Person in Charge, and the Area Manager. These meetings will occur monthly until the compliance plan is fully implemented and will be chaired by a member of the Executive Management Team. Additional oversight will be maintained through Business and Governance meetings between the Person in Charge and Area Manager. These will be conducted on a 6 weekly basis throughout the year	

Regulation 23: Governance and management	Not Compliant

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

A Governance and Oversight Working Group has been established to ensure that all actions identified are implemented in a timely and effective manner, with appropriate support from relevant departments across the organisation. This commenced on 01/07/2025. This Governance & Oversight Forum comprises of the Head of Operations, Head of Human Resources, QSSI, the Person in Charge, and the Area Manager. These meetings will occur monthly until the compliance plan is fully implemented and will be chaired by a member of the Executive Management Team. Additional oversight will be maintained through Business and Governance meetings between the Person in Charge and Area Manager. These will be conducted on a 6-weekly basis throughout the year. Both these oversight meetings will feed into the Compliance Plan Tracker and will give oversight on how actions are progressing or identifying barriers being encountered along the way. The Executive Management Team will also have access to this tracker as required.

Night-time support protocols have been developed to ensure a responsive approach to individuals who are awake during the night while roster reconfiguration is finalised. 07/07/2025. The night-time support protocols outline how to safely and effectively meet the care needs of each individual during the night. It ensures continuity of support, promotes dignity and independence, and responds to any health, behavioural, or personal care needs that may arise during the night. These will be reviewed at staff team meeting to review their effectiveness.

The Provider has conducted a roster review for House 2, incorporating the needs of those supported together with input from staff. The updated roster, which will include waking night duty, is scheduled for implementation on 31/10/25, subject to successful recruitment. Consultation is ongoing with staff affected by the proposed roster changes, in collaboration with union representatives. Should this collaborative process not result in a workable solution, the Area Manager will engage agency support services to ensure on-site coverage, until the vacant positions are filled on a permanent basis.

Training for internal auditors to conduct provider unannounced visits took place on 22/05/2025, ensuring comprehensive oversight of the auditing process. A review of the process of provider unannounced visits took place on 01/07/2025 where feedback from the auditors and from recent HIQA inspections has been incorporated into the guidance template that is used by all auditors.

All restrictive practices in place will be reviewed by the Rights Review Committee to ensure compliance and uphold residents' rights. Organisational training on restrictive

practices took place on 02/07/2025 with Managers in Area 3, with further tailored information sharing on restrictive practices will take pace with staff team in house 2 on 22/07/25. All restrictive practices will be reviewed in accordance with organisational policies and guidelines. A review of restrictive practices commenced on 28/07/25 to ensure all measures are appropriate, proportionate, and compliant with required standards. This was conducted by members of the Rights Review Committee. Following initial findings the Area Manager, in collaboration with the Person in Charge, and relevant MDT is reviewing relevant documentation and checklists. Updates will be reviewed at the Governance & Oversight Forum, comprising of the Head of Operations, Head of Human Resources, QSSI, the Person in Charge, and the Area Manager. These meetings will occur monthly until the compliance plan is fully implemented and will be chaired by a member of the Executive Management Team. Additional oversight will be maintained through Business and Governance meetings between the Person in Charge and Area Manager. These will be conducted on a 6-weekly basis throughout the year.
Training on Risk and the Risk Register took place on 03/06/2025. This training forms part of a broader approach to strengthen oversight of risk management practices in the service.

In House 3, the PIC has ensured that staff members have been nominated and scheduled for relevant training in line with service needs. Training records for all staff will be accessible either on-site or digitally via the most up-to-date application.

A preliminary screening was submitted in accordance with organisational safeguarding policy. The PIC engaged with the Designated Officer who reviewed the information. The Designated Officer will meet with the staff team on 22/07/25 to provide an overview of Adult Safeguarding, clearly outlining staff responsibilities for reporting concerns in accordance with the established process. An overview will also be provided on the Organisations responsibility in respect of concerns raised.

The Registered Provider has established a Governance Oversight Forum for Slieve Rua; to monitor progress of all actions identified in the compliance plan; with progress reflected in the Compliance Tracker. In addition, as internal unannounced inspections identify services that require further organisational support to enhance the quality of the service, a forum will be established to oversee same.

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
The PIC has updated all rights checklists, and these have been resubmitted to the Rights Review Committee.

All restrictive practices in place will be reviewed by the Rights Review Committee to

ensure compliance and uphold residents' rights. Organisational training on restrictive practices took place on 02/07/2025 with Managers in Area 3, with further tailored information sharing on restrictive practices took place with staff team in house 2 on 22/07/25. A review of restrictive practices commenced on 28/07/25 to ensure all measures are appropriate, proportionate, and compliant with required standards. This was conducted by members of the Rights Review Committee. Following initial findings, the Area Manager, in collaboration with the Person in Charge, and relevant MDT is reviewing relevant documentation and checklists. Updates will be reviewed at the Governance & Oversight Forum and through Business and Governance meetings between the Person in Charge and Area Manager.

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
A preliminary screening was submitted in accordance with organisational safeguarding policy. The PIC engaged with the Designated Officer to review the information in conjunctions with the safeguarding team. Immediate actions identified have been completed, and the provider is continuing to work on the long-term oversight as outlined previously.

The PIC has conducted a comprehensive review of daily logs from January to May 2025 to ensure no other notifications were overlooked. This review confirmed that no further similar incidents had occurred. The notification of incidents will also be addressed at team meeting with the staff team. This will be in conjunction with Designated Officer attending the meeting on 22/07/25.

Safeguarding and the notification of incident injury reports are standing agenda items at staff meetings. The Designated Officer has attended these meetings, most recently on 22/07/25, to reinforce staff obligations regarding the reporting of all forms of abuse—suspected or otherwise—and to provide guidance on safeguarding and incident submission procedures. Daily logs will be reviewed monthly by staff, with oversight from the Person in Charge to identify any emerging patterns or issues requiring action.

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 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Not Compliant	Orange	31/10/2025
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.	Not Compliant	Orange	31/07/2025
Regulation 07(4)	The registered provider shall ensure that, where	Not Compliant	Orange	26/09/2025

	restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.			
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.	Not Compliant	Orange	31/08/2025
Regulation 07(5)(c)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation the least restrictive procedure, for the shortest duration necessary, is used.	Not Compliant	Orange	26/09/2025
Regulation 08(7)	The person in charge shall ensure that all staff receive appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse.	Substantially Compliant	Yellow	01/08/2025