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:	Moorehaven Services
Name of provider:	Corlann
Address of centre:	Galway
Type of inspection:	Announced
Date of inspection:	15 April 2026
Centre ID:	OSV-0007838
Fieldwork ID:	MON-0041239

About the designated centre

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

Moorehaven Services is a centre run by Brothers of Charity Services Ireland CLG. The centre is intended to meet the needs of up to four residents, who are over the age of 18 years and who have an intellectual disability. The centre comprises of one two-storey building, which provides some residents with their own apartment, comprising of a bedroom, bathroom and living area. Other residents have their own bedroom, access to shared communal areas and multiple living areas to use as they wish. Staff are on duty both day and night to support the residents who live here. An on-call arrangement is also in place to support this centre's night-time staffing arrangement.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	8

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
Wednesday 15 April 2026	09:40hrs to 17:05hrs	Maureen McMahon	Lead

What residents told us and what inspectors observed

This inspection was carried out to monitor the provider's compliance with the regulations and following receipt of an application to renew the registration of the centre. As part of this inspection, the inspector met with residents who lived in the centre and observed how they lived. The inspector also met with the person in charge, two team leaders, staff on duty and viewed a range of documentation and processes. The provider had reconfigured this designated centre in February 2025, resulting in changes to the houses within the centre, as well as the management team.

While staffing challenges were present, staff endeavored to support residents to partake in activities they enjoyed, achieve best possible health, and to work towards personal goals. However, improvement was required to ensure that staffing levels were aligned with residents' assessed needs. At times, insufficient staffing impacted residents' ability to carry out their preferred activities and contributed to a more restrictive environment. In addition, this inspection found that supports in relation to positive behavior support required improvement, including the guidance available to staff.

The centre consisted of two large houses close to a rural village. The houses were a short drive apart. Their location allowed residents to access large gardens and enjoy the countryside, while also being able to access shops and cafes in the nearby village. The first house in the centre was a detached two-storey house with a separate apartment to the rear. The second house was also a large detached two-storey house, with an individualised apartment attached. The design and layout of both houses provided sufficient space for residents to spend time in private or to meet with family and friends. During a walk-around of the centre, the inspector observed that both houses were personalised with pictures and soft furnishings, and residents had decorated their bedrooms in line with their preferences, including themes of musical interests. All bedrooms were spacious, and some included en-suite facilities.

Residents in this centre had medium to high support needs in relation to positive behaviour support, communication, and healthcare. The layout of the centre promoted an environment where residents did not adversely impact one another. In one house, the provider had identified compatibility concerns between residents and addressed these by supporting one resident to move to a self-contained apartment. In the second house, one resident was supported to live in a self-contained apartment in line with their assessed needs. Overall, these arrangement were effective in supporting residents' needs and promoting a positive living environment.

The inspector had the opportunity to speak with a resident who appeared content and relaxed, they spoke about their plans for the day, including their interest in rugby and recently celebrating Easter. Throughout the inspection, the inspector

observed residents' daily lives and the activities they enjoyed. One resident accompanied by a peer, was seen attending a local place of worship after returning from day services, which was a regular activity for this resident. Other residents were observed settling back into their home and engaging in preferred routines upon arrival home from day services, including one resident who enjoyed sitting by the window watching the garden. However, the inspector observed that staffing levels impacted residents' ability to access a broader range of activities and limited the choices available to them.

The person in charge and team leaders were committed to ensuring the centre promoted a human rights based approach to service delivery. This was evident in their detailed review of restrictive practices and the progression of actions to ensure theses were appropriately overseen and used in the centre. In February 2026, local management had identified that staffing levels required review, as they were impacting on residents' access to activities and contributing to the use of restrictive practices. A roster review was planned to ensure staffing arrangement aligned with residents' assessed needs.

Records reviewed indicated that residents' had opportunities to partake in leisure activities they enjoyed, including days out, shopping trips, attending places of worship, meals out and hotel breaks. One resident had identified a personal goal to visit Lourdes, and on the day of inspection, the person in charge informed the inspector that planning for this was ongoing.

Overall, this inspection found that residents were generally supported to engage in activities and routines in line with their assessed needs. However, improvements were required guidance available to staff, and staffing levels, as identified by local management, to ensure they were aligned with residents' needs.

The next sections of this report present the inspection findings in relation to the governance and management in the centre and, how governance and management affects the quality and safety of the service and quality of life of residents.

Capacity and capability

Based on the findings of this inspection, this centre did not present as adequately resourced. On the day of inspection, the inspector found that staffing resources were insufficient to meet the assessed needs of residents. For example, where residents were assessed as requiring 2:1 staffing for aspects of daily living, this level of support was not consistently available.

There was a clear governance structure with defined roles and responsibilities identified to manage the centre. The person in charge was familiar with residents who lived in the centre and their assessed needs. The person in charge was supported in their role by a team leader in each location who worked full time in the

centre. Day-to-day management of the centre was the responsibly of the team leader. The person in charge retained overall responsibility for governance and oversight. The person in charge delegated appropriate tasks, such as certain audits to team leaders, with regular meetings to maintain effective oversight. The person in charge described how they maintained an active presence in the centre, visiting each house frequently each week and daily phone contact. Staff members spoken with confirmed they had access, support and guidance as needed from the person in charge and team leaders. There was good attendance at staff meetings and areas such as safeguarding, staff training, fire safety and personal planning were discussed. Local management had in addition, recently held specific meetings in relation to medicines management to strengthen the arrangements in place in the centre and following from a review of incidents. Residents were supported by a consistent staff team who were suitably trained and knowledgeable of their preferences and support needs.

The provider had ensured that the centre was subject to ongoing monitoring and review to support a high standard of care. These included provider unannounced audits undertaken every six months and an annual review of the centre. The inspector read the most recent annual review for the service, where improvements were identified a quality improvement plan was in place. For example, where maintenance works were identified they were either completed or logged on the centres maintenance system. There was evidence of consultation with residents and their representatives as part of the annual review and this was included in the report. In addition, a range of audits were undertaken by local management, in areas such as personal plans, infection control, finances, restrictive practices, and healthcare. The inspector read these audits and saw that a high level of compliance had been achieved in certain areas and other areas such as restrictive practices were identified as requiring significant improvements. The inspector reviewed records from February 2026, where local management had conducted an audit of the centre and identified restrictive procedures that required further oversight. This demonstrated a commitment to comprehensively review the current practices in the centre and ensure restrictive procedures are in line with best practice and evidence based practice.

Registration Regulation 5: Application for registration or renewal of registration

The prescribed documentation and information required for the renewal of the designated centre's registration had been submitted to the Chief Inspector of Social Services. The inspector reviewed this documentation and found that it had been suitably submitted.

Judgment: Compliant

Regulation 14: Persons in charge

The provider had appointed a suitable person in change to manage the centre. The role of the person in charge was full-time and they were suitably qualified and experienced.

The inspector reviewed the information submitted to the Chief Inspector in respect of the person in charge. This demonstrated the person in charge was suitably qualified and experienced for the role with experience in managing disability services. Throughout the inspection, the person in charge was found to be very knowledgeable on their regulatory responsibilities and the assessed needs of residents in the centre.

Judgment: Compliant

Regulation 15: Staffing

Staffing levels were found to be insufficient to meet the assessed needs of residents.

The inspector reviewed actual and planned rotas in both houses in this centre. House one was found to be sufficiently resourced with enough staff on duty to meet residents' needs. However, house two was found to not have sufficient staff to meet residents' needs. Rosters were reviewed for April 2026. This review indicated that frequently staff levels were not maintained in alignment with resident's needs. For example, three residents were assessed as requiring a 2:1 staff ratios in the community, given the allocated staff on duty is was not possible for staff to offer choice in relation to community access or to support residents to leave the centre. On a regular basis, three staff were working in the centre when all five residents were home. This minimum staffing level in the centre required the review of the provider to ensure this was in line with residents' assessed needs.

The limitations of this roster also impacted on one resident during day hours who was supported in a wraparound service. For example, it was not always possible for a resident to be supported to leave their home for day activities as they were supported by a 1:1 staff in their home at times, but required 2 staff to leave the centre. It was evident that staff were diligent in the management of resources to support residents as much as possible in the centre with allocated resources and also to access the community where opportunities arose. However, where it was clear that a resident may benefit and enjoy certain trips this was not always possible to facilitate in the centre. For example, where it was identified a resident would enjoy a trip to a religious area during birthday celebrations, staffing resources in the centre were not available and this activity took place at a later date in day services.

In addition, from a review of records it was evident staffing levels in the centre required the review of the provider when two staff were away from the centre providing 2:1 staff supports. For example, records reviewed demonstrated at times

one staff member was responsible for supporting four residents in the centre. This was discussed with local management and staff, this level of staffing was found to impact residents. Staff described using restrictive procedures such as locked doors during periods of low staffing to maintain a safe environment. This will be further discussed under regulation 7.

From discussion had with local management, they had identified this shortfall in staffing resources and had escalated it as a high risk to senior management, seeking further funding and a comprehensive review of the current roster.

Judgment: Not compliant

Regulation 16: Training and staff development

The provider had ensured that all staff who worked in the centre had received mandatory training in areas such as fire safety, positive behaviour support and safeguarding adults from abuse.

The inspector reviewed the staff training records for the centre and found that mandatory training and other appropriate training had been delivered to all staff as required. Most staff had completed training in communication, while some staff were booked to attend enhanced communication training in the coming weeks. Local management clearly described sourcing relevant training for the centre, with some staff recently having completed sensory training.

Staff had received formal supervision in line with the providers own policies and procedures. A supervision schedule for 2026 had been prepared, and local management were in the process of meeting with staff accordingly.

Judgment: Compliant

Regulation 22: Insurance

The provider had ensured that the centre was suitably insured against risk of loss or damage to property and or injury to residents.

The inspector viewed the centre's certificate of insurance which was submitted to the Chief Inspector as part of the centre's registration renewal process and found that it was up to date.

Judgment: Compliant

Regulation 23: Governance and management

Improvement was required to the resources available in the centre to ensure a good-quality and safe service was provided for residents living in the centre. Oversight of restrictive practices also required review.

The provider had developed a clear organisational structure to manage the centre, as outlined in the statement of purpose. There was a suitably qualified person in charge, they also held other managerial duties within the organisation. A team leader was assigned to each house in the centre to support the person in charge with management duties. Both team leaders primarily delivered care to residents, with ten hours per fortnight protected for administrative duties. These hours were flexible and responsive to service needs, increasing where required. The person in charge was frequently present in the centre, and was well known to residents and staff. Local management had identified that staffing resources in one location required review and had escalated this to senior management highlighting this concern. This concern was recorded on the centre's risk register and rated as a high risk.

Staff meetings and staff supervision were taking place as scheduled. Staff confirmed that they regularly attend team meetings and had opportunities to meet their line manager to discuss relevant issues.

A range of audits was in place to monitor the quality of care in the centre. These included unannounced six monthly provider audits, and an annual review of the service. In addition, team leaders and the person in charge completed audits on a weekly, monthly, quarterly, and biannual basis across areas such as incident management, restrictive practices, infection prevention and control (IPC), health and safety, and medicines management. Where areas for improvement were identified, a quality improvement plan was in place. For example, local management has recently identified that restrictive practices were not in line with national best practice or appropriately overseen. The person in charge had raised these concerns with the multidisciplinary team in February 2026 with meetings scheduled for April 2026 to review these practices.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The provider had prepared a statement of purpose which included all the information required by Schedule 1 of the regulations.

The statement of purpose outlined a range of information about the centre, including the facilities and services in the centre, the organisational structure, and the arrangements for consultation with residents.

Judgment: Compliant

Quality and safety

There were systems in place to ensure that residents had a comfortable life. Improvements were required to ensure residents' positive behaviour support needs were appropriately monitored and reviewed. Although the provider had identified staffing resources required review, this inspection also found this impacted on the use of restrictive practices in the centre.

The centre comprised of two houses, located a short distance apart, which could accommodate up to nine residents. The centre suited the needs of residents', was of sound construction and was well maintained. During a walk about of both houses, the inspector found that the centre was clean, comfortable and nicely furnished. The centre was also equipped with Wi-Fi, televisions and facilities for entertainment such as phones and computer tablets. In one location, a tropical fish tank was available in a communal area that was bright, relaxing and enjoyable for residents, staff and visitors.

The provider had arrangements in place to safeguard residents from all types of harm and abuse. These included safeguarding processes and the review of restrictive procedures. Following from a recent review of restrictive practices, the provider had identified some practices that required urgent review and on the day of inspection this was ongoing with reviews planned for April 2026. Local management described a reduction in some restrictive procedures in the centre. For example, the use of equipment on the stairs was currently in the process of data collection with a view to the removal of this restrictive procedure in the coming weeks. The provider had ensured the centre was suited to a resident with a visual impairment, this was achieved through the layout, design, and ongoing environmental considerations such as a clutter free space. The inspector observed artwork created by a resident. This was displayed prominently and enhanced the décor of the room.

Residents' assessed needs in this centre were well-known to staff, and good practices were found in relation to these. There was an effective personal planning system in place, and residents were supported to partake in different activities. The inspector reviewed one residents personal planning records, these were written in the style and manner the resident requested. For example, this plan was written on sticky notes and written in a format that the resident had chosen. This resident was found to have full control over their planning process and their personal goals. The service had a proactive model in supporting residents' healthcare needs. Residents were supported to achieve good health through ongoing monitoring of healthcare

issues, access to national health screening programmes and encouragement to lead a healthy lifestyle. Residents' nutritional needs were well met. Both houses had well-equipped kitchens where food could be prepared and stored. Individual plans of care had been developed for resident's based on their assessed needs to guide staff in areas such as healthcare, safeguarding, and social needs. Where required, positive behaviour support guidance was available to staff. As discussed under regulation 7, this guidance was not always the most up-to-date posing a risk of inconsistent practices and approaches.

The provider had systems in the centre to manage and reduce the risk of fire. These included staff training, emergency evacuation drills, personal evacuation plans, servicing of fire safety equipment by external experts and ongoing fire safety checks by staff. Fire doors were fitted throughout the building to limit the spread of fire. The provider was requested to assure themselves they are satisfied with the evacuation times for a night drill undertaken in January 2026.

Staff were knowledgeable about the support needs of residents and supported them in a caring and respectful manner. However, improvement was required to ensure routines and practices promote residents' autonomy, independence and choice. This is further discussed under regulation 9.

Regulation 17: Premises

The centre suited the needs of the residents and was well maintained, spacious and suitably decorated.

The centre could accommodate up to nine residents in two houses located in rural areas, a short distance apart and close to a small village. During a walk around of the centre, the inspector found both houses were spacious and there was adequate communal space, where residents could meet family and friends or partake in preferred activities. Each resident had their own bedroom and some rooms were en-suite. Residents had adequate storage for their personal belongings. Both houses had well equipped kitchens and dining areas. There were well-kept gardens in both houses where residents could spent time outdoors. The provider had ensured both houses were accessible with ramped access in place where required. In addition, recently the provider had worked with the multidisciplinary team, including an occupation therapist to review the use of living space in one house. This resulted in a sunroom being renovated and a specific area been made available to a resident for their preferred activities. The inspector observed a mini fridge and other items for beauty treatments in this area and discussion with staff indicated that the resident choose the décor for this area. In addition, the inspector observed that appropriate supports were in place to meet the needs of a resident with a visual impairment. For example, the environment was maintained in a clutter-free manner, handrails were available and appropriate lighting was provided in the centre. These measures along with staff awareness supported the resident to reduce potential risks.

Judgment: Compliant

Regulation 26: Risk management procedures

There was a current risk register were both local, environmental and individual risks to residents were recorded. Each identified risk had a risk management plan and this was risk rated appropriately. Risks identified were consistent with the findings of this inspection. Local management had identified staffing and restrictive practices as high risks that required review. The measures in place to reduce these risks included a roster review, an application for additional funding and an overall review of restrictive practices in the centre. Records reviewed evidenced that these risks were well known to local management and control measures were currently being actioned as a priority.

The provider had arrangements in place to identify, record, investigate, and learn from incidents in the centre. The inspector reviewed incidents that had occurred in the centre in January, February, and March 2026. Where an incident had occurred these were comprehensively discussed at the next team meeting, where staff and local management discussed strategies and recorded learning.

Judgment: Compliant

Regulation 28: Fire precautions

There were measures in place to safeguard residents, staff and visitors from the risk of fire. However, the inspector sought assurance that the provider had adequately reviewed fire evacuation times and was satisfied that they were appropriate.

Fire drill records for 2025 and up to 15 April 2026 showed that drills were undertaken at various times and under differing circumstances. A night-time drill in January 2026 recorded an evacuation time of 7 minutes and 38 seconds. It was unclear whether any issues occurred during this drill that contributed to a longer evacuation time, or whether the provider had reviewed and assessed this duration as acceptable. In comparison, previous night-time drills in April and May 2025, demonstrated times of 5 minutes and 21 seconds and 5 minutes and 55 seconds respectively. It was not evident whether the increase in evacuation time had been identified, reviewed or addressed by the provider or whether the provider was assured that this remained an appropriate evacuation timeframe for residents.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Comprehensive assessments of health, personal and social care needs had been carried out and personal plans were in place for each resident based on their assessed needs.

The inspector viewed a sample of two residents' personal plans and found these had been developed with the person supported and the multidisciplinary team. Clear plans of care had been developed to provide staff with the information required to support residents to live meaningful lived. Residents' personal goals had been agreed at annual planning meetings, and progress in achieving these goals was being reviewed and updated. The inspector viewed a residents annual meeting minutes, this meeting was personal centered with the resident choosing the format of the meeting and how the minutes were maintained.

Judgment: Compliant

Regulation 6: Health care

Residents' healthcare needs were well supported and residents were active participants in their healthcare choices. For example, where staff had identified a change in weight for a resident, this had been followed up with a referral to the appropriate healthcare professional.

Residents had access to various allied healthcare professionals, including their general practitioners, occupation therapists, physiotherapists, and positive behaviour support specialists as required. Records reviewed evidenced that residents' were supported to attend their general practitioners for routine annual medicals. Where appropriate residents had access to health screening programmes and local management described supporting residents to access national screening programmes, such as the national bowel-screening programme.

Overall, the inspector was assured that residents' healthcare needs were monitored and that up-to-date care plans were available to guide staff.

Judgment: Compliant

Regulation 7: Positive behavioural support

The provider was required to review the measures in place for managing restrictive practices in the centre. In addition, the guidance relating to positive behaviour

support for one resident was not up to date, which impacted the consistency of staff approaches and, the quality of care provided.

Local management had identified in February 2026 that a number of restrictive procedures were not aligned with national policy or evidence-based practice. Although these practices were long established, they had not been subject to review by the human rights review committee or the multidisciplinary team. For example, one resident living in a self-contained apartment, was at times supported to receive items such as food and medicines through a hatch in a door. There was no clear rationale documented for how this practice had developed. This door was also frequently locked, and staff reported that it was consistently locked during periods of reduced staffing to maintain the safety of the resident and others, particularly if the resident became dysregulated. This hatch system was observed by the inspector on the day of inspection and was found to be highly restrictive and not in keeping with a human rights-based approach to service delivery. This system of exchange between the main house and the self-contained apartment did not promote this resident's right to independence or a restraint-free environment. Local management had escalated this as an urgent concern to the multidisciplinary team and the human rights review committee in February 2026, with a review of the practice scheduled to take place in April 2026.

Overall, where positive behaviour support was required, appropriate arrangements were in place for residents. However, records reviewed indicated that one resident with complex behavioural needs continued to be supported with guidance issued in August 2023. Despite this resident presenting with evolving and complex needs, an up-to-date plan was not available at the time of inspection. While the process of updating this guidance had commenced prior to the inspection, the multidisciplinary team acknowledged that, due to the complexity of the case, this would take time to complete. In the interim, the absence of current guidance impacted staff's ability to implement a consistent approach to care. Observations during the inspection, alongside a review of records and staff feedback, demonstrated variations in practice. For example, existing guidance indicated that staff could support this resident on a one-to-one at certain times. However, the guidance lacked clarity and robustness, resulting in inconsistent approaches among staff.

Judgment: Not 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	Not compliant
Regulation 16: Training and staff development	Compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Quality and safety	
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Not compliant

Compliance Plan for Moorehaven Services OSV-0007838

Inspection ID: MON-0041239

Date of inspection: 15/04/2026

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	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: In Accordance with Regulation 15(1), A comprehensive staffing review has been carried out by local management. This identified the staffing levels required to ensure that People Supported assessed needs are met. Consequently, A staff member commenced in the Centre on 5th May 2026 to facilitate wrap around support. This ensures that both people supported receiving a wraparound service within the Centre have adequate staffing in place. Also, a Social Care Worker is currently going through the recruitment process after a successful interview and they will commence induction within the Centre once all their paperwork is in place. Recruitment of Locum Staff for the service area is also in process to ensure that staffing levels are maintained and consistent within the Designated Centre The introduction of the two new additional staff to the team will ensure adequate resources are in place to effectively meet the assessed needs of Individuals and ensure that restrictive practices are not in place due to insufficient staffing levels.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: In Accordance with Regulation 23(1)(a), A staffing review has been carried out and consequently a new staff member joined the team in House 2 of the Designated Centre on the 5th May 2026 to ensure the wrap around service within the Centre is adequately resourced. A Social Care Worker is also going through the recruitment process and will commence induction within the Centre once all paperwork is in place. Staffing levels in line with assessed needs will be reviewed on a regular basis to ensure a good quality and safe service is provided for all Residents. Restrictive practices were an agenda item at MDTs held on 14th May 2026 for Individuals	

in House 2 with a focus on the reduction of certain restrictive practices in line with the delivery of a safe service.

The Human Rights committee also did a house visit to House 2 in the Designated Centre on 14th May 2026 to review all restrictions within the Centre. Recommendations have been received from this visit and further MDT and management meetings will be required to ensure that the Centre meets best practice in this area. All restrictions will continue to be submitted to the chief inspector on a quarterly basis.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
In Accordance with Regulation 28(2)(b)(ii) Two-night time fire drills have been carried out which have assured the provider that they can effectively support People Supported safely in the event of a fire at night.
Personal evacuation plans for all People Supported have also been reviewed and fire Precautions will remain an agenda item at staff team meetings. The staff team have been asked to carry out more detailed fire drill records and these will be reviewed by the Team Leader and Person in Charge after each drill and any corrective actions followed up on and addressed as appropriate.

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
In Accordance with Regulation 7(1), One Individuals Positive Behavior Support Plan has been updated, however it was acknowledged at this Individuals MDT on 14th May 2026, that further review of the document was required and the Multi-Disciplinary Team acknowledged the requirement to carry out further assessments and consultation with staff team and the person supported.

In Accordance with Regulation 7(4) Restrictive practices were an agenda item at MDTs held on 14th May 2026 for People Supported in house two with a focus on the reduction of certain restrictive practices in line with the delivery of a safe service. The Multi-Disciplinary Team acknowledged the requirement to carry out further assessments and consultation with the staff team and People Supported with the long term goal of the reduction of restrictive practices in line with national policy.

The Human Rights committee also did a house visit to the Centre (house 2) on 14th May 2026 to review all restrictions within the Centre. Recommendations have been received from this visit and further MDT and management meetings will be required to ensure that the centre meets best practice in this area.

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.	Not Compliant	Orange	01/09/2026
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.	Substantially Compliant	Yellow	01/09/2026
Regulation 28(2)(b)(ii)	The registered provider shall make adequate arrangements for	Substantially Compliant	Yellow	18/05/2026

	reviewing fire precautions.			
Regulation 07(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.	Not Compliant	Orange	01/09/2026
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.	Not Compliant	Orange	01/09/2026