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:	No 3 Seaholly
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Cork
Type of inspection:	Announced
Date of inspection:	03 January 2025
Centre ID:	OSV-0005135
Fieldwork ID:	MON-0037113

About the designated centre

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

No 3 Seaholly is based on a campus on the outskirts of a city. The centre provides full-time residential support for two residents over the age of 18, with intellectual disabilities including those with autism who may have complex support needs and may require support with behaviours that challenge. The centre can support both male and female residents. The designated centre is a semi-detached bungalow which has been divided into two apartment-style living areas with each apartment having one resident bedroom, a bathroom, a living room and a kitchen area amongst other rooms. Residents are supported by the person in charge, a social care leader, social care works and care assistants.

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
Friday 3 January 2025	09:35hrs to 17:35hrs	Conor Dennehy	Lead

What residents told us and what inspectors observed

Residents living in this centre did not communicate verbally and did not significant interact with the inspector during the inspection. Positive responses about life in this centre were contained within surveys reviewed. The centre where residents lived was clean on the day of inspection.

This designated centre was located on a campus setting with the centre divided up into two separate apartment areas for one resident each. Upon arrival at the centre to commence the inspection, it was indicated that both residents would be present in the centre on the day of inspection. However, one of these residents had already left the centre when the inspector arrived and the other left the centre shortly after. As such, the inspector did not initially meet either resident during the early stages of the inspection and used this time to review certain documentation and the premises provided. On the day of inspection, this premises was seen to be presented in a clean and well-maintained manner overall with some Christmas decorations on display.

Both apartments of the centre could be accessed through different doors although some of these were kept locked at times. One of the apartments was brightly decorated with some colourful murals in some rooms while the other apartment was barer in its general appearance. Each of the apartments had one individual bedroom, a living room and a kitchen-dining room although food and clothes for both residents was kept in the one of the apartments due to the needs of one resident. In one of the apartments there was also a television room and a room that used for seclusion due to the needs of one resident. This room was monitored by closed-circuit television camera which could be viewed in the staff office.

The centre where residents lived was responded to positively in surveys that had been completed before this inspection. These surveys had been issued to this centre by the Chief Inspector of Social Services in advance of this announced inspection and asked questions on various areas covering life in the centre. Respondents were given an opportunity to indicate answers of 'yes', 'no' or 'it could be better'. A survey had been completed for each resident, one with staff support and the other with staff and family support. Both surveys indicated 'yes' answers for the vast majority of questions. This indicated positive responses in all areas that included visitors, staff support and safety.

Safety was also an area that was queried in the provider's own resident surveys that had been completed in October 2024. Again a survey for each resident was available for the inspector to read with both having been completed by the same member of staff. These provider surveys indicated that both residents liked living in the centre, that staff let residents choose what they wanted to do, and that the residents felt safe in the centre. The same surveys also indicated that residents' activities were interesting and that goals were achieved although one survey stated that this was

"most of the time".

In the afternoon of the inspection, both residents returned to the centre. The first resident returned while the inspector was in the staff office. This resident passed by this office in the corridor outside. The inspector greeted the resident but aside from briefly looking at the inspector, the resident did not interact with the inspector. The resident then went to their living room where staff turned on the television for them. The resident appeared to spend much of their time in this room for the remainder of the inspection. The resident did vocalise for a period with the inspector advised to remain in the staff office during time. Overall, though things were calm in the resident's apartment while they were present.

During the final hours of the inspection, the inspector was informed that the other resident had returned to the centre. The inspector asked if he could meet this resident at this time with this request facilitated. The inspector then met the resident in the corridor area of their apartment in the presence of staff where the resident looked at the inspector and briefly took the inspector's hand before going to their living room and closing the door. This resident was not met again during the course of the inspection and had left the centre again before the end of the inspection. As the inspector was departing the centre he bid farewell to the other resident. Again, this resident briefly looked at the inspector but did not interact with him.

In summary, the residents living in this centre were away from the centre for parts of the day. Both residents were met during this inspection but interaction with them was limited. Surveys completed for the residents and read by the inspector contained positive responses. Such responses included matters related to residents' home which was seen to be clean and well-maintained on the day of inspection.

The next two sections of the report present the findings of this inspection in relation to the governance and management arrangements in place in the centre, and how these arrangements impacted on the quality and safety of the service being delivered.

Capacity and capability

Improvement was found on this inspection compared to the previous inspection. Compliance's were found in areas such as staffing and the centre's statement of purpose. Some actions did remain though in some areas including a provider unannounced visit.

This centre was registered until May 2025 and had last been inspected by the Chief Inspector in February 2024. During that inspection a number of regulatory actions were identified, mostly notably in areas such as fire safety, the use of physical holds and positive behaviour support. The nature of these actions also raised some concern around the oversight and monitoring of this centre. Following that

inspection the provider submitted a compliance plan response outlining the actions that they would take to come into compliance. Since that compliance plan response was received, the person in charge for the centre had changed with an area manager (who had responsibilities in other centres), appointed to fulfil the role pending recruitment. In addition, in December 2024, the provider had submitted an application to renew the registration of the centre for a further three years beyond May 2025.

As such, the purpose of the current inspection was to inform a decision on whether to grant this application or not. Given the findings of the February 2024 inspection, particular focus was paid to the actions identified on that inspection. Overall, the current inspection found that, while some regulatory actions remained, the overall compliance levels in the centre had improved. In particular, there was evidence of good supports provided to residents in areas such as staffing which was found to be in accordance with the centre's statement of purpose. This statement of purpose contained all of the regulatory required information. Other regulatory requirements were also being met such as the maintenance of a directory of residents and the conducting of an annual review and a provider unannounced visit. It was noted though that a complete action plan was not in place for the most recent provider unannounced visit.

Regulation 15: Staffing

This regulation requires that a centre's staffing arrangements must be in keeping with the needs of residents and the centre's statement of purpose. Based on rotas reviewed from 30 October 2024 on and discussions with staff and management, the staffing arrangements being provided in the centre were consistent with the requirements of this regulation. The staff rotas also indicated that there was a core staff team in place. This promoted consistent care for residents which was important given the assessed needs of residents living in this centre.

Specific documentation relating to all staff working in a centre (included agency staff sourced from an external agency) must be obtained. This documentation includes written references, full employment histories, evidence of registration with professional bodies, and evidence of Garda vetting. During this inspection the inspector reviewed staff files relating to three staff employed directly by the provider with these files having all of the required documentation. One agency staff member had also worked in the centre in the weeks leading up to this inspection. Assurances were provided during and after the inspection that required documents for this agency staff had been obtained.

Judgment: Compliant

Regulation 16: Training and staff development

A training matrix that had been reviewed during January 2025 was provided during this inspection which indicated that most staff had completed relevant training in areas to support residents. However, when reviewing this matrix, the following was noted:

- Three staff were overdue refresher training in manual handling.
- Three staff were overdue refresher training in fire safety.
- Two staff were overdue refresher training in de-escalation and intervention.

Judgment: Substantially compliant

Regulation 19: Directory of residents

A directory of residents was being maintained for this centre. This directory was made available for the inspector to review during this inspection. When reviewed, it was seen that this directory included all of the required information such as residents' names, residents' dates of birth, and residents' dates of admission to the centre.

Judgment: Compliant

Regulation 22: Insurance

Documentary evidence of appropriate insurance arrangements for this centre were provided as part of the inspection process.

Judgment: Compliant

Regulation 23: Governance and management

During the February 2024 inspection, it was identified that six monthly unannounced visits to the centre, a key regulatory requirement, were not being conducted in a timely manner. Since then one such visit had been completed in July 2024. This had been carried out in a timely manner and the visit was reflected in a written report. This report did cover relevant areas and indicated that all actions from the February 2024 inspection had been completed. While overall, the current inspection found progress with such actions, it was notable that a specific action relating to training (as discussed under Regulation 7 Positive behavioural support) had not been

completed.

In addition, under this regulation, where any areas for improvement are identified during a provider unannounced visit, the provider must put in place a plan to address relevant issues. An action plan from the July 2024 provider unannounced visit was in place but when reviewed it was noted that while some actions for improvement had progress updates, others had not. The latter actions also did not have responsibilities or time frames assigned for completing such actions. As such from the documentation provided for this provider unannounced visit report, it was unclear if all actions had been addressed or not.

Aside from this, since the February 2024 inspection, an annual review for the centre had been completed. This assessed the centre against relevant national standards and provided for consultation with residents and their families. An action plan was in place for this annual review which assigned time frames and responsibilities for identified actions. Documentary evidence of reviews and audits were also provided which covered areas such as fire safety, infection prevention and control and health and safety. Such documents provided some evidence of systematic monitoring of the centre and it was noted that there was improvement in the overall compliance levels since February 2024. However, the current inspection did identify regulatory actions in most of the same regulations that had been actioned previously. This indicated that the monitoring systems in place did need some improvement to ensure that all relevant matters were promptly identified and addressed.

Monitoring and oversight of the centre was identified as needing improvement during the February 2024 inspection. In response, the compliance plan submitted by the provider's had committed to the person in charge attending staff meetings at least monthly. On the current inspection, the inspector was informed that such meetings were to take place fortnightly but that the frequency and duration of these had been impacted by the needs of one resident. The inspector reviewed notes of the five staff meetings that had taken place since July 2024. These notes were seen to be short with limited detail, while of the five meeting notes reviewed on the day of inspection, it was noted that the person in charge had only attended one such meeting. During the introduction meeting for the inspection it was acknowledged by the current person in charge that they had not always attended such meetings. it was accepted though that since the February 2024 inspection, the person in charge role had changed with the role currently held by an area manager who had a larger remit and who was involved with more centres compared to the previous person in charge. The current person in charge outlined how they kept in contact with the centre and the inspector was informed that ongoing recruitment efforts were being made to recruit a new person in charge for the centre.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

A statement of purpose was in place for the centre that had been recently reviewed. This was read during the inspection and contained the required information such as details of the staffing arrangements in place, the criteria used for admission, and the number, age range and gender of residents that the centre was intended to provide accommodation for.

Judgment: Compliant

Quality and safety

Some actions were identified during this inspection relating to areas such as the provision of certain training. Staff spoken with displayed a good knowledge around supporting residents with their behaviour. Fire safety arrangements had improved since the previous inspection.

The residents in this centre had particular needs with the inspector informed that the presentation of one of these residents had changed in the time leading up this inspection. Additional supports were to be provided to this resident as a result. Given the needs of the residents living in this centre, some restrictive practices were is use and guidance was also available in how to support these residents to engage in positive behaviour. Staff spoken with had a good knowledge in this area and had completed some relevant training. However, not all staff had completed training in a particular hold despite this a previous commitment from the provider for such training to be provided to all staff. Aside from this, the centre was provided with fire safety systems and improvement relating to fire safety arrangements in general had been made since the last inspection. Improvement was also noted to have been made relating to the storage of a toaster for gluten free food but some observations were made during this inspection that indicated further improvement was needed in this area.

Regulation 10: Communication

When reviewing documentation in both residents' personal plans, the inspector noted some varying information relating to residents' methods of communication. For example, the residents' health passports made explicit reference to the residents using a specific means of communication but this was not referenced in other communication documents in their personal plans. While staff spoken with did demonstrate a reasonable knowledge of residents' means of communication, some varied information around how residents communicated was also provided. This included one staff member expressly indicating that a resident used a specific means of communication but a second staff member indicating that the same resident did not.

A training matrix provided indicated that just one staff member working in the centre had completed training in another particular method of communication. The same matrix indicated though that this communication method was not used in the centre. However, both residents' personal plans made referenced to the residents using this communication method with information sheets about this methods included in the residents' personal plans. Varied information was again provided around this communication method. Two members of staff indicated that one resident did not use this method and that the second resident only used it in a basic form. A third staff member indicated that no resident used it.

Judgment: Substantially compliant

Regulation 11: Visits

Given the layout of the centre, which was subdivided into two apartments for one resident each, it was observed by the inspector that sufficient space was available for residents to receive visitors in private in a room other than their bedrooms. During the introduction meeting for the inspection, the inspector was informed by the person in charge that one of the residents received visitors in the centre. This was also referenced in documentation about the same resident that was reviewed by the inspector.

Judgment: Compliant

Regulation 12: Personal possessions

During the February 2024 inspection it was identified that money which residents were legally entitled to was collected by their respective relatives with an allowance then provided for residents. While there had been further engagement about this matter since then, with further engagement planned, the inspector was informed on the current inspection that such arrangements remained unchanged.

Judgment: Substantially compliant

Regulation 17: Premises

During this inspection the premises provided was seen to clean, well-furnished and well-maintained. The layout of the premises into two apartments ensured that residents had sufficient space available to them while appropriate toilet and storage

facilities were also seen to be provided.

Judgment: Compliant

Regulation 20: Information for residents

A residents' guide was provided for the centre that was marked as being reviewed in November 2024. This guide was read by the inspector was and found to contain all of the required information. This included outlining the arrangements for visiting and details of the procedure respecting complaints.

Judgment: Compliant

Regulation 26: Risk management procedures

One resident living in this centre was a coeliac and required gluten free food as a result. On the previous inspection it was observed that an open pack of some gluten free food was stored alongside other food. It was also noted during the February 2024 inspection that the location of a toaster for gluten free bread right beside a toaster for other bread posed a risk in this regard. In response the provider indicated that a risk assessment in relation to cross contamination of gluten and non-gluten products had been developed that included a control measure for the safe storage of a toaster being used for gluten free breads. It was also indicated that this toaster was to be stored in a press with the gluten free food to ensure no risk of cross contamination.

During the current inspection it was observed that the toaster for gluten free food was stored in a press with gluten free food. It was observed that pressed used for the storage gluten free food was labelled as "gluten products only" but these presses largely contained gluten free food. However, in one of these presses the inspector observed three bags of pasta, one of which was opened, that contained gluten. Records reviewed indicated that only the coeliac resident had consumed pasta in the week leading up to the inspection on the day before this inspection. No other open bag of pasta was seen when viewing other presses in the kitchen. The inspector's observations about the storing of pasta with gluten alongside gluten free food were highlighted to management of the centre immediately who removed this.

A relevant risk assessment in place indicated that gluten free food was to be discussed regularly at staff meetings but notes of staff team meetings seen since July 2024 made no explicit reference to this being discussed. During the feedback meeting for the inspection, it was indicated that the pasta with gluten seen by the inspector had been placed in the relevant press in error. It was also suggested that the coeliac resident had not received this pasta the previous day but instead

received gluten free pasta, the bag of which has since been finished and disposed of. The inspector was also informed that the labels for the presses with gluten free food had been changed. While such information was considered, given the observations of the inspector on the current and February 2024 inspections, some improvement was needed to ensure that the risk in this area was appropriately and consistently mitigated.

Identified risks in the centre were reflected in risk assessments and a risk register. The inspector reviewed such documentation and found them to have been recently reviewed. The maintenance of a risk register was in keeping with the provider's overall risk management policy. This policy gave guidance on how risk was to be identified, managed and reviewed. It also outlined control measures to mitigate required specific risks such as self-harm and accidental injury. Within the centre, there was also a system for the recording and review of any accidents and incidents which is an important aspect of a risk management process. Aside from this, two vehicles were assigned to the centre. While the inspector did not see either of these vehicles during the inspection, he did read records of fortnightly checks on both. The documentation provided did indicated though that one vehicle was not checked as often as the other. However, when queried the inspector was informed that the former vehicle had been absent from the centre for a period and was instead replaced with another vehicle.

Judgment: Substantially compliant

Regulation 27: Protection against infection

Wall mounted hand sanitisers were seen to be present in the centre and were operational when tested by the inspector. Supplies of personal protective equipment (PPE) were available in the centre such as gowns and face masks but the inspector did observe three boxes of face masks that had expired since November 2024. Some of these were seen to be removed on the day of inspection after being highlighted by the inspector. The training matrix provided indicated that most staff had completed relevant training in areas such as hand hygiene and PPE. One staff member though was indicated as not having completed training in hand hygiene nor relevant standards related to infection prevention and control.

Judgment: Substantially compliant

Regulation 28: Fire precautions

It was observed this designated centre was provided with appropriate fire safety systems including a fire alarm, emergency lighting and fire extinguishers. These systems were subject to regular maintenance checks by external contractors based

on documentation reviewed. These fire safety systems were present during the February 2024 inspection also but that inspection did raise concerns in other areas related to fire safety. These included varying information being provided from staff around residents who could refuse to evacuate and evacuation plans containing different information.

On the current inspection, improvement overall was noted in this area. For example;

- Staff spoken with were aware of which resident could refuse to evacuate.
- There was also an awareness from staff around how to support residents to evacuate including if they refused to leave the centre.
- Evacuation supports for both residents were found to be placed in the locations that were stated in relevant evacuation plans.
- Personal emergency evacuation plans (PEEPs) and evacuation plans for the centre were in place and had been recently reviewed.

While this was an improvement, it was read that some supports to help a resident to evacuate were documented in the resident's PEEP but not in the centre's overall evacuation plans. In addition, relevant risk assessment indicated that certain training was needed to help a resident to evacuate if they refused. Not all staff had completed this training at the time of inspection. This is addressed under Regulation 7 Positive behavioural support.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Under this regulation, residents must have individualised personal plans provided which are intended to identify the health, personal and social needs of residents while also providing guidance on meeting these needs. During the inspection, the personal plans of both residents were reviewed by the inspector. These were found to contain recently reviewed guidance on supporting the needs of the residents. This included having updated healthcare plans in place for residents which had been an area in need of improvement during the February 2024 inspection. Personal plans were subject to annual multidisciplinary review and the personal plans reviewed indicated that residents' current home was suited to their needs.

However, the inspector was informed that the presentation of one resident had changed in the time leading up this inspection. As a result, further assessments were being carried out for this resident while enhanced support was to be provided to the centre as a result. Given the resident's presentation, the inspector was also informed that maintaining the resident's safety could take priority over quality of life and it was acknowledged that their presentation was challenging. As a result, progressing priorities for this resident had been impacted due to their presentation.

The second resident living in this centre also had priorities identified for them in

June 2024 that referenced going on an overnight stay away. During the inspection, the inspector queried the status of the resident's overnight stay away with a staff member and was informed that this had been planned for September 2024 but had not taken place. Documentation reviewed related to the priorities indicated that these were to be reviewed in December 2024. No records of such a review was provided on the inspection day despite requests made.

The inspector subsequently requested further information about the priorities review intended for December 2024 during the feedback meeting for the inspection. The following day, the inspector was provided with a review of priorities conducted in September 2024. This indicated that priorities for the resident such as visiting new restaurants, enjoying BBQs and trying new walks had progressed. The overnight stay away was not mentioned in this and the documentation provided indicated that the review of the resident's prioritises for December 2024 had not taken place.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

Some restrictive practices were in use and the provider had systems for these to be considered and reviewed. These practices included the use of seclusion in this centre, the use of which had increased in the months leading up to this inspection due to the presentation of one resident. A protocol was in place around seclusion and documentation reviewed during this inspection indicated improved monitoring around the use of seclusion compared to the previous inspection.

Given the needs of residents living in this centre, staff spoken with demonstrated a good understanding of how to support residents to engage in positive behaviour. A training matrix reviewed indicated that staff had completed relevant training in de-escalation and intervention although as highlighted under Regulation 16 Training and staff development, two staff were due refresher training in this area. The same training matrix indicated that that some staff, but not all, had undergone additional training in positive behaviour support but when queried the inspector was informed that this training was not mandatory.

However, the February 2024 inspection had highlighted that staff had not completed training in a particular hold that had been approved for use in August 2023. The hold was related to the particular needs and presentation of one resident. In the compliance plan response, the provider had indicated that all staff would have this training completed by 25 April 2024. Despite this, on the current inspection, it was found that four staff had yet to complete this training. Completing this training had been identified as being required in risk assessments completed in the centre which included one related to challenging behaviour.

Judgment: Not compliant

Regulation 8: Protection

From documentation reviewed and discussions with staff and management of the centre, no safeguarding concerns were identified during the inspection. Records provided indicated that all staff had completed relevant safeguarding training. Information about the provider's designated officer (person who reviews safeguarding concerns) was seen to be present in the centre along with recently issued guidance on the signs of abuse. Guidance was available within residents' personal plans on how to support them with intimate personal care.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 19: Directory of residents	Compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Quality and safety	
Regulation 10: Communication	Substantially compliant
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Substantially compliant
Regulation 17: Premises	Compliant
Regulation 20: Information for residents	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Compliant

Compliance Plan for No 3 Seaholly OSV-0005135

Inspection ID: MON-0037113

Date of inspection: 03/01/2025

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 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: The person in charge will ensure that the training matrix for the centre is kept updated for all training required in the Centre and ensure • All three staff members who were overdue for refresher Manual Handling training will have completed this training by 28/2/25. • All three staff members who were overdue for refresher Fire Safety training will have completed this training by 28/2/25. • One staff member completed refresher training for the de-escation and positive intervention training on the 16/1/2025. An application has been submitted to the services training department for the remaining staff to be trained as necessary including training for staff on a particular hold to support the needs of one resident which is to be completed by 31/5/25.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The register provider will ensure the following • All six-monthly provider audits will continue to be completed within the established timeframe, ensuring a comprehensive review of the actions outlined in the centre's reports and audits. These actions will be closely monitored and accurately reported as either completed or in progress. The individual responsible for each action will be clearly identified, with specific timeframes outlined in the provider's audit action plan. Upon completion of any action, the completion date will be clearly documented for reference. 28/2/2025	

• The person in charge has developed a centre-specific meeting template that includes a clearly outlined agenda. This template addresses standing agenda items as well as any additional business for discussion at team meetings. It incorporates sections for discussion points and action items, ensuring each item is assigned to the staff responsible along with defined timeframes. Furthermore, the template provides space to record when each action is completed, promoting accountability and timely follow-up. Meeting minutes will be reviewed and signed by the person in charge following their occurrence ensuring oversight. 30/1/2025

• The provider continues to recruit for a new Person in Charge who will regularly attend team meetings

Regulation 10: Communication	Substantially Compliant

Outline how you are going to come into compliance with Regulation 10: Communication:

The register provider and the person in charge will ensure the following actions are carried out:
• A review of the personal profiles of the residents will be conducted, including their communication passports and health passports, to verify that the language used accurately reflects the residents' preferred communication methods. This review will be undertaken in collaboration with the involved Speech and Language Therapist. 28/2/2025.
• A meeting will be scheduled with the staff team, facilitated by the involved Speech and Language Therapist, to ensure consistency in staff practice and to enhance staff knowledge regarding the residents' preferred communication methods which is Picture Exchange Communication including objects of reference. 28/2/2025
• All staff members will continue complete refresher training on communication techniques as required, with training being updated every two years to maintain current best practices.

Regulation 12: Personal possessions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 12: Personal possessions:

The person in charge has taken the necessary steps to ensure that the residents have direct access to their own finances. Following meetings held with residents' families on the 22/1/2025 and 23/1/2025, agreements were reached regarding the residents receiving their funds directly into their personal bank accounts. This arrangement is set to be fully implemented by 31/3/2025.

Regulation 26: Risk management procedures	Substantially Compliant

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

The registered provider has ensured the following actions:
• a thorough review of the center's risk assessment concerning gluten-free products and storage practices, as well as the potential risk of cross-contamination was completed. 11/1/2025
• the person in charge has ensured that the issue of coeliac disease will be a standing

item on the center's meeting agenda.
• clear and accurate labels have been printed and applied to the relevant presses to ensure proper segregation and storage of gluten and gluten-free products. This measure was implemented on 11/1/2025 as part of ongoing efforts to maintain food safety and minimize the risk of cross-contamination.

Regulation 27: Protection against infection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:

The registered provider has ensured the following actions;
• a system within the centre to ensure the immediate disposal of outdated Personal Protective Equipment. 11/1/2025.
• the Person in Charge will ensure that the staff member has completed training in hand hygiene and infection prevention and control. 28/2/2025

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:

The registered provider has ensured the following actions;
• The person in charge has completed a thorough review of the residents' PEEPs, ensuring that both the day and night evacuation plans are now consistent and accurately reflect the necessary information. 12/01/2025.
• All three staff members who were overdue for refresher Fire Safety training will have completed this training by 28/2/25.
• one staff member has successfully completed training, specifically focused on supporting a resident who may refuse to evacuate the building. The remaining staff members, including the night awake supervisors, are currently awaiting confirmation of a scheduled date to complete this training. 28/02/2025

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 will ensure that individual goals for residents are reviewed in a manner that accurately reflects their current status and progress. Any barriers or challenges that may impact the achievement of these goals, cause delays, or necessitate adjustments will be identified and addressed accordingly. 30/4/2025

Regulation 7: Positive behavioural support	Not Compliant

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

The person in charge has ensured one staff member has successfully completed training on the 16/01/2025, specifically focused on supporting a resident who may refuse to evacuate the building. An application has been submitted to the services training department for the remaining staff including night staff, to be trained as necessary including training on a particular hold to support the needs of one resident which is to be completed by 31/5/25. In the interim the staff roster will be planned to ensure adequately trained staff on duty.

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 10(2)	The person in charge shall ensure that staff are aware of any particular or individual communication supports required by each resident as outlined in his or her personal plan.	Substantially Compliant	Yellow	28/02/2025
Regulation 12(1)	The person in charge shall ensure that, as far as reasonably practicable, each resident has access to and retains control of personal property and possessions and, where necessary, support is provided to manage their financial affairs.	Substantially Compliant	Yellow	31/03/2025
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate	Substantially Compliant	Yellow	31/05/2025

	training, including refresher training, as part of a continuous professional development programme.			
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	30/04/2025
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.	Substantially Compliant	Yellow	28/02/2025
Regulation 26(2)	The registered provider shall ensure that there	Substantially Compliant	Yellow	28/02/2025

	are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.			
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.	Substantially Compliant	Yellow	28/02/2025
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.	Substantially Compliant	Yellow	28/02/2025
Regulation 05(6)(d)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more	Substantially Compliant	Yellow	30/04/2025

	frequently if there is a change in needs or circumstances, which review shall take into account changes in circumstances and new developments.			
Regulation 07(2)	The person in charge shall ensure that staff receive training in the management of behaviour that is challenging including de-escalation and intervention techniques.	Not Compliant	Orange	31/05/2025