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:	Ashfield Lodge
Name of provider:	Attuned Programmes Ireland
Address of centre:	Carlow
Type of inspection:	Unannounced
Date of inspection:	05 August 2025
Centre ID:	OSV-0008767
Fieldwork ID:	MON-0043792

About the designated centre

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

Ashfield Lodge is a designated centre operated by Attuned Programmes Ireland. The centre comprises of one semi-detached house located in a residential area in Co. Carlow that is close to local amenities and public transport links. The centre can provide full-time residential care to two adults over the age of 18 with an intellectual disability, autism spectrum disorder, Mental health and/or physical disabilities. Each resident has their own bedroom. Other facilities provided in the centre include a sitting room, kitchen/dining area, utility room and bathroom facilities. The residents are supported by a team of social care workers and a full-time person in charge.

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
Tuesday 5 August 2025	09:40hrs to 16:30hrs	Jennifer Deasy	Lead

What residents told us and what inspectors observed

This was an unannounced inspection to monitor ongoing regulatory compliance in the designated centre. The inspection was completed over the course of one day and the inspector had the opportunity to meet with both of the residents that lived in the designated centre. The inspector used conversations with residents and staff, observations of care and support and a review of documentation to inform judgments in respect of the quality and safety of care.

Overall, this inspection findings showed care was being provided that was safe, meeting residents' assessed needs and enhancing their quality of life. Some improvements were required to ensure residents were empowered to use the provider's systems in order to make complaints and express their views and feedback on areas which could be improved in the service.

The designated centre is located in a residential area close to Carlow town close to many public amenities and is also provided with a service vehicle to support residents to travel further afield. Each resident has their own bedroom in the centre and they share a communal sitting room, kitchen and utility. One resident's bedroom has an en-suite and the other resident uses a main bathroom on the first floor. A walk-in shower had recently been installed to this bathroom to enhance the accessibility arrangements for residents. The centre was observed to be generally very clean and well-maintained throughout.

Both residents showed the inspector their bedrooms and said they were happy with them. The inspector saw that both bedrooms were decorated in line with residents' individual preferences. One resident said they wished to paint their bedroom a different colour. The person in charge was aware of this as the resident had recently communicated this through a resident satisfaction survey.

Both of the residents were at home when the inspector arrived to the centre. They sat with the inspector at the kitchen table and told her their views on the service. One resident, who had moved to the centre within the last 10 months, said that they liked the house and especially the back garden. They were proud of the gardening that they did and the work they completed to help maintain it. The resident said that they had lived in a different residential service previously that it was very far from their family home. They liked that this centre was closer to their family and said that the staff team help them to visit their family regularly.

Both residents said that they knew the staff who worked in the centre and that the staff team were good at providing support when they needed it. Residents were supported to have autonomy with managing their finances and with cleaning their own bedrooms and bathrooms. Both residents were proud of their skills in these areas. One of the residents was working on developing their skills in managing their own medications. The inspector saw that this was supported during the inspection. Residents told the inspector about their daily routines and activities which they

enjoyed. These included attending day service, going to the cinema and going on the train to Dublin. One of the residents had planned a hair appointment on the day of inspection. They were also being supported to trial a new, more local day service as their previous day service had been located some distance away in Dublin.

Residents showed the inspector the photographs of the staff team on the notice board. They were familiar with the staff team including senior managers. The inspector saw positive and familiar interactions between staff and residents throughout the morning.

While residents overall expressed that they were happy and comfortable living in the centre, they did communicate a number of areas for improvement to the inspector. For example, residents told the inspector that there was a need for enhanced sound-proofing in their bedrooms. They also communicated that they were unhappy with how staff were responding when they wished to consume specific drinks. The inspector asked the residents if they had made complaints regarding these issues but residents communicated that they did not know how to make a complaint. The inspector asked residents if they had told their keyworkers about these issues. One resident's keyworker had recently left the service and they were unsure who their new keyworker was. This resident told the inspector that they had told the staff team about these issues but they did not feel that they had been listened to.

Both residents left the centre for the afternoon with staff. The inspector reviewed documentation and discussed the issues raised by the residents with the person in charge. While residents had regular meetings with staff to discuss their goals and areas such as budgeting and activities, the agendas for these meetings were often set by the staff members and were not the most effective forum for residents to raise feedback, concerns or complaints. Additionally, residents presented with behaviours around consumption of specific drinks and compulsive purchasing of high-priced items which posed specific risks to financial safeguarding and to their well being. The provider and staff team were endeavouring to take a positive approach to risk-taking and to uphold residents' autonomy in this regard. However, the guidelines detailed on risk assessments, care plans and the kitchen notice board, to assist staff in supporting residents in these areas, was inconsistent. The impact of this is discussed further under Regulation 9.

Overall, it was evident that the residents were living in a safe home and were being supported by a consistent and suitably trained staff team. Residents' health needs were being met and they were being supported to develop links with their new community and to maintain positive relationships with their families and friends. Residents had forums to meet with the staff team regularly and to provide feedback to the provider. However, improvements were required to ensure that residents fully understood the complaints procedure and how to raise any complaint or concerns.

The next two sections of the report will describe the governance and management arrangements and how effective these were in ensuring the quality and safety of care.

Capacity and capability

This section of the report describes the oversight arrangements of the service. There were consistent and stable management systems and residents were supported by a familiar and stable staff team. However improvements were required to the implementation of the provider's complaints procedures.

The residential service had clearly defined governance structures which set out lines of authority and accountability. There was an internal management team which was appropriate to the size and function of the designated centre. The managers clearly understood the needs of the residents and ensured sufficient staffing resources to provide person-centred services. The provider also had in place a system of audits and regular meetings to drive continuous improvements in the service.

The centre was adequately resourced to provide suitable care and support to the residents. Contingency plans were implemented to ensure consistency of staffing. This was effective in supporting continuity of care and ensuring that relationships were maintained. Staff members had the necessary skills to provide care and support. They were in receipt of regular training and supervision to ensure that they had the competencies to deliver safe care and to ensure they were informed of their roles and responsibilities. Each staff member's performance was formally appraised and written records of supervision and appraisals were maintained in the centre.

Admissions policies and procedures considered the safety of current residents and explored any potential risks. Admissions were planned in a slow and considered manner which enabled the provider to assess the residents' needs and to determine the suitability of a placement.

Although residents were provided with information on the complaints procedure on admission, there was no accessible complaints procedure on display in the service. The provider appeared to have a culture of openness and transparency that welcomed feedback; for example, residents' views on the service had recently been sought through resident surveys; however, these did not appear to be wholly effective as residents raised some complaints to the inspector which had not been identified through these surveys. This required review by the provider.

Regulation 15: Staffing

The provider had recently increased the staffing whole-time-equivalent numbers in the centre in response to the new admission of a second resident in late 2024. Staffing levels were maintained which were suitable to meet the needs of and number of residents.

There were no staff vacancies in the centre and a small panel of regular in-house

relief staff filled any gaps in the roster. This was ensuring continuity of care for the residents. Residents told the inspector that they were familiar with the staff team. They were aware of who was on duty that day and which staff would be competing sleepover duty that night.

The inspector reviewed the rosters for the designated centre from June and July 2025. Across four dates examined in detail, it was seen that staffing levels were in line with the roster and were sufficient to meet the needs of the residents.

Judgment: Compliant

Regulation 16: Training and staff development

A training record was maintained for the centre which showed that there was a very high level of compliance among the staff team with mandatory and refresher training. All staff were up-to-date with training in key areas including safeguarding vulnerable adults, fire safety, infection prevention and control and safe administration of medications.

Staff members were in receipt of regular supervision and support through monthly staff meetings and biannual one-to-one supervisions with the person in charge. Arrangements were implemented to ensure a high level of staff attendance at staff meetings. The inspector reviewed the records of staff meetings from March and June 2025 and saw that these covered topics relevant to the service delivery including residents' needs, safeguarding and risk assessments.

The inspector also reviewed the supervision records for two staff. It was seen that supervision was carried out as frequently as defined by the provider's policy and that supervision was used to performance manage and develop staff.

Judgment: Compliant

Regulation 23: Governance and management

There were clearly defined management systems in the centre which were effective in ensuring consistent oversight of the quality and safety of care. The centre was adequately resourced. The staff team reported to a person in charge. They had oversight of an additional designated centre which was located nearby. The person in charge was supernumerary and was based out of the designated centres, dividing their time between both. This ensured consistent on-the-ground presence of management in the centre to oversee the delivery of care. The person in charge was further supported in their role by a team leader who assisted them in having oversight of both centres.

The staff team were performance-managed through staff meetings and supervisions, as discussed under regulation 16. Staff members were given the opportunity to raise concerns regarding the quality or safety of care through the management systems.

The person in charge also received monthly supervision from the Director of Operations. Weekly governance meetings were held with senior management. This afforded the person in charge the opportunity to raise any concerns about key areas including staffing, finances or residents' needs to the provider level. The records of one of these meetings in July 2025 was reviewed by the inspector along with a corresponding weekly report which the person in charge used to raise issues regarding the service to the Director of Operations. It was seen that the Director of Operations responded in writing to the report and detailed actions to be taken to enhance the service.

The provider had completed one six monthly unannounced visit in December 2024 and the inspector was told that a second visit was due. The audit identified areas for improvement and an action plan was implemented. An annual report on the quality and safety of care for 2024 was in progress at the time of the inspection. Residents' views on the service had been ascertained through surveys and these were being used to inform the annual report.

Judgment: Compliant

Regulation 24: Admissions and contract for the provision of services

The provider had effected an admissions policy which had been reviewed within the past three years as required by the regulations. The inspector reviewed the admissions documents in respect of the most recent admission to the centre. It was seen that the admission was planned in a careful manner which considered the resident's assessed needs and the impact of the new admission on other residents.

A transition plan was developed which provided opportunities for the new admission to visit the service and to meet the current resident. A 12 week review was completed which reviewed any incidents or risks identified.

A contract of care was in place for the new admission. This detailed services provided and any fees to be paid. It was signed by the resident.

Judgment: Compliant

Regulation 34: Complaints procedure

Improvements were required to ensure that residents were informed of the

complaints procedure and of how to raise any issues or concerns to the complaints officer. There was no accessible complaints procedure on display in the centre when the inspector arrived. The person in charge placed one in the kitchen before the end of the inspection.

Residents expressed a number of complaints to the inspector about the service they were receiving. These included issues relating to noise complaints. The inspector and person in charge heard the noise which residents had complained about in the afternoon of the inspection.

Residents also told the inspector that they had told the staff about some of their concerns; however, they felt that they had not been listened to. The inspector reviewed the keyworker meetings of both residents. It was seen that these meetings were generally used by staff members to provide education and support to residents about their personal goals and identified risks. The agendas appeared to be set by staff and the minutes did not provide detail on whether or not residents were asked if they had any concerns.

The inspector saw, on one keyworker meeting record in June 2025, that a resident communicated to their keyworker that staff were always telling them what to do however, this had not been lodged as a complaint made by the resident. Through discussion with the person in charge, they agreed that this should have prompted the staff member to enquire if the resident wished to make a complaint.

Judgment: Not compliant

Quality and safety

This section of the report describes the quality of the service and how safe it was for the residents who lived there. The inspection found that residents were in receipt of care and support which was meeting their assessed healthcare needs and was ensuring that they were safe from abuse; however, improvements were required to some aspects of care plans and risk assessments to ensure that there was clear guidance communicated to staff in meeting residents' needs in a manner which was consistent, upholding their rights and empowering residents to express their views in respect of the service.

Each resident had a personal plan which detailed their health and social care needs and outlined some of the supports required to maximise their potential; however, some improvements were required to the detail in these plans. This was required to ensure consistency across care plans and risk assessments in respect of assessed needs and to provide suitable guidance to staff in meeting those needs.

Residents' health and development was promoted. Residents had access to required multidisciplinary professionals to meet their assessed needs and were referred for

health screening in the community as appropriate.

Education and guidance was provided to residents in respect of diet and nutrition and money management, as these were two areas which were identified as requiring support. While the provider was promoting a positive risk-taking approach and documentation detailed that residents' should have autonomy and control in respect of their decision-making, it was not clearly established through care plans how, and if, staff should intervene when residents engaged in behaviours which put their well being or their finances at risk.

There was also conflicting information across documents, through speaking to staff and in informal written communications in the centre regarding how staff should provide support in these areas. This was potentially contributing to inconsistent practices and confusion for residents, who reported that they did not always feel listened to and supported when it came to some of their opinions and decisions that they made.

There were policies and procedures to ensure that residents were protected from abuse. Staff practices ensured that residents were protected during the provision of intimate care and in reporting any safeguarding concerns. Allegations of abuse were responded to in an effective manager and comprehensive safeguarding plans were implemented where required to further protect residents.

Regulation 5: Individual assessment and personal plan

The inspector reviewed both of the residents' individual assessments and care plans. Each resident had an up-to-date assessment of their health and social care needs. The assessment reflected residents' ambitions, goals and their preferences in respect of their care.

Care plans were regularly updated and reflected input from multidisciplinary professionals. Some care plans were seen to require additional detail on specific supports to be implemented by staff or to direct staff to where they could find this information; for example, one care plan in respect of a mental health need stated that staff should provide support, however it did not provide detail on the type of support or direct staff to consult the resident's behaviour support plan or risk assessment.

One of the resident's behaviour support plans also required review to ensure that it clearly detailed supports to be implemented by staff in respect of known behaviours; for example, there was a lack of clear guidance on how staff should respond to particular comments or questions made by the resident of staff.

Some care plans were also in place which were not required. For example, there was a choking care plan on file for one resident however this was not an assessed need of the resident.

Judgment: Substantially compliant

Regulation 6: Health care

The provider had enhanced access to multidisciplinary support for residents since the last inspection of the centre. Residents now had access to a range of multidisciplinary professionals in line with their assessed needs. These included psychiatry, psychotherapy and dietitians. Residents, who were at an appropriate age, had also been referred for national screening programmes.

Some residents, on occasion, declined to attend health care appointments and their wishes in this regard were respected. The inspector saw that education and support was provided to residents to assist them in understanding the purpose for health care appointments and that an associated risk assessment detailed strategies to reduce anxiety and facilitate attendance where possible.

Judgment: Compliant

Regulation 8: Protection

All staff in this centre had received and were up to date in required safeguarding training. Residents' files included safeguarding risk assessments which detailed person-centred support to ensure the safety of residents. Residents' files also included intimate care plans which detailed their needs and how to support residents in this area. The provider had in place an intimate care policy to guide staff in providing suitable care and support.

There had been generally a very low number of incidents of abuse reported for this centre. The two incidents which had been identified as such were reviewed by the inspector. These has been reported in line with statutory requirements and appropriate safeguarding plans had been implemented to protect the residents.

Judgment: Compliant

Regulation 9: Residents' rights

The designated centre was being run in a manner which promoted positive risk taking and which was supporting the development of residents' individual goals and ambitions. For example, one of the residents who wished to have their own apartment in the future had been supported to put their name on the social housing

waitlist. This resident also had access to an independent advocate to support them.

Another resident had identified a goal to be more autonomous in managing their medications and the inspector saw that this was being worked on during the inspection.

Both residents were supported to maintain contact with their families and one of the residents spoke positively of the impact that living closer to their family had on their well being.

Residents were also empowered to maintain control of their finances and their possessions; however, there was a lack of clarity regarding the supports that one resident required with managing their finances. The inspector was told that one resident had a poor understanding of money and was at risk of financial abuse. A risk assessment had been implemented in this regard along with a financial care plan. However, these plans and associated control measures were inconsistent as they detailed that the resident was "financially independent" but then detailed supports required to safeguard the resident.

Additionally, while the plans detailed that the resident had the freedom to spend their money as they chose, the inspector saw that the notice board in the kitchen directed staff to place limits on the resident in respect of their purchasing on that day. The lack of clarity across these plans and directives posed a risk of inconsistent implementation of supports and to the resident's rights in respect of their finances.

The provider had implemented systems to consult with the residents and to ascertain their views on the service. Residents' views were sought through an annual survey which asked, among other areas, if residents had any complaints. The surveys detailed that residents did not have any complaints; however, this was different to what residents told the inspector on the day.

Residents described interactions with staff which were not wholly upholding their rights; for example, residents said that they, at times, felt not listened to and that they were not allowed to purchase specific items. The inspector saw that weekly residents' meetings were held. The minutes of these detailed that they tended to cover areas such as menu planning and activity planning but did not provide a forum for complaints or concerns to be raised.

Similarly, weekly keyworker meetings also took place, but the records of these showed that agendas tended to be driven by staff and were used as a forum to provide education to residents and progress their goals, rather than to discuss concerns.

These systems required review to ensure that residents were empowered to direct the service and to express their opinions and feelings as they communicated to the inspector on the day.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Compliant
Regulation 24: Admissions and contract for the provision of services	Compliant
Regulation 34: Complaints procedure	Not compliant
Quality and safety	
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Ashfield Lodge OSV-0008767

Inspection ID: MON-0043792

Date of inspection: 05/08/2025

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 34: Complaints procedure	Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
The registered provider shall provide an effective complaints procedure for residents which is in an accessible and age-appropriate format and includes an appeals procedure, and shall display a copy of the complaints procedure in a prominent position in the designated centre. The registered provider shall ensure that complainants are assisted to understand the complaints procedure.

1. Key working sessions are completed regularly with all residents on the company's complaints procedure via an accessible and age appropriate format. Going forward, The company's Appeals procedure will also be discussed via these key working sessions ensuring residents are fully informed of their rights to complain and to make an appeal should they wish to do so. 30/08/2025 and ongoing each month.

2. Easy read version of the complaints procedure is now displayed on the noticeboard in the kitchen and is accessible to all residents to view and read with the support from staff via the weekly resident's forum. Completed

3. PIC ensures that supporting residents' rights is on the agenda of each residents forum meeting and their concerns are discussed at the team meetings and ensure that any complaints are resolved in a proactive and timely manner. This will be an ongoing monthly action – 30/08/2025 and ongoing

4. Complaints officer met with both residents in Ashfield and informed them of their right to make a complaint. Any complaints discussed with the complaints officer will be logged to the central complaints register and a resolution will be discussed with the residents making the complaint. Picture of the complaints officer to be displayed in a prominent place on the wall in the communal area to further make all residents aware of who will be dealing with their complaint - Completed

Regulation 5: Individual assessment and personal plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which outlines the supports required to maximise the resident's personal development in accordance with his or her wishes.
1. PIC to conduct a full review of the existing Personal plan paying particular attention to the behaviour support plan and amend to include clear, step-by-step guidance for staff on how to respond to identified behaviours. Psychotherapist to support this review, and guidance on how better to support the residents will be shared with the team via daily handovers, and monthly team meetings. 30/09/2025 and ongoing
2. PIC to also review the residents risk assessment to include detailed descriptions of required supports and clear directions to the staff team on where to access relevant documents – 30/09/2025
3. The Psychotherapist to continue delivering behaviour support training to the staff team at team meetings ensuring there is clear guidance and no confusion to staff directly supporting residents – 30/09/2025
4. Full review of the individuals care plan was completed and the choking risk was removed as it is no longer relevant, after the review of their assessed needs.– 21/08/2025
5. PIC to continue to regularly review care plans as per the residents' needs and record outcomes of reviews – 30/09/2025 and ongoing

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
1. The staff team supports the residents to exercise their personal independence and choice in their daily lives. Due to one of the resident's limited understanding of their financial planning, a referral for a capacity assessment on finances has been made in order to evaluate an individual's ability to manage their money and make sound financial decisions. While this is ongoing, the risk assessment has been updated to reflect this - Completed
2. An easy read version of the complaints procedure is now displayed on the noticeboard in the communal area and is accessible to all residents to view and read with the support from staff via the weekly resident's forum. Completed

3. The PIC has ensured that all staff supporting the individuals complete a training on Putting People at the Centre of Decision-making - Applying a Human Rights-based Approach in Health and Social Care: Putting national standards into practice. The PIC will conduct refresher training and reflective practice sessions to maintain awareness of resident's rights during team meetings and during supervision sessions, following the FREDA principles of a human rights-based approach to care 30/09/2025
4. PIC ensures that supporting residents' rights is on the agenda of each residents forum meeting and their concerns are discussed at the team meetings and ensure that any complaints are resolved in a proactive and timely manner. This will be an ongoing monthly action – 30/09/2025 and ongoing
5. Resident's views are sought through the weekly forum and through key worker sessions. This is an ongoing weekly action.
6. PIC has arranged for one resident to complete a self advocacy course to help them gain a better understanding of their rights – 30/09/2025
7. PIC will ensure residents continue to have access to independent advocacy services and their details are clearly on display in the centre – 30/09/2025
8. Resident satisfaction surveys on the implementation of residents' rights which was conducted yearly, will now be completed every six months. Learnings and improvements from these surveys will be shared at the staff team meetings and supervision sessions 30/10/2025 and ongoing.

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 34(1)(d)	The registered provider shall provide an effective complaints procedure for residents which is in an accessible and age-appropriate format and includes an appeals procedure, and shall display a copy of the complaints procedure in a prominent position in the designated centre.	Not Compliant	Orange	30/08/2025
Regulation 34(2)(c)	The registered provider shall ensure that complainants are assisted to understand the complaints procedure.	Not Compliant	Orange	30/08/2025
Regulation 05(4)(b)	The person in charge shall, no later than 28 days after the resident is admitted to the	Substantially Compliant	Yellow	30/09/2025

	designated centre, prepare a personal plan for the resident which outlines the supports required to maximise the resident's personal development in accordance with his or her wishes.			
Regulation 09(2)(b)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability has the freedom to exercise choice and control in his or her daily life.	Substantially Compliant	Yellow	30/09/2025