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:	Stewarts Care Adults Services Designated Centre 20
Name of provider:	Stewarts Care DAC
Address of centre:	Dublin 20
Type of inspection:	Announced
Date of inspection:	08 July 2025
Centre ID:	OSV-0005857
Fieldwork ID:	MON-0038816

About the designated centre

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

Stewarts Care Adult Services Designated centre 20 is a designated centre operated by Stewarts Care DAC. The designated centre provides a full-time residential service for up to six male residents over the age of 18 years with intellectual disabilities, and can accommodate residents with complex support needs. It is a large bungalow located on a campus setting in Dublin. The bungalow offers six individual bedrooms for residents, a separate kitchen, a dining room, sun-room, relaxation room, living room, main shower room, bathroom, two shower cubicles and an accessible back garden area. The centre is staffed by a team of nurses (two whole time equivalent staff) and care assistants (six whole time equivalent staff) and is managed by a full-time person in charge. Residents have nursing support provided from within the home, and access to a team of allied health professionals employed by Stewarts Care, such as psychology, occupational therapy and physiotherapy services.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	6

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 8 July 2025	09:30hrs to 16:30hrs	Jennifer Deasy	Lead

What residents told us and what inspectors observed

This inspection was an announced inspection carried out in response to the provider's application to renew registration of the designated centre. The inspector had the opportunity to meet with five of the six residents on the day and spoke with a number of staff who were on duty. The inspector used observations of care and support being provided, conversations with staff and a review of documentation to inform judgments on the quality and safety of care. Overall, it was seen that, residents were in receipt of care and support from a consistent and familiar staff team, which was meeting their assessed needs however, they had very limited opportunities for meaningful activities or to develop relationships and friendships outside of the centre.

The designated centre is located on the provider's campus close to Dublin City. It is a single storey bungalow and is registered to provide care and support to six residents with intellectual disabilities. Each resident has their own bedroom and the house is designed to promote accessibility; for example, ceiling tracking hoists are available where required, there is a large accessible bathroom and there is plenty of storage space for mobility aids and other appliances required. Residents share communal bathrooms, a kitchen, dining room, sitting room and sensory room. There is a also a staff office and a utility room available. A large, accessible back garden is available for residents to enjoy.

The inspector completed a walk around of the premises with the person in charge. The centre was seen to be very clean and appeared homely. Residents' bedrooms were decorated according to their preferences and art work, photographs and ornaments decorated bedrooms and communal areas. There was some upkeep required to the premises; for example, flooring in the dining room was damaged and so could not be effectively cleaned. The inspector also saw that a large section of a wall in the sitting room was damaged. The wall was powdery in places and the paint appeared to be bubbling and peeling away in a number of areas. The inspector was told that there were ongoing issues with this wall and that it was thought to be attributed to a previous leak in the bathroom.

Five of the current six residents were at home on the day of inspection. One resident had returned to their family home for a visit. Some residents were up and dressed when the inspector arrived while others were being supported with personal care. Some residents chose to walk around the house and observe what staff and other residents were doing. One resident was seen lying on a couch in the sitting room. The inspector was told that the resident had a poor night's sleep and was tired. All of the residents presented with assessed communication needs. Some residents made eye contact with the inspector and were interested in what she was doing during the day but none of the residents communicated their views or opinions about the service.

Residents were seen to be relaxed and comfortable in their home. Staff were seen providing drinks and breakfasts to the residents. Food and drink was modified in line with residents' assessed needs. The inspector spent some time with one resident who was being assisted with their breakfast by a staff member. The staff member described the resident's assessed feeding and swallowing needs and was seen to provide care and support in a gentle and relaxed manner. The staff member was seen to communicate with the resident during the meal, checking with them to see if they were ready for another spoonful and chatting to them throughout.

Most meals were provided by a centralised kitchen, although the centre did have a hob and air fryer and could produce other meals if required. Residents' dietary needs were provided for by the centralised kitchen. Staff members told the inspector that they had also received training in modifying residents' food in order to meet their assessed needs. Staff said that they had training in a human rights based approach to care and in communication. They described to the inspector how this training had impacted the way in which a particular restrictive practice was implemented. This is discussed further under regulation 7.

The inspector spent much of the morning in the sitting room and dining room of the centre, within sight of the residents and staff. The inspector saw that residents' assessed needs were being met and that, while meeting these needs, staff communicated with residents in a gentle and respectful manner. However, there was generally a lack of stimulating or personally motivating activities available for residents on the day of inspection. Two residents went for a drive; however, it was not seen that they were offered a choice of where to go for a drive to, or if there was any meaningful activity to happen with the drive.

The other three residents spent much of the morning in the sitting room. One resident was asleep, while another resident watched television. The inspector asked staff about the second resident's usual routine and if they would be going out today. The staff member indicated that the resident did not usually go out on this day, and that they typically went out twice per week. Once to go to a shop and the second time to go to mass. There appeared to be very little other opportunities to go out during the week for the resident. Another resident was observed sitting in an armchair for much of the morning. A music kit had been placed beside them; however, they were not seen to engage with it and staff did not interact with the resident to encourage them to engage with it.

The inspector reviewed the daily notes for three of the residents and their financial records and saw that, typically, residents had very little opportunity to participate in meaningful and personally motivating activities in the centre and in the community. Residents' financial records showed that they spent very little money and, that when they did spend money, they were often not involved in the purchases in a meaningful way. This is discussed under regulation 12.

Much of the care provided, as detailed in the daily notes and as observed on inspection, appeared to be task orientated and intended to meet residents' assessed needs. While this care was provided in a respectful manner, it did not provide

opportunities for residents to develop their relationships with others and to connect with their wider community. This is discussed further under regulation 13.

The next two sections of the report will describe the oversight arrangements and how effective they were in ensuring the quality and safety of the service.

Capacity and capability

This section of the report describes the governance and management arrangements of the centre and how effective they were in ensuring the quality and safety of care. This inspection found that the residents were in receipt of care and support from a consistent staff team who were suitably qualified and who had received training which was suitable to meet the residents' assessed needs. The provider was meeting the requirements of the regulations in many areas; for example, in respect of the maintenance of documentation required by the regulations and the submission of notifications of adverse incidents to the Chief Inspector. However, the management arrangements for the centre were not effective in driving service improvements to ensure the quality and safety of care for the residents.

There was a consistent and stable staff team employed in the centre which was ensuring continuity of care for the residents. Staff had access to training in order to ensure that they had the required competencies to provide care and support in line with the residents' assessed needs.

A person in charge and programme manager oversaw the centre at local level. While there were appropriate management systems at the time of inspection, there had been a number of changes to the person in charge role within this registration cycle. This had resulted in deficits in oversight; for example, the management arrangements had not been effective in achieving planned service objectives efficiently.

Provider audits were comprehensive and had identified deficits in areas including relating to residents' general welfare and development. However, actions were not progressed across the audits in order to respond to deficits. Therefore, it was not evident that these audits were effective in driving service improvements and ensuring that actions were completed in a timely manner. The impact on this for residents was that actions required to ensure that residents had meaningful days and were supported to achieve their goals were long outstanding. This is discussed further in the quality and safety section of the report.

Additionally, the changes to the management arrangements had resulted in a deficit being identified in respect of staff supervision. Staff were not seen to be effectively performance managed to exercise their professional responsibilities. While staff had received training in areas such as a human rights based approach to care and in disability awareness, this training did not appear to have resulted in changes to residents' lives in the centre. There were a number of areas which required

improvement to ensure that residents had autonomy, choice and control in their lives.

The provider had submitted a full and complete application to renew the centre's certificate of registration. All of the required documentation such as statement of purpose, certificate of insurance and residents' guide was reviewed and was found to be accurate.

Registration Regulation 5: Application for registration or renewal of registration

The provider made a full and complete application to renew the centre's certificate of registration. The application was made, fee was paid and all prescribed information was submitted within the defined time frame. This afforded the centre the protections of Section 48 of the Health Act 2007 (as amended) while going through the registration renewal process.

Judgment: Compliant

Regulation 14: Persons in charge

A new person in charge had been recently appointed for the centre. They were employed in a full-time capacity and had oversight solely for this designated centre. They were suitably qualified and experienced, having a healthcare management qualification and having worked as a senior staff member for over three years. They demonstrated a comprehensive understanding of their regulatory responsibilities and of the assessed needs of the residents.

Judgment: Compliant

Regulation 15: Staffing

Planned and actual rosters were maintained for the centre. The inspector reviewed the rosters from April to July 2025. It was seen that the staffing arrangements were consistent. There was very little reliance on relief or agency staff which supported continuity of care for the residents. The number of staff and their qualifications was in line with the statement of purpose.

Across four dates explored in detail during April and May 2025, it was seen that the staffing levels were maintained in line with the statement of purpose and appeared to be suitable to meet the needs of and the number of residents. For example, on

27 April 2025 and 18 May 2025, there were four staff rostered on during the day and one on waking night duty.

Schedule 2 files of staff members were not reviewed as part of this inspection.

Judgment: Compliant

Regulation 22: Insurance

The provider submitted a contract of insurance as part of their registration renewal application. The inspector saw that the provider had effected a policy of insurance against injury to residents.

Judgment: Compliant

Regulation 23: Governance and management

This inspection found that the management arrangements of the centre were ineffective in driving service improvements which were required to ensure that residents were in receipt of a good quality service which was promoting their welfare and development.

Actions required to ensure the quality and safety of the service were not progressed in a timely manner. For example, it had been identified on the provider's six monthly audit in December 2024 that residents were not in receipt of meaningful days. This issue remained unaddressed on the following six monthly audit in June 2025.

The June 2025 audit found that residents were not supported to leave the centre on a regular basis and that many of their goals, such as attending a small live music event or going to the cinema, had been in place since 2023 and had not been achieved. The six-monthly audit in June 2025 clearly detailed that this was not acceptable and required action; however, this was known to be a long-standing issue having been identified on the last audit of the centre in December 2024. Other known issues, including damage to a living room wall from a suspected leak was known for some time and had not been effectively addressed.

The provider's annual report from 2024 detailed that many of the actions required from the 2023 annual report had not been completed. It detailed that only 14 of 33 required actions had been completed with 19 of these actions "partially completed".

The designated centre was not wholly meeting the aims and objectives of the service as defined by the statement of purpose. The statement of purpose detailed that the centre aimed to support and empower people with intellectual disabilities to

live meaningful and fulfilling lives; however, as detailed in the quality and safety section of the report, it was not evident that this objective was being met.

Staff supervision records from 2024 were not maintained in the centre. The provider's human resources department provided information on the levels of compliance with supervision within the centre during 2024. The inspector saw that there were some gaps in compliance and was told that this was due to changes to the management systems. For example, in quarter 1 of 2025, only four staff had received supervision.

Staff in this centre had received training in areas such as human rights and communication; however this training was not seen to be promoting a better quality of life for the residents. It was not evident that staff members were being performance-managed to exercise their professional responsibilities for the quality of service that they were delivering.

While there were defined management systems in place at the time of the inspection, it was not evident that the management systems which had been in place during this regulatory cycle were effective in driving service improvements required for the wellbeing of residents.

Judgment: Not compliant

Regulation 3: Statement of purpose

A statement of purpose was available in the designated centre. It was reviewed by the inspector and was found to contain all of the information as required by the regulations; for example, information on the facilities, services and staffing arrangements was provided.

Judgment: Compliant

Regulation 31: Notification of incidents

The inspector reviewed the records of incidents in the centre from January to June 2025 for two of the residents. It was seen that all incidents were reported to the Chief Inspector in line with the requirements of the regulations.

Judgment: Compliant

Quality and safety

This section of the report describes the quality of the service and how safe it was for the residents who lived there. Overall, the inspector found that residents were being very well cared for and that their assessed needs were being met. Staff communicated in a kind manner with residents during the provision of care for activities such as feeding, intimate care and dressing. However, residents had very few opportunities for meaningful activities which enabled them to develop personal relationships outside of the centre. It was not evident that residents were empowered to exercise choice and control in respect of their daily lives.

Residents were living in a house which was designed and laid out to meet their assessed needs. There were suitable facilities for residents to spend time alone or with others in communal areas. Each resident had their own bedroom and staff practices were seen to uphold residents' dignity and privacy when providing care in bedrooms and bathrooms. However, there were a number of premises issues which posed and infection prevention and control (IPC) risk, including a wall which appeared to be damaged from damp or a leak.

Residents' files contained individual assessments which detailed their needs. These assessments were informed by multi disciplinary professionals and were used to inform care plans. Staff spoken with were informed of residents' assessed needs and care plans and were seen to be providing care and support which was generally in line with these, in particular in respect of the provision of food and nutrition and personal care. However, some care plans required updating to be in line with recent changes to residents' assessed needs. Additionally, while residents each had a communication profile on file which detailed how best to support their communication and to facilitate them to have a good day, these supports were not seen to be used or implemented on the day of inspection.

The inspection found that residents were not supported to exercise choice and control in respect of their day or their finances. Residents' weekly routines appeared to be repetitive and offered little opportunity to engage with persons outside of the designated centre or to develop personal relationships. It was not evident that residents had choice and control over their finances. Their financial records showed that residents spent very little money and when they did it was often on basic items rather than on meaningful activities or experiences. Often, residents were not with staff when items were purchased for them which demonstrated that they did not have control over the purchases.

Overall, while residents' assessed needs were being met by a consistent staff team, improvements were required to ensure that care and support was provided to promote autonomy and a good quality of life for the residents which was enabling them to participate in the community.

Regulation 10: Communication

Residents in this centre presented with assessed communication needs. The inspector was told that residents communicated using Lámh, gesture, objects of reference, touch and visual schedules. Staff members spoken with told the inspector that they had received communication training and intellectual disability awareness training which had assisted them in understanding how best to support communication.

Each resident had a communication profile on their file which clearly detailed how best to support their comprehension and to facilitate them to make choices in their daily lives. The profile also detailed what a good day looked like for each resident. For example, one resident's profile detailed that they enjoyed scent bottles, making dough and using edible finger paints.

Visual schedules and choice boards were available in the centre which detailed the planned activities.

While supports to facilitate communication such as communication profiles, staff training and choice boards had been implemented, they were not seen to be utilised on the day of inspection to assist residents to communicate their needs and wishes.

Judgment: Substantially compliant

Regulation 12: Personal possessions

The inspector reviewed the contracts of care and the financial records for three of the five residents. These three residents each had an up-to-date contract of care which detailed the fees to be paid and the services to be provided.

Residents in this house did not have their own bank accounts. Instead, the provider acted as an agent on their behalf and each resident had a debit card which could be topped up with their own funds. A social story detailed that residents had choice between having their own bank account and having the provider act as an agent; however, it was not detailed how the residents had been supported to understand this information and consented to having the provider act as their agent.

In reviewing the residents' financial records, it was seen that residents generally spent very little money and, when they did, this money tended to be on basic items such as socks, pillows, toiletries and sheets. Some of these items were detailed as being provided for within the contract of care and so it was not evident why residents were purchasing them.

The inspector was told that some residents preferred to purchase their own sheets and toiletries; however, in cross referencing the daily records with the financial records, it was seen that residents did not accompany staff to purchase these items. Therefore, it could not be demonstrated that residents had chosen them or that they had consented to their purchase on their behalf. For example, it was detailed that in

June 2025, one resident had purchased a wash bag and a plush toy; however, their daily notes showed that they were not present for the purchase.

It was not evidenced that residents were supported to manage their finances and that they were involved in decisions about how to spend their money.

Judgment: Not compliant

Regulation 13: General welfare and development

Residents living in this centre had very few opportunities for meaningful activities or to make social connections and friends outside of the designated centre. The inspector spent most of the inspection in communal areas of the designated centre, such as the dining room and the sitting room and saw that there was very little opportunity for residents to choose activities or to direct their day. Most of the interactions observed between staff and residents were task orientated; for example, in the provision of care and support with showering, dressing and feeding.

Two residents were supported to go for a drive on the bus during the morning; however, residents were not seen to be provided with information about the drive or given choices of where to go. The remaining three residents spent most of the time in the sitting room. One resident appeared to be watching television, one resident sat in an armchair and was not looking at the television and the third resident was asleep on the couch for much of the morning. It was not evidenced that residents had chosen the television programme which was on or that they had been offered alternative, more stimulating, or personally motivating activities.

One resident was seen to have a music kit beside them. They did not use the kit and staff were not seen to interact with the resident to encourage this. There did not appear to be any barriers to providing meaningful activities as there appeared to be sufficient staff on duty.

The inspector reviewed the daily records for three of the residents over a two week period in June and July 2025. It was seen that there were very limited opportunities to engage in social activities. Most of the daily notes detailed care provided in respect of intimate care and there were very few examples of community activation. Many of the times when residents left the centre, it was detailed that this was for walks on campus.

One resident, over this two week period period, went for three walks on campus and attended a church service on one day. This showed that they left the centre on four occasions within that time. Another resident went to a cafe on one occasion during this two week period. It was noted that they declined activities such as a drive on three occasions; however, it was not detailed that they were offered any alternative activities. A third resident went for two walks on campus during this time period, and on one occasion went for a drive and had dinner in a restaurant.

A visual schedule was on display in the centre. There were very limited opportunities for community activities detailed on the schedule. One resident's weekly schedule detailed that they would only leave the centre on two occasions over the course of the week. Once to go to a supermarket and the second time to go to church.

Residents' financial records were also reviewed, as detailed under regulation 12, and it was seen that residents spent very little money. When they did, this was on a limited range of activities, such as take away dinners and massages, many of which occurred within the centre. One resident, in the month of May had spent money on toiletries and other items such as hangers and towels but had not used their money to avail of any community services or facilities such as meals out, sports or hobbies. A second resident, in the month of June, had visited the same coffee house on four occasions and had purchased take away food twice. There were no other expenses recorded.

The provider's six monthly audits had detailed, since December 2024, that there was a lack of meaningful days for the residents and that residents were not being supported to achieve their goals. For example, one resident had a goal of attending the cinema which had been set in 2023. This goal had not been achieved since being set.

Judgment: Not compliant

Regulation 20: Information for residents

A residents' guide was maintained in the designated centre. It contained all of the information as required by the regulations including, for example, information on the complaints procedure and how to access Health Information and Quality Authority inspection reports of the centre.

Judgment: Compliant

Regulation 27: Protection against infection

The premises of the designated centre posed a number of risks to infection prevention and control (IPC). The flooring was damaged in places and therefore could not be effectively cleaned. A wall in the sitting room was damaged and had a powdery substance on it. The inspector was told by staff that this was a long-standing issue and was potentially damp from a leak in the bathroom behind the wall. This wall was in the main sitting room where residents were observed to spend most of the day. It posed a risk to the health of residents if it was from damp or mould and required attention by the provider.

An IPC audit carried out by the provider in June 2025 had also identified premises issues which posed risks including, for example, the damaged flooring in the dining room.

There had been an outbreak of Influenza in the centre in March 2025 and all six residents had been impacted. The provider's policy detailed that their IPC committee would meet quarterly and review outbreaks and any other IPC risks. There were no records of a review of the Influenza outbreak having taken place.

It was not evidenced that there had been any learning taken from the outbreak. Residents in this centre presented with particular needs which posed a risk to limiting the spread of infection during an outbreak; for example, the inspector was told that most residents would be unable to self-isolate. There was no outbreak management plan to guide staff in managing these risks in the event of there being another outbreak of infection.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

The inspector reviewed the individual assessments for two of the residents. These had been reviewed within the past 12 months as required by the regulations and were informed by the multi disciplinary team. The individual assessment was supported by an "all about me" document which detailed important information about the resident, their needs and their preferences.

Care plans were derived from the individual assessment. These provided guidance for staff in the delivery of care and support. For example, care plans were available in respect of intimate care, nail care and feeding, eating, drinking and swallowing (FEDS).

Some of the care plans required review and updating. For example, a care plan for a resident with oesophageal issues had not been updated since January 2024; and another care plan for a resident with osteoporosis had been last updated in January 2024. This resident had subsequently had a fall and suffered a fracture. While a risk assessment was implemented and updated recently in respect of this need, the associated care plan had not been reviewed and updated.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

There were a number of restrictive practices in this centre as required by residents' assessed needs. These restrictive practices had been approved by the provider's

associated committee. There were very clear protocols for their use and measures had been implemented to ensure that they were as minimally invasive and used for the shortest duration possible.

One restrictive practice, which was required periodically for personal care, had the potential to restrict a resident's freedom and autonomy in choosing to decline this intervention. The inspector saw that the resident's nominated decision making representative had been consulted with regarding this restrictive practice and was in agreement with the protocol.

Consideration had also been given to the potential for this restrictive practice to impact on the resident's relationship with their staff team. The protocol in place accounted for this and had measures in place to limit this potential impact. A planned reduction programme was also detailed including further desensitisation and a plan to reduce the number of staff required and the duration of the restrictive practice.

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	
Registration Regulation 5: Application for registration or renewal of registration	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 10: Communication	Substantially compliant
Regulation 12: Personal possessions	Not compliant
Regulation 13: General welfare and development	Not compliant
Regulation 20: Information for residents	Compliant
Regulation 27: Protection against infection	Not compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 7: Positive behavioural support	Compliant

Compliance Plan for Stewarts Care Adults Services Designated Centre 20 OSV-0005857

Inspection ID: MON-0038816

Date of inspection: 08/07/2025

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 23: Governance and management	Not Compliant

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

The Register Provider will ensure that the care management team are committed to urgently addressing the concerns identified.

The Register Provider will ensure that a person-centered and quality focused environment for all residents in this Designated Centre. Actions have already commenced to address deficiencies noted in the areas of activities, resident choice, and infection prevention and control (IPC).

The Register Provider has arranged and has commenced a hands-on review by the Director of Care (Residents) and his management team of all individual activity plans, in consultation with residents and their key workers, to include a review of residents' assessments and personal goals.

The Register Provider has arranged and commenced a review of all Provider Audits and Visits, including IPC audits, by the Director of Care (Residents) and his management team. Actions outstanding will be addressed and Persons in Charge will inform an improved system to prevent any reoccurrence.

The Register Provider will ensure and instigate a new management oversight meeting focused on resident's wellbeing, rights, and quality of care in each campus home. These will occur monthly in a formal format with minutes available for review.

The Register Provider has arranged an increased frequency of unannounced in-home visits by the Director of Care (Residents) and his management team to review the impact of the aforementioned, and to ensure improvements are tangible and sustainable.

All Supervisions for Quarter 3 will be completed by 30/09/2025 by the new management team in the designated Centre.

All staff in the designated Centre will have completed refresher training in human rights training before the 31/10/2025. All staff will also complete total communication training, person centered training and key worker training before 31/10/2025.

Weekly on-site support from the person-centered planning coordinator to support residents and staff on developing smart goals and completing PATH goals.

Regulation 10: Communication	Substantially Compliant

Outline how you are going to come into compliance with Regulation 10: Communication:
The Person in Charge, with the support of the social care worker, will ensure that appropriate communication systems are effectively utilized to assist residents in expressing their needs and wishes by all staff. They will also ensure continuous monitoring to confirm that staff are actively engaging with and involving service users in all aspects of decision-making related to their lives.

The Person in Charge will ensure all staff complete Key Worker training and total communication training so they are maximizing the use of existing communication systems. This training will be completed for all staff before 31/10/2025. This will ensure that residents are empowered to advocate for their needs and that their choices are consistently respected.

Regulation 12: Personal possessions	Not Compliant

Outline how you are going to come into compliance with Regulation 12: Personal possessions:
The Person in Charge will ensure that the Residents understand their financial options and are supported to make an informed decision by ensuring that the existing social story is revised and enhanced regarding financial choices (e.g., holding a personal bank account vs. the provider acting as an agent) to ensure it is accessible, clear, and tailored to each resident's communication needs and that they are supported to understand this information and consented to having the provider act as their agent. The Person in Charge with the support of Social Care worker and key workers will ensure that there is clear evidence that residents have understood and consented to the financial arrangements in place. This will be completed by 31/08/2025.

The Person in Charge will ensure that a review in resident expenditure practices are in place by auditing financial records to identify all instances where residents have been purchasing items already included in their contract of care and to identify inappropriate or unnecessary resident spending. The Person in Charge will ensure that staff have clear guidelines to staff outlining what items are provided by the service and under what circumstances residents may choose to purchase alternatives. The Person in Charge will ensure that staff are informed and residents are not spending personal funds on items included in their contract of care unless by informed choice. The audit commenced on the 31/07/2025, and discussion of residents' expenditure practices is scheduled for discussion on August 2025 staff meeting and Q3 2025 staff supervision.

From the 14/07/2025, The Person in Charge has commenced ensuring that the documentation of resident choice in purchases is in place through key worker meetings and daily recordings by ensuring that when purchases are made on behalf of residents, there is a clear record showing: That the resident has expressed a preference. That the residents were involved in the selection process and that consent of the purchase was recorded. This practice will ensure transparent documentation that upholds residents' autonomy and consent.

The Person in Charge with support from social care worker will ensure residents are actively involved in personal purchases, supporting autonomy and dignity that the key workers are facilitating residents' participation in shopping by ensuring that the residents are supported to accompany staff when shopping or provide alternative methods for them to be actively involved in selecting items (e.g., catalogues, online browsing, visual aids) This work commenced on the 21/07/2025.

The Person in Charge will ensure that there is an increased staff understanding and improved practice around resident financial management by arranging for staff training and awareness by ensuring that staff completes a revision training in Supported decision-making, Human Rights Based approach and that this will be discussed and monitored on quarterly supervisions. This will be discussed on August 2025 staff meeting, Q3 2025 staff supervisions and staff will have completed all training by 31/10/2025.

The Person in Charge will ensure that continued compliance and improvement in supporting residents manage their finances and support for choice are in place by conducting monthly audits of financial records, consent documentation, and shopping logs, meaningful activities and key worker meetings. This commenced on 31/07/2025.

Regulation 13: General welfare and development	Not Compliant

Outline how you are going to come into compliance with Regulation 13: General welfare and development:

The Person in Charge with the support of social care worker and key workers will ensure that a person-centered profile of each resident's preferences and activity goals is in place and that staff are supporting residents to have meaningful activities, social inclusion and autonomy. The Person in Charge will ensure that a robust system is in place in reviewing and assessing each resident's interests and preferences by conducting a thorough review of each resident's interests, hobbies, social goals, and preferred activities through key worker engagement and person-centered planning. This will be completed by 31/08/2025. Additionally, the person-centered planning coordinator will support residents and staff to develop smart goals and complete PATH goals weekly from the 11th of August.

The Person in Charge will ensure that each resident has an individualized activity plan that reflects their preferences and promotes autonomy and community involvement, and these are discussed on the residents' weekly service users meeting. The Person in Charge with the support of social care worker will develop a weekly activity plan tailored to each resident's interests, ensuring a balance of in-house and community-based opportunities for engagement, choice, and social interaction. This commenced on 14/07/2025.

The Person in Charge will ensure that improvement in staff understanding and practice in supporting resident-led lives and meaningful interactions are in place and will arrange for Staff to complete a training on Person-Centered training and key worker training before the 31/10/2025.

Weekly on-site support from the person-centered planning coordinator to support residents and staff on developing smart goals and completing PATH goals. This will commence on the 11th of August 2025.

Regulation 27: Protection against infection	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
The Register Provider has arranged for the IPC Nurse on 16th of July 2025 to provide a report for the review of the influenza outbreak and to ensure that guidance is provided in completing Health Care Associated Infections contingency and management plan. The Person in Charge with the support of the nurses in the centre will ensure that an individual Health Care Plan is in place for Health Care Associated Infection by 30/09/2025.

The Register Provider has arranged for an on-site visit and assessment on the 31/07/2025, in the Centre to review the premises issues such as wall, flooring and other

issues contributing to Infection Prevention Control. The Register Provider will ensure that Technical Services department has completed any outstanding jobs by the 30/09/2025.

Regulation 5: Individual assessment and personal plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
The Person in Charge along with the nursing team in the designated Centre will ensure that a full audit of all resident's care plans is in place to identify any overdue reviews or missing updates, this is to be completed by 31/08/2025.

The Person in Charge will ensure that the care plan for the resident with oesophageal issues to is updated to reflect current needs and that care plan for the resident with osteoporosis is updated and to include post-fall care, fracture management, and to have increased risk monitoring. This is to be completed by 31/08/2025.

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 10(1)	The registered provider shall ensure that each resident is assisted and supported at all times to communicate in accordance with the residents' needs and wishes.	Substantially Compliant	Yellow	31/10/2025
Regulation 12(1)	The person in charge shall ensure that, as far as reasonably practicable, each resident has access to and retains control of personal property and possessions and, where necessary, support is provided to manage their financial affairs.	Not Compliant	Orange	31/08/2025
Regulation 13(2)(b)	The registered provider shall provide the following for residents; opportunities to participate in	Not Compliant	Orange	31/08/2025

	activities in accordance with their interests, capacities and developmental needs.			
Regulation 13(2)(c)	The registered provider shall provide the following for residents; supports to develop and maintain personal relationships and links with the wider community in accordance with their wishes.	Not Compliant	Orange	31/08/2025
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	31/08/2025
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and	Not Compliant	Orange	31/10/2025

	quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.			
Regulation 23(3)(a)	The registered provider shall ensure that effective arrangements are in place to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.	Not Compliant	Orange	30/09/2025
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.	Not Compliant	Orange	30/09/2025
Regulation 05(6)(d)	The person in charge shall	Substantially Compliant	Yellow	31/08/2025

	ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall take into account changes in circumstances and new developments.			