



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

## Issued by the Chief Inspector

Name of designated centre:	Villa Maria
Name of provider:	Sunbeam House Services CLG
Address of centre:	Wicklow
Type of inspection:	Unannounced
Date of inspection:	17 February 2026
Centre ID:	OSV-0001686
Fieldwork ID:	MON-0048561

## About the designated centre

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

Villa Maria is a designated centre operated by Sunbeam House Services CLG. Villa Maria is located in a town in Co. Wicklow. The designated centre can provide residential care for up to six male or female residents over the age of 18 years. The centre provides services for residents who are dependent in many areas of their daily life and require staff support to maintain and increase independence as much as possible. Staff also support residents to manage personal risks and provide healthcare supports. The centre is managed by a full-time person in charge. A senior services manager is also assigned to the centre and provides supervisory support to the person in charge.

**The following information outlines some additional data on this centre.**

Number of residents on the date of inspection:	6
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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 February 2026	08:40hrs to 17:30hrs	Sarah Barry	Lead
Tuesday 17 February 2026	08:40hrs to 17:30hrs	Kieran McCullagh	Support

## What residents told us and what inspectors observed

This was an unannounced inspection to assess the safeguarding arrangements in the centre. The inspection was completed by two inspectors over the course of one day.

Overall, this inspection found that there had been significant deficits in the governance oversight arrangements of the centre which in turn were failing to ensure the safety and wellbeing of the residents living here.

The inspection was facilitated by the person in charge and the centre's former person in charge. The new person in charge had very recently commenced working in the centre and was being supported by the previous person in charge as part of their induction to the service. The inspectors used observations and interactions with residents, in addition to a review of documentation and conversations with key staff, to inform judgments on the quality of the service being provided.

The designated centre was comprised of a two story detached house in a large town in Co. Wicklow. The centre was home to six people. The inspectors completed a walk around of the centre in the presence of the person in charge and previous person in charge. The house comprised of six bedrooms, a sitting room, kitchen/dining room, four bathrooms, a laundry room, two offices and a TV room, which one resident accessed.

Inspectors observed, during their walk around of the centre, that there were a number of environmental restrictions on residents' full access to their home. For example, inspectors observed a half door leading to the kitchen. The reason for this restriction was unclear. Inspectors asked multiple staff members the reason for this door and received various answers in response, relating to risks with two residents behaviours.

In addition, while there was a garden to the rear of the property, residents could not freely and independently use the garden area as the door to the garden was locked and residents needed to ask staff to open the door to access it.

A staff member, advocating for the residents, directed the inspectors attention to three large potholes, adjacent to the house. The staff member raised concerns in relation to residents' mobility difficulties and the risk this posed to them when entering and exiting the vehicle due the uneven ground. This had been previously escalated to the provider's maintenance team as an issue that required addressing, however, no time line or plan for these works to be completed was in place.

Residents in the centre communicated in their own unique styles. Residents did not use verbal communications as their main form of communication and this meant the inspectors were unable to receive verbal feedback from them about their lives in the

centre and the care and support they received. Staff members did not have appropriate training in Lámh or Total Communication, as evidenced through a review of the training records. Inspectors noted that staff members on duty did not communicate with residents in line with their communication assessed needs. This is discussed further under Regulation 10: Communication.

The centre was home to six residents. On the day of the inspection, all residents mainly engaged in activities in their home. For example, the inspectors observed some residents engaged in music therapy and massage therapy, which were provided by external professionals. Another resident was supported to go bowling, which was an activity they enjoyed. However, inspectors noted that residents appeared to spend the majority of their day in the designated centre. For example, at various times throughout the inspection, the inspectors observed residents sitting in the sitting room, not engaging with staff or each other. It was unclear how choice was offered to residents regarding their preferred daily activities. For example, there were no visual or documented activity plans in place for residents to inform them of their plan for the day, or to facilitate their involvement or choice in what activity they would like to engage in.

Inspectors spoke with six staff over the course of the inspection. This included the person in charge, the former person in charge, the senior services manager, two agency staff and a member of the core staff team. A consistent concern they expressed to inspectors was that the centre did not meet the needs of one of the residents. They talked about the crowded environment in the centre where six residents were being supported by five staff and the person in charge in the centre. They also outlined issues in relation to transport options for residents. The centre was resourced with one vehicle. However, opportunities for all residents to engage in activities and access the local community were limited as a result of the vehicle being used to facilitate individual needs of one resident.

In response to the high levels of non-compliance found on inspection, the Chief Inspector of Social Services invited the provider to attend an escalation meeting requiring the provider to bring the centre back into compliance.

In summary, the provider had failed to ensure their management systems were providing a service that was safe, appropriate to residents' needs, consistent, and effectively monitored at all times. Strategies to support residents were not effective and there remained an ongoing risk to residents well being and safety.

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 to each resident living in the centre.

## Capacity and capability

This inspection identified significant and sustained failures in governance and management arrangements of the centre. Oversight systems were ineffective and inconsistent, resulting in gaps in risk management, safeguarding and the overall quality of care and support provided to residents. As a result, the provider was failing to ensure residents were effectively and appropriately safeguarded. This inspection found significant improvements were required under Regulation 15: Staffing, Regulation 16: Training and staff development, and Regulation 23: Governance and management.

At the time of inspection, a newly appointed person in charge had recently commenced in the centre. This was the third individual to hold the role within a three-month period. In addition to the repeated changes at person in charge level, there had also been changes to the senior services manager role. Furthermore, the centre had been operating without a deputy client service manager, since December 2025. The cumulative effect of these significant and sustained changes in key leadership and management positions for this centre were impacting on the consistency and continuity of governance and oversight of the centre, which was reflected in the high levels of non-compliance identified on this inspection.

Appropriate training is fundamental in supporting staff to understand behaviours that challenge and promoting environments that respect residents' rights and dignity. The provider and person in charge had not ensured that all staff had up-to-date mandatory training in critical areas such as safeguarding of vulnerable adults, and managing behaviour that challenges. Furthermore, service specific training pertaining to total communication, and autism had not been completed by all staff members working in the designated centre.

The provider had not ensured that the designated centre was adequately resourced to ensure the effective delivery of care and support. The provider failed to put in place suitable contingency arrangements to respond to residents' assessed, and known behavioural support needs, incompatibility, and ongoing safeguarding concerns. The heavy reliance on agency staff meant there was no continuity of staffing which supported the building of relationships between staff and the residents who relied on staff support.

In February 2025, HIQA published an overview report of governance and safeguarding in designated centres operated by Sunbeam House Service CLG as part of a regulatory escalation programme. The report included findings of not compliant under five regulations. The provider submitted a compliance plan that outlined actions to improve compliance with those regulations and its governance and management systems. The regulatory escalation programme concluded in February 2026.

The next section of the report will reflect how the management systems in place were contributing to the quality and safety of the service being provided in this designated centre.

## Regulation 15: Staffing

Overall, improvements were required to the oversight of staff rosters, and staffing arrangements to ensure continuity of care for all residents residing in the designated centre.

On the day of this inspection there was a staffing deficit of 1.4 whole time equivalent (WTE) posts in the designated centre. Although the provider was endeavouring to back fill vacant shifts, it was found that there was an over reliance on agency staff to cover vacant shifts, which was negatively impacting all residents.

For example, following a review of the planned and actual rosters maintained in the designated centre for the months of October 2025 and November 2025 it was found that;

- Nine different agency staff covered a total of 62 shifts across the month of October 2025
- 12 different agency staff covered a total of 47 shifts across the month of November 2025.

Improvements were also required to the recording of agency staff used to back fill vacant shifts. For example, there were numerous occasions in which the full name of the agency staff or the agency used was not recorded. This required enhancement to ensure the provider and person in charge had easy access to accurate and up-to-date staff rosters.

The provider had previously committed to ensuring one additional staff member per shift to provide specific support to one resident in line with their assessed needs. Inspectors completed a review of rosters from September 2025 to February 2026, and identified multiple occasions where this additional staff member was not in place. In addition, rosters did not identify which staff member was supporting this resident. As a result, inspectors were unable to establish if the staff member working with the resident was a familiar staff member, as per the resident's assessed need.

Judgment: Not compliant

## Regulation 16: Training and staff development

Staff were required to complete training as part of their professional development and to support them in the delivery of appropriate care and support to residents. A review of the most recent training records made available to inspectors evidenced gaps in relation to both mandatory and non-mandatory training for staff. Following review, inspectors noted the following:

- One staff member had not completed safeguarding of vulnerable adults training
- Two staff members were overdue refresher training in safeguarding of vulnerable adults
- Two staff members had not completed positive behavioural support training
- Five staff members had not completed autism specific training
- No staff members had completed total communication training.

Furthermore, inspectors noted that one staff member had not completed a number of mandatory training modules including people handling, and emergency first aid.

Given the ongoing compatibility and safeguarding concerns in the designated centre, the insufficient staff training created a risk to staff delivering safe, person-centred, and effective support to residents, and required comprehensive review by the person in charge.

Inspectors did not review supervision arrangements as part of this inspection.

Judgment: Not compliant

## Regulation 23: Governance and management

Improvements were required to ensure the provider and person in charge had suitable oversight of the centre and that effective governance arrangements were in place to ensure the service was safely and effectively managed. The registered provider had not effectively resourced or monitored the centre in a way that ensured effective delivery of care and support to residents at all times.

Following receipt of notifications of concern from this service in relation to the safeguarding of residents, the Chief Inspector issued a provider assurance report to the provider in August 2025. The response received detailed numerous assurances regarding actions that were being taken to safeguard residents in their home. An update on the progress of implementation of these actions was requested and received in November 2025.

However, during the course of this inspection, it was found that these actions had not been progressed in line with commitments and time frames as set out by the provider in their the previous two assurance reports to the Chief Inspector. In addition, inspectors identified that responsibility for implementing the actions to improve the service had not been formally assigned to an individual as being responsible for completing. As a result, many of the necessary actions, the provider had committed to completing, in order to improve the quality of service to residents, remained outstanding.

Improvements were required in the induction and handover arrangements for the person in charge. For instance, the handover documents provided to the new person in charge lacked critical governance information, including safeguarding protocols,

the number of open safeguarding concerns, the specific procedures for safeguarding, and current staffing resources and staff supervision arrangements. As a result, critical information relating to residents' safeguarding needs, personal risks and support arrangements was not effectively transferred, undermining continuity of care and support for residents.

The provider had not ensured that suitable staffing arrangements were in place to ensure continuity of care for residents. This was of concern given the incompatibility and safeguarding risks in the designated centre, and required comprehensive review by the provider. For example, inspectors noted, the staffing resource deficit for the centre, which had been going on for a period of time, had only been assessed and identified by management of the centre the day before the inspection. This demonstrated how the previous unstable management and governance oversight and arrangements of the centre were impacting on ensuring effective resourcing to ensure good quality care.

In May 2025, there arose a significant change in the assessed needs of one resident. The provider's multidisciplinary team, determined that the resident's needs were no longer compatible with the current environment and that a new living arrangement was necessary. In a prior assurance report to the Chief Inspector, the provider had committed to presenting a formal business case proposal to their funder to secure alternative accommodation for this resident. However, at the time of this inspection, no plans or time line for relocation had been established, and the business case proposal had not yet been drafted or initiated resulting in continued incompatibility issues in the centre which were having a negative impact on the residents lived experience in the centre.

Internal and external premises deficits had not been addressed by the provider with the necessary urgency despite staff raising the issues. For example, inspectors observed three large potholes adjacent to the house, in the parking area for the designated centre's transport vehicle for residents.

The uneven surface was impacting in particular on residents with assessed mobility equipment needs and accessing the vehicle and were also posing a risk of trips and falls for residents and staff utilising that area of the centre. Despite repeated escalation by the staff team to the maintenance department, the provider had failed to implement timely corrective action. At the time of this inspection, no clear timeline or decisive plan had been put in place to rectify this issue and mitigate any potential risks.

Judgment: Not compliant

## Quality and safety

The provider did not demonstrate the capacity or capability to operate the service in compliance with the regulations, and in a manner which ensured safe quality care to residents. Overall, strategies in place to support residents were not effective, and there remained an ongoing risk to residents of further safeguarding incidents occurring, and negatively impacting on their lived experience and their human rights.

The provider had failed to implement the actions in their provider assurance plan response, which set out actions to improve the quality and safety of the service provided to residents. Of particular concern were the ongoing deficits found under communication and protection, as well as deficits found under positive behavioural supports and residents' rights, which were negatively impacting on the wellbeing of residents, and overall posed a risk to the safety of residents.

Residents in this centre presented with communication support needs. Guidance in place for staff did not reflect the current needs of residents and recommendations contained therein were not in place in the centre. In addition, staff working in the centre did not have the required training to support residents in line with their assessed communication needs.

The designated centre failed to adequately meet the assessed needs of one resident, which directly impacted all residents living in the centre, and compromised the delivery of person-centred care.

Not all restrictive practice were being reported to the Chief Inspector, in line with the regulations. There were not appropriate supports in place for residents with behaviours of concern or residents who were at risk from their own behaviors or that of others.

The service had not put in place safeguarding measures to promote and protect residents' human rights and their health and wellbeing. There was a significant lack of oversight of the safeguarding arrangements and guidance in place for staff did not reflect staff practices in responding to safeguarding concerns.

The centre was not managed in a way that maximised residents' capacity to exercise personal independence and choice in their daily lives, with routines, practices and facilities not promoting residents' independence and preferences.

Overall, strategies in place to reduce behavioural incidents occurring were not effective, and there remained an ongoing safety risk to residents living in this designated centre.

## Regulation 10: Communication

Residents in this designated centre had diverse communication support needs, yet inspectors found a critical lack of communication governance.

After reviewing the communication passports for three residents, it was evident that none had been reviewed or updated since 2024. During the intervening period, one resident had experienced a significant life event and information on the the outdated guidance in their communication passport was no longer effective and could, if implemented cause the resident further distress. For instance, the instructions on the resident's communication passport directing staff in their communication and topics to discuss with the resident were no longer appropriate given recent events in their life and risked triggering their distress or escalating behaviours that challenge for that resident if implemented.

Another communication support plan recommended the use of a visual daily planner for one resident. However, this tool was not being used during this inspection. There were a small amount of laminated pictures of daily activities being used by staff to communicate with the resident. However, the communication support plan in place stated that the resident did not prefer paper-based communication aids. This plan required review to ensure it contained accurate and consistent guidance to support the resident in line with their preferred communication needs.

Furthermore, another communication support plan, completed by a member of the provider's multidisciplinary team, recommended the use of Lámh (a form of sign language) to help the resident build recognition and association with spoken word. Yet, on the day of this inspection, no staff had completed necessary Lámh or total communication training. This absence of communication support left residents without the crucial, individualised communication support they required, compromising their ability to understand, engage, and express themselves effectively.

Staff spoken with confirmed that a number of residents responded positively to visual communication aids. However, inspectors observed a lack of these supports throughout the designated centre. For instance, there were no visual staff rosters / information boards in place to inform residents who would be supporting them on a particular day, nor was there a visual menu to help residents understand meal options or make informed food choices.

This lack of visual communication support aids, left residents without accessible information, limiting their independence, and their ability to engage confidently in daily activities.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

The designated centre was failing to adequately meet the assessed needs of one resident, which in turn was directly impacting on the lived experience of all residents living in the centre, and compromising the effective delivery of person-centred care.

Staff members who were engaged in individual assessment and personal planning raised concerns with inspectors regarding the loud environment, and told inspectors this did not align with the resident's personalised assessment. This failure in governance of individualised care also extended to resource allocation. For instance it was highlighted to inspectors that having only one dedicated vehicle severely restricted transportation requirements. While some residents could utilise public transport, this was not a feasible option for all residents. As a result, activities for some residents were often curtailed or delayed to return the vehicle for others. This further highlighted the gap in individualised assessment, personal planning, and the responsive management of residents' assessed needs.

Inspectors reviewed the provider's multidisciplinary reports, which clearly emphasised the need for an alternative, appropriately tailored environment for one resident, based on their individual assessment.

One multi-disciplinary assessment report specifically outlined plans for a dedicated activity / sensory room in order to better support this resident's needs. However, during this inspection, the dedicated activity/sensory room, was found to be inadequately resourced and prepared to provide an effective space for residents to use.

Inspectors observed the dedicated activity/sensory room was cluttered with miscellaneous items, such as a fold-up bed and a broken sofa which appeared to be stuck in a recliner position presenting as a falls for injury or falls. A review of incident records from February 2026 confirmed that the resident had fallen in this room due to the position of the broken sofa. While residents enjoyed a light projector located in the room, some activity items provided in the space were not adult age appropriate and the person in charge confirmed residents generally did not use or engage with those items.

Judgment: Not compliant

## Regulation 7: Positive behavioural support

Inspectors found that improvements were required pertaining to the positive behavioural support arrangements in place for some residents, and to the oversight, and monitoring of restrictive practises used within the designated centre.

All residents had assessed positive behavioural support needs, and had positive behaviour support plans on file. However, inspectors identified a significant gap in the plans for three residents. For example, plans lacked critical details about existing restrictive practices, and did not include up-to-date guidance on PRN (as needed) medicine protocols. This omission raised concerns about the plans effectiveness. As

a result, a thorough review of all plans was essential to ensure they fully supported each resident's safety, dignity, and positive development.

Inspectors completed a detailed review of all restrictive practices in use within the designated centre, with a specific emphasis on ensuring compliance and safeguarding rights. They found that not all restrictive practices were reported to the Chief Inspector as required by regulations. For instance, a stair gate at the bottom of the stairs was restricting residents' access to the upstairs area, and one resident's bed was permanently fixed to the floor. In addition, a restrictive practice involving three nightly checks of one resident had not been appropriately risk assessed in line with the provider's established policy. Notably feedback in August 2025 from the provider's Human Rights Committee (HRC), raised concerns about the lack of a clear rationale for this practice, and had requested the implementation of alternative solutions.

On the day of this inspection, no steps had been taken to address these concerns, leaving residents exposed to unnecessary restrictive measures.

Judgment: Not compliant

## Regulation 8: Protection

This inspection found evidence that there was inadequate and ineffective arrangements in place to protect residents from all forms of abuse. For example, since January 2025, a total of 36 safeguarding concerns were reported to the Chief Inspector. Upon review, inspectors found that 30 of these concerns were directly related to peer-to-peer incidents.

The provider acknowledged that the current living arrangement for one resident was not suitable. Assurances were given to the Chief Inspector in 2025 that a business case proposal would be submitted to the provider's funder to secure funding for relocating the resident to a more suitable property. However, at the time of this inspection, the business case had not been initiated, and there was no clear timeline or action plan in place to address ongoing safeguarding and incompatibility concerns in the designated centre.

Inspectors examined safeguarding protocols in place intended to protect residents from abuse, However, upon review, gaps were identified. For instance, safeguarding protocols lacked information on who devised and authored them. The person in charge confirmed they they were not written by a social worker or designated safeguarding officer. In addition, the protocols in place did not align with actual staff practices, and failed to reflect the actions taken following previous safeguarding incidents. This lack of robust, accountable safeguarding measures exposed residents to increased risk of harm.

Inspectors reviewed a live safeguarding document, intended to serve as the central record of all active safeguarding plans within the designated centre. However, this

document was insufficient, as it contained only two safeguarding actions for a single resident, with no additional details.

As a result, it failed to provide staff with any meaningful guidance on the safeguarding risks within the centre or the specific actions required to mitigate those risks. Compounding this issue, not all staff members had completed training on safeguarding vulnerable adults, further heightening the risk to the safety and wellbeing of all residents. This required comprehensive review from the provider.

Judgment: Not compliant

## Regulation 9: Residents' rights

This inspection found that residents lived in a very restrictive environment. The provider had not ensured that residents' rights were promoted and protected within the centre. As discussed throughout the report, ongoing safeguarding concerns had not been mitigated, and were adversely impacting on the residents' quality of life, and overall wellbeing.

Evidence found during this inspection highlighted a serious compromise of residents' fundamental human right to a safe, dignified, and supportive living environment. Specific instances observed during the inspection revealed staff members did not always knock on residents' bedroom doors before entering their personal space.

During episodes of challenging behaviour by another resident, there were arrangements where doors were locked to prevent risks to other residents in the centre, however, this curtailed those residents' freedom of movement in the centre and posed a significant restriction on their rights during these times.

As previously reported, inspectors found evidence that some residents were being subjected to unnecessary intrusive measures that undermined their right to privacy. For instance, one resident was receiving nightly checks at 1am, 3am, and 7am. There was no documented justification or risk assessment in place to support these interventions. As a result, these intrusive checks disrupted the resident's ability to get a restorative night's sleep, causing them to return to bed during the day.

Furthermore, when residents were in each others company, close staff supervision was mandated at all times, and one resident was continually supported by a staff member throughout their entire day. While these measures mitigated safeguarding risks, they also impacted on resident's rights to privacy and freedom of movement and choice during their day.

Inspectors observed that a back door leading to an enclosed garden space was locked, preventing residents from freely accessing and enjoying outdoor areas. When asked, staff on the day of inspection were unable to explain why the door was locked. These practices infringed on the residents' rights to autonomy, privacy, and

access to their environment, necessitating immediate review and action to uphold their dignity and rights.

Judgment: Not 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
<b>Capacity and capability</b>	
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
<b>Quality and safety</b>	
Regulation 10: Communication	Not compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Not compliant

# Compliance Plan for Villa Maria OSV-0001686

Inspection ID: MON-0048561

Date of inspection: 17/02/2026

## 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 15: Staffing	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 15: Staffing:</p> <ol style="list-style-type: none"> <li>1. Workforce planning has been reviewed to reflect both short- and long-term absences. Approval has been secured to recruit 4 WTE staff (combined vacancies and absences). Recruitment is underway: 2 Social Care Worker WTE interviews completed with offers issued and compliance checks in progress (anticipated start dates of 30/05/26). Care Assistant interviews commenced 16/03/2026. Completion date: 30/06/2026</li> <li>2. A weekly escalation meeting between the Person in Charge and HR (Recruitment) commenced on 25/02/2026 to oversee vacancies, recruitment progress and service coverage until vacancies are filled. Completion date: 30/06/2026</li> <li>3. The Person in Charge has reviewed the roster and identified areas for improvement (04/03/26). The Person in Charge and HR are reviewing staffing arrangements to ensure they align with resident needs and service requirements. Completion date: 31/07/2026</li> <li>4. The Person in Charge is prioritising the use of regular agency staff, where possible, to support continuity of care while recruitment is ongoing. Agency staff complete an initial induction overseen by the PIC. Ongoing.</li> <li>5. The Person in Charge has ensured that all staff rosters record the full name of each staff member, clearly identifying agency or relief staff and the agency provider to ensure accurate and transparent staffing records. The PPIM will check rosters during governance. Completion date: 17/02/2026</li> <li>6. The Person in Charge will ensure, as far as practicable, that familiar staff from the core team are prioritised when allocating the additional support staff member, in line with the resident's assessed needs. Completion date: 02/03/2026 &amp; ongoing</li> <li>7. The core staff member allocated to support the resident is now clearly identified on the roster each day. Completion date: 17/02/2026 &amp; ongoing ]</li> </ol>	
Regulation 16: Training and staff development	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 16: Training and staff development:</p>	

1. A new training matrix has been implemented to clearly identify all mandatory and location-specific training requirements and any outstanding training required. This will be reviewed monthly by the person in charge. Completion date: 06/03/2026
2. All outstanding safeguarding training is completed. Completion 23/03/26
3. The PIC has a tracker in place to monitor the completion of online mandatory training. All outstanding training will be completed by 31/03/26
4. A tailored autism specific training event will be held for 8 staff who were unable to attend a previous session on 02/04/26. If, for any reason, a staff member is unable to attend, they will be enrolled on this course as part of the organisation's training schedule. Completion date 31.05.26
5. In person positive behaviour support training has been scheduled for 3 staff. Completion date: 28/06/2026
6. Location-specific Lámh training will be provided to staff to support residents communication needs and improve staff competency in communication supports. Completion date: 16/04/2026.
7. Four location-specific Total Communication Workshops are scheduled for staff throughout the month of April, 2026. Completion date: 30/04/2026

Regulation 23: Governance and management	Not Compliant
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Outline how you are going to come into compliance with Regulation 23: Governance and management:

1. A Root Cause Analysis was completed by the Senior Manager and Deputy CEO/Operations Director, reviewed by the Senior Leadership Team, and shared with the Chair of the Board on 19/03/2026. A follow-up review meeting is scheduled with the CEO and Chairperson on 26/03/2026. Completion date: 26/03/2026
2. The PPIM will complete a quarterly governance audit. The governance visit will include review of safeguarding, restrictive practices, training and resident outcomes, with actions tracked through the Service Improvement Plan. Completion date: 01/03/2026 & ongoing
3. A full-time permanent Person in Charge commenced in the centre on 04/02/2026. Any gaps in the handover process have been addressed and the handover template is currently under review to ensure all essential handover elements are covered. This will be shared as an organisational learning. Completion date: 10/04/2026
4. Recruitment for a Deputy Service Manager (0.8 WTE, specified purpose 6 months) has commenced to strengthen local governance and management. Interviews are scheduled for the week commencing 30/03/2026.
5. Governance oversight is embedded through quarterly governance visits, quarterly business support meetings, the annual appraisal process and (current) weekly Service Improvement Plan reviews. Ongoing.
6. The PPIM and Person in charge will meet weekly for the next 3 months to review the service improvement plan and actions arising from inspection findings and governance reviews. Completion date: 30/06/26
7. The progress and impact of the Service Improvement Plan is reviewed monthly by the Senior Leadership Team at scheduled meetings. Completion date: 19/03/2026
8. The Service Improvement Plan will be reviewed quarterly by the Board-led Quality and Risk Management Committee (QRMC). Completion date: 30/07/2026
9. Progress and impact of the Service Improvement Plan will be included as a standing

agenda item for Board review. Completion date: 07/05/2026

10. Workforce planning has been reviewed to reflect both short- and long-term absences. Approval has been secured to recruit 4 WTE staff (combined vacancies and absences). Recruitment is underway: 2 Social Care Worker WTE interviews completed with offers issued and compliance checks in progress (anticipated start dates of 30/05/26). Care Assistant interviews commenced 16/03/2026. Completion date: 30/06/2026

11. A weekly escalation meeting between the Person in Charge and HR (Recruitment) commenced on 25/02/2026 to oversee vacancies, recruitment progress and service coverage until vacancies are filled. Completion date: 30/06/2026

12. The Person in Charge has reviewed the roster and identified areas for improvement (04/03/26). The Person in Charge and HR are reviewing staffing arrangements to ensure they align with resident needs and service requirements. Completion date: 31/07/2026

13. All restrictive practices within the centre have been reviewed and submitted to the Human Rights Committee. A member of the provider's Human Rights Committee attended the centre to review current restrictions. Completion date: 05/03/2026.

14. Human Rights Committee workshop is scheduled for 23, 24 and 25th March on the specific topic of Restrictive Practice for PICs, front line representatives, advocates and families. Completion 25/03/26

15. The Person in Charge has updated a risk assessment in relation to night checks one resident. There are currently no night checks in place within the centre. Any future checks will be based on assessed need and risk assessment and will be documented accordingly. Completion date: 16/03/2026

16. All restrictive practices for Quarter 4 2025 have been submitted retrospectively and will continue to be reported through quarterly returns. A shared learning notice regarding HIQA notification submissions will be issued to all persons in charge. Completion date: 31/03/2026

17. Terms of reference and key milestones have been established for the relocation project for one resident, and a working group has been set up to progress planning. The group will meet regularly to review actions. Completion date: 30/09/2026

18. A draft business case has been completed; however, property costs are pending as a suitable property has not yet been identified. The working group is progressing property identification, following which the business case will be submitted. Completion date: 30/04/2026

19. Interim works have been completed to improve the surface of the parking area outside the house to reduce immediate trip and fall risks. Completion date: 26/02/2026

20. Full resurfacing works for the parking area and driveway have been submitted for costing and scheduling through the provider's maintenance department. Completion date: 30/05/2026 ]

Regulation 10: Communication	Not Compliant
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Outline how you are going to come into compliance with Regulation 10: Communication:

1. All residents communication passports have been reviewed and updated by keyworkers to ensure guidance reflects current communication needs and preferences. The Person in Charge has reviewed and signed off on all updated passports. Passports will be reviewed at least annually, or sooner if residents communication needs change. Completion date: 13/03/2026

2. Four location-specific Total Communication Workshops are scheduled for staff throughout the month of April, 2026. Completion date: 30/04/2026
3. The Total Communication Audit has been reviewed and service objectives have been set with the Person In Charge. Speech and Language Therapy consultation has taken place and location-specific recommendations regarding Total Communication strategies and specific supports including visual supports, a visual menu, individualised planners and a visual staff board have been provided. These recommendations will be provided by 27/03/26 and actioned by the person in charge. Completion date: 27/03/26
4. The Person in Charge completed Lámh training on 10/03/2026 to support the implementation of communication strategies within the centre. Completion date: 10/03/2026
5. Location-specific Lámh training will be provided to staff to support residents communication needs and improve staff competency in communication supports. Completion date: 16/04/2026 ]

Regulation 5: Individual assessment and personal plan	Not Compliant
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- Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
1. The quiet room identified as a sensory space has been decluttered and reviewed to ensure it is safe and functional. The development of this space is being informed by Occupational Therapy to ensure it meets resident's needs. The focus is on incorporating sensory elements that are meaningful and beneficial for residents, rather than creating an overstimulating or overwhelming environment. Completion date: 22/04/2026.
  2. Occupational Therapy has reviewed the activity resources available within the centre and provided recommendations for meaningful resources that support residents engagement and reflect their individual interests and abilities, acknowledging that what is considered age-appropriate varies depending on individual needs and preferences. The Person in Charge is sourcing these items to enhance residents' participation in activities. Completion date: 30/05/2026
  3. The quiet room has a replacement sofa that was ordered prior to inspection, consisting of two individual recliner chairs better suited to the needs of the resident who primarily uses the space. Completion date: 27/02/2026
  4. Terms of reference and key milestones have been established for the relocation project for one resident, and a working group has been set up to progress planning. The group will meet regularly to review actions. Completion date: 30/09/2026
  5. A draft business case has been completed; however, property costs are pending as a suitable property has not yet been identified. The working group is progressing property identification, following which the business case will be submitted. Completion date: 30/04/2026
  6. The provider is exploring internal options to replace the current vehicle with an accessible vehicle to meet residents mobility needs. Completion date: 30/05/2026
  7. A second vehicle is being included as part of a business case linked to the development of a new service for one resident. This would reduce reliance on the existing vehicle and support residents access to community activities and appointments. In the interim, the use of a second vehicle is being explored for the evenings and weekends from within the organisation. Completion date: 30/04/2026
  8. One resident has commenced accessing a nearby sensory space with appropriate

equipment. Visits are incorporated into the resident's weekly activity planner in line with their preferences and interests. Completion date: 27/02/2026

9. All Personal Plans are under review by the assigned keyworker and will be reviewed by the Person in Charge. Completion date: 31/05/2026

10. Keyworking Policy and expectations will be discussed at next staff meeting  
Completion date: 30/04/2026

11. Weekly activity planning will be developed with residents to support choice, participation and meaningful engagement in activities both within the centre and in the community. Completion date: 30/03/2026 ]

Regulation 7: Positive behavioural support	Not Compliant
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Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:

1. The Behaviour Support Specialist visited the centre (24.02.26/05.03.26) and all residents have been referred for review of their Positive Behaviour Support plans to ensure plans include up-to-date personal information, identified triggers, proactive supports, and related restrictive practices i.e. PRN protocol. Completion date: 01/05/2026
2. Updated Positive Behaviour Support plans will be shared for review with the staff team to ensure staff understand the guidance and consistently implement recommended supports in practice. All staff will be required to sign the plans. Completion date: 08/05/2026
3. All restrictive practices for Quarter 4 2025 have been submitted retrospectively and will continue to be reported through quarterly returns. A shared learning notice regarding HIQA notification submissions will be issued to all persons in charge. Completion date: 31/03/2026
4. All restrictive practices within the centre have been reviewed and submitted to the Human Rights Committee. A member of the provider's Human Rights Committee attended the centre to review current restrictions. Completion date: 05/03/2026.
5. The Person in Charge has updated a risk assessment in relation to night checks one resident. There are currently no night checks in place within the centre. Any future checks will be based on assessed need and risk assessment and will be documented accordingly. Completion date: 16/03/2026
6. The Person in Charge is establishing a local restrictive practice review group to review each restriction individually. The group will identify restrictions for elimination, reduction, or alternative supports where possible. Completion date: 30/06/2026
7. The register of restrictive practices has been updated within the centre to ensure all restrictions are documented, reviewed and monitored in line with the provider's policy. Completion date: 20/03/2026 ]

Regulation 8: Protection	Not Compliant
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Outline how you are going to come into compliance with Regulation 8: Protection:

1. The Person in Charge is completing a review of all safeguarding incidents reported within the past 12 months to identify trends, recurring risks and outstanding actions. Findings from this review are informing updated safeguarding support plans for residents. Completion date: 30/04/2026
2. The live safeguarding tracker is being updated to ensure all safeguarding concerns,

actions and outcomes are clearly recorded and monitored. Completion date: 31/04/2026

3. Preventative measures have been reviewed with updated safeguarding strategies incorporated into residents local safeguarding plans to reduce the risk of further peer-to-peer incidents. Completion date: 23/03/2026

4. Terms of reference and key milestones have been established for the relocation project for one resident, and a working group has been set up to progress planning. The group will meet regularly to review actions. Completion date: 30/09/2026

5. A draft business case has been completed; however, property costs are pending as a suitable property has not yet been identified. The working group is progressing property identification, following which the business case will be submitted. Completion date: 30/04/2026

6. A previously developed protocol pertaining to safeguarding incidents has been reviewed and updated with social work input. This has also been communicated to staff. Completion date: 23/03/2026

7. A tailored autism specific training event will be held for 8 staff who were unable to attend a previous session on 02/04/26. If, for any reason, a staff member is unable to attend, they will be enrolled on this course as part of the organisation's training schedule. Completion date 31.05.26

8. In person positive behaviour support training has been scheduled for 3 staff. Completion date: 28/06/2026 ]

Regulation 9: Residents' rights	Not Compliant
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Outline how you are going to come into compliance with Regulation 9: Residents' rights:

1. All restrictive practices for Quarter 4 2025 have been submitted retrospectively and will continue to be reported through quarterly returns. A shared learning notice regarding HIQA notification submissions will be issued to all persons in charge. Completion date: 31/03/2026

2. All restrictive practices within the centre have been reviewed and submitted to the Human Rights Committee. A member of the provider's Human Rights Committee attended the centre to review current restrictions. Completion date: 05/03/2026.

3. Human Rights Committee workshop is scheduled for 23, 24 and 25th March on the specific topic of Restrictive Practice for PICs, front line representatives, advocates and families Completion 25/03/26

4. The Person in Charge has updated a risk assessment in relation to night checks one resident. There are currently no night checks in place within the centre. Any future checks will be based on assessed need and risk assessment and will be documented accordingly. Completion date: 16/03/2026

5. The Person in Charge is establishing a local restrictive practice review group to review each restriction individually. The group will identify restrictions for elimination, reduction, or alternative supports where possible. Completion date: 30/06/2026

6. Terms of reference and key milestones have been established for the relocation project for one resident, and a working group has been set up to progress planning. The group will meet regularly to review actions. Completion date: 30/09/2026

7. A draft business case has been completed; however, property costs are pending as a suitable property has not yet been identified. The working group is progressing property identification, following which the business case will be submitted. Completion date: 30/04/2026

8. In response to this inspection report, families will be engaged through the open

disclosure process. Completion date: 30/04/2026

9. All staff have been reminded to knock before entering residents' bedrooms, reinforcing the standard practice for respecting dignity and privacy. Completion date: 18/03/2026

10. The use of locked doors during incidents has been sent for review by the provider's Human Rights Committee to confirm it is necessary, proportionate, and only applied as a last resort during serious incidents. All instances are now recorded in a log. Completion date: 18/03/2026

11. The provider ensures safeguarding supervision supports residents' rights, promoting autonomy, dignity, and safe freedom of movement. Staff use a proximity-based approach, encouraging residents to move freely and make choices wherever possible, while maintaining necessary safety oversight. Completion date: 17/02/2026

12. The back door and stair gate will be reviewed as part of a local Restrictive Practice Review Group taking into account resident needs, environmental considerations, staffing ratios and any modifications required. Completion date: 30/06/2026

13. All restrictive practices are documented on the provider's electronic system and are accessible to staff. The person in charge will review at team meetings each quarter. Completion date: 13/03/2026 ]

## 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(1)	The registered provider shall ensure that each resident is assisted and supported at all times to communicate in accordance with the residents' needs and wishes.	Not Compliant	Orange	30/04/2026
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.	Not Compliant	Orange	30/04/2026
Regulation 10(3)(b)	The registered provider shall ensure that where required, residents are facilitated to access assistive technology and aids and appliances to	Not Compliant	Orange	30/04/2026

	promote their full capabilities.			
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Not Compliant	Orange	31/07/2026
Regulation 15(3)	The registered provider shall ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.	Not Compliant	Orange	31/07/2026
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Not Compliant	Orange	28/06/2026
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and	Not Compliant	Orange	30/09/2026

	support in accordance with the statement of purpose.			
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.	Not Compliant	Orange	30/09/2026
Regulation 05(3)	The person in charge shall ensure that the designated centre is suitable for the purposes of meeting the needs of each resident, as assessed in accordance with paragraph (1).	Not Compliant	Orange	30/09/2026
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	08/05/2026
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used,	Not Compliant	Orange	08/05/2026

	such procedures are applied in accordance with national policy and evidence based practice.			
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	30/09/2026
Regulation 08(7)	The person in charge shall ensure that all staff receive appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse.	Not Compliant	Orange	30/09/2026
Regulation 09(2)(b)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability has the freedom to exercise choice and control in his or her daily life.	Not Compliant	Orange	30/09/2026
Regulation 09(3)	The registered provider shall ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and	Not Compliant	Orange	30/09/2026

	personal care, professional consultations and personal information.			
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