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:	The Meadows
Name of provider:	Resilience Healthcare Limited
Address of centre:	Cork
Type of inspection:	Unannounced
Date of inspection:	13 October 2025
Centre ID:	OSV-0005734
Fieldwork ID:	MON-0048449

About the designated centre

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

The Meadows is a two storey-house located in a rural area but within short driving distance to a nearby town. The centre can provide a full-time residential service or shared for up to four residents of both genders between the ages of 18 and 65 with Autism, intellectual disabilities and physical/sensory needs. Support to the residents is provided by the person in charge, a team leader and social care support staff. Each resident has their own bedroom with one resident having their own individual apartment within the layout of the house. Other rooms in the centre include bathrooms, sitting rooms and kitchen areas.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	4

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 13 October 2025	09:35hrs to 17:30hrs	Deirdre Duggan	Lead

What residents told us and what inspectors observed

From the evidence viewed during this inspection, there were good indications that the individuals living in this centre enjoyed good quality person centred services, tailored to their individual needs and preferences. Local management systems in place in the centre were contributing to safe and effective services. While overall, there was evidence of a good rights based culture in the centre, some issues were identified in relation to consultation with residents.

The centre comprises a large detached two-storey house. This was subdivided into a main three bedroom unit and an interconnected annex apartment space. The main house provides accommodation to three individuals, each with their own sitting/living room area and bedroom and one individual is accommodated in the apartment, which has it's own entrance and apartment area, as well as an interconnecting door to the main house. There is large secure garden areas available to the individuals living there and the centre is located in a rural area with pleasant views. There was some outdoor recreation equipment available to residents if desired. As noted on previous inspections, the centre was spacious, homely, and bright and laid out to suit the needs of the individuals that lived there.

This centre was fully occupied at the time of this inspection, providing accommodation to four young adults, both male and female who in the years before had transitioned into adulthood while living in the centre. Shortly after the inspectors arrival, the residents departed on planned breaks and the inspector was told that works were commencing that day to upgrade some areas of the centre, such as flooring, while residents were away and would not be impacted.

The inspector had an opportunity to meet briefly with two of the residents of this centre prior to their departure and both appeared to be looking forward to their break away. Residents were departing for two different locations. The inspector saw that arrangements had been made to ensure that residents were fully supported by their familiar staff team while away and that consideration had been given into the type of environments that they preferred and compatibility between residents when selecting suitable holiday locations. However, there was limited evidence to demonstrate that all residents had been fully consulted with about these arrangements and this will be discussed under Regulation 9: Residents' rights.

Residents' information and discussion with the person in charge and team leader indicated that residents were very active in this centre and left the centre regularly to access community based activity and recreation. Some residents were supported with home visits and had overnight stays with their families. One resident enjoyed a break away on a regular and scheduled basis as per their own wishes and preferences.

The inspector did not have an opportunity to meet with or speak with family members during this inspection. However, four responses to a satisfaction

questionnaire completed by family members as part of the most recent annual review completed in early 2025 were reviewed. These provided generally positive feedback from family members about the service their relatives received. Some comments were noted in relation to the staff turnover in the centre and a spike in safeguarding incidents that had occurred for a period prior to the annual review being completed.

Overall, this inspection found that there was evidence of very good compliance with the regulations and that this indicated that residents were being afforded safe services that met their assessed needs. The next two sections of the 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.

Capacity and capability

The findings of this inspection showed that the management systems in place in this centre were ensuring that good quality services, safe and effective services were being provided to residents. This inspection found good compliance with the regulations. This was an unannounced adult safeguarding inspection.

The previous inspection of this centre took place in October 2023. Since then, a provider assurance report had been requested and submitted in respect of an allegation of an incident of concern that had been notified to the Chief Inspector by the Chief Inspector. This response set out numerous actions taken by the provider in response to this allegation to ensure that residents were protected in the centre.

Documentation reviewed during the inspection included resident information, safeguarding documentation, the annual review, the report of the unannounced six-monthly provider visit, audit schedule and incident reports. There was evidence that the provider was identifying issues and taking action in response to them and that ongoing consideration was being given to safeguarding residents in this centre.

There was a clear management structure present and there was evidence that the management of this centre were maintaining good oversight and maintained a strong presence in the centre. The person in charge reported to a regional manager, who was a named person participating in the management of the centre (PPIM). The regional manager reported to the Director of Social Care, who in return reported to a Chief Executive Officer (CEO) and a Board of Directors.

The person in charge had a remit over another two designated centres at the time of this inspection following a recent increase in remit. The inspector was told that this remit would be reducing again in January 2026 to two centres. The person in charge told the inspector that they were supported in their role by team leaders in

each centre and had no concerns about their capacity to maintain oversight in this centre.

The person in charge and team leader both made themselves available on the day of this unannounced inspection and facilitated the inspection. These individuals were seen to be very familiar with the assessed needs of residents and knowledgeable about care and support residents required in the centre. Due to the residents departing on planned breaks, the inspector did not have an opportunity to meet at length with all staff working in the centre. The team leader facilitated a staff member to meet with the inspector for a period prior to the residents' departure. This individual was very familiar with residents' needs and preferences and reported that they were well supported by the management structures in the centre.

Management systems in place including provider policies and procedures and audit systems were seen to be in place to identify and respond to any issues that arose in the centre as will be detailed under the next sections of this report.

The centre was seen to be adequately resourced at the time of this inspection and staffing levels and competencies were seen to provide for a good quality and personalised service. The training needs of staff were being appropriately considered and all staff had completed training in the area of safeguarding.

In summary, this inspection found that there was evidence of good compliance with the regulations in this centre and the findings of this inspection indicated that residents were being afforded safe and person centred services. The next section of the report will reflect how the management systems in place were contributing to the quality and safety of the service being provided in this designated centre.

Regulation 15: Staffing

The number, qualifications and skill mix of staff in the centre was seen to be appropriate to the assessed needs and size and layout of the centre. There was a planned and actual roster maintained in the centre and continuity of care and support was provided to the residents. Some further assurances were requested and provided in relation to the information specified in Schedule 2 in respect of staff.

The inspector reviewed a sample of five weeks planned and actual rosters and saw that staffing levels were sufficient to provide for safe and effective services. The staff team consisted of a team leader and social care support staff. Three residents were assessed as requiring 2:1 supports one resident was supported with 1:1 staffing by day in the centre. One residents had day service staff provided by another organisation most days. Rosters reviewed showed that generally six to seven staff were available to residents by day depending on the availability of day service staff. At night two waking staff provided supports. On occasion sleepover staff would provide supports to cover unexpected leave or absences if it was not possible to staff this with a waking staff member. A team leader provided support to the person in charge in maintaining oversight, while also providing assistance to the

staff team with direct support duties. This individual was rostered to work Monday-Friday. On the day of this inspection, a team leader was present and was supporting staff and residents to prepare for a planned break away and was seen to complete medication counts and checks with staff prior to residents departing.

The local management spoken with, consisting of the person in charge and a team leader, reported some recent turnover among the staff team and told the inspector that two staff had recently departed and two more had been recruited and were due to join the team in the coming weeks. These were the only vacancies reported. Rosters indicated that efforts were made to ensure that familiar staff worked with residents at all times. For example, a sample of shifts reviewed showed that these were staffed by permanent staff with regular relief staff identified to fill any gaps. The inspector was told by the person in charge that no agency staff were employed in the centre. The inspector was told about and saw that there were some occasions where staffing levels were not at optimum levels. There was no evidence that this has impacted on residents and safe staffing levels had been maintained. A risk assessment in relation to staffing was regularly updated and set out the minimum safe staffing levels in the centre.

A sample of the documentation held in respect of four staff was reviewed. While overall, this showed that the required information as under the Regulations was in place, some information was not fully complete. For example, the employment history of one staff member did not indicate if gaps in employment had been verified and accounted for. The person in charge subsequently provided assurances by way of a letter from the providers' human resources business partner with the provider confirming that all gaps in employment history had been reviewed and verified by the talent acquisition team.

Judgment: Compliant

Regulation 16: Training and staff development

This inspection found that this service supports staff to reduce the risk of harm and promote the rights, health and wellbeing of each person by providing training, development and supervision. The person in charge had ensured that staff had access to appropriate training, as part of a continuous professional development programme. Staff were being provided with training appropriate to their roles and the person in charge was maintaining oversight of the training needs of staff.

The inspector reviewed a training matrix for 16 staff that were also named on the current centre roster, including relief staff. The matrix viewed indicated that staff had access to and had completed training in keys areas to provide for safe care and support for residents. This included training in safeguarding, fire safety, infection prevention and control, positive behaviour support, and the management of actual and potential aggression. Staff were also seen to have access to training specific to the needs of the residents in this centre. For example, all staff had received sensory

training, trauma informed care training and training specific to administering an emergency medication. The training matrix clearly identified when refresher training was due and provided a good system for oversight.

A supervision schedule was reviewed that showed staff working in the centre were receiving formal supervision quarterly.

Judgment: Compliant

Regulation 23: Governance and management

This inspection found that the provider was ensuring that this designated centre was adequately resourced to provide for the effective delivery of care and support in accordance with the statement of purpose. For example, premises works were being completed to upgrade the physical environment, staffing levels were good and the premises was laid out and equipped to cater for residents in a manner that promoted privacy and dignity to residents. The premises was seen to be safe and suitable for the type of supports provided there and was overall adequately maintained.

Management systems were in place that were contributing to providing a service that was appropriate to residents' needs and that the service's approach to safeguarding was appropriate, consistent and effectively monitored. There was a clear governance structure in place that set out the lines of accountability within the service and this was set out in the statement of purpose for the centre. The provider had appointed a designated officer to promote and manage safeguarding within the service. This individuals' details were displayed prominently in the service and a staff member spoken with was aware of safeguarding procedures and how to raise a concern if needed.

The inspector was shown an email that had been sent to all staff in respect of the breaks away that were taking place at the time of this inspection. This comprehensively outlined the staffing, governance, and practical arrangements in place to ensure residents' welfare and safety during the break. This also highlighted changes to an emergency rescue medication protocol.

An annual review had been completed in respect of the centre in January 2025 and the inspector reviewed this document. This included evidence of consultation with residents and included details on safeguarding review. A schedule of audits was being completed, including environmental audits, vehicle checklists and medication audits were being completed. A sample of audits reviewed showed that there was good oversight of these audits and that where issues were identified, action was taken to respond to them. There was evidence of learning and review of incidents as outlined under Regulation 26 also.

The minutes of team meetings held in July, August and September were reviewed and showed that staff were well informed and consulted about any issues or

changes. Topics including safeguarding, incident reviews, activities and resident changes were all discussed. Staff spoken to in the centre reported that the person in charge was very supportive to the staff team and that they would be comfortable to raise any concerns to any of the management team.

The inspector reviewed a sample of the safeguarding documentation in place in respect of previous concerns in the centre and saw that safeguarding concerns raised had been notified to the office of the Chief Inspector and were also reported to the Health Service Executive (HSE) safeguarding and protection team. Safeguarding plans had been put in place in response to any safeguarding concern raised. These plans contained guidance on measures to take to ensure the safety of residents and this inspection found that actions identified were completed and monitored. For example, a resident had visited his general practitioner following an incident. Safeguarding plans in place in respect of one resident were seen to be effective, with a reduction in incidents indicating this. The incidents in the centre were reviewed for a period of two months and these showed that no peer-to-peer or staff related safeguarding incidents had been reported in that period.

Judgment: Compliant

Quality and safety

Safe and good quality supports were being provided to the four residents that availed of residential services in this centre. The well-being and welfare of residents in this centre was maintained by a good standard of care and support, provided by a consistent and committed core staff team. A high level of compliance with the regulations was found during this inspection. Some issues in relation to consultation with residents and some documentation on display in the centre are outlined under Regulation 9: Residents' rights.

There were good indications that safe and good quality supports were being provided to the four residents that availed of residential services in this centre. The wellbeing and welfare of residents in this centre was maintained by a good standard of care and support, provided by a consistent and committed core staff team. A high level of compliance with the regulations was found during this inspection.

Residents were benefiting from a premises that provided an overall good standard of accommodation and continued to meet their assessed needs in relation to their environment. The inspector saw that there were ongoing efforts to ensure that the centre was well maintained and appropriate to the needs of the residents living there. On the day of this unannounced inspection, works were commencing to upgrade some areas of the centre. This included the replacement of tiled flooring that was considered to present a slipping hazard and painting. Any issues noted during the walk-around of the premises were planned to be addressed through these works

A culture that promoted safeguarding and rights was indicated as being present in the centre. Safeguarding was discussed regularly at staff team meetings and individualised personal plans and positive behaviour support plans were in place that provided clear guidance to staff about how to support residents in a manner that promoted their safety and well-being.

The inspector saw that the residents met with on the day of the inspection appeared to be comfortable, content and happy in their home. Residents were offered choices and had a degree of autonomy over their own lives. Risk management systems were in place that balanced the need to keep residents safe, while promoting residents rights. Compatibility of residents was a consideration and one resident was due to have an assessment of need review to consider if this environment best met his needs.

Records provided during the inspection showed that all staff working in the centre had completed training in safeguarding and were appropriately Garda vetted. The staff spoken with during this inspection demonstrated a good working knowledge of safeguarding procedures and complaints procedures and presented as being very aware of these topics and how to manage any issues, should they arise.

Regulation 10: Communication

The registered provider was ensuring that residents were assisted and supported to communicate in accordance with their needs and wishes. Rosters reviewed showed that familiar staff were allocated to the centre on an ongoing basis and this meant that the staff supporting residents were familiar with them and would be familiar with their communication style and preferences. For example, a staff member spoken with told the inspector how objects of reference, such as an overnight bag, were used to assist with communicating to one resident about their upcoming holiday. The inspector reviewed the communication guidance in two residents' personal plans and saw that detailed, relevant guidance was available to staff in relation to supporting residents to communicate. For example, both residents were seen to have a personal Communication Dictionary in place. This described what this resident might say or do and what this is communicating. Also visual aids were viewed to be in use to provide information to residents about various issues and a communication passport was seen to provide good guidance to staff.

The inspector observed visual information about meals, staffing arrangements and activities on display for residents and easy-to-read information about complaints, infection prevention and control and safeguarding was available. A choice board was observed also. Residents had access to media such as smart televisions and radio. Residents had access to internet and mobile or tablet devices if desired. The inspector observed one resident was clearly enjoying a television show that staff had supported them to put on.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The person in charge had ensured that appropriate assessments were completed of the health, personal and social care needs of each resident and that the centre was suitable for the purposes of meeting the assessed needs of each resident. The registered provider was ensuring that arrangements were in place in the centre to meet the assessed needs of the residents using the centre. Staffing levels were considered based on the assessed needs of each resident and were seen to be appropriate to meet the needs of residents and residents had access to a variety of allied health professionals to inform the support plans in place for them.

A sample of two residents' personal plans and files were reviewed by the inspector. Plans in place for residents contained relevant guidance for staff about the assessed needs of residents and these were being updated as required to reflect any change in circumstances. This meant that the care and support offered to residents was evidence based and person centred.

Annual assessments of need reviews were seen to be completed. Residents' files included details about relevant screening programmes and individualised health checks that residents had been supported to access, in line with their medical history and assessed needs. Medical notes and records of health appointments viewed indicated that there was regular review and follow up following any issues identified. For example, an occupational therapy review had been sought after a weight change to review if a weighted blanket a resident had been recommended still met their requirements. Residents had access to a variety of allied health professionals.

There was evidence that residents had been supported to set and achieve goals as part of the person centred planning process within the previous year and there was evidence of progression, completion and ongoing review of goals. Goals were identified based on residents' assessed needs and preferences. For example, residents had set goals that included breaks away, restarting horse riding and improving contact with important people and progress of goals was documented in monthly keyworker meetings.

Judgment: Compliant

Regulation 7: Positive behavioural support

The person in charge had ensured that staff had up-to-date knowledge and skills to respond to behaviours of concern and support residents to manage their behaviour.

The registered provider had in place a positive behaviour policy and a restrictive practice policy also and these were provided to the inspector for review on request.

Positive behaviour support plans were in place to guide staff and overall it was seen that positive behaviour support was well managed in the centre. Staff had received training relevant to their roles in this area. This meant that residents could be supported in a manner that met their assessed needs and were provided with appropriate care and support to safeguard themselves and others from the impact of behaviours of concern.

Incident records reviewed in the centre, indicated that guidance and strategies in place for residents were being followed in practice. Training records reviewed indicated that staff had access to and had completed training in this area also. Residents had access to allied health professionals to support them holistically with managing behaviours of concern where required, including psychiatry, speech and language, occupational therapy and the providers own behaviour support team.

Residents had positive behaviour support plans in place. The inspector reviewed the plans in place for two residents who presented with specific needs in this area and saw that these provided good guidance and strategies for staff to support residents manage their behaviour, including self-injurious behaviours. All residents were provided with 1:1 or 2:1 staffing by day to support them and reduce any potential impact of behaviours on themselves or other residents. All incidents that occurred in the centre were reviewed monthly and debriefed with the staff team. Incident reviews were an agenda item for team meetings.

Some restrictions in place for residents in this centre noted in previous inspections remained in place. For example, there were restrictions, such as a locked door between the main house and apartment and specific protocols in place that meant that some residents did not interact regularly. Overall, restrictions in place were seen to be carefully considered and were in place to address identified risks and meet the needs of the individuals that lived there. Documentation viewed showed that input had been received from an external advocate in relation to some of these. A review meeting attended by numerous members of management, multi-disciplanary team members and an external individual had been carried out earlier in the year and one restrictive practice had been removed following this. There was evidence that a residents' medication had been reviewed in the previous year and successful reductions had been made.

There were some restrictions in place due to potential responsive behaviours and safeguarding concerns between two residents living in the main house. An assessment of need review was scheduled in relation to one resident to consider the ongoing impact of living with the other resident following some behaviours that indicated they did not enjoy sharing a home with this individual. While this was well managed to protect all residents, this showed consideration was ongoing about how to protect residents while still considering their rights and the impact of the environment on residents' behaviours.

Judgment: Compliant

Regulation 8: Protection

The findings of this inspection indicated that the registered provider had appropriate measures in place to protect residents from abuse. The person in charge had ensured that all staff had received appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse. Guidance on supporting residents with intimate personal care was contained within residents' personal plans.

The provider had in place a safeguarding policy. As set out under Regulation 23, the provider had a system in place to respond to and notify relevant bodies of any concerns raised and it was seen that concerns reported to the Chief Inspector had corresponding paperwork to show that these had also been reported to the Health Service Executive Safeguarding and Protection team and safeguarding plans were in place where required. Safeguarding measures in place in the centre included the provision of one-to-one and two-to-one staffing for residents. Staff rotas reviewed, observations on the day of this inspection, and discussions with staff indicated that staffing levels were maintained at safe levels in the centre at all times. A training matrix showed that staff working in the centre had completed relevant safeguarding training and the designated officer for the provider had visited the centre to speak about safeguarding and enhance staff understanding during the most recent team meeting. Staff and management spoken with during the inspection were familiar with safeguarding procedures and reported that they felt that residents were safe and well protected in the centre. It was not possible to ascertain residents' views on this matter during this inspection due to the communication needs and availability of residents, but brief observations carried out prior to residents departing the centre indicated that two residents met with were content and comfortable in their home and in the presence of the staff that supported them.

Three months of team meeting records reviewed indicated that safeguarding scenarios were discussed during some team meetings. The inspector was provided with evidence that all staff working in the centre had received appropriate garda vetting disclosures. This included the training matrix which tracked the dates the most recent garda vetting disclosures had been received in respect of all staff, and a randomly requested sample of staff garda vetting disclosures cross referenced against this.

Judgment: Compliant

Regulation 9: Residents' rights

While overall, the registered provider was making efforts to ensure that each resident's privacy and dignity was being respected in relation to their living arrangements, some issues were identified in relation to documentation on display in the centre. Information received during this inspection indicated that efforts were being made to ensure that each resident had the freedom to exercise choice and control in his or her daily life and to live a life of their own choosing and, for the most part, residents' rights were respected in this centre and a rights based culture was promoted in the centre. However, it was not fully evidenced that residents' were consulted with fully about all matters that impacted them.

Reports about residents' dietary and eating requirements were on display on a notice-board in the kitchen. Some residents' information, including medical and personal information, was seen to be included in this and this did not offer full privacy and dignity to these individuals. The inspector highlighted this to management and this was addressed. Also, the inspector noted incontinence wear was stored in open view in one residents' bedroom.

Overall, there was a strong focus on human rights in this centre and residents were seen to be supported to exercise choice and control in their daily lives relative to their capacities to communicate this. However, while the inspector was told about how residents were informed and consulted with about the break away that they were taking at the time of this inspection, the documentation in place did not fully reflect that efforts were made to fully inform and consult with residents about this. Some residents did have goals to go on overnight breaks but the progress documented under these goals did not indicate how all residents were consulted with about this specific break away. It is acknowledged that due to residents' very specific environmental needs, careful consideration was required to ensure that the holiday premises met their needs and this did limit the choices available. Family members had been informed about the break and consulted with also.

There were measures in place to ensure that residents' were afforded privacy in their own personal spaces. For example, the house was very spacious and was laid out with private bedrooms, en-suite or adjoining bathrooms and private living spaces for residents to spend time alone in if they wished. Consideration was given to providing separate areas for residents to relax in to reflect some incompatibility that was noted between residents, and the inspector was told of ongoing consideration of this matter.

Staff spoken to during the inspection presented a positive overview of residents and their lived experiences, including residents' preferences and communication styles and told the inspectors that residents' rights were regularly discussed and highlighted in this centre.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

The registered provider had a risk management policy in place that provided for the identification, assessment and review of risk in the centre. The same policy also outlined the control measures for specific risks as required including self-harm and accidental injury and policies such as a Safeguarding Adults policy, Restrictive Practice Policy and Positive Behaviour Support policy also contributed towards the providers' risk management systems. A recently updated service business continuity plan was observed in a prominent location that provided guidance to staff on the measures in place to cover specific scenarios, including information technology issues, staffing issues and loss of communication. This plan also included a hazards analysis. A surge capacity plan in relation to COVID-19 was also in place.

The risks associated with the outbreak of fire had been considered. Works being completed that required fire doors be taken down were completed while residents were not in situ in the centre. The inspector was provided with evidence in the period following the inspection that these doors had been reinstalled and certified by a competent person. Personal emergency evacuation plans were in place for two residents reviewed and had been updated within the previous year.

From documentation reviewed in the centre including incident debriefing reports for the previous months, and speaking to residents, staff and management, the inspector saw that there was a prompt response and ongoing learning following any incidents or near misses that occurred in the centre. For example, following a significant incident that had occurred during a family visit, it was documented that actions had been taken to support the resident and their family, and consideration was given into how to reduce the likelihood of re-occurrence.

Individualised risk assessments were viewed in residents' files and a risk register was in also seen to be in place. There were no escalated risks at the time of this inspection. Risk assessments were seen to be subject to regular review and updating. Where risk was identified, efforts had been taken to reduce or mitigate the impact of this on residents and ongoing review of risk was seen to be a part of the day-to-day operations of this centre. For example, the inspector saw that risks associated with the residents' break away had been considered and plans were in place to mitigate against these including clear communication with staff about the arrangements in place.

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	Compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Substantially compliant
Regulation 26: Risk management procedures	Compliant

Compliance Plan for The Meadows OSV-0005734

Inspection ID: MON-0048449

Date of inspection: 13/10/2025

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 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
The Person In Charge and Team lead will strengthen systems to ensure that all residents are consulted and supported to participate in the organisation of the designated center in line with their wishes, age, and the nature of their disability.
Residents' meetings will be held on a regular basis and facilitated using accessible communication methods (e.g. easy-read formats, visual supports, advocacy support, and one-to-one consultations where required). Feedback from residents will be recorded, reviewed, and used to inform decision-making within the center.
Where residents choose not to participate in group forums, individual consultation will be facilitated and their views documented. Outcomes of consultations and actions taken will be communicated back to residents in an accessible format.

The Person In Charge will ensure that residents' privacy and dignity are respected at all times in relation to personal and living space, personal communications, relationships, intimate and personal care, professional consultations, and personal information. Staff will support residents in a respectful, person-centred manner, in line with their assessed needs, preferences, and rights. Privacy will be promoted through appropriate use of private spaces, consent, respectful communication, and adherence to confidentiality and data protection procedures. Ample storage will be provided for all incontinence wear for all 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 09(2)(e)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability is consulted and participates in the organisation of the designated centre.	Substantially Compliant	Yellow	05/01/2026
Regulation 09(3)	The registered provider shall ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and	Substantially Compliant	Yellow	05/01/2026

	personal information.			