Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Disabilities (Children).

Issued by the Chief Inspector

Name of designated centre:	Gleneden
Name of provider:	Daffodil Care Services Unlimited
Address of centre:	Tipperary
Type of inspection:	Unannounced
Date of inspection:	09 February 2026
Centre ID:	OSV-0007981
Fieldwork ID:	MON-0049506

About the designated centre

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

Gleneden comprises a large two-storey dwelling in a scenic rural area in Co. Tipperary, with access to the local community and amenities. The centre has a capacity for two residents at any one time and services are provided through a bespoke residential service. Services will accommodate for persons aged 18 or younger with the exception of a young person currently completing their final year of second level education. Residents have their own bedrooms. Gleneden provides social care disability services to those requiring support for complex physical or cognitive needs as a result of ADHD, intellectual disability, autism spectrum disorder or other related disability. Staffing levels will be reflective of individual support needs of service users; staff team will be a combination of support and senior support workers. Emergency admissions may be facilitated if the premises is otherwise unoccupied.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	2

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Monday 9 February 2026	10:00hrs to 17:00hrs	Sarah Mockler	Lead
Monday 9 February 2026	10:00hrs to 17:00hrs	Conor Brady	Support

What residents told us and what inspectors observed

The purpose of this unannounced risk based inspection was to follow up on actions taken by the provider following an inspection in October 2025. In October 2025 there were concerns in relation to the governance and management arrangements in this centre and the implementation of positive behaviour support measures for the young people living there. The current inspection found that the provider had failed to take the necessary actions to come back into compliance with these regulations. There continued to be concerns around the standard of local governance and management arrangements and managerial oversight, positive behaviour support to young people, effective risk management and safeguarding follow up at centre level. Although incidents had recently been low in the centre this was not due to good risk management practices and inspectors found that further action was needed to ensure robust systems were in place to keep the young people safe at all times.

On the day of inspection, there was no person in charge appointed to the centre. The person in charge that had been nominated by the provider did not meet the relevant standards as set out in the Regulations as they did not have the required qualifications/experience.

The inspection was facilitated by the staff team and the recently appointed person participating in management (PPIM) who was in the role of Senior Support and Integration Manager within the organisation and came to the centre at the request of the provider.

Two inspectors completed this inspection. The centre is registered to accommodate two young people under the age of 18. There were two young people living in the centre on the day of inspection and both were met with and spoke with inspectors freely.

On arrival to the centre, inspectors were welcomed in by a staff member and introduced to the young person present. The young person present was off school for the day (the school was closed for staff training). They were sitting in the kitchen enjoying a warm drink. Two other staff members were also present at this time. The other young person who lived in the centre had left and gone to school.

The young person present spent time with the inspectors and told them about their life. They stated that overall they were happy living in the centre. The had regular contact with their Child and Family Agency (TUSLA) social worker, an EPIC (Empowering People in Care) advocate and spoke about the roles they had in their life. They said that overall they felt supported by the staff team at present but also stated that they did not always get on with all staff. If this happened they would know who to talk to. They confirmed that they were happy with the staff team at the moment. They showed the inspector around their home. Personal items were on

display in their bedroom and 'man cave'. They had video games, access to the Internet, editing tools to edit social media content, instruments, SMART television, gaming devices, and other items that were important to their life. They showed the inspector how they learned to play the key board and also spent time explaining to the inspector around their interests in editing clips for a social media platform. They confirmed that they felt happy and safe in their home.

The young person had plans to take a train to a town in Co. Tipperary as they were working on their independent living skills. A staff member was due to accompany the resident on this trip and the inspectors observed the staff member and young person get ready for this trip.

The young person overall had very good access to activities and their community. They attended school five days a week, went hiking, went to the gym, went on holidays, had friends and spent time in the community when they so wished. The young person spoke in detail about the activities they liked to do and confirmed with the inspectors that they got to plan activities and events in line with their interests and needs. For example, the young person explained to the inspector that they were able to invite their friends to their home if they so wished.

The inspectors completed a full walk around of all areas of the home. For the most part the home was clean and well maintained. Each young person's bedroom was well personalised with items, posters and pictures. The young people also had access to a sitting room, kitchen conservatory and 'man cave' (a term used by the young people themselves). The 'man cave' had exercise equipment, gaming devices and other activities. This was located in a garage to the side of the property.

The second young person came home in the afternoon after school. They were observed to get a snack in the kitchen. The inspectors introduced themselves and asked the young person how they were getting on. They stated that it was 'ok' living in the centre but did not expand on this. They confirmed they had a good day at school and went back to making their snack.

Some direct quotes from young people -

"I like living here and feel safe"

"Some staff are good but we have had a few characters who were not so good"

"I don't like too much change"

"I'm looking forward to going mountain hiking in Wales with staff"

"Staff are good to me"

"I have no worries living here"

"Living here is okay for now"

As part of the inspection process one inspector spoke with family representatives, TUSLA Social Worker, HSE representatives and a Guardian Ad Litem. Some of the feedback in relation to the service provided was complimentary and in line with some of the findings such as access to activities and school. However, some feedback highlighted concerns in relation to the care and support within the service and in particular risk management and safeguarding of one young person. This also included concerns in relation to the complaints process, communication, and positive behaviour support/clinical oversight.

Overall, it was found that while young people were safe and well at the time of this inspection, a number of improvements were needed to ensure the service provided was in line with the Regulations and met the minimum standards required to ensure care and support was in line with best practice. The next two sections of the report present the findings of this inspection in relation to the the overall management of the centre and how the arrangements in place impacted on the quality and safety of the service being delivered.

Capacity and capability

Overall, the inspectors were not assured their were effective systems in place to manage and monitor the service provision within the centre on a consistent and robust basis. Local implementation of accountable oversight systems required attention.

The provider had failed to take the necessary actions following the most recent inspection to ensure that effective oversight had been put in place.

Resources such as the appointment of a full-time person in charge was still in process on the day of inspection. In addition, the systems for oversight, monitoring and auditing were not identifying areas of improvement and there were no plans in place on how to bring the service back into compliance in any type of systematic manner.

Overall, while there was a stable staff team in place, gaps were found on the roster on a number of occasions.

There were a number of vacancies on the staff team on the day of inspection. Staff training required improvements with a number of staff requiring training in key areas of care and support.

This was a repeated failure in this Regulation across the three most recent inspections. The provider was therefore informed on the day of inspection that this matter would escalate requiring them to submit a clear plan to bring this centre into compliance.

Regulation 15: Staffing

The inspectors reviewed the staffing arrangements in place in the centre. This included speaking with staff members and a member of the management team, reviewing rosters and making observations across the day of inspection.

Staff spoken with were found to be kind, respectful and well known to the residents. A very experienced staff member was on duty who outlined a lot of key working duties and gave good insight into how young people were being supported. Although the centre was striving to provide continuity of care, vacancies within the staff team were impacting on the provider's ability to fully staff the centre at all times.

The inspectors were informed that there were four whole time equivalent vacancies on the day of inspection. On review of the rosters from November 2025 until the inspection day, it was found that the centre frequently operated below the optimum number of staff. The optimum number of staff rostered per day was four staff members on duty. The inspectors reviewed a six week period whereby 35 shifts were not filled to the level of having four staff present. Although there was a risk assessment around this, it required to be addressed to ensure sufficient staff were in place at all times and continuity of care could be provided at all times to supervise children/young people. This negatively impacted children/young peoples quality of life at evening times and weekends in particular.

The centre was staffed with a team leader, social care workers and relief social care workers. Due to the staff vacancies agency staff were also used on a regular basis. For the most part, regular agency staff were employed in the centre. On review of the rosters it was found that the full name of the agency staff were not in place on each roster.

Judgment: Not compliant

Regulation 16: Training and staff development

Previous provider assurances regarding this regulation had not been implemented.The inspectors asked to review the training matrix in place that accounted for all staff training within the centre. On review of this document it was found that there were significant gaps in staff training across all areas of care and support. The manager present indicated that this was possibly not the most up-to -date record in place.

The provider was given an opportunity to submit the training matrix the day following the inspection but gaps remained in the training requirements which indicated that not all staff had up-to-date training in the following areas;

- Fire safety
- Managing Behaviour that is Challenging including de-escalation techniques
- Ligature Training
- Manual Handling
- Safe administration of medications
- First Aid

While the inspectors acknowledge a number of initial trainings and refresher trainings were booked in the above areas, as the provider had committed to have all training completed by the 31 January 2026 as per their compliance plan response to the Chief Inspector of Social Services, they had failed to meet this commitment. This was a repeated failing on part of the provider.

This issue had been highlighted in previous inspection reports and remained outstanding on the current inspection. This meant that the staff team did not have up-to-date training that enabled them provide safe care and support to children and young people, in line with regulatory requirements and best practice.

Judgment: Not compliant

Regulation 23: Governance and management

The governance and management systems in place were not robust, comprehensive or fully effective on the day of inspection . Inspectors found systems failures around key areas of care and support. The absence of a person in charge was having a negative impact on provision of services to young people. There was a disconnect between the registered provider and the centre through an absence of clear and accountable management.

The inspection found that the designated centre was not adequately resourced to ensure the effective delivery of care and support. At the time of inspection, there was no full-time person in charge appointed to the centre. This post had been vacant since December 2025 and although the provider was in the process of appointing a person in charge up on the day of inspection this was still in progress. There were a number of changes to the governance structure that were due to occur in the coming weeks. Time was required to ensure these changes could embed and demonstrate positive change in the reporting structures in place.

Due to the changes in governance, there had been some gaps in oversight. For example, incident reviews were not occurring in line with the provider's policy which noted incident reviews were to occur on a monthly basis which was not happening.

The inspectors reviewed the most recently six monthly unannounced audit that had taken place in the centre. This report had been completed on the 12 and 13 of November 2025. Three actions had been identified in this audit. The actions detailed were the following:

- Submission of notifications in line with the requirements of Regulation
- Completion of incident reports before staff leave their shift
- All registers such as risk, complaints and restrictive practice registers to be kept up-to-date

The inspectors found that these actions had not been completed and were still outstanding on the day of inspection. For example, on review of incidents, a safeguarding incident had been described and this had not be submitted to the Chief inspector of Social Services, in line with the requirements of the regulations. This was submitted retrospectively following the inspection.

The restrictive practice register was not reflective of all restrictive practices in place and there continued to be gaps in the reporting of incidents.

Overall, there was insufficient oversight in place in the centre around risk management, positive behaviour support and safeguarding.

Judgment: Not compliant

Quality and safety

For some young people, aspects of the care and support provided ensured that they could access activities, school and their community offering them a good quality of life. This was positive for these young people but was not a consistent finding across all aspects of service provision in the centre.

However, the governance issues and a lack of clear and coherent management systems observed, were a risk in this centre. This impacted quality and safety of care being delivered. A number of improvements were required in areas such as risk management, positive behaviour support and safeguarding.

The inspectors reviewed the systems in place to keep the young people safe. The inspectors found that the documentation available to staff was inadequate and not guiding staff practice. Risk assessments in place were not reflective of actual risks and had not been updated nor were adequate control measures developed or implemented.

Guidance in relation to positive behaviour support lacked detail, and there was a lack of recognition of restrictive practices or least restrictive methods/approaches being considered.

In addition, safeguarding procedures were not operating in line with *Children First: National Guidance for the Protection and Welfare of Children (2017).*

Regulation 13: General welfare and development

Overall young people were found to enjoy a good quality of life in the centre with school attendance, social activities, meaningful days and weeks, life skills development and person centred planning, all found to be taking place to a good standard.

One child outlined his plans to go to Wales to hike mountains (over the summer), go to Blackpool and talked about his interests in terms of making online content, going to the gym, hiking and spending time with friends.

Life skills programmes such as money management/paying bills, food and meal planning, shopping, using public transport were all taking place as was clear linkages with aftercare supports and planning for adulthood.

This was all found to be very positive and meeting the requirements of the regulations for young peoples general welfare and development.

Judgment: Compliant

Regulation 17: Premises

Overall, the premises was maintained to a good standard. The inspectors completed a full walk around of all aspects of the premises with one of the young persons and a member of staff.

The inspectors saw that the residents had access to a sitting room, kitchen come dining area, conservatory, bathrooms. Young people had their own bedrooms and access to their own bathrooms. Outside the garage had been converted to a recreational area, gym and (as young people described it) the 'man cave', with sporting equipment, gaming items and other recreational games and items.

Bedrooms had been personalised with photo's, posters, certificates of achievement and other items that were important to the young people. The house was clean and warm and residents were seen to move through all parts of the home with ease.

The layout of the designated centre met the needs of the young people living there.

Judgment: Compliant

Regulation 26: Risk management procedures

Overall, the inspectors were not assured that the risk management systems in place were effective or safe.Young people were not safe and or adequately safeguarded due to the absence of comprehensive risks management systems in place. Identification, assessment management and regular review for trending / identification of risk trends or additional risks e.g. absconsion, access, online safety and exploitation etc.

There were 50 risks recorded on the centre risk register, the majority had not been properly reviewed, fully completed in terms of assessment/risk rating and many had no recorded control measures in place. There was insufficient managerial oversight and review of the recorded risks. For example, 10 risks were (red rated) deemed a high risk, but were not fully assessed, completed or signed off by management. These included risk such as young people absconding, fire safety, behaviours that challenge and risks associated with supporting young people in care going on supervised/unsupervised home access.

A significant absconsion incident had occurred in September 2025 in this centre. There had been no serious incident review following this incident and limited corrective actions taken on foot of this. Although, a risk assessment had been developed, this was in relation to safeguarding and had not not been updated or reviewed since 15 September 2025. It did not fully account for the absconsion risks. In the absence of proper investigation of serious incidents, corrective action and learning were not demonstrable. This is poor risk management.

The inspectors reviewed all incidents that had occurred in the centre in recent months. It was found that incidents were not always documented in line with the requirements of the organisation's policy. There were gaps in the information, or information was missing or repeated and limited learning was identified.

Judgment: Not compliant

Regulation 7: Positive behavioural support

The inspectors reviewed the systems in place to manage behaviours of concern and restrictive practices within the centre. Again there were significant gaps found in both process and practice.

The inspectors reviewed the behaviour support plans that were in place to guide staff. The plans in place were dated May and December 2025. There was limited evidence in the plans that a suitably qualified health and social care professional had been consulted in the drafting or reviewing plans. Both plans had been signed off by staff members. There was no evidence of a functional based assessment being completed in line with best practice and the guidance in the plans was not in line with what was occurring in the centre. For example, one behaviour support plan referenced locking all doors when a specific behaviour of concern was occurring. It referred to a protocol in relation to this. This protocol was not present in the young person's file and there was no reference/guidance for the use of this restrictive practice in any other documentation.

The inspectors were informed that all restrictive practices should have risk assessments in place. On the day of inspection, only one risk assessment was in place which related to one restrictive practice. There was at least seven restrictive practices in place on the day of inspection with no corresponding risk assessment or appropriate in place.

The inspectors saw evidence of two restrictive practices being utilised and these were both confirmed by staff. These practices were the use of door sensors at night and regular phone checks. These practices had not been identified as restrictive practices and therefore were not subject to assessment and review in line with best practice around the use of restrictions. Due to the lack of recognition of these practices within the centre the inspectors were not assured that a least restrictive approach to care and support was being adopted, considered or reviewed within the centre.

Overall, the documentation around behaviour support and restrictive practices was not in line with what was actually occurring in the centre with limited guidance for staff. This areas needs to be reviewed and monitored in terms of the need for restrictive practices, the review of these practices, the recording and assurance that least restrictive alternatives have been considered and how they impact on young peoples/children's rights.

Judgment: Not compliant

Regulation 8: Protection

Overall, safeguarding measures in place were not robust or in line with Children First National Guidance for the Protection and Welfare of Children (2017) . The inspectors were not assured that effective measures were in place to keep the young people safe at all times. For example, while using devices on line. In addition, safeguarding incidents were not reported in line with regulations, relevant polices and Children First (2017).

The previously described absconsion incident involving one young person had not been reported in line with the the requirements of Children First (2017), despite it falling into the category of a child protection concern. The inspectors asked for evidence that it had been reported and it was confirmed by the staff present that this report had not been made through the relevant Child Protection and Welfare Reporting Form. This was a significant lack of oversight on the part of the provider and required immediate attention. This young person absconded from the centre despite having specifically allocated staff members supervising them - in the absence of an appropriate investigation, inspectors were not assured that risks to individual young people were were effectively recognised, assessed and managed nor that safeguarding practices generally were appropriately robust in this centre.

In addition, the safeguards around the young people's use of online devices were not sufficient or in line with assessed needs. There was a blanket approach to checking phones with no guidance available to staff on what they should be looking for or what should be escalated and specific guidance on how this should be done was absent.

On review of the phone check documentation that was recorded in November 2025, the inspectors saw that on four occasions that messages had been deleted, or other settings had been put on the message application to delete messages or the phone was not checked. This had not been escalated or any corrective actions taken. In addition, for another resident phone checks had not occurred for a seven day period between the end of October 2025 and beginning of January 2026. Therefore the safeguards around young people's online presence needed a clearer and more comprehensive approach to ensure that they were safe.

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	
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Not compliant

Compliance Plan for Gleneden OSV-0007981

Inspection ID: MON-0049506

Date of inspection: 09/02/2026

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: Senior Management will continue to send weekly recruitment updates and attend weekly meetings with the Recruitment Department and liaise with them to facilitate interviews. At present the centre has two staff members engaging in the on-boarding process. The Registered Provider is committed to ensuring staff levels are in adherence to the centre's purpose and function. During this interim period, the centre will continue to utilise support of consistent agency staff members, to support the roster needs. A Person in Charge application is currently in process with HIQA. Centre Management complete weekly roster reviews to ensure there is adequate staffing levels in place to ensure residents fully participate in their individualised plans. Senior Management will also continue to monitor the rostering arrangements in the centre, whilst ensuring where agency staff members are utilised, their full names are included in the roster.	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: Senior Management has completed a review of training over the last six months, to identify areas for improvement and failure within the previous system utilised to identify and schedule the training needs of the centre. Senior Management has enhanced the system in place, with further oversight and governance, whereby training needs will be reviewed within the monthly regional meeting and an agreed action plan will be set in place. Bi-monthly training audits continue to be completed with training scheduled based on the requirements of the team. This is overseen by the Person Participating in Management	

(PPIM) who ensures adequate levels of training are scheduled, to meet the training needs of the staff team in a timely fashion.

Centre Management will continue to schedule and roster the staff team for required training

The training policy will be reviewed within the team meeting on the 27.03.2026.

Staff have been booked on and attended training this month. All current centre staff will be fully compliant with training requirements by 22.04.2026.

Regulation 23: Governance and management	Not Compliant

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

A Person in Charge application is currently in process for the centre.

In addition to this appointment, the registered provider has introduced a number of mechanisms and systems which support effective governance and management. These include;

- Centre Management team attended a workshop on the 26.02.2026, which focused upon the principles of positive oversight and governance, risk management and positive behaviours support.
- Centre Management complete a Monthly Governance report, which includes an overview of the centre and residents, with regards to incident, complaints, risk management, restrictive practices etc. Centre management also track and report on supervision and training. This is overseen and reviewed by the Person Participating in Management (PPIM) and feedback is provided where necessary.
- Team and Management meetings occur on a fortnightly basis. These are attended by a member of Senior Management, and provides a forum for effective system review, risk management, restrictive practice and incident review.
- A Monthly Senior Management report is completed by the PPIM, which has a number of standing items relating to the quality of care provided to the residents, identifies areas of strengths and areas for improvement to be addressed.
- An auditing schedule is currently in place for centre management / Person in Charge to complete. This includes; IPC, medication and personnel file audits. These audits are overseen and monitored by the PPIM.
- The PPIM attends the centre on a weekly basis and conducts bi-weekly service review meetings.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:

- The Centre Management team attended a workshop on the 26.02.2026, which focused upon the principles of positive oversight and governance, risk management and positive

behaviours support.
- Risk identification and management is a standing item in the Team and Management meetings which occur on a bi-weekly basis. All open risk assessments are reviewed and updated on a regular basis.
- The centre has introduced hard-copy risk registers which record all centre and residents' risks, which allows a clear view of how centre management oversight is achieved.
- Risk Management Training for the staff team has been scheduled for 03.04.2026.
- The Monthly Senior Management report focuses upon Risk Management as a standing item, where commentary or feedback reported and followed up with the team.
- The Centre has adopted a new filing system which promotes clearer understanding and recording of open risk assessments. This has been in place since 01.03.2026

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:

- The centre has introduced new templates for Person Centred plans and Behaviour Support Plans across the residents' files, the purpose of which is to provide the staff team with clear guidance on how to support and work with residents.
- The above plans have been reviewed, by a qualified health and social care practitioner and will continue to be reviewed monthly, to ensure all relevant and up-to-date information is recorded.
- Monthly Incident Review Group meetings are taking place. These commenced in February 2026. Centre Management completes the Monthly Incident Review Group reports, which highlight any behavioural patterns, risk or behaviour of concerns. This information is reviewed by a Clinical Case Manager, and feedback is provided where 0ecessary
- All Behaviour Support Plans have been reviewed to ensure they include any current risk assessments and restrictive practices.
- Centre Management conducted a centre review on all risk assessments and restrictive practices, to ensure all restrictive practices have a corresponding risk assessment completed. This occurred on the 27.03.2026
- All Person-centred plans, Behaviour Support Plans, and Safeguarding Plans have been reviewed to ensure that they are responsive to the needs and risks to the service users. These were discussed with the staff team on the 27.03.2026.
- Person-centred planning and positive behavior support training, as per the centre's Model of Care has been scheduled for 21.04.2026 and 29.04.2026

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
- From January 2026, all incidents have been reviewed and commented upon by centre management and Senior Management personnel. This dual oversight approach is to ensure that all incidents are appropriately managed and reported in line with Children's First Guidelines.
- The Centre Incident SOP (Standard Operation Procedure) was updated in December 2025 to provide clear guidance in relation to reporting Child Protection Welfare Reports

with corresponding NF06s.
- Centre Management has conducted a review of all residents' risk assessments and Safeguarding Plans. This occurred on the 24.03.2026, to ensure they provide the staff team with clear guidance surrounding safeguarding measures and practices.
- The threshold for NFO in line with the Notification Handbook will be refreshed at regional meeting with Centre Management on the 26.03.2026

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Substantially Compliant	Yellow	01/05/2026
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Not Compliant	Orange	22/04/2026
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to	Substantially Compliant	Yellow	01/05/2026

	ensure the effective delivery of care and support in accordance with the statement of purpose.			
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	01/04/2026
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Not Compliant	Orange	01/04/2026
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	Not Compliant	Orange	01/04/2026

	evidence based practice.			
Regulation 7(5)(a)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation every effort is made to identify and alleviate the cause of the resident's challenging behaviour.	Not Compliant	Orange	12/04/2026
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	01/04/2026
Regulation 08(5)	The registered provider shall ensure that where there has been an incident, allegation or suspicion of abuse or neglect in relation to a child the requirements of national guidance for the protection and welfare of children and any relevant statutory requirements are complied with.	Not Compliant	Orange	01/04/2026