



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

Issued by the Chief Inspector

Name of designated centre:	Fair Winds
Name of provider:	St Catherine's Association CLG
Address of centre:	Wicklow
Type of inspection:	Unannounced
Date of inspection:	15 July 2025
Centre ID:	OSV-0005580
Fieldwork ID:	MON-0045370

About the designated centre

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

Fair Winds is a designated centre operated by St Catherine's Association. The centre is as a large detached residential home located in County Wicklow and provides full-time residential services with a maximum capacity for three male or female residents at any one time. The current registration conditions for this centre state that only persons 18 years or older shall be accommodated at the designated centre. The centre provides residents with single bedrooms which are decorated in line with their personal tastes and interests. Communal spaces in the property include two living room spaces, a kitchen and dining area and a utility room. A garden space is located to the rear of the property. There are two separate outside cabins; a staff office and a sensory room for residents. The person in charge works in a full-time capacity and manages this designated centre and one other designated centres within St. Catherine's Association. A deputy manager also forms part of the management team alongside nurses, social care workers and social care assistants. The centre is resourced with two transport vehicles to support residents' participation in community activities.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	3
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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 15 July 2025	10:30hrs to 16:00hrs	Jennifer Deasy	Lead

What residents told us and what inspectors observed

This inspection was an unannounced inspection scheduled to review the safeguarding arrangements in the centre. The inspector assessed compliance against eight regulations as part of an adult safeguarding inspection framework. The inspector had the opportunity to meet all three of the residents who lived in this centre and with a number of staff who were on duty. The inspector also spoke with one parent of one of the residents over the phone on the day of inspection. Conversations with staff and the parent, observations of care and support and a review of documentation was used to inform decision making in respect of the safeguarding arrangements for this centre.

Overall, this inspection found that residents were in receipt of care and support from a consistent and suitably qualified staff team who knew the residents' needs and preferences well. Residents' communication systems were supported and this was effective in ensuring that residents had autonomy and freedom in their everyday life. Residents were protected from abuse and, when they required assistance with personal care, this care was provided in a manner which upheld their dignity and privacy. There had been several changes to the oversight arrangements of the centre within this regulatory cycle and this resulted in some gaps in compliance; for example, in the oversight of restrictive practices. However, these gaps were not seen to be resulting in a medium to high risk to the residents.

The designated centre is a single-storey bungalow located in County Wicklow on large grounds. It provides care and support to three adult residents with intellectual disabilities and other assessed needs. The inspector was told that these residents had lived together since they were children and had aged into adult services together. The inspector was told by staff on duty that the residents got on well together and there were no compatibility concerns.

The designated centre was large, spacious and homely. It provided sufficient space for residents to be together in communal areas or to be alone if they preferred. Each resident had their own bedroom, the inspector saw two of the residents' bedrooms and observed that these were decorated in line with their individual preferences. One bedroom was sparsely decorated and the inspector was told that this was in line with the resident's needs and preferences. Two of the residents had en-suite bathrooms and all of the residents had access to a large, communal bathroom. The bathrooms were seen to be very clean and well-maintained.

The centre provided two sitting rooms for residents to use. One of these sitting rooms was equipped with sensory equipment including a ceiling-mounted hammock, a television, sensory toys and a keyboard. The inspector observed one of the residents using the hammock throughout the day. The second sitting room provided a couch and television. Two residents were seen relaxing in the sitting room in the afternoon.

The garden of the centre provided further opportunities for recreation and relaxation. A large, wooden cabin was equipped as a multi-sensory room. It included sensory equipment such as a bubble tube, fibre optic lights and a disco ball. The garden also had a swing, basket swing, sandpit and a trampoline. Due to the hot weather, at the time of inspection, a large paddling pool had been provided for the residents.

The kitchen of the designated centre required refurbishment. The paintwork was very worn and chipped away in places. It was unsightly and could not be effectively cleaned. This was a long-standing issue in this centre. The inspector was told that plans were underway to replace the kitchen and that this was due to commence in the coming weeks.

The inspector had the opportunity to meet all three of the residents, although none communicated verbally to the inspector their views on the quality of the service. All of the residents usually availed of day services; however, on the day of inspection, two residents were unwell with mild, viral infections and so had stayed home to rest.

One of the residents was up and was seen freely using the facilities of the house. For example, throughout the morning, they used the swing in the large sitting room, the basket swing in the garden and were seen using their tablet device. They engaged with staff on duty regularly to seek their support, for example in requesting speakers to listen to music or in asking for a snack and a drink. Staff members were responsive to the resident's communication, they engaged in a positive and kind manner and supported them with their activities of daily living.

The second resident woke up at lunch time and the inspector saw that staff greeted them kindly and offered them lunch and a drink. Both of the residents who were at home on the day of inspection were provided with healthy lunches which were in line with their associated care plans. Staff were available to provide assistance and support to residents who required this with their meals. Staff were seen to provide assistance in a gentle manner. For example, one resident attempted to leave the table while they still had food in their mouth. The inspector was told that this resident was at risk of choking and so staff gently reminded the resident to stay seated until they had finished eating.

The third resident was in day services, however they returned to the centre in the afternoon. The inspector saw staff greet the resident fondly when they arrived and supported the resident to get a snack and offered them their preferred activities.

At all times, throughout the day, interactions between staff and residents were seen to be gentle, respectful and kind. The inspector met all of the staff who were on duty and spoke to three of these staff members in more detail. The staff members were informed of the governance and management arrangements of the centre and of how to escalate any concerns through these systems. They were also informed of their safeguarding roles and responsibilities and had received training in a human rights based approach to care. They described to the inspector how they ensured residents' rights to communicate were upheld. The inspector saw that staff were responsive in ensuring that damaged communication devices were repaired or

replaced quickly, so as not to impact on residents' autonomy in communication.

A parent of one of the residents spoke to the inspector over the phone. They told the inspector that their child had lived in the centre for over ten years and that they were generally very happy with the care and support provided to them. They told the inspector that many of the staff members had worked there for a long time and knew the resident's needs well. The parent reported that the staff team support the resident's communication needs very well and offer them choices so that they can direct their daily life. They reported that the centre does "a fantastic job in balancing risks and needs".

The parent also told the inspector that the provider put considerable work into ensuring the compatibility of the residents during the admissions phase. This was effective in ensuring the safety of the residents and their general quality of life while living there. The parent expressed concerns regarding wider funding limitations in particular in respect of access to publicly available clinical services; however, they said that they were satisfied with the multidisciplinary inputs that the resident was in receipt of at present.

Overall, the inspector found that residents in this centre were in receipt of a good standard of care and that they were protected from abuse. The next two sections of the report will describe the oversight arrangements of the centre and how these were effective in ensuring the quality and safety of care.

Capacity and capability

This section of the report describes the governance and management arrangements and how effective these were in ensuring that residents were safeguarded from abuse. The inspection found that residents were supported by a suitably qualified and experienced staff team who knew the residents' needs and preferences well. Overall, the governance and management arrangements were effective in ensuring the safety of care; however, there were some areas for improvement identified, in particular in respect of the maintenance of required documentation in the centre.

The designated centre was staffed by a team of nurses, social care workers and healthcare assistants. The nurses had been a recent addition to the staff complement following a roster review by the provider. It was found that the staff team had the required competencies and skills to meet the residents' needs. There was consistency of staffing which was ensuring continuity of care and the maintenance of relationships between the residents and the staff team.

Staff members spoken with were informed of the governance and management arrangements and of their safeguarding roles and responsibilities. They had received suitable safeguarding training and described the steps to be taken in the event of identifying a safeguarding concern. Staff members told the inspector that the management team were responsive and that they felt confident in escalating any

concerns.

A new person in charge had recently been appointed to oversee the delivery of care in the centre. There had been a number of changes to the person in charge role within this regulatory cycle and that had resulted in some gaps in the maintenance of required paperwork. For example, minor injuries to residents had not been notified to the Chief Inspector as required by the regulations and a restrictive practices log book was not able to be located on the day of inspection.

Some enhancements were also required to the governance and management systems at provider level. A number of policies were out of date and required review, a long-standing action to update a kitchen had not been completed in a timely manner, and the provider had not completed an annual report of the quality and safety of care for 2024. The provider had self-identified these deficits and actions to address them were underway at the time of inspection.

Regulation 15: Staffing

The provider had recently reviewed and enhanced the staffing allocations for the centre due to changes to the residents' assessed needs. For example, one resident's needs had changed which meant that they required nursing oversight of their care. The provider had recruited two staff nurses for the centre in order to meet this need.

Planned and actual rosters were maintained in the centre. These demonstrated that staffing levels were maintained at a level suitable to meet the residents' needs and to provide person-centred care and support. The inspector reviewed the rosters for June and July 2025 and saw that, across four dates examined in detail, there were sufficient staff on duty.

The schedule 2 files were not reviewed as part of this inspection.

Judgment: Compliant

Regulation 16: Training and staff development

There was generally a very high level of compliance with mandatory and refresher training which related to safeguarding in the centre. The inspector reviewed a training matrix and saw that all staff members were up to date with training in Safeguarding Vulnerable Adults and Children First. All staff had also participated in training in a Human Rights Based Approach to care.

Staff members spoken with were informed of their roles and responsibilities in respect of safeguarding. They described to the inspector how they would recognise

and report incidents of abuse and spoke to their responsibility to advocate on behalf of residents to ensure that their human rights, including their right to be safe, were upheld.

Staff members told the inspector that they felt well supported in their roles. They were aware of the management arrangements and of how to contact on-call managers if required. They reported that they were in receipt of regular formal supervision and that they discussed safeguarding at their monthly staff meetings.

The inspector reviewed the staff meeting records from April and May 2025 and saw that they discussed staff safeguarding roles and responsibilities, among other important service related issues. The inspector reviewed the most recent supervision records for two staff and saw that these provided staff members with an opportunity to raise any concerns, and also identified staff training needs.

Judgment: Compliant

Regulation 23: Governance and management

There were defined management structures in place in the centre at the time of inspection; however, there had been a number of changes to the management arrangements of the centre within this regulatory cycle, in particular to the person in charge role. This had resulted in some deficits in respect of the local oversight arrangements. For example, although minor injuries received by residents were recorded, these injuries were not reported to the Chief Inspector in line with the requirements of the regulations. A log book of restrictive practices for quarter one of 2025 was also requested on the day of inspection; however, it could not be located and made available for review on that day.

Additionally, there were a number of areas which required enhancement at the provider level. Several of the provider's policies were out of date and required review. These policies included the restrictive practices policy, the risk management policy and the positive behaviour support policy. The inspector was told that the provider was aware that these policies required updating and was in the process of reviewing them.

There was a long-standing deficit in respect of the kitchen of the designated centre. The kitchen was very worn and posed an infection prevention and control risk. It was also damaged and did not contribute to a homely aesthetic. This issue had been identified across several of the provider's audits over many years and a number of Health Information and Quality Authority (HIQA) inspections. The provider had committed to installing a new kitchen however this action was not completed in a timely manner. The inspector was told on the day of inspection that a new kitchen would be fitted before the end of August 2025 and saw contractors in the centre discussing the plans for the new kitchen with the person in charge.

The inspector reviewed the last of the two of the provider's six monthly

unannounced visits. These were seen to be very comprehensive and clearly identified deficits and areas for improvements. The audits informed an action tracker plan which detailed actions to be taken to come into compliance.

The provider had completed an annual review of the quality and safety of care for 2023; however, an annual review of 2024 had not yet been completed. The provider is required by the regulations to complete and make available an annual report of the service.

Judgment: Substantially compliant

Quality and safety

This section of the report describes the quality of the service and how safe it was for the residents who lived there. This inspection found that residents were in receipt of a good quality service which was meeting the requirements of the regulations in many areas. Improvements were required in respect of the oversight of restrictive practices and to the implementation of some care plans.

Residents in this centre were supported to exercise choice and control in their daily life and in accordance with their preferences. The activities of the centre were structured to meet residents' needs. They were supported to attend day service if they wished to do so. The centre had two vehicles to facilitate access to the community and residents enjoyed a variety of community activities in line with their preferences including horse riding, attending rugby matches and swimming.

Residents were supported by staff to communicate their wishes and preferences. There was information available in the centre to support residents to make decisions and to have choices. This ensured that residents' right to autonomy was upheld. Some residents presented with assessed needs for which restrictive practices were deemed necessary in order to meet those needs in a safe manner. Improvements were required to ensure that all restrictive practices were logged as such and the impact of these on residents' privacy was assessed.

Each resident had a personal plan which detailed their assessed needs and they also had access to multi disciplinary professionals to inform their assessed needs. However, there were gaps in personal plans, in that they did not include all of the recommendations as made by those professionals.

The residential service was seen to be homely, accessible and promoted the privacy and dignity of residents. Residents had access to their own private spaces as well as communal areas, and staff practices when delivering care were seen to uphold residents' rights to privacy and dignity.

Residents were protected from abuse and their safety was promoted. Staff had received training in safeguarding and this was a standing topic at staff meetings for

discussion. Residents in this centre had lived together for some time and appeared to get on well together. There were very few safeguarding incidents recorded for the centre. Staff members spoken with were informed of how to identify, record and respond to incidents of concern.

Regulation 10: Communication

All of the residents who lived in this centre presented with assessed communication needs. Staff members were well-informed of residents' communication systems and their support plans. There was a detailed communication support plan on each residents' file which described how residents communicated using multi-modal communication, including augmentative and alternative communication (AAC) devices, pictures, facial expression and body language.

Residents' AAC devices were charged and were readily available in the centre. Key staff had received training in these devices and the inspector, on reviewing one device, saw that the vocabulary reflected the current activities and preferences of the resident. One device had been broken the day prior to inspection and staff members had already made arrangements to have the device repaired.

Staff members told the inspector that they had also received training in Lamh, which was a sign system used by some of the residents. One staff member showed the inspector the objects of reference which were readily available and the photographs of places and food which were used to support decision making. Staff members were seen to support residents' communication throughout the day in line with residents' care plans.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The inspector reviewed all three of the residents' individual assessments and care plans. Each resident had an individual assessment which had been reviewed and updated within the past 12 months. The assessment was used to inform care plans in respect of assessed needs. Care plans were written in a person-centred manner and reflected residents' preferences in respect of their care.

Residents had access to allied healthcare professionals as required by their individual needs. Assessment reports and recommendations from these professionals were available on residents' files; however, these assessments and recommendations were not consistently used to inform relevant care plans. For example, the inspector saw that some residents had received a physiotherapy assessment which recommended a foot desensitisation programme. There was no associated care plan available for this need. The person in charge told the inspector

that this programme had been attempted with the resident but that they had declined it. There was no available record of the programme being offered or evidence that it had been therefore referred back to the professional for review.

Other assessments made specific recommendations; for example an occupational therapy assessment recommended a weighted blanket, weighted back pack and regular input from occupational therapy and speech and language therapy. Some of these recommendations had been implemented while others had not.

Improvements were required to ensure that care plans clearly detailed supports, as recommended by multi disciplinary professionals, to meet each assessed need. Enhancements were also required to ensure that recommendations were consistently implemented, and if not, that the rationale for this was recorded, care plans were updated and that residents were referred back to the multi disciplinary professional for review if required.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

A number of key policies relating to positive behaviour support were out of date and required review. The provider's positive behaviour support policy was last updated in August 2015 and the restrictive practices policy was updated in 2019. All Schedule 5 policies are required to be updated at least every three years as defined by the regulations. The inspector was told that these policies were under review at the time of the inspection.

Residents' files each had an up-to-date positive behaviour support plan which was informed by a relevant multi disciplinary professional. These plans detailed proactive and reactive strategies to assist residents with managing behaviours of concern.

Known restrictive practices had been reviewed and approved by the provider's restrictive practices committee; for example, a locked cupboard had been reviewed and approved in January 2025. However, the inspector identified other restrictive practices which had not been identified as such. These included a locked entrance gate to the property and nightly checks on residents. While checks were completed to ensure the safety of some residents, due to their assessed healthcare needs, the potential impact of these on residents' rights to privacy had not been assessed.

The record keeping in respect of restrictive practices also required improvement. The inspector wished to review a restrictive practice which had been reported to the Chief Inspector in quarter one of 2025; however, the log book for this quarter was not available in the centre during the inspection.

Judgment: Substantially compliant

Regulation 8: Protection

All staff in this centre were up to date in training in Safeguarding Vulnerable Adults and Children First. Staff members spoken with were well-informed of their safeguarding roles and responsibilities. They described to the inspector how they would identify and report incidents of abuse and what steps would be taken to safeguard the wellbeing of residents.

The provider had in place up-to-date policies in respect of safeguarding and intimate care. Staff were informed of these policies. Safeguarding was discussed at staff meetings and staff members were reminded of the procedures for reporting safeguarding concerns.

The inspector reviewed the three individual assessment and care plans for the residents. Each resident had an intimate care plan which clearly detailed their preferences in respect of their care, and also detailed steps on how staff should ensure residents' dignity, privacy and autonomy in the delivery of intimate care.

Judgment: Compliant

Regulation 9: Residents' rights

The designated centre was being operated in a manner which was upholding residents' rights. Staff had received training in a human rights based approach to care and clearly described to the inspector how they ensured that residents had freedom in their everyday lives and autonomy in decision making. Staff members told the inspector how they watch for residents' non-verbal communication to determine their preferences and also advocate for residents when required.

The inspector saw that staff members communicated with residents in a respectful manner and that they used communication supports to empower residents to make decisions. Information was provided to residents in a format suitable to meet their communication needs and enable them to make choices.

Residents' privacy and dignity was upheld in respect of their personal and living space and their intimate and personal care.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Substantially compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Fair Winds OSV-0005580

Inspection ID: MON-0045370

Date of inspection: 15/07/2025

Introduction and instruction

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

This document is divided into two sections:

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

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

A finding of:

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: 1. The Registered Provider has implemented a Minor Injuries Log to capture top-line details of all minor injuries on a monthly basis. The Minor Injuries Log captures injury details from all adverse events, accidents, and/or unobserved injury occurrences. Moving forward the Minor Injury Log will form the basis of quarterly reporting to the Regulator. The Person-In-Charge will have overall responsibility for maintaining the Minor Injury Log, and ensuring the appropriate paperwork, as per St Catherine's policy, procedures and guidelines, is completed for all minor injuries. St. Catherine's will implement the Minor Injury Log from 1st July onwards, and it will form the basis for quarterly reporting in Quarter 3 no later than 31st October 2025. 2. The Restrictive Practice is currently under review with the St Catherine's Audit and Risk Board Committee. Policy review will be completed on or before 31st December 2025. 3. The Quality Safety and Risk Management Policy is currently under review with the St Catherine's Audit and Risk Board Committee. Policy review will be completed on or before 31st December 2025. 4. The Positive Behaviour Support policy is currently under review with the St Catherine's Senior Management Team. Policy review will be completed on or before 31st January 2026. 5. Planned upgrade works on the kitchen commenced on 5th August 2025. All upgrade works were completed on 7th August 2025. Upgrade works included; new kitchen cabinetry, and new kitchen countertops. All upgrade works are IPC compliant. 6. The registered provider is currently in process of completing an annual review of the quality and safety of care and support in the designated centre for 2024. This review will be completed no later than 31st October 2025.	

Regulation 5: Individual assessment and personal plan	Substantially Compliant
Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan: 1. All policy deficits have been addressed noted under Regulation 23 corrective response. 2. The Person-In-Charge will conduct a full review of all resident's Personal Plans, and cross-reference with the latest multi-disciplinary recommendations available for each. The Person-In-Charge will create a report detailing deficits for discussion with to the Head of Operations. The report will document the following; a. Clinical reports / recommendations per resident; incl. review dates b. Recommendations in place, and evidence of tracking / progress c. Recommendations attempted but no longer in use, and rationale for change incl. referral back to clinician where necessary d. A review schedule for all care plans ensuring updates are completed on an annual basis, or sooner as required, incl. when new updated recommendations are received. 3. The Person-In-Charge will delegate identified work to the relevant key-worker for completion. All delegated tasks will be time-bound. Once complete, updates will be circulated to the staff team, and tabled for discussion at the next team meeting. All updates to care plans will be completed on or before 30th September 2025.	
Regulation 7: Positive behavioural support	Substantially Compliant
Outline how you are going to come into compliance with Regulation 7: Positive behavioural support: 1. All policy deficits have been addressed noted under Regulation 23 corrective response. 2. The registered provider commits to completing a full and comprehensive restrictive practice review within St Catherine's DCDs to identify all restrictive practices in use across DCD's no later than 30th September 2025. a. Once a baseline is established, it will form part of the policy review to identify a non-exhaustive list of restrictions in use across the organisation. b. The registered provider will ensure that the organisational restrictive practices log is reviewed against this review, and updated where necessary, no later than 31st October 2025. c. Where required, restrictive practices will be referred, by the local Person-In-Charge, to the St Catherine's Right Review Committee for assessment, both ensuring provider level oversight of all restrictive practices, and timely review of all restrictive practices, in use in St Catherine's. d. The quarter notifications will be reviewed, and updated, to ensure all restrictive practices are reported to the Regulatory in a timely, and transparent, manner. e. Local recording of restrictive practices will be enhanced to ensure, where	

implemented, restrictions are for the shortest duration and that they were the least restrictive.

3. The Person-In-Charge will complete Rights Review Forms for submission to the St Catherine's Rights Review Committee for restrictions identified during inspection no later than 30th September 2025. Referrals to include;

- a. Restricted access to the property; i.e. electric gates
- b. Night checks on residents

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Substantially Compliant	Yellow	31/10/2025
Regulation 23(1)(d)	The registered provider shall ensure that there is an annual review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards.	Substantially Compliant	Yellow	31/10/2025
Regulation 05(6)(a)	The person in charge shall ensure that the personal plan is the subject of a review, carried out	Substantially Compliant	Yellow	30/09/2025

	annually or more frequently if there is a change in needs or circumstances, which review shall be multidisciplinary.			
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.	Substantially Compliant	Yellow	30/09/2025
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 changes in circumstances and new developments.	Substantially Compliant	Yellow	30/09/2025
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used,	Substantially Compliant	Yellow	31/01/2026

	such procedures are applied in accordance with national policy and evidence based practice.			
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