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:	Saol Beo
Name of provider:	Positive Futures: Achieving Dreams. Transforming Lives. Company Limited by Guarantee
Address of centre:	Leitrim
Type of inspection:	Unannounced
Date of inspection:	19 August 2025
Centre ID:	OSV-0005696
Fieldwork ID:	MON-0047575

About the designated centre

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

Saol Beo is a full time residential service, which is run by Positive Futures. The centre can accommodate three male or female adults over the age of 18 years, with an intellectual disability. The centre comprises of one bungalow located in a residential area on the outskirts of a busy town with access to amenities such as cafes, shops and religious services. Residents have their own bedrooms, a shared kitchen and dining area, bathroom, utility and sitting room. Residents also have access to a garden area which is wheelchair accessible. The staff team comprises of nursing staff and support workers. Waking night support is provided.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	3

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 19 August 2025	09:00hrs to 17:30hrs	Úna McDermott	Lead

What residents told us and what inspectors observed

This was an unannounced risk based inspection. It was completed in order to monitor compliance with the Care and Support of Residents in Designated Centres for Persons with Disabilities Regulations (2013) and in response to an upward trend in solicited information received by the Chief Inspector of Social Services. It was completed over one day and during this time the inspector met with all three residents and with four staff.

The inspector found that the residents at Saol Beo were happy and content. They were provided with good quality care and support by the staff team and were supported to spend time with their families and to access their community. There was a change in the support needs of some residents since the previous inspection and the provider had identified issues with interpersonal compatibility. While some actions were taken by the provider to address these matters, the inspector found that not all safeguarding processes used were protecting residents from harm. In addition, non compliant finding were enacted under Regulation 31 as there were concerns relating to the submission of statutory notifications and in Regulation 4 as not all policies to guide staff were reviewed in line with the requirements of the regulation.

The inspector spent time with all three residents at the centre. One resident was finishing their breakfast at the table. The inspector noted that they appeared well and the staff on duty agreed, telling the inspector that there was an improvement in their wellbeing due to the actions taken following a fall and a medical review. They requested that the inspector complete an activity with them and they smiled and used some words from time to time. The second resident was preparing for their day. It was clear that they had a specific routine which was important to them. When asked by a staff member, they demonstrated agreement for the inspector to visit their room. They accompanied the inspector to their bedroom which was cosy, comfortable and cheerfully decorated. After a short period, it was clear that they wanted to close their bedroom door and this was respected. Later, they were observed making a cup of coffee with staff support. They got milk from the fridge for the inspector and sat for a while at the table. The third resident also came to the table. While they presented as cheerful and chatty, the inspector noted a change in the facial expression of another resident. They appeared to frown, rose from their seat nearby and left the kitchen. Overall, the residents were observed as well and while it was a very busy house on the morning of inspection, the staff on duty ensured that the atmosphere was as calm as possible.

As outlined, the inspector met with four staff members. All staff noted that the needs of the residents were changing. They said that there were issues with interpersonal compatibility and risks of peer to peer abuse which were compounded by the limited space available in the house. The inspector completed a walk around of the property and while it provided a pleasant home which was kept in a good state of repair, the arrangements for communal and private space was limited.

There was one sitting room which one resident like to sit in. This meant that other residents were required to use the combined kitchen dining area to relax.

The next two sections of this report present the findings of this inspection in relation to the governance and management arrangements in place in the centre and how these arrangements impacted on the quality and safety of the service being delivered to each resident living in the centre.

Capacity and capability

While there were some good governance systems in place at the centre, the inspector was not assured by the safeguarding processes used. In addition, there were concerns relating to the timely review of the Schedule 5 policies provided to guide staff, and concerns in relation to the timely submission of statutory notifications to the Chief Inspector.

The person in charge had changed since the last inspection. Staff told the inspector that they were regularly present at the centre and supportive. Adequate staffing levels were in place at the time of inspection and staff training was up to date. The service was well resourced with staff, equipment, transport and other required resources.

While the provider had a schedule of routine audits and unannounced visits, these arrangements required strengthening to ensure that they were fit for purpose and influenced positive change.

Regulation 14: Persons in charge

This centre had a change in person in charge since the last inspection. The inspector found that the person in charge was employed full-time, they were skilled and experienced and had a competent understanding of the regulatory requirements of their role.

Judgment: Compliant

Regulation 15: Staffing

The provider ensured that there were enough staff with the right skills, qualifications and experience to meet the assessed needs of the residents living at the centre. A review of the planned and actual rotas found that while there were staff shortages

in past, that this was recently resolved. Staff spoken with agreed that there were sufficient trained consistent staff employed at the time of inspection with two additional staff due to commence in the role of support worker.

The role of the person in charge was supported by a deputy service manager. They met with the inspector and competently described how they supported the person in charge and the staffing structure. The inspector found that they had a good understanding of the needs of the residents and the service. The staff team consisted of support workers and those met on the day of inspection had worked in the service for a number of years. They were supported by a panel of relief staff who were also described as familiar with the residents and an agency staff member who was regularly available to support the service.

An on-call service supported the staff team during out of hours periods and at weekends. This was reported to work well. Overall, the inspector found that consistency of care and support was provided and this enhanced the day-to-day lived experiences of residents living at the centre.

Judgment: Compliant

Regulation 16: Training and staff development

The inspector reviewed the training matrix which recorded staff training events. This information was stored on a electronic system and the inspector found that it was well maintained and subject to regular review.

A review of a sample of training modules which had particular relevance to the service found that they were up-to-date. This included fire training, training in safeguarding and protection and training in positive behaviour support. Where modules were due for completion, there was a reason for this, such as staff leave.

Staff were supported with one to one supervision meetings with the person in charge. These were taking place on a regular basis and a sample of three supervision records reviewed found they were completed in line with the provider's policy.

Judgment: Compliant

Regulation 23: Governance and management

The inspector found good governance arrangement as service level as demonstrated on the day of inspection. The deputy service manager facilitated the first part of the inspection with competence until the person in charge arrived. They both demonstrated a good knowledge of the residents and their assessed needs. In

addition, they had a good awareness of the operational risks at the service as outlined.

While the centre had space limitations, it was well resourced and the inspector found that residents had what they needed. This included two vehicles, adapted equipment if required and there were sufficient numbers of trained staff to support their needs.

At centre level, the provider had an audit schedule. This included a range of weekly, monthly and quarterly audits. A review of a sample of these completed by the inspector found that they were well maintained and up to date.

At service level, the annual review of care and support was completed in September 2024. When asked, the person in charge told the inspector that the unannounced six-monthly provider-led audit had taken place in July, however, the inspector found that the report was not yet available for review. The inspector requested the previous six-monthly audit recommendations, however, this was not available either. A copy of the July audit (7 July 2025) was forwarded to the inspector following the inspection. While this did not pose a medium or high risk to the care and support of the residents at the centre, a review of the systems for documentation management was required to ensure that up to date and current information was available to inform the service improvement plan.

As outlined there were compatibility issues arising at the centre which were impacting on the day-to-day lived experience of the residents. While the provider had escalated the compatibility risks, the compatibility assessment had not been updated since 10 September 2023, which meant that the information was not current. In addition, while actions to address the issue were ongoing, a documented solution focused plan was required to strengthen the process and resolve the issues arising.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

A review of incidents occurring at the centre found that not all notifiable incidents were submitted to the Chief Inspector of Social Services in line with requirements of this regulation. For example, a notification relating to an incident reported in February 2025 was not reported within the three day reporting requirement.

In addition, some details recorded on incident records did not match the information submitted in the notification to the Chief Inspector. For example; an incident report completed in October 2024 was reviewed by the inspector. They noted that the incident report form documented that a resident was scratched by their peer, however, on the notification form the information provider referred to a tap to the arm.

Judgment: Not compliant

Regulation 4: Written policies and procedures

A review of the Schedule 5 policies, procedures and guidelines found that not all were reviewed as required by the Chief Inspector and therefore were not in date. For example; over three years had passed since the policy on nutrition intake for residents and the policy on provision of information to residents were last reviewed.

Judgment: Not compliant

Quality and safety

The care and support provided by the staff of the centre was of good quality, however improvements in safeguarding and protection and the overall management of compatibility risks were required in order to ensure the service was safe.

From observations made and documentation reviewed, the inspector found that residents had active lives in their communities and their healthcare needs were well looked after. Multi-disciplinary supports were provided if required.

While the premise provided was cosy and welcoming, the footprint of the service required review in order to ensure that it met with the changing needs of the residents, respected their rights and alleviated compatibility risks.

Regulation 17: Premises

The inspector found that Saol Beo provided a warm and welcoming home for the three residents living there. It was clean, tidy and in a good state of repair. It was cheerfully decorated with items of personal interest displayed for the residents. Residents had their own bedrooms, one of which was en-suite.

However, from a review of the documentation and from conversations with staff, it was clear that the needs of the residents were changing and the provider had identified that additional space was required. For example; there was one sitting room which meant that if one resident was using that room, others were required to go to their bedrooms to relax, or to sit at the dining table which was located in the kitchen. In addition, if a resident had visitors, it was not always possible to provide a space where residents and their families could spend time together in private.

When discussed with the person in charge and the person participating in management, they said that ongoing discussions were taking place with the owner of the property and their service funder in order to assess the options available. While this was helpful, a comprehensive action based plan was required in order to guide discussion and make improvements to ensure that adequate private and communal accommodation was available to meet with residents' changing needs.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

The provider had governance arrangements for the assessment, control and prevention of risks arising at the centre, including a system to respond to emergencies. However, a review of risk management documentation systems found that they required strengthening.

The inspector reviewed a health and safety folder which was at the designated centre. It had a safety policy statement (30 June 2026) and an up to date venue risk assessment (13 August 2025). This documented service level risks such as the risk of fire, moving and handling risks and falls risks.

In addition, residents had individual person centred risk assessments which identified a range of risks and the associated control measures used. For example, a resident who was at risk of falls had a medical review following a significant fall in May 2024. This identified links to the resident's medical presentation which were addressed through the use of prescribed medicines and a weight management programme. This was reported to work very well and as outlined, the resident was observed to be well and happy on the day of inspection.

However, a review of other assessments found that they required review in order to ensure that the control measures used were clearly documented under the risk identified. For example; a resident at risk of epileptic seizures had an audio monitor in their bedroom. This was not documented as a control measure on their risk assessment.

In addition, while compatibility risks were identified on some risk assessments, they required review to ensure that compatibility risks were clearly documented, adequately risk rated and that a comprehensive plan was in place to manage them in the longer term.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Residents had comprehensive assessments of their health, personal and social care needs which were documented clearly and available to guide staff.

The inspector reviewed two of three residents' folders. These included information on how best to support the resident and a range of goals, which were known as 'hopes and dreams'. These included home and community based activities which residents were reported to enjoy and longer term plans such as planning overnight trips. One resident enjoyed a trip away recently, where they stayed in a hotel and were reported to enjoy a music event. Another trip involved an overnight near a beach where the resident had the opportunity to use a beach wheelchair so that they could go on the sand, which they had not had the chance to do before.

The inspector observed the activities taking place at the centre on the day of inspection and found that resident's were supported with their wishes. Some enjoyed nail painting and colouring at home. Later they were observed leaving the centre to go to a tennis activity and have lunch. Overall, it was clear that residents were supported to enjoy active lives at home and in their community.

Judgment: Compliant

Regulation 6: Health care

The person in charge ensured that residents had the support of a range of health and wellbeing professionals in line with their assessed needs. Where medical treatment was recommended and agreed by the resident and/or their representatives, it was facilitated.

Access to a local general practitioner (GP) was provided. In addition, residents had the support of allied health professionals if required. For example; following a fall, a resident had the support of occupational therapy and physiotherapy. Risks were reviewed and additional aides and appliances were provided such as a new bed and accessible bathroom equipment. This meant that the resident had a circle of support to assist them to return to best possible health.

Where consultant-led care was recommended, this was provided. Residents attended neurology, urology and mental health supports as required.

Judgment: Compliant

Regulation 7: Positive behavioural support

The person in charge had ensured that staff had up to date knowledge, skills and understanding of how to support residents with behaviours of concern. The

inspector reviewed the training matrix and found that relevant modules were up to date.

Residents had assessments of their behaviour support needs if required. These were documented on care plans or if warranted, formal behaviour support plans were used. There was one such plan used at this centre at the time of inspection. This was linked to the compatibility issues arising at the centre.

A review of the documentation completed by the inspector found that where issues arose these were assessed and action was taken. For example; due to an increase in peer to peer incidents occurring, a residents positive behaviour support arrangements were reviewed. This was completed by a positive behaviour support specialist who completed on site observations and updated the associated documentation in order to guide staff (July 2025). In addition, an bespoke training event was due to take place at the designated centre at the end of the month.

Some restrictive practices were used. These related to the use of audio monitors to control risks relating to epilepsy. Staff told the inspector that the monitors were used only as required and for the shortest duration necessary. A log was in place which was reviewed by the inspector. A review of a risk assessment found that one resident had not had a seizure for over twenty five years. The person in charge told the inspector that they sought a medical review of the use of this restriction with a view to removing it. This was ongoing and will be addressed under Regulation 26 Risk Management below.

Judgment: Compliant

Regulation 8: Protection

The inspector was not assured by the standard of safeguarding practices at this centre and therefore was not assured that residents were protected from abuse. While staff had training and knowledge in relation to safeguarding and were aware of what to do if required, the inspector found that incidents, allegations or suspicions of abuse were not always appropriately investigated in line with the provider's policy and national safeguarding requirements.

A review of documentation found that a safeguarding concern was reported to the provider on 26 February 2025, however, it was not acknowledged as such until some time later. For example, on 13 March 2025 the person participating in management visited the centre to assess the welfare of the resident and on 30 April 2025 a notification outlining a suspicion of psychological abuse was submitted for the attention of the Chief Inspector.This meant that there was a delay in putting measure in place to reduce the risk of harms to residents and was not in line with the provider's safeguarding policy (9 June 2023).

In addition, there was an upward trend in safeguarding incidents occurring in the centre which related to compatibility of residents as previously described. The

inspector completed a review of the safeguarding documentation held at the centre, at the provider's office and on the electronic information sharing system. This found that formal safeguarding plans to guide staff on how to ensure residents were safe from harm were not available in three of the five instances reviewed. This was not in line with local or national safeguarding policy.

Judgment: Not compliant

Regulation 9: Residents' rights

In the main, the provider had arrangements in place to ensure that a person centred service was provided to the residents living at Saol Beo which respected their human rights. However, ongoing work was required in order to ensure that all residents had peaceful enjoyment of their home and the freedom to access all rooms in their house as they wished.

Rights promoting activities at the centre included weekly residents' meetings where residents made choices about their day to day lives at the centre. If residents did not wish to engage in pre-planned activities their right to decline was respected. A review of the roster completed by the inspector found sufficient staff were available to support residents with activities of their choices.

As outlined throughout this report, the provider was managing complex interpersonal compatibility issues at the centre. These impacted on the residents living at Saol Beo. Some were described as upset at time and to request to go to their bedroom or to leave their home on the transport provided.

In addition, one resident was supported to have their meals in the sitting room at times in order to manage compatibility issues in the space provided. While staff told the inspector that they sought consent from the resident for this to happen, the inspector was not assured that this was informed fully as the residents was observed and described as a sociable person that enjoyed the company of others. When this resident was in the sitting room, staff told the inspector that it was best if others did not use the same space unless carefully supervised. As there was only one sitting room, this meant that other remained in the shared kitchen dining room.

The provider was aware of this impact and had put a number of actions in place such risk assessments and behaviour support guidance. In addition, they were working with the Health Service Executive (HSE) to assess the living requirements for all residents. However, at the time of inspection this was an ongoing situation and not yet resolved. While the actions taken showed that the provider was responding to the situation further work was required in order to reach full resolution.

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 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 4: Written policies and procedures	Not compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Saol Beo OSV-0005696

Inspection ID: MON-0047575

Date of inspection: 19/08/2025

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: Action 1: By 31.10.25 Operations Manager will conduct a comprehensive review of systems for documentation management, including monitoring systems, to ensure all reports are readily accessible at all times. Action 2: By 31.10.25 a dedicated workshop will be delivered by the Operations Director to Operations Managers, PPIMs, and PICs to ensure comprehensive understanding of regulatory compliance requirements. The session will place particular emphasis on governance, management responsibilities, and monitoring expectations, reinforcing best practice and accountability across all operational levels to ensure robust monitoring. Action 3: The PBS Specialist will conduct a comprehensive review of the compatibility assessment to ensure all information is current, accurate, and reflective of the individual's needs and support requirements. Action 4: By 30 November 2025, the action plan addressing housing solutions and compatibility issues will be reviewed and formally agreed with the HSE. This collaborative approach aims to ensure a comprehensive housing strategy is in place that effectively meets the individual needs of each of the three people supported.	
Regulation 31: Notification of incidents	Not Compliant
Outline how you are going to come into compliance with Regulation 31: Notification of incidents:	

Action 5: A dedicated workshop will be delivered on 31.10.25 by the Operations Director to Operations Managers, PPIMs, and PICs to ensure comprehensive understanding of regulatory compliance requirements. The session will place particular emphasis on governance, management responsibilities, and monitoring expectations, reinforcing best practice and accountability across all operational levels to ensure robust monitoring and completion of notifications.

Regulation 4: Written policies and procedures	Not Compliant
Outline how you are going to come into compliance with Regulation 4: Written policies and procedures: Action 6: A review of all policies has commenced, and a schedule put in place to ensure all out of date policies will be reviewed by 30.11.25.	
Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: Please refer to actions 2 and 3 regarding the compatibility and housing issues. These actions will ensure the needs of the people we support are assessed, reviewed and an action plan agreed to support resolution of the assessed need.	
Regulation 26: Risk management procedures	Substantially Compliant
Outline how you are going to come into compliance with Regulation 26: Risk management procedures: Action 7: By 31.10.25 undertake a comprehensive review of both the venue and the individual person-centred risk assessments currently in place. This process will ensure that all identified risks continue to be relevant, appropriately mitigated, and aligned with best practice standards for safety and support. Action 8: By 31.10.25 The Service Manager will undertake a comprehensive review of the Person Centred Portfolio (Care Plan). This review will ensure that all protocols are fully in	

place, robustly detailed, and reflect the most current and accurate information to best support the individual and best practice.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
Action 9: By 31.10.25 conduct a thorough review of safeguarding practices within the service to ensure all measures are effective, up to date, and aligned with current regulatory standards. This review will help identify any gaps, reinforce best practice, and strengthen the protection and wellbeing of the person we support.

Action 10: By 31.10.25 The Service manager will conduct a comprehensive review of all safeguarding plans to ensure they are in place for every resident with a safeguarding concern, that they are accessible to all staff at all times, are completed to the required standard and that they reflect current risks and control measures.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
Action 11: The Service Manager to review the Person-Centred Portfolio to ensure there is clear documentation of the resident's informed choice to eat in the sitting room. A decision-making tool will be implemented, and visual supports will be explored to facilitate daily choice-making. This will ensure the residents' preferences are respected and that consent is clearly evidenced.

Please refer to actions 2 and 3 regarding the compatibility and housing issues. These actions will ensure the needs of the people we support are assessed, reviewed and an action plan agreed to support resolution of the assessed need.

Please also refer to Actions 7, 8 and 10 that will ensure the assessed needs, risks and the rights of the people we support are fully reviewed and documented within the PCPs (Care Plans) for each of the 3 people we support.

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 17(1)(a)	The registered provider shall ensure the premises of the designated centre are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.	Substantially Compliant	Yellow	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.	Substantially Compliant	Yellow	30/11/2025
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre	Substantially Compliant	Yellow	31/10/2025

	for the assessment, management and ongoing review of risk, including a system for responding to emergencies.			
Regulation 31(1)(f)	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 allegation, suspected or confirmed, of abuse of any resident.	Not Compliant	Orange	31/10/2025
Regulation 04(3)	The registered provider shall review the policies and procedures referred to in paragraph (1) as often as the chief inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.	Not Compliant	Orange	30/11/2025
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	31/10/2025
Regulation 09(2)(b)	The registered provider shall ensure that each resident, in accordance with	Substantially Compliant	Yellow	31/10/2025

	his or her wishes, age and the nature of his or her disability has the freedom to exercise choice and control in his or her daily life.			