

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

Issued by the Chief Inspector

Name of designated centre:	The Lighthouse
Name of provider:	Nua Healthcare Services Limited
Address of centre:	Offaly
Type of inspection:	Unannounced
Date of inspection:	03 July 2025
Centre ID:	OSV-0008721
Fieldwork ID:	MON-0047604

About the designated centre

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

The Lighthouse can provide full time residential care to both male and female adults with disabilities such as autism (ASD), intellectual disabilities and challenging behaviours, from the age of 18 years onwards. The centre ensures that the age group of individuals will be of appropriate range. The number of individuals who can be accommodated will not exceed five. The centre is a large house with an integrated self-contained apartment with separate gardens. There are also two separate self-contained living areas in the grounds of the building. The centre is in a rural area, close to a village and a town where residents have access to a range of amenities. Residents are supported by a staff team of social care workers and assistant support workers, and a manager is based on site daily. Staff are allocated to support residents both during the day and at night. Multidisciplinary team support including psychiatry, psychology, occupational therapy, speech and language therapy and nursing is also available to residents.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	5
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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
Thursday 3 July 2025	09:20hrs to 19:00hrs	Jackie Warren	Lead
Thursday 3 July 2025	09:20hrs to 19:00hrs	Mary Moore	Lead

What residents told us and what inspectors observed

This inspection was unannounced and was carried out to monitor the provider's compliance with the regulations relating to the care and welfare of people who reside in designated centres for adults with disabilities. As part of this inspection, inspectors met with three residents who lived in the centre and observed how they lived. The inspector also met with a manager who was deputising for the person in charge, a senior manager and staff on duty, and viewed a range of documentation and processes.

Inspectors had the opportunity to visit all parts of the centre with the exception of one resident's apartment. Inspectors extended repeat invitations to the resident through the management team to meet with inspectors or an inspector but the resident declined each invitation and this was respected.

The centre was found to be visibly clean, well maintained externally and internally and in good decorative order throughout. The design and layout of the centre suited the assessed needs of residents. For example, three residents lived in the main house. One resident had their own self-contained area of the house, while two residents had their own en suite bedrooms and shared communal facilities such as the kitchen and dining room. These residents' rooms were nicely personalised with family photographs and other items that reflected their personal interests such as their interest in personal care and their personal appearance. Inspectors saw that one resident was supported to lock their bedroom door when they were not present in the house so as to secure and protect their personal space and items. The living arrangements ensured that each resident had access to the levels of private space that they required. Laundry facilities were available in the utility room and plans were in progress to provide additional facilities. Staff were seen bringing back freshly laundered clothing in separate basket to each resident.

The stairwell in the main house was pleasantly adorned with photographs of residents involved in different activities and outings that they had enjoyed individually or with peers. The self-contained apartment in the main house was spacious but more minimalist in presentation and reflected the resident's assessed needs and preference. The resident had a large selection of soft toys and had these neatly arranged throughout their apartment. There was a hand-painted mural on one wall that reflected the resident's spiritual beliefs.

Residents had choice and control in their daily routines. Inspectors saw one resident was having their breakfast at the kitchen table. The resident looked and listened when inspectors spoke to them, but did not express any great interest or communicate what their view might be of the presence of the inspectors in the house. There was an easy rapport between the resident and the staff member allocated to support them on the day. After their breakfast the resident engaged in a game of ping-pong with the staff member before leaving the centre for a scheduled speech and language appointment. Other residents were getting ready for their

plans for the day at their own pace, while one resident was having a morning in bed and was supported by staff to get and up and get dressed when they were ready to do so. The resident came to see the inspectors, waved hello but did not engage any further. Residents were supported to visit family and friends as they wished. Arrangements were also in place for residents to have visitors in the centre.

In the two external apartments, inspectors saw that access required the use of a keypad but an easily used button was accessible to the residents on the inside. In one apartment and external area inspectors saw that numerous sensory items were available to the resident as well as a swing and some garden seating. The resident looked well and was dressed appropriately and similar to peers of the same age. The resident and their supporting staff were seated on the floor using some large building blocks. The resident presented as very relaxed with these staff members while they uses the building blocks together.

Inspectors observed the interaction with a resident who required support with communication. The resident held good eye contact with the inspectors and used single words in response to what was said. Inspectors noted that the resident also used, without prompting, some of their sensory items such as their sensory ball to complete squashes and their safe chewy items. The resident had access to the remote control for their television and also had access to table top activities such as jigsaws.

Inspectors saw that residents had busy days and spent most of the day out and about doing things in the community. Each of the residents had different plans and routines and spent part of the day out and about with staff attending appointments, and scheduled and unscheduled activities such as swimming or going for a cup of coffee.

Inspectors reviewed the management of concerns raised and were satisfied they were managed in line with the provider's complaints management policy and procedure. The provider had a complaints process which was available to residents and or their representatives if they wished to raise any issues of concern or dissatisfaction. Information such as how to contact the designated safeguarding officer and how to make a complaint was prominently displayed. Records viewed by inspectors showed that the complaints process was being used to raise issues of concern with the provider.

Inspectors found that residents had good access to the provider's multidisciplinary team (MDT) and there was good evidence that MDT recommendations such as in relation to communication and positive behaviour support were put into practice.

Based on the findings of this inspection the facilities, support and care provided were responsive to the needs, abilities and risks of each resident. Plans to support the general health, welfare and development of residents were in place and the provider continued to develop these plans as residents' needs changed. In general, there was good consistency between what inspectors were told, what inspectors read and observed. However, inspectors did find that there was some inconsistency in the records that supported and informed the use and review of restrictive

practices and, some inconsistency in practice. This inconsistency meant that there was an absence of assurance as to how the provider maintained robust oversight of the use of, and the ongoing need for, some restrictions.

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

The provider's management arrangements ensured that a good quality and safe service was provided for residents who lived in this centre, and that residents' quality of life was well supported. There were management structures in place to ensure that care was delivered to a high standard. However, improvement was required to the consistency of some documentation and records related to the care of residents.

There was a clear organisational structure in place to manage the service. There was a suitably qualified and experienced person in charge who worked closely with staff and with the wider management team. The person in charge had responsibility for the day-to-day management and oversight of the service. The person in charge worked full-time and was supported in their role by a deputy person in charge. These arrangements supported consistency of management and oversight and were evident from the staff duty rota. The rota showed a daily presence in the designated centre of either the person in charge, the deputy person in charge or a shift lead manager, which that there was always a manager present in the centre both on weekdays and at weekends.

The centre was suitably resourced to ensure the effective delivery of care and support to residents. These resources included appropriate levels of suitably staff levels, comfortable accommodation, and transport vehicles for residents' use. There were sufficient staff on duty during the inspection to support residents to take part in the activities that they preferred, and to ensure that each resident had individualised care and support. The provider had an ongoing process of recruitment and there were no reported staff vacancies. The staff numbers and staffing arrangements were based on the assessed needs of the residents, any risks associated with those needs and other factors such as the design and layout of the centre. Inspectors noted that the staffing levels on the day of inspection were as described on the staffing roster and were adequate to support the assessed needs of residents, and their preferred routines. An inspector reviewed the staff training matrix and saw that the person in charge maintained good oversight of staff training attendance, with no gaps identified in training needs. All staff had attended training relevant to their roles, including training in safeguarding residents from abuse, fire safety and responding to behaviour that challenged including de-escalation and intervention techniques.

Auditing systems were in place in the centre to ensure that a safe service was being provided to residents. Systems of quality assurance included the completion of an annual review of the service and provider led reviews of the quality and safety of the service provided to residents were carried out at least once every six months. The report of the most recent review was awaited. However, an inspector read the report of the most recent annual review and the provider led review completed in November 2024. The annual review provided for consultation with residents and included feedback provided by residents, representatives and others. Staff had supported residents to complete questionnaires and the feedback provided was reported to be positive. The provider led reviews had been completed on schedule and included a progress update on the previous quality improvement plan. The auditor reported improvement between the May 2024 and November 2024 provider led reviews. Most actions referred to gaps in documentation, such as, in relation to the follow-up of actions from the restrictive practice review meetings. On this inspection, inspectors found a good level of compliance with the regulations but also found some inconsistencies in relation to some records.

There were processes in the centre to manage and investigate complaints. It was found that complaints were being taken seriously by the provider and that systems were in place to investigate and resolve any issues brought to the attention of the management team. Information about the complaints process was made available to residents.

Regulation 15: Staffing

Staffing levels and skill-mixes were sufficient to meet the assessed needs of residents at the time of inspection. Inspectors observed that there were adequate numbers of staff throughout the day to ensure that residents were supported to go out to activities that they enjoyed and to attend appointments.

Members of the management team explained to inspectors how the staffing levels and arrangements in the centre were based on the assessed needs and associated risks of each resident. The staffing levels observed during the inspection reflected the identified staffing needs, such as the 2:1 staffing arrangement in place for four residents. The person in charge had developed planned and actual rosters which were being updated as required. Inspectors reviewed the current staff duty rota which showed that a team of social care workers and social care assistants were consistently assigned to care for residents. The rota was well maintained, named each staff member on duty, their roles and the hours that they worked. The director of operations described the systems in place for monitoring the hours worked by each staff member to ensure that they were appropriate. Inspectors noted the whiteboard in the kitchen displaying the staff-to-resident allocations and the designated shift-leader for the day. Staff told inspectors that this arrangement worked well for staff and residents and provided both variety and consistency.

Judgment: Compliant

Regulation 16: Training and staff development

The provider had ensured that staff who worked in the centre had received appropriate training to equip them to provide suitable care to residents.

An inspector reviewed staff training records and saw that staff had completed up-to-date training such as safeguarding residents from abuse, fire safety, the safe management of medicines, first aid, the provision of intimate care and responding to behaviour that challenged including de-escalation and intervention techniques. The date refresher training was due was listed to ensure that training would be delivered as required.. Additional relevant training completed by staff members included promoting a human rights base approach to support and care and understanding intellectual disability and autism. The training matrix also indicated that new staff had completed an induction process on start of employment. The arrangements for supervising staff included a management presence on site each day, unannounced night checks completed by managers and procedures, such as, for the management of personal phones while on duty. Inspectors saw that staff had access to information such as safeguarding and human rights guidance issued by the Chief Inspector of Social Services.

Judgment: Compliant

Regulation 23: Governance and management

There were effective leadership and management arrangements in place to govern the centre and to ensure the provision of a good quality and safe service to residents. This was being achieved by a clearly defined management structure, management meetings, and auditing systems. Annual reviews of the service were being carried out as required by the regulations.

There was a clear organisational structure in place to manage the centre, which included a suitably qualified and experienced person in charge, and arrangements in to support the person in charge both in the day-to-day management of the service and when the person in charge is absent. The person in charge was absent on the day of inspection and these arrangements were effective. The person who deputised for the person in charge was based in the centre during the absence and facilitated the inspection with inspectors. They were very knowledgeable of the provider's processes, the support needs of the residents and of their legal responsibilities. A senior manager also came to the centre during the inspection and they were also very familiar with the care needs of the residents and the management of the service.

The service was subject to ongoing monitoring and review. Audits, including unannounced audits on behalf of the provider, were taking place. These audits showed high compliance levels, and plans were in place to ensure that any required improvements were being promptly addressed. The centre was suitably resourced to ensure the effective delivery of care and support to residents. During the inspection, inspectors saw that these resources included the provision of suitable, safe and comfortable accommodation and furnishing, transport, Wi-Fi, television, and adequate staffing levels to support residents' preferences and assessed needs.

Judgment: Compliant

Regulation 34: Complaints procedure

The provider had good process in place for the management and investigation of complaints. It was found that complaints were being taken seriously by the provider and that there was a process to investigate and resolve them.

There was a complaints process in the centre to enable residents or their representatives to raise any complaints or concerns. Inspectors saw that there was an up-to-date complaints policy, a complaints procedure which was clearly displayed in the centre, and a complaints register was being maintained. A member of staff showed an inspector the template for recording complaints and this was suitable and in line with the requirements of the regulations, and provided for the recording of complaints investigations and outcomes. An inspector reviewed the complaints register and found that any complaints received were recorded, investigated and referred to the provider's safeguarding process if appropriate. Inspectors saw that the complaints process was also available in an easy-to-read format for residents.

Judgment: Compliant

Quality and safety

Based on the findings of this inspection, there was a good level of compliance with regulations relating to how residents who lived in the centre were protected from any form of harm and were supported to live their lives in accordance with their wishes and preferences. The person in charge and staff were focused on ensuring that residents had information about being safe, were supported to communicate effectively, had comfortable and safe living environments, and were made aware of their rights.

The centre suited the needs of the residents, was of sound construction and well maintained, and was clean, safe and was suitably decorated and equipped

throughout. The centre could accommodate up to five residents, three of whom occupied individualised accommodation. During a walk around the centre, inspectors found that the accommodation was clean, comfortable and nicely furnished. There was adequate furniture such as wardrobes, bedside lockers and chests of drawers in residents' bedrooms, where they could safely store their clothing and belongings. Some residents preferred minimal furnishing and décor and their living spaces were furnished accordingly. The centre was also equipped with Wi-Fi and televisions which residents could use for entertainment, information and communication.

The provider had arrangements in place to safeguard residents from any form of harm. There were included safeguarding processes, and systems to support resident to manage behaviours of concern as required. These included the use of recommended restrictive interventions as required. There were processes in place for the management of restrictive interventions. The provider had also ensure that risks specific to each individual resident had been identified and measures to manage these risks were recorded to guide staff. However, improvement to the recording and overview of restrictive interventions, and the risks associated with them, required stronger overview as some inconsistencies were noted.

Residents had access to information, including information about their rights and about keeping safe. The provider had ensured that residents were supported and assisted to communicate in accordance with their needs, and that they had been provided with information about protection and staying safe. Information was made available to residents in user friendly formats to increase their awareness and understanding of safeguarding. Residents had access to both complaints and advocacy processes.

Assessments of health, personal and social care needs were in place for each resident. Individualised personal plans had been developed for residents based on their assessed needs. Plans of care had been developed to guide staff on the appropriate and safe management of residents' healthcare, safeguarding, and social and developmental needs.

Residents had busy lifestyles and were supported to do things that they enjoyed in the centre, in the local community and elsewhere. There were adequate staffing levels and sufficient transport vehicles to ensure that each resident could attend activities of their choice at times that suited them. Most residents were out during the day on the day of inspection. Activities that residents enjoyed and took part in included, going for outings, drives and walks, shopping, gardening, swimming and use of technology, games, television and watching movies.

Residents could receive visitors in accordance with their own wishes, and there was sufficient room in the centre for residents to meet with visitors in private. Residents were also supported to meet with, and visit, family and friends in other places. The deputy person in charge described to inspectors how each resident was supported to have ongoing contact with home and family. These arrangements were recorded in residents' personal plans. The arrangements were specific to each resident and included announced and unannounced family visits to the centre and visits to home

supported by the staff team.

Regulation 10: Communication

The provider had ensured that residents were supported and assisted to communicate in accordance with their needs and wishes, and that they had been provided with information, including information about protection and staying safe.

The person in charge and staff were very focused on ensuring that they communicated appropriately with residents. This was through a combination of verbal communication and other systems that suited their needs. Inspectors saw that communication systems in place included up-to-date communication plans for each person. Visual images were in place to support some residents to make choices, and social stories were also in use for some residents. Inspectors saw records that confirmed that staff held frequent one-to-one key working sessions with residents to discuss matters of interest to them. On the day of inspection, inspectors saw that staff communicated appropriately and respectfully with residents and residents appeared to be comfortable with this.

Judgment: Compliant

Regulation 17: Premises

The design and layout of the centre met the aims and objectives of the service, was safe, and met the assessed needs of residents.

There were no issues identified in the centre which would impact negatively on the safety or comfort of residents. The centre comprised one house and two self-contained apartments on the same site. The centre was situated in a rural area, but close to a village. Transport was available for residents to access the facilities of the neighbouring villages and towns. During a walk around the centre, inspectors saw that the centre was well maintained, clean, comfortably decorated and safe. There were self-contained living units for three residents, one in the main house and the other two nearby in the grounds. In these units, each resident had access to a bedroom, living room, kitchen facilities, a bathroom and an adjoining garden. These living arrangements were in place to suit the assessed needs of residents. Two residents had bedrooms in the main house and had use of all the facilities, such as kitchen bathrooms and laundry as well as a garden.

Judgment: Compliant

Regulation 26: Risk management procedures

There were good systems in place for the management of risks in the centre. The provider's risk management arrangements ensured that risks were identified, monitored and regularly reviewed.

The provider had procedures in place for identifying and managing risk in the centre. For example inspectors saw that individual risk management plans had been put developed for residents based on the information gathered from residents' comprehensive assessments of needs. Risk management plans and the controls to manage each risk were kept under regular review by the person in charge. The risks identified reflected what was discussed with inspectors such as the risk for behaviour that challenged, the risk posed by a resident's lack of general safety awareness or the risk that a resident might eat non-edible items. The controls in place and the controls described by staff generally reflected the risk management plans and included controls such as staffing arrangements, positive behaviour support plans and environmental restrictions. The provider had local and general procedures for reviewing any incidents or accidents that occurred in the centre. For example, inspectors noted that the provider led reviews examined the management of incidents and the oversight of controls such as the use of restrictive practices. However, inspectors did find that there was some inconsistency in relation to controls that met the definition of restrictive practices. There was also scope to improve how incidents were recorded. These improvements are discussed in Regulation 7: Positive behavioural support.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

Comprehensive assessment of the health, personal and social care needs of residents had been carried out, and individualised personal plans had been developed for each resident based on their assessed needs. Based on the samples viewed by inspectors, these were of good quality, were up to date, and were informative.

Inspectors followed a definitive line of enquiry and reviewed a purposeful sample of two personal plans. Inspectors saw that a comprehensive assessment of resident health, personal and social care needs had been completed. Support plans were in place for matters identified by these assessments such as any support needed for personal care, communication and behaviour support. These plans of care were clear and were up to date. Representatives and other relevant stakeholders were consulted with in relation to the plans. For example, the deputy person in charge described how oversight of residents' care and support was also maintained by persons such as representatives of the Health Service Executive who had visited the

designated centre for both announced and unannounced visits.

Staff maintained records (key working meetings) of the discussions they had with residents about their care, support and general welfare needs. Staff recorded how residents were engaging with their plans and with the progress of their goals such as developing their activities of daily living skills and their communication skills. Regular updates of the plans were recorded in response to changing needs.

Judgment: Compliant

Regulation 6: Health care

The provider had ensured that appropriate healthcare was provided for residents.

Inspectors viewed the healthcare plans for two residents and found that their health needs had been assessed and they had good access to a range of healthcare services, such as general practitioners (GPs) and medical consultants. The deputy person in charge had sound knowledge of each resident's healthcare needs and the director of operations described how residents were supported to access GPs of their choice. Access to healthcare professionals was arranged as required. In the personal plans viewed, inspectors saw that residents had regular access to the providers multidisciplinary team including, psychiatry, positive behaviour support, speech and language therapy and occupational therapy.

Comprehensive assessments of residents' healthcare needs had been completed. Plans of care for good health had been developed for residents based on each person's assessed needs. These plans were comprehensive and stated the required care and support for identified healthcare needs. For example, inspectors saw plans for maintaining skin integrity in consultation with the treatment prescribed by the GP. Inspectors also found that the plans viewed were up to date. For example, an inspector saw that a plan had been updated to include a new, recently diagnosed healthcare need and a staff member described to the inspector the supports in place, such as the use of a device to alert staff.

Judgment: Compliant

Regulation 7: Positive behavioural support

The provider had suitable measures in place for the support and management of behaviour that challenges. Inspectors saw that there were procedures to support residents to manage behaviours of concern, which enabled them to live their lives as safely and comfortably as possible. However, improvement was required to the oversight of use of restrictive interventions.

Residents had access to the provider's multidisciplinary team which included behaviour support and psychology specialists who worked with and supported residents as required. The centre was adequately staffed to ensure residents had appropriate behaviour support at all times in the centre and when out in the community. Staff who spoke with inspectors were very clear about the behavior management strategies that were in place to support each resident. Staff were trained in positive behaviour support and in the use of de-escalation and intervention techniques. Inspectors saw the implementation of the therapeutic supports such as the range of sensory items available to and used by a resident as discussed in the opening section of this report.

Inspectors viewed the support plans that had been developed for two resident who required support to manage their behaviours. These plans included detailed positive behaviour support guidance as advised by a positive behaviour support specialist. These plans was clear and up to date. Plans viewed set out the behaviours that could be exhibited, possible triggers for the behaviour, therapeutic supports, reactive planning and crisis intervention.

Inspectors reviewed the use of restrictive practices in the centre. There was evidence that the provider reviewed, sought to reduce, and had reduced where safe to do so, the restrictions in place. For example, locked door restrictions were being reduced for residents who were provided with, and supported to use, exit buttons from their individualised apartments, A resident was also being educated in the use of the keypad controlled exit. Inspectors also saw that there was a reduction plan in place for a resident in relation to the access they had to personal items. The provider had changed the system for recording the restrictive practices in use so that it was less generalised and more specific to the needs of each resident. Inspectors saw that there was a restrictive practice register in place for each resident. There was documentary evidence that techniques, such as social stories, were used by staff to discuss with residents the restrictions that were in place.

However, inspectors found some inconsistency between the different records and also some inconsistencies in practice. For example, there was inconsistency between an individual risk management plan, an individual restrictive practice register, the restrictions passport and the record of the restrictive practice review meeting completed in June 2025. There was inconsistency in relation to the number and type of restrictions in place meaning that all restrictive practices were not listed as having being reviewed at the review meeting. This did not provide strong assurance as to how the provider maintained oversight of each restriction in use, assured the ongoing need for each restriction, and ensured it was the least restrictive intervention that could be used.

In addition, inspectors found some ambiguity in relation to the management of items such as a resident's access to toiletries and foodstuffs. While a resident's toiletries were locked away in response to a possible risk of ingestion, inspectors noted there was ready access to hand-soap in the resident's living area on the day of inspection. In addition, the risk management plan made reference to the increased risk for anxiety that could occur if food and fluids were readily available to a resident. Inspectors saw that these items were very limited in the apartment on

the day of inspection (the residents fridge was reported to be broken). However, inspectors found that there was no associated restrictive practice process or record available to view.

Inspectors requested to see a limited but purposeful sample of incident reports. One record indicated good implementation of therapeutic support by staff and resident engagement with these strategies that prevented escalation of an incident. However, another record where a physical intervention had been used was not recorded in a way that provided assurance that the intervention was used as it should have been and had been used as a last resort when all other alternative interventions had failed.

Judgment: Substantially compliant

Regulation 8: Protection

The provider had good systems in place to safeguard residents from any form of harm and to ensure that residents were safe. The provider's systems continued to keep residents safe, ensure that they knew about safeguarding, and provide for the management of safeguarding concerns should this be required.

Inspector reviewed the arrangements in place in the centre to safeguard residents from harm. These included provision of information to residents in user friendly formats to increase their awareness and understanding of safeguarding. Inspectors saw good display of accessible safeguarding information in the hallway of the centre. This included information issued by the Chief Inspector such as recognising indicators of abuse, and information on how to contact the identified designated safeguarding officers was displayed. Safeguarding processes also included development of intimate care plans and missing person profiles for each resident, The intimate care viewed described the levels of staff support and supervision needed while also acknowledging how this might impact on choice and privacy. also prominently displayed.

Residents had access to a safeguarding process. A designated safeguarding officer was available in the local area to support residents and staff, and all staff had attended safeguarding training. An inspector viewed the training matrix which indicated that all staff had completed safeguarding training. While reviewing the provider's own internal reviews, inspectors noted from the reports of these reviews, that the provider had evaluated and was satisfied as to staff knowledge of the provider's safeguarding procedures. There was also an up-to-date policy to guide practice.

Judgment: Compliant

Regulation 9: Residents' rights

There were systems in place to support residents' human rights. Throughout the inspection, inspectors saw that residents had choice and control in their daily lives. Each resident was being supported in an individualised way to take part in whatever activities or tasks they wanted to do.

Based on what inspectors observed, the care and support provided and the daily routines in the centre were individualised to the needs and choices of each resident. The inspector observed that staff had established and recorded residents' likes, dislikes and preferences, based on discussions with residents, assessments, observation, and knowledge of each individual.

Staff described to inspectors how residents expressed their choices and preferences. For example, staff said that they would offer a resident support to have a shower, would respect the resident's choice if they declined and would support the resident to shower when it suited the resident. Staff also maintained records of how residents were consulted with and expressed their choices. For example, staff recorded how a resident consented to taking their prescribed medication by putting out their hand when offered their medication. Further records attested to a resident's use of manual signs such as a thumbs-up or pointing at different visuals and emoji's to communicate how they were feeling. Residents had access to complaints and advocacy processes and this information was freely available in the centre to inform residents.

Residents had comfortable accommodation. Each had their own bedroom and there was ample communal space, which ensured that residents could enjoy privacy or time alone as they wished. Some residents had self-contained, individualised accommodation to meet their assessed needs. Residents were also being supported to keep in contact with family and friends and to access the local community.

Training records confirmed that all staff had attended training in human rights and it was clear during the inspection that residents' rights to choose were being taken into consideration and were being supported.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for The Lighthouse OSV-0008721

Inspection ID: MON-0047604

Date of inspection: 03/07/2025

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 7: Positive behavioural support	Substantially Compliant
Outline how you are going to come into compliance with Regulation 7: Positive behavioural support: 1. The Person in Charge (PIC) in conjunction with the Centre Behavioral Specialist will conduct a full review of restrictive practices within the Centre to ensure all restrictions are identified with a clear rationale for same and the least restrictive intervention is being used. Completed: 22 August 2025 2. The PIC will ensure all restrictions are detailed consistently in relevant documents such as Individual Risk Management Plans, Restrictive Practice Registers, Restriction Passports and any meeting record of the restrictive practice reviews. Completed: 22 August 2025 3. The PIC and the Director of Operations (DOO) shall conduct a full review of the Individual Risk Management Plans (IRMP's) to ensure all control measures are appropriate to the risk presented with and implemented. Completed: 22 August 2025 4. The PIC will provide training to Team Members at the next two Team Meetings regarding consistently detailing all proactive measures implemented and exhausted prior to implementing a restrictive practice in line with the Policy on Report Writing and Record Keeping [PL-OPS-004]. Due Date: 31 October 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 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.	Substantially Compliant	Yellow	31/10/2025