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:	Kilshrewley Gardens
Name of provider:	Orchard Community Care Limited
Address of centre:	Longford
Type of inspection:	Announced
Date of inspection:	17 June 2025
Centre ID:	OSV-0008913
Fieldwork ID:	MON-0045986

About the designated centre

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

This centre can support up to three people with intellectual disabilities and/or Autism aged 18 years of age and over. The centre can also cater for people who require support with their mobility and there is wheelchair access to the centre. This centre provides care based on the social care model of support. There is a person in charge who manages this centre to facilitate appropriate oversight and governance. Residents will be supported by a team of carers (social care workers and healthcare assistants) over a 24 hour period including a waking night duty staff and a staff sleeping over at night time. The centre is a four bedroom bungalow in the countryside. Each resident has their own bedroom with one resident's bedroom having an en-suite bathroom and there is a shared bathroom for the other two residents. There are two communal sitting rooms. Residents have access to a kitchen and utility room within the centre.

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
Tuesday 17 June 2025	10:45hrs to 18:50hrs	Karena Butler	Lead

What residents told us and what inspectors observed

On the day of the inspection, the inspection findings were positive. The residents were receiving a good standard of care from a staff team who were aware of and ensured their assessed needs were being met. However, some improvements were required in relation to governance and management with regard to the maintenance of records, and the testing of the centre's water. Those areas will be discussed in more detail later in the report.

The inspector had the opportunity to meet and observe the three residents that were living in the centre at different times of the day. They appeared content and comfortable in the presence of the staff on duty.

One resident, with alternative communication methods, did not share their views with the inspector, and they were observed on different occasions in their home on the day of the inspection. They smiled when asked if they were happy and if the staff were nice. They indicated through their body language that they did not wish to speak any further to the inspector and their preference was respected.

The inspector had the opportunity to speak briefly with two residents. Both communicated that they were happy and that staff were nice. One communicated that they felt safe living in the centre and that if they had any concerns that they would tell a staff member. The other resident said they liked their bedroom and smiled when the inspector spoke to them about different items they had on display.

The staff spoken with and the person in charge communicated to the inspector that activities residents participated in were based on their personal preferences. There were three vehicles available for the residents to facilitate community access and each resident had a dedicated one-to-one staff to support them to participate in activities of their choosing.

As part of their weekly schedule all three residents attended a day service programme five days a week. Staff respected their choice if they ever chose to take a day off to stay at the centre instead. On the day of this inspection, two of the three residents chose to attend their day service programme and on the way home one resident went shopping to buy personal items. The other resident returned home and later went out to a nearby town for a walk. The third resident was offered different choices for the day but chose to relax in their room and watch their favourite programmes and music on their electronic device.

The inspector had the opportunity to speak with the three staff on duty and the person in charge. They came across as professional and caring. They demonstrated they were aware of any support requirements for the residents and referred to residents' support plans for when they may require further information.

The provider had arranged for the majority of staff to have training in human rights. The staff member spoken with communicated how they had put that training into every day practice. They communicated that in the past that when they were supporting a resident to attend appointments, for example a hairdressers, to get their hair done they may not have asked which hairdresser's the resident preferred. They now ensured that they support the resident to make a choice about which hairdressers they would like to attend.

As part of this inspection process residents' views were sought through questionnaires provided by the Office of the Chief Inspector of Social Services (The Chief Inspector). The three questionnaires were returned by way of staff representatives supporting the residents to complete the questionnaires. Feedback was positive and the majority of answers were ticked 'yes' when asked about the service and care provided. Some answers were ticked 'no' with regard to staff knowledge of one of the residents and if they had made any friends living in the centre yet. It was recorded that this was due to the resident having only recently moved into the centre. When asked if the resident could make a call in private, two answered either "no" or "it could be better"; however, there was no elaboration on this answer. The only elaboration recorded on the questionnaires was that one resident would like two dogs, two residents would like televisions. One resident would like to visit another country with a relative. They would also like to attend a particular service and the person in charge confirmed on the day of the inspection that an application for this service was already submitted on their behalf.

The inspector observed the house to be nicely decorated, clean and tidy. There were two sitting rooms and both had televisions for use. One had a karaoke machine. along with balls, toys, and puzzles.

Each resident had their own bedroom and they were decorated as per each of their preferences. For example, bedrooms had personal pictures displayed and personal items displayed. One resident had a sofa in their room. The bedrooms had adequate storage facilities for any personal belongings.

There was an accessible garden that wrapped around the house with neatly cut grass. The person in charge communicated that staff were looking into getting some suitable garden furniture for the residents to use in times of good weather.

At the time of this inspection there were no visiting restrictions in place. The person in charge confirmed there were no volunteers used in the centre. There were no vacancies and the last resident had moved into the centre one month prior to this inspection. According to the person in charge, the individual appeared to be settling in well in the centre and appeared to be getting on well in particular with one other resident. The inspector did not have the opportunity to speak with a family representative as none were available on the day of the inspection.

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

Capacity and capability

This inspection was announced and was undertaken as the first inspection of this centre since it was registered. Some improvements were required with regard to governance and management with aspects of records and a potential infection prevention and control risk, and they will be discussed further under the specific regulation.

The findings of this inspection indicated that the provider had the capacity to operate the service within substantial compliance with the S.I. No. 367/2013 - Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (the regulations). The provider and the person in charge were operating the service in a safe manner which ensured the delivery of care was meeting the residents' needs.

The inspector reviewed the provider's governance and management arrangements and found that for the most part there were appropriate systems in place in order to ensure the quality and safety of the service. For example, there were arrangements for specific monthly management oversight audits to review the service. The inspector also found that any complaints made were observed to be adequately reviewed and responded to.

The inspector found that there was suitable staffing arrangements in place to meet the assessed needs of the residents. From a review of a sample of rosters across four months, staffing levels had never gone below the safe minimum staffing ratio that the provider had determined was necessary to safely support the residents. Staff were found to be in receipt of a suite of training in order to effectively support the residents, for example staff received training related to feeding, eating, drinking, and swallowing.

Residents were provided an opportunity to visit the centre prior to their admission and they had a copy of their terms and conditions of residency which were recorded in a contract of care and kept on file for them.

Regulation 14: Persons in charge

The person in charge was employed in a full-time capacity and had the necessary experience and qualifications to fulfil the role. For example, they held a qualification in managing people. They demonstrated a good understanding of the residents and their needs, such as what the positive behaviour support needs were for each resident.

They were also found to be aware of their legal remit to the regulations and were responsive to the inspection process. For example, they were aware that it was their responsibility to ensure the reporting of any adverse incidents that occurred to the Chief Inspector.

The person in charge was responsible for three designated centres, with a plan of reducing that to two centres in approximately two months time from this inspection. The inspector found that they were actively involved and participated in the operational management of the centre. For instance, they attended the centre two times per week in order to provide oversight, provide informal supervision for staff, and ensure oversight of the schedule of audits.

Judgment: Compliant

Regulation 15: Staffing

There were sufficient staff available, with the required skills to meet the assessed needs of residents.

As previously mentioned, the staff on duty on the day of the inspection were observed to be caring and respectful towards the residents.

The inspector reviewed a sample of rosters over a three month period from April to June 2025. The review demonstrated that there were planned and actual rosters maintained by the person in charge with the full names and job titles of the staff that worked in the centre recorded on the rosters. The arrangements in place to cover any gaps that arose on the roster facilitated continuity of care for residents with two consistent relief staff filling any required shift cover.

Staff personnel files were not reviewed at this inspection. However, the inspector reviewed a sample of the person in charge, and three staff members' Garda Síochána (police) vetting (GV) certificates. All four were completed within the last year which demonstrated that the provider had arrangements for safe recruitment practices that were in line with best practice. The person in charge also confirmed that all staff working in the centre had a level five qualification in health, social care or equivalent.

Judgment: Compliant

Regulation 16: Training and staff development

There were suitable arrangements in place to support training and staff development. The inspector reviewed the training oversight matrix for mandatory training completed. Additionally, the inspector reviewed a sample of the certification

for eight training courses for all staff and two staff who worked in the centre on a relief basis. Those reviews demonstrated to the inspector that staff received a number of training courses in order for them to carry out their roles safely and effectively in order to support the residents.

Examples of the training staff had completed included:

- safeguarding vulnerable adults
- eating, drinking and swallowing
- medication management
- epilepsy awareness
- fire safety.

The inspector observed that, one staff member was due to undertake medication management refresher training and they were scheduled to undertake it the day after this inspection. Two staff were due to undertake first aid training in addition to clamping of wheelchairs training. However, the person in charge had identified this and was in the process of arranging dates for those staff.

Staff had received additional training to support residents. For example, staff had received training in human rights. Further details on this have been included in 'what residents told us and what inspectors observed' section of the report.

The inspector also reviewed the supervision files and probation meeting minutes for three staff members. From that review, the inspector found formalised supervision and probation arrangements in place, which followed the organisation's policy. From a review of supervision meeting minutes, the inspector found that the formal supervision meetings offered the chance to staff to raise any concerns they may have.

Judgment: Compliant

Regulation 23: Governance and management

The inspector found that for the most part there were appropriate governance and management systems in place at the time of this inspection.

There were clear lines of authority and accountability in this service. The centre had a clearly defined management structure in place which was led by the person in charge. The person in charge communicated that a team leader was recently employed for the centre and they would be commencing their role the day after this inspection. This was in order to further support the person in charge in the oversight arrangements of the centre. Two staff spoken with were clear on the reporting structure if required.

Management systems ensured that the service provided was safe, consistent and for the most part appropriately monitored. For example, there were arrangements for

annual reviews and six-monthly unannounced provider led visit reports as per the requirements of the regulations. The provider had arranged for the first six monthly visit to take place the week prior to this inspection by the quality compliance officer. Additionally, there were local audits completed by staff and the team leader with support from the director. They included:

- monthly person in charge audit
- monthly governance and oversight audits
- monthly medication audits.

From speaking with the person in charge, the inspector found there was no evidence to suggest that the centre had been risk assessed or tested for Legionnaires' disease since the provider had taken over the property. Legionnaires' disease may occur when a bacteria may live in stagnant water which has the potential to cause illness and this property had been dormant for approximately one year prior to residents moving in.

A review of records found they were not always accurately maintained or complete. For instance, minutes were missing for some key meetings, and some audits or documents completed in relation to the centre or residents did not have a date recorded as to when they were completed. For example, while the inspector observed the completed last six monthly unannounced provider led visit, it was not evident what date it was undertaken.

The inspector observed on two residents' original assessment of need documents it was recorded that they did not have any support requirements with regard to eating. This was not accurate as both residents had eating support plans devised by a speech and language therapist prior to their admission. The inspector found that any documented information post admission related to supports required for eating contained the accurate information. In addition, an intimate care plan for a resident had information recorded that could potentially lead to staff inconsistencies related to supports they required while bathing. This was brought to the attention of the person in charge on the day who explained that the plan was still a work in progress being developed in consultation with the staff team at meetings. They assured the inspector that the plan would be amended to ensure accuracy and consistency of approach. Staff spoken with were familiar with the appropriate support requirements with regard to intimate care, and dietary plans and therefore this was more of a documentation and oversight issue. However, inaccurate information had the potential to incorrectly inform support plans and could lead to residents receiving inappropriate supports. Therefore, this required review to ensure all recorded information was accurate.

The inspector found that some staff had raised concerns that some of the staff team were not always consistent in their approach or completing their share of the workload. It was not always clear what the management response was in relation to those matters. For example, in one supervision session when a staff member had highlighted their concerns, there was no recorded management response. From speaking with the person in charge and the area manager, they communicated that in response to staff concerns as well as their own management observations, the

team required further development. As a result of their findings, the frequency of team meetings was increased from monthly to weekly in order to support the staff team. Additionally, a separate weekly management meeting was arranged for the next several months to review any issues that may be arising for the team, until they were assured that the team were supported to develop a good working relationship and ensure consistency. The area manager also confirmed that one objective of the management meeting was to identify the correct supports and the relevant people to provide those supports, to ensure staff have the appropriate knowledge and skills to support the residents. While the inspector acknowledges that these were positive steps the provider was taking, no records were kept for those meetings and therefore the inspector could not review the minutes or any actions arising to verify the information. Without a formal record of those meetings, there was a risk of a lack of accountability for assigned actions which had the potential to negatively affect the consistency and quality of care.

The inspector reviewed the records of the minutes of team meetings and found that they were occurring regularly. The minutes demonstrated that if any incidents were to occur within the centre that they would be reviewed for shared learning with the staff team. Topics at meetings included, a discussion on the residents, safeguarding, fire safety, restrictive practices, infection prevention, medications, and complaints.

From the three staff spoken with they communicated that they would feel comfortable going to either the person in charge, or the area manager if they were to have any issues or concerns and they felt they would be listened to.

In summary, while many of the records held in the centre were of good quality, improvements were required to the oversight and documentation of all pertinent information to ensure they were accurate and available for review.

Judgment: Substantially compliant

Regulation 24: Admissions and contract for the provision of services

The inspector reviewed the most recent admission to the centre and found that the resident was provided with an opportunity to visit the premises in advance of admission. They were supported with a transition plan to facilitate a smooth admission into the centre.

Two of the three residents had signed contracts of care in place which described the terms and conditions of what it meant to live in this centre and what service would be provided to them and any fees to be charged to them.

The most recent admission to the centre was awaiting the support of a translator known to them in order to promote understanding of what the terms and conditions of residency of this centre meant to them before they were asked to sign their contract. The person in charge informed the inspector that this was due to take place the week after this inspection. Post inspection the person in charge confirmed

in writing that the translator had called to the centre and supported the resident to understand the contract of care.

Some aspects of the contracts of care were found to be vague in places as to what was included in the residents' terms and conditions, for example if WIFI was included. Vague contract terms regarding fees and included services could lead to future misunderstandings and this lack of clarity has the potential to cause unnecessary anxiety for residents. However, the area manager confirmed to the inspector that no fees were being charged to the residents in this centre and that all utilities were included for the residents including WIFI. They confirmed that a meeting was being arranged in the coming weeks with other senior managers to further develop and clarify the document to ensure the contract was not vague or open to interpretation.

Judgment: Compliant

Regulation 34: Complaints procedure

The provider had suitable arrangements in place for the management of complaints. For example, there was an organisational complaints policy in place dated April 2025. The inspector observed that complaints was a standing agenda item for discussion at team meetings and residents' meetings. The inspector also observed that there was a complaints procedure displayed in the hall of the centre and it identified who the complaints officer for the centre was.

The inspector found that there was a complaints and compliments log in place which was an overview document of any complaints or compliments the service received. There had been two complaints in the centre since it opened. The inspector found that the complaints had been listened and responded to with learning taken from the complaints and actions implemented as required. For example, with regard to one complaint, actions taken included, the person in charge emailed the staff team with an aim to promote consistency and with actions to be taken. In addition, the complaint was discussed at the team meeting in order to ensure staff understood the identified issues and expectations for going forward. The person in charge met with the family to gather the particulars of the complaint. A senior manager was then in contact with the complainant to inform them of actions taken and the complainant confirmed they were happy with the actions being taken.

The centre had received one compliment from a family representative in June 2025 whereby they thanked staff for their support arranging a birthday party for their family member and that 'the party was lovely.

Judgment: Compliant

Quality and safety

Overall, the inspection found that residents living in this service were supported in line with their assessed needs.

There were systems in place to meet residents' assessed needs, for instance residents had assessment of need documents completed prior to admission and post admission to ensure their assessed needs were known and recorded.

There were adequate arrangements in place with regard to positive behaviour support as residents had a positive behaviour support plans in place as required to guide staff as to how best to support them should they be experiencing periods of distress.

The inspector also reviewed the arrangements for personal possessions, and general welfare and development. It was found that residents were supported to retain control over their personal possessions, and additionally that the residents had access to opportunities for recreation.

There were suitable arrangements in place to ensure they were safeguarded in the centre and in the community. For example, staff were suitably trained to recognise and and escalate any safeguarding concerns.

The inspector observed the premises to be clean and tidy which in turn facilitated in the arrangements for good infection prevention and control (IPC).

There were suitable risk management, and fire safety management systems in place. For example, there was a risk register in place for risk associated with the centre or residents, and there were fire detection and alert systems in place.

Regulation 12: Personal possessions

The inspector found that residents had access to and retained control over their own possessions, and where needed, support was provided to manage their finances.

Residents kept their personal belongings in their bedrooms and there was adequate space to store for their clothes and possessions.

There were arrangements in place to keep account of and protect residents' finances. This is discussed further in regulation 8. Residents chose what they wanted to spend their money on, and regular shopping trips were arranged to buy preferred items or for community activities. For example, on the day of this inspection, one resident purchased a particular item on the way home from their day service programme. They were very excited to show the inspector and staff their

new item and there were lots of discussion about this item between the staff and the resident.

Judgment: Compliant

Regulation 13: General welfare and development

The person in charge had ensured that residents had access to opportunities for leisure and recreation. Residents engaged in activities in their home and community and were supported to maintain relationships with family.

Residents were supported to set and achieve personal goals in order to enhance their quality of life. For example, from a review of a sample one resident's goals, they were being supported to apply for day service programmes nearer the centre. They were being supported to develop more independence with regard to their money management as well as fun activities like organising their birthday party and going on a short holiday break.

From a review of two residents' activity schedules over a period from April to June 2025, the inspector observed that residents were being offered a variety of activities. Ranging from music therapy, heritage parks, attending the cinema, gardening, pet farms, coffee out and going to the pub.

Judgment: Compliant

Regulation 17: Premises

The layout and design of the premises was appropriate to meet residents' needs. The premises was found to be in a state of good repair and was found to be clean and tidy. The facilities of Schedule 6 of the regulations were available for residents' use, for example there was access to cooking and laundry facilities.

There were suitable arrangements for residents to have access to communal spaces; such as the two sitting rooms, as well as a private bedroom space. This would also facilitate residents being able to have visitors in private if they wished.

Each resident had their own bedroom with sufficient space for their belongings and one resident had an en-suite bathroom. Bedrooms were observed to be individually decorated to suit the preferences of each person. For example, there were personal pictures and items displayed.

Judgment: Compliant

Regulation 26: Risk management procedures

From observation and a review of information, the inspector found that there were adequate systems in place to manage risk.

There were centre specific and individual risk assessments on file with control measures in place to mitigate identified risks so as to support residents' overall safety and wellbeing. Risks specific to individuals, such as choking risks, had also been assessed to inform care practices and appropriate control measurements implemented to minimise the risks to the resident. For example, staff were trained in first aid, and feeding, eating and drinking training. The resident had a eating and drinking plan devised by a speech and language therapist and the person in charge and a staff member spoken with were familiar as to the support requirements.

As part of the standing agenda items for staff meetings, whenever an incident might occur they would be discussed with the staff for shared learning.

On review of other arrangements in place to meet the requirements of this regulation the inspector found the provider had in place:

- a risk management policy last reviewed April 2025
- there was also a risk register in place documenting the main risks in the centre
- the centre was due to get a new boiler installed in the coming weeks which would ensure it was safe for use
- an emergency evacuation plan was displayed in the hall which guided staff on what to do in an emergency and alternative accommodation should it be required
- from a sample of one of the three centre's vehicles, the inspector was found to be next due for a service in April 2026, it had a national car test (NCT) in date until April 2027, and it was observed to be taxed. This would facilitate that the car was road worthy and safe for use by the residents.

Judgment: Compliant

Regulation 27: Protection against infection

There were measures in place to control the risk of infection in the centre on an ongoing basis. The centre was maintained in a clean condition throughout. Hand washing facilities with hand wash and disposable towels for drying were available for use which would facilitate good hand hygiene practices.

Staff had received relevant training. For example, from a review of the entire staff teams certificates for two IPC trainings and a review of the training oversight

document for a third IPC training, staff had received training in hand hygiene, standard and transmission based precautions, and cough etiquette and respiratory hygiene, in order to help prevent or minimise the occurrence of a healthcare associated infection.

From a review of a sample of the cleaning roster for May and June 2025, it demonstrated that daily cleaning was taking place in the centre. The inspector also observed that there were colour coded mops, cleaning cloths and chopping boards in use and signage on how to use them was displayed to guide staff. These measures further helped to prevent or minimise the occurrence of healthcare associated infections within the centre.

The inspector found that there was personal protective equipment (PPE) available for use in the centre and antibacterial gel, for instance surgical masks and antibacterial gel were available beside the front door if required.

While the provider has not arranged for Legionnaires' disease testing to be completed on the water prior to the centre opening to ensure the water was safe for use, this was actioned under Regulation 23: Governance and management.

Judgment: Compliant

Regulation 28: Fire precautions

There were suitable fire safety management systems in place, including detection and alert systems, emergency lighting and firefighting equipment, each of which was regularly serviced.

For example:

- the fire extinguishers were last serviced June 2025
- the fire alarm and emergency lighting were last serviced June 2025 with no actions arising
- the inspector found that staff had received training in fire safety.

From a review of the three residents' personal emergency evacuation plan (PEEP) it demonstrated to the inspector that there were fire evacuation plans in place for residents in order to guide staff as to evacuation supports required in the event of an emergency. Periodic fire drills were completed in order to assure the provider that residents could be safely evacuated from the building at all times. From a review of the last three drill records, the inspector found that alternative doors were being used for evacuation as part of the practice drills in order to assure the provider that residents could be evacuated from all areas of the building if required.

There were fire containment doors in place where required and they were fitted with self-closing devices. The inspector tested the fire containment doors and found that while the majority closed correctly, two failed to close fully on their own. That would

mean in the event of a fire that the doors could not effectively prevent the spread of smoke or fire. The person in charge arranged for the doors to be fixed on the day of the inspection with evidence shown to the inspector.

The inspector also observed that staff completed different daily and weekly fire safety checks. From a review of January to June 2025 checks, the inspector observed that staff were checking emergency exits to ensure they weren't blocked and they visually checked emergency lighting to ensure it was working. The inspector observed times when issues were identified with one emergency light and the issue was rectified. This demonstrated to the inspector that staff were identifying and escalating issues as required in order to ensure a safe environment for the residents.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

There were adequate systems in place to meet the requirements of this regulation. While improvement was required to the accuracy of some information contained in some assessment of need documents, and an intimate care plan, this was actioned under Regulation 23: Governance and management. This is due to the fact that the information required to support the residents was known by the staff team and at the time of this inspection was not negatively impacting the residents as the correct supports were in place. .

Based on a review of the two residents' assessment of need documents, they were found to be up to date and identified the residents' health, social and personal care needs. For example,

The inspector found that the assessment informed the residents' personal support plans and for the most part suitably guided the staff team. Personal plans reviewed, of which some were developed by relevant professionals, included a physiotherapy programme plan, feeding, eating and drinking plans, and a hospital passport to guide hospital staff should a resident require a hospital stay. This would promote a inclusive approach along with allied healthcare professionals in order to ensure the residents were in receipt of appropriate supports in the right manner.

Judgment: Compliant

Regulation 7: Positive behavioural support

Residents were supported to experience best possible mental health and where required had access to the support of allied health professionals, for example a

psychiatrist or a behaviour support therapist. From a review of two residents' files, this demonstrated to the inspector that where required, residents had a positive behavioural support plan in place which was reviewed by a behaviour specialist. The plans provided guidance to staff as to how to best support a resident when they were experiencing periods of distress and promote consistency of the staff team's approach

Behaviour Support plans were found to outline strategies that staff needed to follow to support the residents in times of distress.

For example:

- they contained a list of potential behaviours that may be seen
- triggers that may lead to the behaviours
- proactive responses staff could engage in with the resident
- responses to when the resident is becoming anxious
- responses to when the resident is in distress
- what it may look like and the response to be taken to when the resident is returning to baseline.

In addition, the inspector found from a review of all the staff team's certification, that they had received training that included positive behavioural supports.

The person in charge was promoting a restraint free environment. There was no use of chemical restraint in use. Only one restrictive practice was in use in the centre at the time of this inspection. Bed rails were in use for one resident and they were found to be used at the request of the resident themselves as the bed rails supported them to feel safe while in bed. The person in charge had submitted a referral to the human rights committee for the organisation to have the restrictive intervention assessed and approved. The resident was also supported with other less restrictive alternatives to keep them safe while they were in bed.

Judgment: Compliant

Regulation 8: Protection

There were suitable arrangements in place to protect the residents from the risk of abuse. For example:

- there was an organisational adult safeguarding policy in place which was last reviewed April 2025
- staff had training in safeguarding vulnerable adults
- there was a reporting system in place with a designated officer (DO) nominated for the organisation and a poster of the DO was displayed in the hall of the centre.

Any potential safeguarding risk was reviewed, was reported to the relevant statutory agency, and where necessary, a safeguarding plan was developed. In addition, two staff spoken with were familiar with the immediate steps to take should a safeguarding concern arise and confirmed they would report any safeguarding concerns to the person in charge.

From a review of two residents' file, the inspector observed that there was an intimate care plan in place for each resident to guide staff as to supports they required. The plans had recently been updated and reviewed with the staff team in order to promote staff consistency and ensure staff were familiar with the required supports.

Additionally, the inspector found, from a review of the finance records for one resident during the period of 30 May to 16 June 2025 records, that a daily finance check was being completed of the resident's finances. This was in order to assure the provider that there was appropriate oversight of the resident's finances in order to ensure their money was safeguarded. The inspector, while in the presence of the person in charge, completed a check of the balance of money for that resident and found that it matched the balance recorded on their finance recording sheet. This demonstrated to the inspector that there were appropriate systems in place to safeguard residents' money.

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 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 24: Admissions and contract for the provision of services	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 12: Personal possessions	Compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Kilshrewley Gardens OSV-0008913

Inspection ID: MON-0045986

Date of inspection: 17/06/2025

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 23: Governance and management	Substantially Compliant

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

Orchard Community Care's pre-admission assessment process will be reviewed in line with the OCC Admissions, transitions and discharges policy and procedure document. The policy will be further enhanced with steps of the process divided into phases to ensure timely completion of all appropriate documentation within the required phase. Timeline for completion: 30th September 2025.

Orchard Community Care will review the procedure for dormant properties or unused water outlets, to ensure that the risk for legionnaires is identified in policy and managed as required. Timeline for completion 30th September 2025.

Formal records with assigned actions of all meetings is now in place- Completed 24th July 2025

Full review of records will be completed to ensure all records are accurate and to ensure consistency of approach. - Timeline for completion 15th August 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 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Substantially Compliant	Yellow	30/09/2025