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:	Community Residential Service Limerick Group J
Name of provider:	Avista CLG
Address of centre:	Limerick
Type of inspection:	Unannounced
Date of inspection:	24 June 2025
Centre ID:	OSV-0005754
Fieldwork ID:	MON-0047422

About the designated centre

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

Community Residential Service Limerick Group J comprises of two houses, located in a rural setting but within a short driving distance to a nearby city. The centre provides full time residential support for a maximum of eight residents, over the age of 18 with intellectual disabilities. Support to residents is provided by the person in charge, social care workers and care assistants with some nursing support also. Each resident has their own bedroom and other facilities in the centre include bathrooms, a living room, a kitchen/dining room and staff rooms.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	7

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Tuesday 24 June 2025	14:40hrs to 20:05hrs	Lisa Redmond	Lead
Tuesday 24 June 2025	14:40hrs to 20:05hrs	Kerrie O'Halloran	Support

What residents told us and what inspectors observed

This was an unannounced risk based inspection completed in the designated centre Community Residential Service Limerick Group J. This inspection was carried out following the receipt of solicited and unsolicited information about the quality of care and support provided to residents living in the designated centre. Overall, this inspection found that there was a high level of non-compliance with the regulations. Information required to evidence actions taken in response to incidents and complaints in the centre were not provided to inspectors to provide assurances that residents received a good quality of care and support in their home.

This designated centre comprises of two houses which provided full-time residential services to a maximum of eight residents. At the time of this inspection, seven residents lived in the designated centre. One resident had temporarily transitioned to another designated centre operated by the registered provider.

This was a focused inspection. Therefore, this inspection was carried out in one of the designated centre's houses. The inspectors met with the three of the seven residents living in the designated centre on the inspection day.

On arrival to the designated centre, one resident was observed watching television in the sitting room. This resident received one-to-one staff support each day where they were supported to attend a retirement group. On the day of the inspection, the resident had attended a medical appointment with a staff member. Staff spoken with told the inspectors the resident had also had their lunch while they were out.

When inspectors entered the office in the centre, the cabinet containing residents' medicines and money were open. The key to open the cabinet was hanging in the cabinets lock. It was noted that the office door was not locked and therefore residents' finances and medicines were not safely and securely stored.

Two residents were met with when they returned home after their day services. When the inspectors went to meet with residents they were observed to be eating their dinner. As two of these residents had associated support needs in relation to eating and drinking, the inspectors asked staff members if the inspector's presence may pose a risk to residents by distracting them from their meal. Staff members advocated on behalf of the residents that this may pose a risk and it was agreed that the inspector would meet the residents after they ate their dinner.

One resident had plans to visit a family member on the evening of the inspection. Before they left, the resident came to say goodbye to the inspectors.

Throughout the evening of the inspection, residents were observed relaxing in communal areas and their bedrooms. Vocalisations from one resident could be heard by inspectors during the inspection day. Staff spoken with informed inspectors that the resident's vocalisations were related to a medical issue for which the

resident was currently undergoing treatment. A behaviour support plan and safeguarding plans had been developed in response to this. At the time the resident was heard vocalising the other residents present did not appear to be impacted and were observed relaxing in their bedroom.

Residents living in the centre were unable to verbally express to the inspectors their views on what it was like to live in their home. Inspectors met with all of the staff on duty on the inspection day. It was evident from speaking with staff members that the centre was very busy, and that staff members found it difficult to complete the tasks associated with their role in the centre. Staff members noted that the health and safety of residents was their top priority, however they felt that 'residents lose out' due to the current staffing levels in the designated centre. Since the previous inspection in April 2024, where it was identified that staff levels were not sufficient, there had been no increase in the staffing levels in the centre. It was noted that there was a temporary resident vacancy due to a resident transitioning to another designated centre for an interim period. However, staff and management in the centre were clear that this resident was due to return to their home after this inspection had taken place.

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.

Capacity and capability

At the beginning of the inspection, an introductory meeting was held with the registered provider. This meeting outlined the documentation that inspectors needed to review to assess compliance with the regulations. The meeting was also used to discuss the care and support provided to residents in line with the regulations. At this meeting, inspectors requested information relating to complaints made in relation to the care and support of all residents in the designated centre. Inspectors also requested to review documentation relating to the safeguarding of residents. This information was not provided to inspectors as requested to ensure compliance with the regulations.

Due to the high levels of non-compliance identified on this inspection, and the delays in the receipt of information requested by inspectors, an urgent action was issued to the registered provider. An urgent action is issued when an urgent risk is identified by inspectors which must be brought to the attention of the registered provider. The urgent action was issued under the following regulations

- Regulation 8 Protection
- Regulation 23 Governance and Management
- Regulation 21 Records

The response provided by the registered provider did provide assurances that urgent actions would be taken to come into compliance with the regulations.

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 registered provider had not ensured that the number of staff was appropriate to the number and assessed needs of the residents. At the previous inspection of the designated centre in April 2024, it was identified that the current staffing levels in the centre impacted on residents' ability to access community activities. In response to this finding, the registered provider had stated that they would come into compliance with this regulation by the end of August 2024.

Inspectors reviewed the rota from 30 March to 06 July 2025. It was evidenced on this inspection from a review of the designated centre's rota and discussions with staff members on duty that staffing levels in the centre had not increased since the inspection completed in April 2024. A funding request had been submitted in response to findings of the inspection in April 2024 however, documentation reviewed by inspectors noted that this continued to impact on residents' ability to access their local community. Management in the centre noted that residents' support needs had increased since the inspection had taken place in August 2024. It was noted at recent staff meetings that the requests for additional staffing resources were referenced, with staff members highlighting that additional staffing was required to support resident outings.

It was evident however that regular and consistent staffing was provided to residents living in the designated centre. This included the use of consistent agency and relief staff members.

Judgment: Substantially compliant

Regulation 21: Records

The registered provider had not ensured that the records specified in Schedule 4 were maintained and available for inspection by the chief inspector. This included;

- A record of all complaints made by residents or representatives or relatives of residents or by persons working at the designated centre about the operation of the designated centre, and the action taken by the registered provider in respect of any such complaint.

- A record of any allegation, suspected or confirmed abuse of any resident.

An urgent action was issued to the registered provider under this regulation. The response provided by the registered provider did provide assurances that urgent actions would be taken to come into compliance with the regulations.

Judgment: Not compliant

Regulation 23: Governance and management

The registered provider had not ensured that management systems were in place to ensure that the service provided to residents was safe, appropriate to residents' needs, consistent and effectively monitored. As previously discussed, information requested by inspectors on the inspection day were not made readily available to inspectors to ensure compliance with the regulations. An urgent action was issued to the registered provider under this regulation. The response provided by the registered provider did provide assurances that urgent actions would be taken to come into compliance with the regulations.

Serious incident and management team meetings had been held following a serious incident that occurred in the designated centre. It was identified in the meeting record in June 2025 that a review of the incident was to be completed be a clinical nurse manager in the organisation, with support from the organisation's quality and risk advisor. Evidence of the completion of a local incident review was submitted to the Chief Inspector after this inspection took place. This review identified a number of recommendations and areas for improvement in the centre.

Management in the centre outlined that staff meetings were to be held in the designated centre quarterly. Inspectors reviewed the team meeting schedule and records of staff team meetings and it was not evident that these had not occurred as outlined. Inspectors requested to review the team meeting records and these were provided for February 2025 and February 2024.

Judgment: Not compliant

Regulation 31: Notification of incidents

The person in charge had not ensured that the Chief Inspector was given notice in writing within three working days of any allegation of suspected or confirmed abuse of any resident. It was noted that two complaints contained information regarding the care and support of residents which constituted alleged abuse. These allegations of suspected abuse were not notified to the Chief inspector in line with this

regulation. This will be further discussed under Regulation 8, protection and Regulation 34 Complaints.

When a resident had received a serious injury which required immediate medical treatment, this was notified to the Chief Inspector. However, it was identified that the dates submitted in this notification were incorrect. The notification submitted had outlined that the resident had sustained the injury on the same date that they received medical treatment. Following a review of documentation relating to this incident, it was noted that the date the resident had reported their suspected injury was the day prior to the date that was referenced in the notification to the Chief Inspector.

Judgment: Not compliant

Regulation 34: Complaints procedure

At the beginning of the inspection, an introductory meeting was held with the registered provider. At this meeting, inspectors requested information relating to complaints made in relation to the care and support of all residents in the designated centre. It was evident that information relating to two complaints were not forthcoming by the registered provider. As a result, the registered provider committed to submitting records relating to these complaints the day after the inspection had taken place. A record of these complaints was submitted to the Chief Inspector the day after this inspection took place. This is actioned under Regulation 23, governance and management.

Inspectors reviewed information relating to four complaints in the designated centre. Two of the complaints were documented to have been closed to the satisfaction of the complainants. It was noted that these two complaints contained information regarding the care and support of residents which constituted alleged abuse. This is further discussed under Regulation 8, protection and Regulation 31 notification of incidents.

An easy-to read complaints procedure was also located in a prominent location on the designated centre. This document included the timelines to resolve complaints and how to seek appeals if residents are not happy with the outcome of their complaint. However, it was noted that the complaint's officers details including their name and contact details were left blank in the complaints procedure.

Judgment: Substantially compliant

Quality and safety

The registered provider had not ensured that residents living in Community Residential Services Limerick Group J were provided with a good quality of care and support in their home. A lack of effective oversight and management systems in place in the centre impacted on the quality of supports provided to residents in their home.

Inspectors were not provided with information requested to ensure safeguarding measures were put in place in response to allegation of suspected and/or confirmed abuse. Improvements were also required to ensure effective guidance was in place to support the transition of residents.

Regulation 25: Temporary absence, transition and discharge of residents

Inspectors requested to review the transition plans developed to support two residents as they transitioned between residential services operated by the registered provider. One resident did not have a transition plan developed as their transition was deemed as an 'emergency' transition. Staff members noted that resident's transition was a temporary transition following an injury. The rationale for the resident's transition to another designated centre was that staff members did not have appropriate training or equipment to support the resident and that a significant increase in staffing levels would be required.

It was noted in meeting records observed that funding had been secured to support the resident to transition to another residential setting operated by the registered provider. Representatives of this resident had made a complaint the day after this meeting had taken place. It was evident from a review of the documentation that the resident and their representatives had not been informed of the plans to transition this resident to an alternative residential setting until after resources had been secured, and they had made a complaint. This did not ensure that residents were consulted in decisions relating to their care and support.

The transition for the second resident was a planned transition. The registered provider's admission, discharge and transfer within services policy stated that a transition plan must be put in place. The transition plan was reviewed by inspectors. However, it did not include details of the provision of information on the services and supports available to the resident as outlined in the regulations. For example, it was noted that this plan included details of planned visits to their new home. However, there was no details or guidance for staff members on moving the resident's belongings or furniture to their new home. There was no evidence of them being provided with the residents' guide for their new home, or staff members communicating to them the supports they would receive in their new home. This required review.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

Inspectors completed a review of two residents' personal files. It was evident that residents were supported to develop goals however, staff members noted that they residents' goals were limited by staffing resources in the centre. This was documented in the individual preference and needs assessment for one resident. This is actioned under Regulation 15, staffing.

Following the registered provider's review of an incident occurring in the designated centre, a number of actions and areas for improvement were identified. It was noted that documentation relating to a resident's support needs were inconsistent with practice. It was also noted that there was a discrepancy in the practice being utilised and that which was documented. A recommendation was made to review the resident's care plan to reflect their current level of support.

Residents living in the centre had received a new vehicle in the weeks before this inspection took place. It was evident that the new bus was not suitable to meet the assessed needs of all residents living in the centre. Staff members identified that there was no space to safely secure residents' wheelchairs, and that the step into the bus was too high. Each of the residents required a wheelchair when accessing their local community. However, all three residents could not use the vehicle together to access their local community as they could only brig one wheelchair on the bus at the time of the inspection. Staff in the centre were liaising with the transport manager to rectify these issues and it was noted that there were plans to make some adjustments to the centre's vehicle.

Judgment: Substantially compliant

Regulation 8: Protection

Inspectors requested to review evidence of safeguarding plans, statutory notification of alleged abuse and records of trust in care investigations completed in the centre which related to specific allegations. This information was not provided to inspectors as requested. Therefore, inspectors were not assured that the registered provider had ensured that residents were protected from all forms of abuse, or that an investigation in relation to such incidents had taken place. An urgent action was issued to the registered provider under this regulation. The response provided by the registered provider did provide assurances that urgent actions would be taken to come into compliance with the regulations.

Vocalisations from one resident could be heard by inspectors during the inspection day. Staff spoken with informed inspectors that the resident's vocalisations were related to a medical issue for which the resident was currently undergoing treatment. A behaviour support plan and safeguarding plans had been developed in response to this. The safeguarding plan outlined that one measure in place to

protect residents from suspected and or confirmed abuse was team meetings which were held every six to eight weeks. Inspectors reviewed the team meeting schedule and records of staff team meetings and it was not evident that these had not occurred as outlined.

A designated safeguarding officer had been appointed by the registered provider. A photograph of this person was on display on the notice board in the kitchen of the centre.

Judgment: Not compliant

Regulation 9: Residents' rights

Audio monitoring was used to monitor a resident while they were in their bedroom at night, due to their increased risk of falls. There was no evidence of any guidance for staff members as to the use of the audio monitoring. For example, it was not documented when this should be turned on or off, or if the resident was aware that audio monitoring was in place. It was not evident that the resident had consented to this support, or that their privacy and dignity was maintained while this was in use. This required review.

Monthly resident meetings were held with residents. Inspectors reviewed the records of these meetings in April, May and June 2025. Items discussed at these meetings included complaints, the charter of rights, privacy and meal planning. It was evident that residents had been informed of the emergency transition of one resident, where they were reassured about the well-being of their friend.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Substantially compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 25: Temporary absence, transition and discharge of residents	Not compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Community Residential Service Limerick Group J OSV-0005754

Inspection ID: MON-0047422

Date of inspection: 24/06/2025

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

This document is divided into two sections:

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

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

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: The current rostering of staff was reviewed for the designated centre by the PIC and PPIM. Any necessary changes to the current roster were made within the staff complement to ensure that staff are rostered based on the needs of residents and activity planning. In addition, the service manager and PPIM have, since inspection allocated three hours of community nurse support directly to the designate Centre from week commencing 06.07.2025. A review of the current staffing in 1 house of the designated centre to meet the assessed needs of the individuals is being completed by the Nurse Practice Development Co-Ordinator and Quality and Risk team, this is scheduled to be completed by September 19th. While an initial date of the 31st of August was agreed, an extension has been granted for this due to leave and a covid outbreak in the centre. Recommendations from the review in relation to staffing will be considered by the service manager and a review of the residents' living environment will be completed to determine the most appropriate location dependent on their identified needs. If this location doesn't meet the residents' needs the provider will examine alternative designated centres within the service which will support residents identified needs, both support and environmental. This process will involve the individual and their representatives and MDT. The provider and PIC ensure that regular and consistent staffing is provided for residents living in the designated centre. This includes the use of consistent agency and relief staff members.	
Regulation 21: Records	Not Compliant
Outline how you are going to come into compliance with Regulation 21: Records: The service manager, PPIM and PIC will ensure that all records specified in Schedule 4 are maintained and available for inspection by the chief inspector. Documentation which was held in the service managers office that related to complaints which was not	

available in the designate centre on the day of the inspection, has since been filed in the complaints log in the designated centre.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
6 monthly provider Audits completed on 27.03.2024 and 10.12.2024 were available in the designate centre on the day of inspection for review by inspectors. 6 monthly provider audit for the designated centre was completed on 30.06.2025 and the second provider audit will be completed in line with timeframes as per regulation. One of the two outstanding actions from the last 6 monthly audit, painting in 1 house in the designate centre has been completed; the second action - a review of the current staffing in 1 house of the designated centre to meet the assessed needs of the individuals is being completed by the Nurse Practice Development Co-Ordinator and Quality and Risk team and is scheduled to be completed by September 19th. While an initial date of the 31st of August was agreed, an extension has been granted for this due to leave and a covid outbreak in the centre. Staff team meeting was held on 30.06.2025 and dates for further meeting have been scheduled for the remainder of 2025. All complaints & safeguarding discussed at staff team meeting on 30.06.2025. Complaints and Safeguarding is a standing item on agenda for all team meetings and also a standing item on the service manager meeting with PPIM and PIC's. Recommendations from the local incident review following injury to a resident are being implemented.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
Preliminary safeguarding meetings were held on 30.06.2025 for 2 identified complaints and retrospective notifications were submitted for same. Provider has ensured that a system is in place for all notifications to be submitted in line with the requirements of the regulation.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
The service manager, PPIM and PIC will ensure that all documentation relating to complaints, safeguarding or concerns regarding the designated centre will be available

and accessible to inspectors on the day of their visit. All complaints will be documented and recorded as such in line with service policy on complaints. Preliminary safeguarding meetings held on 30.06.2025 for 2 identified complaints and notifications submitted for same. Complaints training has been provided to PICs, CNM2s and CNM3s on 10.06.25 and 19.06.25. Additional complaints training was provided to the staff team and Manager on 02.07.25 by Quality, Risk and Safety department. Safeguarding training was completed by Social Worker on 08.07.2025 to include recognition of safeguarding concerns within a complaint, further training sessions scheduled for September 2025. All complaints & safeguarding discussed at staff team meeting on 30.06.2025. Complaints and Safeguarding is a standing item on agenda for all team meetings and also a standing item on the service manager meeting with PPIM and PIC's. Documentation which was held in the service managers office that related to complaints which was not available in the designate centre on the day of the inspection, has since been filed in the complaints log in the designated centre. Learning from review of complaints was shared with staff team and complaints log was updated to include details of same. Picture of complaints officer and contact details circulated to all areas for inclusion in Easy Read Complaints for residents' information.

Regulation 25: Temporary absence, transition and discharge of residents	Not Compliant

Outline how you are going to come into compliance with Regulation 25: Temporary absence, transition and discharge of residents:
The Transforming Lives officer for Avista will support with transitioning plans for all residents planning moves between residential services. The Quality, Risk and Safety department have supported with short term transition plans for residents being discharged from acute services or on an emergency basis. A Local guideline is being developed by The Quality, Risk and Safety Department with Transforming Lives Officer for use between services to support short term/emergency transition between residential services to ensure the resident is supported with all aspects of their transition. All decisions/plans in relation to Admission, Discharge and Transfer will be discussed with the resident and their representatives to ensure that residents are consulted in decisions relating to their care and support.

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:
Resident remains in residential services post discharge from hospital for rehabilitation. Resident had an MDT manual handling review completed on 16.05.2025 and is due a further review following referral sent on 08.08. 2025. Ongoing review will be completed as the resident rehabilitates. Resident's care plan has been updated to incorporate all

Manual handling and MDT recommendations in line with their current level of support needs. Hospital communication passport has been updated to include commonly used phrases to support hospital staff when engaging with her. All staff team have manual handling training in date and refreshers will be scheduled.
Arrangements have been put in place to have the required works completed to the new service vehicle to ensure it is suitable for the needs of the residents. In the interim, an alternative vehicle is in use in the designate centre while these works are being completed.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection: Documentation relating to preliminary screening under trust in care and staff disciplinary are retained by service manager and HR. These will be made available for inspectors to view on the day of inspection where requested. Due to the information contained in these documents they are retained by the service manager and CNM3. At the Quarterly governance meeting with PIC and staff team safeguarding concerns and updates are a standing item on the agenda. Templates for these meetings were reviewed by Service Manager, CNM3 and Quality, Risk and safety department and are in place. /CNM3 will attend these meetings. Minutes of meetings to be available for all staff and for the inspector to view. Monthly governance meetings held by service manager with PPIM's and CNM3's. In addition, governance meetings held every 2 months with the PIC's and the Service Manager where safeguarding is a standing item agenda. Service manager and CNM3 will ensure that all safeguarding concerns are managed in line with organisational Policy for the protection of vulnerable adults. Staff and management safeguarding training is all in date and all due refreshers will be scheduled. Social Worker, who is designated officer, provided input on safeguarding processes to the staff and management team in the Centre on 08.07.2025. Further session is being provided by social worker on 24th September 2025. Training completed January 2025 for all PIC's in DOCS039 (Management of personal finances, property and possessions of individuals the organisation supports). All staff will have received training on this policy by 12th September 2025.Team meeting has occurred on 30.06.2025 and are also scheduled for remainder of 2025 where all safeguarding plans will be reviewed.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights: Resident remains in residential services post hospital discharge. On return to Community Residential services the restrictive practice of audio monitor will be discussed with resident with use of a social story and easy read document to augment understanding. Details of the conversation will be documented in residents care plan. Restriction will be

implemented and tracked as per DOCS053 (maintaining a restraint free environment) with use of same monitored annually by Restrictive practices committee. Use of audio monitor will be discussed with all staff including rationale for use and when it is to be used. All restrictions for discussion at all team meetings. All restrictions in use within the designated centre including bed rails were reviewed by restrictive practices committee in July 2025. Use of this monitor will be discussed with staff on return of the resident to ensure it is used in the least restrictive manner for the resident.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Substantially Compliant	Yellow	19/11/2025
Regulation 21(1)(c)	The registered provider shall ensure that the additional records specified in Schedule 4 are maintained and are available for inspection by the chief inspector.	Not Compliant	Red	01/07/2025
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre	Not Compliant	Red	01/07/2025

	to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.			
Regulation 25(3)(a)	The person in charge shall ensure that residents receive support as they transition between residential services or leave residential services through:the provision of information on the services and supports available.	Not Compliant	Orange	19/11/2025
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	01/07/2025
Regulation 34(1)(a)	The registered provider shall provide an effective complaints procedure for residents which is in an accessible and age-appropriate format and includes an appeals procedure, and shall ensure	Substantially Compliant	Yellow	25/09/2025

	that the procedure is appropriate to the needs of residents in line with each resident's age and the nature of his or her disability.			
Regulation 05(2)	The registered provider shall ensure, insofar as is reasonably practicable, that arrangements are in place to meet the needs of each resident, as assessed in accordance with paragraph (1).	Substantially Compliant	Yellow	19/11/2025
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Red	01/07/2025
Regulation 08(3)	The person in charge shall initiate and put in place an Investigation in relation to any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.	Not Compliant	Red	01/07/2025
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	Substantially Compliant	Yellow	19/11/2025

	communications, relationships, intimate and personal care, professional consultations and personal information.			