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:	Pinewood
Name of provider:	Nua Healthcare Services Limited
Address of centre:	Clare
Type of inspection:	Short Notice Announced
Date of inspection:	07 May 2025
Centre ID:	OSV-0008875
Fieldwork ID:	MON-0045090

About the designated centre

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

Pinewood provides a 24-hour residential service for residents from the age of 18 years onwards with a diagnosed intellectual disability and-or autism spectrum disorder. The maximum number of residents to be accommodated within this service is four. The designated centre is operated from a detached two-storey premises located on its own spacious site. Two residents share the facilities of the main house; these facilities include a living room and a spacious kitchen-dining area. Each of these residents has their own ensuite bedroom. A further two self-contained units comprised of an ensuite bedroom and a kitchen-dining-living area are also provided within the house. Additional facilities in the main house include a staff office, a bedroom for staff if needed and a laundry facility that services the needs of all residents. Residents have access to secure outdoor areas and grounds and daily access to transport. The model of care is social and staffing levels are based on the occupancy and the assessed needs of the residents. The day-to-day management and oversight of the service is delegated to a person in charge supported by a deputy person in charge, a shift lead manager and the director of operations.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	3

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 7 May 2025	10:00hrs to 16:00hrs	Mary Moore	Lead

What residents told us and what inspectors observed

This was the first inspection of this designated centre by the Health Information and Quality Authority (HIQA). The centre was registered by the Chief Inspector of Social Services in October 2024. The findings from this inspection were satisfactory with the provider demonstrating a high level of compliance with the regulations. Improvement was needed in further developing staff knowledge and skills in the area of behavioural support.

This designated centre is situated in a rural location a short commute from a busy town. On the day of this inspection there were three residents in receipt of a residential service and each resident had access to transport. The house is a spacious detached two-storey property on a mature landscaped site. The inspector noted that the site was unobtrusively secured for the safety of the residents and the grounds were well-maintained. Internally, the house was subdivided creating two self-contained units each with an ensuite bedroom and kitchen-living area while two residents were provided with their own ensuite bedroom while sharing the facilities of the main house.

The house was found to be bright and spacious, visibly clean and in good decorative order throughout. The presentation of the house reflected the assessed needs of the residents. For example, the inspector saw that while therapeutic equipment and items were in place, one residents private accommodation was quite minimalist. The bedrooms of the other two residents were personalised with family and personal photographs and items of interests to the residents such as a poster of a favoured television programme.

On arrival, the inspector was greeted by the person in charge and the deputy person in charge. The direction of operations was also present for this short-notice announced inspection. One resident had left to attend their off-site day service and two residents were in the process of leaving the centre to engage in their daily programme of activities. As the inspection was concluding one resident was just returning to the centre. The assessed needs of the residents include communication differences. The resident looked at the inspector when spoken with but was engaging with their staff and communicating by gesture to staff that they wanted to leave again in the car. This choice was facilitated. Records seen by the inspector indicated that the resident would often choose to just sit in the car and would at times decline to leave the car when the resident and staff arrived at a chosen destination. However, on the day of this inspection staff said that the resident had enjoyed a long walk in a popular scenic amenity.

There had been changes to the governance structure of this designated centre since it was registered. However, these changes, based on these inspection findings were managed well by the provider and did not impact on the level of compliance evidenced. The person in charge was relatively recently appointed as person in charge of this designated centre but had sound knowledge of residents needs and

circumstances and was familiar with the staff team and the general operation of the centre.

The provider had and was gathering information about each residents needs and abilities and this information informed the arrangements put in place such as the staffing levels needed by each resident and the need for controls to manage risks such as the risk from behaviour of concern. The arrangements in the centre reflected these needs and risks such as the design and layout of the house as described above and the safety and security of the overall site. While there was an element of still getting to know each resident plans of support and care were in place. The support and care records created each day by staff were respectful and person centred and described how residents communicated by gesture or direction what they wanted and did not want.

The annual review of the quality and safety of the service (that must provide for consultation with residents and their representatives) was not due to be completed until late 2025. The provider had however completed the first six-monthly quality and safety review of the service. Areas for improvement were noted but the overall findings were satisfactory.

The person in charge described how each resident was supported to have ongoing contact with family and home. This included regular visits by family to the designated centre. The director of operations confirmed that families were met with on a regular basis and had raised no concerns about the quality and safety of the service. The inspector saw positive feedback provided by one family following a recent visit to the designated centre.

Overall, based on the findings of this inspection the facilities, support and care provided was individualised to the needs, abilities and risks of each resident. For example, one resident in addition to having their own area of the house also had access to their own safe outdoor area. The person in charge described how residents generally had their own routines and the staffing levels in the centre supported this. Plans to support the general welfare and development of the residents were in place and the provider continued to develop these plans as residents settled into the service and further information was gathered about resident needs and preferences. For example, staff were collecting, for the behaviour support team, information on behaviours that were exhibited so as to best inform preventative and responsive strategies.

In that regard, while staff had completed training, based on observations of this inspection, further guidance and support for staff was needed so as to develop staff knowledge and skills in preventing, responding to and supporting residents to manage their behaviour. The director of operations based on feedback from the inspector took actions to put this in place including requesting the presence on site of members of the provider's multi-disciplinary team to meet directly with the staff team.

The next two sections of this report will describe the governance and management arrangements in place and how these ensured and assured the appropriateness,

quality and safety of the service provided to residents.

Capacity and capability

The findings from this inspection indicated that the service was well managed. There was a clear governance and management structure in place for managing and overseeing the quality and safety of the service provided to residents. The centre was adequately resourced. The provider demonstrated a high level of compliance with the regulations reviewed and was open and receptive to the improvement needed as identified by this HIQA inspection.

The day-to-day management and oversight of the service was delegated to the person in charge. The person in charge worked full-time and was supported in their role by a deputy person in charge, a shift lead manager and, their line manager the director of operations. The person in charge had responsibility for another designated centre and described to the inspector how they prioritised and managed their presence in each centre.

The provider had ensured that the staff numbers and arrangements were in line with the assessed needs of the residents and other factors such as the design and layout of the centre. The inspector noted that the staffing levels on the day of inspection were as described and were adequate to support the residents. The person in charge described how the planning of the duty rota considered skills such as driving so that there were a minimum of two staff members on duty each day with the required skills and authority to drive. The staff duty rota clearly set out the management and staff on duty each day, their roles and the hours that they worked.

The person in charge described the formal and informal systems in place for supervising and supporting the staff team. These included induction, probationary reviews, supervision meetings and appraisals. The inspector saw a record of the date reviews were completed with individual staff members.

The inspector reviewed the staff training matrix and saw that staff training was completed and was in date such as in safeguarding residents from abuse, fire safety, the management of medicines, first aid, infection prevention and control and, responding to behaviour that challenged including de-escalation and intervention techniques.

As discussed in the opening section of this report the provider had arranged for the first six-monthly quality and safety review of the service to be completed in January 2025. The inspector read the report that issued. It was a detailed report, reviewed and quality assured core areas such as incidents that had occurred and how these incidents were recorded and responded to. Actions to improve the quality and safety of the service did issue such as improving the detail provided in incident reports so as to support better review and analysis. However, the overall findings were

satisfactory and that would concur with the findings of this HIQA inspection.

Regulation 14: Persons in charge

The person in charge worked full-time. The person in charge had the qualifications, skills and experience needed for the role. The person in charge could clearly describe to the inspector how they managed and maintained oversight of the designated centre. While recently appointed as person in charge of this designated centre the person in charge had sound knowledge of the needs and circumstances of each resident, was familiar with the staff team and the general operation of the designated centre.

Judgment: Compliant

Regulation 15: Staffing

Staffing numbers and staffing arrangements were based on the assessed needs of each resident. The inspector saw that past and current planned and actual staff duty rotas were in place and these confirmed the staffing levels assessed as needed were maintained. For example, there were four staff on waking duty each night and a minimum of five staff members were on duty each day from 07:00hrs. Two of the three residents living in the designated centre had support from two staff so that they could for example, safely access the community. The person in charge confirmed that there were no staff vacancies and therefore no obstacles to maintaining these staffing levels. The staff duty rota was planned and prepared in advance, it's preparation and maintenance was overseen by the person in charge. The inspector saw that where there were changes, the replacement staff member were clearly indicated on the duty rota. The model of care was social. If nursing advice was needed this could be accessed from the providers own resources.

Judgment: Compliant

Regulation 16: Training and staff development

The provider had ensured that all staff who worked in the centre had received mandatory training in areas such as fire safety, positive behaviour support and safeguarding residents from abuse. Additional training was provided to staff to support them to meet the support needs of residents including training in infection prevention and control, the administration of medications, first aid, supporting persons with a disability and promoting the rights of residents.

The inspector saw that there was a training record in place for each staff member listed on the current staff duty rota. Staff had completed training in positive behaviour support and in de-escalation and intervention techniques. However, the need for further support and guidance in this regard will be discussed again in the next section of this report.

The person in charge described the systems in place for supporting and supervising the staff team. The person in charge supervised and mentored the deputy person in charge and the shift lead manager. The person in charge described how they maintained oversight of any staff supervision not completely directly by them. The inspector saw a log of the probationary reviews and supervision meetings completed with each staff member to date in 2025

Judgment: Compliant

Regulation 21: Records

The inspector was provided with any of the records requested to inform and validate these inspection findings. These records pertained to the regulations reviewed by the inspector and included for example, the assessment of the resident's needs, a recent photograph of the resident, details of their next of kin and more general records such as the staff duty rota and fire safety records. The records seen were well maintained.

Judgment: Compliant

Regulation 23: Governance and management

Based on the findings of this inspection this was a well managed service. While changes in the management structure had occurred there was no evident impact on the quality, safety or continuity of the care and support provided to residents. The centre presented as adequately resourced. For example, residents were provided with a safe and comfortable home, with transport and staffing levels suited to their needs.

The inspector found clarity on roles, responsibilities and reporting relationships. For example, the person in charge understood their role and described how they maintained oversight of duties delegated to members of the staff team. The provider supported and maintained oversight of the local systems of management. The person in charge reported excellent access and support from their line manager the director of operations. The director of operations called regularly to the centre, generally unannounced and was in daily contact with the person in charge.

The inspector found accountability for the quality and safety of the support and care provided to residents. For example, the actions taken to improve that quality and safety of the service in response to the verbal feedback of these inspection findings.

The provider had arranged for the first quality and safety review to be completed within six months of the opening of this service.

Judgment: Compliant

Regulation 3: Statement of purpose

The inspector read the statement of purpose and saw that it contained all of the required information such as the conditions of registration, details of the local and wider governance structures and a summary of the admission and complaint management procedures. The inspector noted that the statement of purpose had been updated to reflect the changes in the management structure.

Judgment: Compliant

Regulation 31: Notification of incidents

Records seen by the inspector included the restrictive practices register, an individual incident log and the report of the providers six-monthly quality and safety review. These records indicated that the Chief Inspector of Social Services had been notified of events and incidents such as minor injuries, how they were sustained and treated.

Judgment: Compliant

Quality and safety

As mentioned in the first section of this report this was a relatively new service. The provider had and continued to gather information about residents' needs, abilities, choices and preferences. That information was used to inform the arrangements put in place so that residents were safe and well and had a good quality of life.

Based on observations made the inspector reviewed one resident's personal plan. The inspector saw that a comprehensive assessment of the resident's health, personal and social care needs had been completed. Support plans were in place for matters identified by that assessment such as any support needed for personal care,

behaviour support and for supporting the resident to make good lifestyle choices such as in relation to the diet, activities and exercise.

The person in charge reported that all three residents generally enjoyed good health and the personal plan seen included plans outlining the care to be provided so that the resident stayed healthy and well. For example, plans to ensure the resident would eat and drink safely and was monitored by staff for possible seizure activity. Records seen including the daily notes completed by staff confirmed that the staff team monitored the resident's wellbeing and sought medical advice and care when they had concerns. For example, from the resident's general practitioner (GP) and out-of-hours GP service.

The providers own multi-disciplinary team (MDT) inputted into the assessment of the resident's needs and into the plans and arrangements put in place to support identified needs. For example, there was documentary evidence of ongoing input from speech and language therapy, occupational therapy and the positive behaviour support team.

Guidance was in place for supporting the resident to manage their behaviours. It was understood that behaviour was at times used as a form of communication. As mentioned in the opening section of this report staff were collecting additional information each day on behaviour that presented. This information was to be analysed by the positive behaviour support team to further develop an understanding of the behaviour, possible triggers and appropriate staff responses. Staff had completed training in positive behaviour support and in de-escalation and intervention techniques. However, there were evident challenges to a resident transitioning from the centre to their vehicle on the morning of this inspection. While de-escalated, the transition and some minor behaviour exhibited was not in general managed well. What was observed by the inspector highlighted the need for further guidance and training for staff.

The provider had systems in place for identifying and managing risk in the centre. For example, the inspector saw that an individual risk management plan was put in place based on the information gathered from the comprehensive assessment of needs. The risk management plan and the controls to manage each risk were kept under review by the person in charge.

Controls to manage risks such as for property damage or a resident leaving the centre without staff when it was not safe for a resident to do so, were in place and met the criteria of restrictive practice. There was a documented risk based rationale for the restrictions in use and systems for reviewing their ongoing use and impact. The inspector noted reviews completed by the person in charge in conjunction with the behaviour support specialist. These reviews and the provider led review completed in January 2025 reviewed incidents that had occurred and the restrictions in place including any physical interventions implemented by staff. Reviews were completed to establish that the latter were used only as a last resort.

The house was designed and laid out to safely support the assessed needs of the residents living in the designated centre. The arrangements in place were responsive

to individual needs and abilities and risk that could present. The house was spacious, comfortable, visibly clean and where safe to do so, the house was furnished and decorated in a homely style.

Based on what the inspector observed and read good fire safety management systems were in place. For example, it was evident that the provider had given due consideration to the use of inner rooms as bedrooms in the two self-contained apartments. The inspector saw the provision of fire-doors and an alternative means of escape had been provided in both bedrooms. Regular evacuation drills tested the evacuation procedure.

Regulation 11: Visits

As they transitioned to living in the designated centre, residents were supported to have ongoing contact with home and family as appropriate to their individual circumstances. This included regular visits to the centre by family members, outings with family with or without support from the staff team and, visits to family and the family home. The arrangements in place were very specific to the needs of each resident and their families.

Judgment: Compliant

Regulation 17: Premises

The accommodation provided to residents was of a high standard. The house was well maintained internally and externally, was bright and spacious and located on a mature landscaped site. The provider had secured the site so that residents could access the garden and equipment such as a swing with support and supervision from the staff team. Internally, the provider had modified the house so as to create two self-contained units. This arrangement meant that needs and controls, such as restricted access to cooking appliances did not impact unnecessarily on other residents. The facilities of the main house included a spacious kitchen and dining area with access to an external paved area. A laundry with capacity to meet the needs of all residents and with sufficient space to manage clean and not-clean laundry was provided. Each resident had their own bedroom with ensuite accessible shower-room.

Judgment: Compliant

Regulation 26: Risk management procedures

There were systems in place for the identification, management and ongoing review of risk. This was evident from discussion with the person in charge, the review of an individual incident log, an individual risk management plan and, the observations of this inspector. The provider had contingencies for responding to events such as loss of power. A generator was in place on the day of this inspection in response to a planned local power outage.

The risk management plan seen by the inspector reflected the findings of the comprehensive assessment of needs, the restrictive practices register and what was discussed with the person in charge. For example, risks identified and controlled included the risk for behaviour of concern, a risk for choking and the risk that could present and how this was managed to the residents choices and quality of life from the restrictive practices in use in the designated centre.

There was a system in place for recording, reporting and reviewing incidents and accidents that occurred and for highlighting any improvements that were needed so as to improve the safety and the quality of the support provided. For example, ensuring sufficient detail was provided when staff documented incidents.

Judgment: Compliant

Regulation 28: Fire precautions

Good oversight was maintained of the designated centres fire safety arrangements. For example, there was documentary evidence in place of the inspection and testing of the fire detection and alarm system, the emergency lighting and fire-fighting equipment. The actions to be taken in the event of a fire and details of the evacuation routes were prominently displayed. On visual inspection there was good provision of doors with self-closing devices designed to contain fire and its products including smoke. The escape routes were noted to be clearly indicated and unobstructed. Each resident had a personal emergency evacuation plan (PEEP) that set out the support and guidance they would need from staff to safely evacuate the centre. Staff and residents participated in drills that tested the effectiveness of the PEEP. The inspector noted that drills were convened to coincide with changes such as the admission of an additional resident. The four drill records reviewed by the inspector reported that different staff members had participated in these drills and staff and residents vacated the centre in good time.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

Records in place confirmed that the provider gathered information about the

resident, their needs, abilities, medical and educational history prior to the residents admission to the designated centre. The inspector noted that the comprehensive assessment of needs was completed in consultation with family and the care and support that could and would be provided was discussed with family. A personal plan was developed based on the findings of the assessment. Key-workers were responsible for the maintenance of the person plan and sought to maximise through key-working meetings the residents participation in their personal plan. The person in charge and the provider (for example during the provider-led review that had been completed) monitored the maintenance of the personal plan. The inspector reviewed one resident's personal plan. There was documentary evidence of regular MDT input and review. The personal plan referred to the development of personal goals and objectives with and for the resident that would support their ongoing welfare and development and perhaps support the resident to engage with activities they had previously enjoyed. Staff completed monitoring records so as to assess the effectiveness of the plans in place or to identify the need for additional support. For example, staff monitored the quality of the residents sleeping pattern, the variety of their diet and daily fluid intake.

Judgment: Compliant

Regulation 6: Health care

The assessment of needs included an assessment of the resident's general health and wellbeing and identified any pre-existing health concerns. Plans were put in place to support resident health and wellbeing and further assessments were completed by the providers own MDT as needed. The inspector saw records of reviews completed since admission by speech and language therapy and occupational therapy. Staff monitored resident health and well-being and sought advice and care when they had concerns, for example, from the on-call GP service. The person in charge ensured that residents had access to the healthcare services that they needed and was seeking, for example, alternative General Practitioner (GP) arrangements geographically better suited, to the location of the centre and the needs of a resident. Staff maintained a record of any occasion when a resident declined care and why this may have happened such as the waiting time.

Judgment: Compliant

Regulation 7: Positive behavioural support

There were times when residents could present with behaviour of concern and that behaviour could impact on the residents own safety and the safety of others including the staff team. The provider gathered information about the type of behaviour that presented as part of the comprehensive assessment of needs and

continued to assess behavioural support needs following admission to the designated centre. Staff were, at the time of this inspection, collecting information to submit to the behaviour support specialist. Guidance on preventative and responsive strategies was in place such as redirection and communication. These strategies were informed by the MDT. For example, speech and language therapy with regard to communication. Staff had been provided with training including training in de-escalation and intervention techniques.

The restrictions that were in place were largely of an environmental nature such as the provision of modified furniture and restricted access to certain items and areas of the designated centre.

However, the inspector observed as a resident transitioned from the centre into their service vehicle. This transition was not managed well in terms of the general busyness of the environment, the number of staff present which was more than the residents allocated staffing level and the use of an unsanctioned intervention with the resident. The incident could have escalated but it did not. The resident was supported by a staff member who stood calmly beside the resident while holding the residents hand palm-to-palm. What this incident highlighted was the need for further guidance, support and learning for the staff team so that they had the knowledge and skills to prevent, appropriately respond to and support the resident to manage their behaviours.

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 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 21: Records	Compliant
Regulation 23: Governance and management	Compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Substantially compliant

Compliance Plan for Pinewood OSV-0008875

Inspection ID: MON-0045090

Date of inspection: 07/05/2025

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) will ensure the appointment of two Specific Matter Experts (SMEs) in Safety Intervention within the Centre to support best practice and provide guidance to the staff team. Due Date: 20th July 2025 2. The PIC will ensure that all relevant staff attend refresher training in Safety Intervention, in line with the Crisis Prevention Program, to maintain competency in proactive and safe intervention strategies. Due Date: 26th June 2025 3. The PIC will ensure that all Staff, including Management, complete comprehensive training and attend workshops in Positive Behaviour Support (PBS), delivered by a qualified Behavioural Specialist. This training will promote consistency in practice, a shared understanding of PBS principles, and support the delivery of person-centred care across all levels of the service. Due Date: 7th July 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(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.	Substantially Compliant	Yellow	07/07/2025
Regulation 07(5)(b)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation all alternative measures are considered before a restrictive procedure is used.	Substantially Compliant	Yellow	20/07/2025