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:	Helensburgh
Name of provider:	Sunbeam House Services CLG
Address of centre:	Wicklow
Type of inspection:	Unannounced
Date of inspection:	11 May 2026
Centre ID:	OSV-0001703
Fieldwork ID:	MON-0049177

About the designated centre

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

Helensburgh is a designated centre operated by Sunbeam House Services CLG. It provides a full-time community residential service for up to six adults (male or female) with a disability. The centre comprises of a two-storey house which consists of six individual bedrooms, two offices, two sleepover rooms, a sitting room, dining room/kitchen, a shared bathrooms and utility room. The centre is managed by a full-time person in charge and a team of social care workers and care assistants.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	4

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
Monday 11 May 2026	09:15hrs to 16:30hrs	Jacqueline Joynt	Lead

What residents told us and what inspectors observed

This unannounced risk-based inspection took place over the course of one day and was to monitor the designated centre's level of compliance with the regulations and to review the improvements the provider had made since the last inspection in October 2025, where a high level of non-compliances were found.

The findings from this inspection demonstrated the provider had made significant improvements and had addressed many of the deficits found on the previous inspection to good effect. Many of the non-compliant regulations had come back into full compliance or substantially compliant. The inspector found that the improvements had resulted in positive outcomes for residents and in particular, residents were now experiencing a positive lived experience in their home. While compatibility issues remained in the centre, there were a number of effective measures now in place that were resulting in a significant reduction of peer to peer incidents. Residents who spoke to the inspector on the day relayed positive feedback about the recent changes in the centre and their enjoyment of living in their home.

The inspector used conversations with residents, key staff and the person in charge alongside observations and a review of documentation to inform judgments on the residents' quality of life. The inspection was facilitated by the person in charge for the duration of the inspection. The senior service manager, who is one of the centre’s personal participating in management (PPIM), called to the centre in the morning to meet with the inspector. They returned later in the afternoon to attend the feedback meeting at the end of the inspection. The deputy CEO (who is one of the centre’s PPIMs) also attended the feedback meeting via video call.

The designated centre was registered to accommodate six residents. On the day of the inspection, there were four residents living in the centre. Since 2025, all residents have lived in the downstairs section of the house and do not access the upstairs facilities in the premise. Due to residents physical and aging support needs, they were unable to avail of this area of their home independently. Since the last inspection, the provider and person in charge have progressed actions in finding alternative accommodation to better meet the residents' needs. This is discussed in detail under regulation 17: Premises.

The inspector was provided with the opportunity to meet and speak with all four residents. On the day of the inspection, one resident attended their day service, one resident attended a new knitting course in their local town in the morning and in the afternoon attended an activity club in Bray. The other resident told the inspector they were having a relaxing day at home in preparation for a medical appointment the following day. Throughout the day the inspector observed the resident enjoying time in the kitchen with their staff team having cups of tea and jovial conversations. Another resident who had retired, was observed relaxing in the house for most of

the day chatting with staff members. In the early evening time, the resident enjoyed a visit from their family members in the front sitting room of the house.

Where appropriate, staff supported residents with conversations and provided prompts, in line with their communication needs, to support them relay their views. One of the resident's, who met with the inspector independently, told the inspector that they were happy living in the house. They were happy with the support from their staff and the person in charge. They said they knew who they could speak with if they were upset.

The resident told the inspector that they liked to bake buns and cakes. They said they had invited friends around to the house for tea and cakes which they had baked themselves. The resident told the inspector that their friends really liked their baking. The resident smiled when relaying the information and seemed proud of their achievement. The resident said that they also had friends living in the house with them. However, they missed one of their friends who had passed away last year and this made them feel sad from time to time. The inspector was informed that there was a plan in place for a remembrance ceremony to take place for the resident who passed. Each resident was currently choosing a different coloured rose bush to plant in memory of their friend. The inspector also observed in residents easy-to-read personal plans, that there was an easy-to-read information booklet on grief and supports available after the passing of a loved one.

Another resident was happy to show the inspector their bedroom. They told the inspector that they had chosen the colour of the room and were happy with it. There were some hand knitted throws on their bed which, the resident advised that one had been made by their friend who had recently passed.

The resident expressed their happiness at living in the house. They said there had been a lot of change for the better. The resident told the inspector that they now knew all the staff working in the centre. They said that it was nice having staff that they knew, supporting them. They also relayed that there was a 'very good manager' in place. The resident talked about their new knitting club and how happy they were attending it. They talked about their plans to continue going and were hopeful that another one of their friends would join the club with them.

One resident who spoke with the inspector several times during the day, took some time out to sit with the inspector in the sitting room and look through their family photographs. The resident had recently been supported by their staff to buy new frames for two of their childhood family photographs. The resident told the inspector that they picked out the frames themselves. The inspector observed the resident to appear proud and content at their display of family photographs on the sitting room window shelf. The resident told the inspector that they liked living in the house, were happy with the food and liked the staff who were supporting them.

On entering the kitchen the inspector observed one resident eating their breakfast. The resident was assessed to have a specific feeding and eating plan in place which required the resident's food to be cut in to small pieces. The inspector observed staff supervise the resident during their meal in a discrete way which promoted the

dignity and independence of the resident. On speaking with staff, they advised the inspector that the resident liked to complete activities at a slow pace and that this was respected. The staff talked about how the resident like to be independent as much as possible when supported with their personal care and that all staff were made aware of this, verbally and through care plans.

During a walk around of the centre, the inspector observed that residents were provided with their own individual bedrooms. The rooms were laid out in line with each residents' assessed needs and preferences. They contained personal and individualised items and memorabilia that was important to them. Two of the residents who showed the inspector their room, seemed proud of the layout and décor of their room. Residents' bedrooms were observed to contain framed photographs, soft furnishing, cushions with family photographs, framed photographs of friends and family, residents' own artwork on walls, computer gaming consoles, televisions and radio sets, but to mention a few.

Communal areas in the house presented as welcoming and homely. The sitting room to the front of the house included pictures on the walls, paintings and photographs. There was a fish tank that was well maintained and provided a relaxing ambiance to the room. The room contained a large couch, arm chairs, a television and a table and chair by the bay window. The table and chair was in place to provide an option for one resident, who enjoyed sitting in the room and watching television, to have their dinner there. The inspector was advised by staff, that the resident had recently asked for another resident to join them to have dinner together in the room which was a new and positive change for both residents.

The kitchen was located to the rear of the house and included a dining area with tables. There was an accessible bathroom on the ground floor which included a parker bath. Residents were provided with their own shower chairs and where required, other mobility equipment to support them their during personal care. However, while there was one other accessible bathroom and shower facility in the house, this could not be accessed by residents as it was upstairs. As such all four residents were sharing the one facility for baths and showers.

There was a grassed and cemented area out the back of the house that contained a clothes line and small seating area. The inspector observed that the area required upkeep so that it provided a welcome space for residents to sit out in the summer time if they so wished. It also potentially provided an addition communal space for resident to use and would likely enhance the current safeguarding measures in place.

The entrance and hallway into the house was observed to be clean, bright and welcoming and included a mural of a large tree on the wall, with an array of photographs of residents with their family and friends, placed on the branches of the tree. There was a notice board that provided a lot of easy-to-read and picture format information for residents. The information related to safeguarding, advocacy, the designated officer and other information that kept residents informed about their home and the service. A photographic format of the staff day and night time roster was hung up on the hall wall. The inspector was informed that the roster

supported some residents with their anxieties relating around staffing working in the centre. The person in charge pointed out that currently there were lots of photographs of the core staff team on the roster, in comparison to previous months, where there had been a lot of agency staff names instead of photographs.

The inspector observed that residents appeared relaxed and happy in the company of staff and that staff were respectful towards residents through positive and caring interactions. Staff members on duty were knowledgeable of residents' needs and the supports in place to meet those needs. On speaking with two staff the inspector found that staff were knowledgeable about the strategies within residents' positive behaviour support plans, as well as residents' safeguarding plans and communication passports. Staff were also aware of each resident's likes and dislikes.

The two staff talked about the changes in the centre since the last inspection and with the change in management. Staff noted that there was a cultural change among the staff in the service which had resulted in a lot of positive outcomes. Staff relayed how they were supported and empowered to take responsibility and be more accountable than previously. They said there was a significant reduction in safeguarding peer to peer incidents occurring in the house and that they felt this was due to the reduction in use of agency staff as well as better understanding of positive behaviour support so that they could pre-empt incidents and spot triggers to avoid potential incident occurring. Staff advised the inspector that all this has resulted in positive outcomes for residents and that residents seemed a lot happier living in their home. They said that there had been an increase in residents availing of community activities which overall, supported the measures in place to mitigate the risk of peer to peer safeguarding incidents occurring.

The provider and local management had implemented arrangements to support residents to make choices and decisions, and consulted with them about their care and support, and on matters related to their home. Residents were provided with monthly meetings that included items to be discussed such as safeguarding, complaints procedures, human rights, maintenance, activities, and any news or information that was important to them. The inspector saw on one meeting where each resident spoke on an individual basis about how their rights and choice were promoted when visiting friends and family.

The residents communicated using primarily verbal communication however, they were also provided with a selection of easy reads, social stories and photographic options, to support their understanding of matters that were important to them. The inspector saw that each resident was provided with a white board in their bedroom. The boards were in place to support each resident plan the next days (or weeks), activity. Residents, supported by their staff, had cut out photographs or symbols that represented different activities which they took part in. These were then displayed on the whiteboard to remind the resident of their plans for the next day or week. The person in charge informed the inspector that for some residents, having the photographic planning boards in place, lessened their anxieties and provided a level of certainty and control in their lives.

Overall, this inspection found a significant increase in compliance since the last inspection of the centre in October 2025. The provider had self-identified deficits in local governance and management systems of the designated centre in 2025 and, in response had created a specific service improvement plan to address the deficits. On review of the current specific service improvement plan in place, the inspector saw that there had been a lot of traction of the required actions and that overall, many actions had been completed. While there remained a number of actions relating to premises, staffing and protection, a lot of steps had been completed that allowed for final actions to be implemented or moved to the next required step. Overall, the improvements since the last inspection resulted in a better lived experience for residents and in particular, regarding residents' safety, wellbeing and rights.

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

Capacity and capability

The purpose of this inspection was to monitor the levels of compliance with the regulations and to review the improvements the provider had made since the last inspection in October 2025, where a high level of non-compliances were found.

This section of the report sets out the findings of the inspection in relation to the leadership and management of the service, and how effective it was in ensuring that a good quality and safe service was being provided to residents.

Overall, the findings of this unannounced inspection demonstrated that the provider had made significant improvements and had addressed many of the deficits found on the previous inspection to good effect.

Many of the non-compliant regulations had come back into full compliance or were now substantially compliant. There had been significant traction of the provider's own specific-location service improvement plan that resulted in quality improvements and overall, positive outcomes from residents living in the centre. For example, there had been a reduction in safeguarding incidents, a reduction in the use of agency staff and a safer environment for residents to live in.

A number of governance and management oversight and monitoring systems had been enhanced or developed since the last inspection. These supported the person in charge and the management team ensure the effective governance, operational management and administration of the designated centre.

Staffing levels had improved with the employment of four new staff members. A number of part-time staff moved to full-time employment and a new roster shift pattern was coming on line in June 2026. All these measures supported continuity of

care and a person-centred centred approach to the care and support of residents living in the centre.

Overall, the improvements had resulted in positive outcomes for residents and in particular, residents were now enjoying a positive lived experience in their home. While compatibility issues remained in the centre, there were a lot of effective measures now in place that were resulting in a significant reduction of peer safeguarding incidents. There were some further actions required to bring protection, premises and staffing back into full compliance and these are address in detail under each of the associated regulations.

Regulation 14: Persons in charge

The person in charge, who worked full-time in this centre only, commenced in their role in November 2025. The person in charge, supported by a senior service manager, (PPIM), had developed and implemented number of local oversight and monitoring systems in place that better ensured the effective governance, operational management and administration of the designated centre.

The inspector found that the person in charge had the appropriate qualifications and skills and sufficient practice and management experience to oversee the residential service to meet its stated purpose, aims and objectives.

Through speaking with the person in charge, the inspector found that they demonstrated sufficient knowledge of the legislation and their statutory responsibilities of their role. The person in charge had developed an additional local oversight system; for example, a monthly duty allocation list for staff had been created which the person in charge monitored. This oversight system saw staff take responsibility for checking areas related to fire safety, health and safety, resident and staff meeting minutes as well as updates on the centre's computer information system. These local systems, further enhanced and ensured the effectiveness of local monitoring systems in place by the person in charge.

The person in charge was familiar with the residents' needs and was endeavouring to ensure that they were met in practice. The inspector found that the person in charge had a clear understanding and vision of the service to be provided and, supported by the provider, fostered a culture that promoted the individual and collective rights of residents living in this centre.

Staff who spoke with the inspector advised that the person in charge was very approachable and supportive. They said the person in charge had made a lot of positive changes which had resulted in positive outcomes for residents as well as the staff team.

Judgment: Compliant

Regulation 15: Staffing

The provider was endeavouring to ensure that there were enough staff with the appropriate skills, qualifications and experience to meet the assessed needs of residents at all times. There had been significant improvements to staffing levels and arrangements in place which had resulted in better levels of continuity of care provided to residents since the last inspection. This meant that attachments were not disrupted and support and maintenance of relationships between residents and their staff were promoted. It also meant that residents' assessed needs and preferences, of support from familiar staff, were being met.

The provider and person in charge had carried out a review of the roster. As a result, changes to the working shift patterns in the centre were due to commence in June 2026. The new shift pattern meant that staff were employed to work 12 hour day shifts instead of 24 hour shifts. Waking night shifts were in place instead of sleepover shifts. This shift pattern allowed for better outcomes for residents, supported a person-centred approach and in particular, provided increased options for residents to engage is day-long community activities if they so wished.

While there were four staff vacancies in the centre, a number of measures had been put in place to reduce the high use of agency staff working in the centre. A number of the part-time staff had changed to working full-time hours. Four new staff had been recruited and had commenced working in the centre. Recent interviews saw three positions offered to potential candidates. In addition, an internal staff recruitment drive resulted in another new member of staff. They were due to commence in their role in one month's time.

On review of a sample of rosters from February 2026 to May 2026, the inspector saw that the use of agency staff had reduced from nine in February to four in April and to three in May. This change saw positive outcomes for residents and in particular, relating to the provision of continuity of staffing and care.

There was an induction folder in place in the centre and this was available for new staff as well as agency staff, to review. Since the last inspection, the folder had been reviewed and updated and included pertinent information for staff to familiarise themselves with residents' support needs and other service delivery matters. The inspector saw that the folder included satisfactorily completed induction forms for new and agency staff members. In addition, the folder included instructions about the centre's computer system so that all staff working in the centre knew how to access to it, in particular when writing up daily notes about each resident. There was also an improved system in place to ensure staff were provided passwords to access the system on an ongoing basis. This system ensured all staff, who were new or not working on a permanent basis, were provided access to information about each residents' care support needs as well as being able to update information at the end of each shift about the resident they supported.

The person in charge appropriately maintained the centre's planned and actual staff rosters. The inspector reviewed a sample of rosters for the months of February to May 2026, and found that rosters accurately reflected the staffing arrangements in the centre, including the full names of staff on duty during both day and night shifts.

The inspector spoke with two staff members in detail on the day and found that they were knowledgeable about the support needs of residents and overall, about their responsibilities in the person-centred care and support of residents living in the centre.

Overall, there had been a lot of improvements to the centre's staffing levels and arrangements which had resulted in positive outcomes for resident with a significant reduction in the use of agency staff. However, the inspector was informed that the new change in roster shift patterns, that was due to commence in June 2026, meant that there would be an increase in staff whole-time equivalent requirements for the centre. This also meant that there would likely be an interim increase in the use of agency staff until all positions were filled. As such, some further action was required by the provider to ensure the timely recruitment of the required staffing.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Effective systems were in place to record and regularly monitor staff training in the centre. The inspector reviewed the staff training matrix and found that staff had completed a range of training courses to ensure they had the appropriate levels of knowledge and skills to best support residents.

Some of the training courses provided to staff include, fire safety, safeguarding of vulnerable adults, positive behaviour supports, manual handling, Children's first, safe administration of medication, first aid, human rights, feeding, eating, drinking and swallowing (FEDS), infection prevention and control (IPC), food safety, and safe administration of medication.

The matrix included the dates of when staff training was completed and when it was next due. The person in charge contacted staff near the due date to remind them of their upcoming training. The inspector saw on the matrix that, where staff refresher training was due, a course date had been booked and was included on the matrix.

All staff were in receipt of supervision and support relevant to their roles from the person in charge. The person in charge advised the inspector that they had completed one to one supervision meetings with the staff team in January 2026 and the next set of supervision meetings were due in June 2026.

Judgment: Compliant

Regulation 23: Governance and management

There had been improvements to the governance and management systems in place in the centre since the last inspection which saw this regulation come back into compliance. In addition, the provider had ensured that compliance plan actions from the last inspection had been, for the most part, completed which resulted in regulations relating staffing, premises, protection and rights either coming in to full compliance or substantial compliance. Overall, this had resulted in positive outcome for residents and in particular in terms of their safety and wellbeing.

There was a clear management structure in place with clear lines of accountability. It was evident that there was regular oversight and monitoring of the care and support provided in the designated centre and there was regular management presence within the centre.

An annual review of the quality and safety of care had been completed in May 2025. The annual report demonstrated that residents, their family, and staff had all being consulted in the process. The current annual review was due to be completed this month, with a provider visit due to the centre the week after the inspection. The person in charge had collected feedback from residents, and on review of the feedback the inspector saw that overall, it was positive. Residents were happy living in their home, with the service that was provided to them including meals, their accommodation and staff suport.

Two six month unannounced visits of the centre to monitor the quality of care and support had been completed in May and November 2025 and the next visit was due in May 2026. The inspector saw that most of the actions had been completed for both. The person in charge had a system in place that monitored the progress of actions from the visit. This was to ensure effective traction the timely completion of actions.

There was a centre-specific service improvement plan that had been put in place by senior management just ahead of the previous inspection in October 2025. The plan was updated since this time to include the previous inspections' compliance plan actions. The inspector saw that there had been significant on-going progress made on actions. The person in charge and their senior service manager met on a monthly basis to review the plan and note progress made, actions completed and work to be done, as well as a review of time lines. Overall, the inspector found that the monthly meetings and plan updates were effective in driving quality improvements for residents living in the centre.

Since the last inspection a new local monitoring system, called the 'governance - monthly checklist', had been implemented. The checklist reviewed the quality assurances systems in place, as well as their effectiveness. Some of the areas reviewed on the checklist included, medication, housekeeping inspection, staff and training records, health and safety audit, client finance audit, client folder audit, actions from six monthly visit and annual review, Health Information and Quality

Authority (HIQA) actions plans, quarterly notifiable events, restrictive practice logs, induction forms and infection prevention and control folder.

The person in charge ensured staff were provided with regular team meetings. On review of the minutes from two of the meetings, the inspector saw that meetings provided staff an opportunity for reflection and shared learning. Updates on the care and support provided to residents were discussed as well as topics such as staff culture, change in roster, HIQA compliance plan actions, service improvement plan updates, medication audit results, residents' rights and restrictive practices, safeguarding measures in place, strategies in residents' positive behaviour support plans, but to mention a few.

Judgment: Compliant

Regulation 31: Notification of incidents

There were effective information governance arrangements in place to ensure that the designated centre complied with notification requirements.

The person in charge had ensured that all adverse incidents and accidents in the designated centre, required to be notified to the office of the chief Inspector, had been notified and overall, within the required timeframes as required by S.I. No. 367/2013 - Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (the regulations).

The inspector found that incidents were managed and reviewed as part of the continuous quality improvement to enable effective learning and reduce recurrence. Where there had been incidents of concern, the incident and learning from the incident, had been discussed at staff team meetings.

Judgment: Compliant

Regulation 34: Complaints procedure

The provider had established and implemented effective complaint handling processes. For example, there was a complaints and compliments policy in place. In addition, staff were provided with the appropriate skills and resources to deal with a complaint and had a full understanding of the complaint's policy. All staff had been provided training relating to complaints.

Residents were supported to make complaints, and had access to an advocate when making a complaint or raising a concern. The inspector observed that the complaint's procedure was accessible to residents and in a format that they could

understand. Residents were provided with easy to read information in the personal plan about how to make a complaint and how to access an advocacy service should they wish.

There was also a residents' advocacy forum in the organisation run by a facilitator and number of the organisations' residents. The person in charge advised that regular updates were provided to each centre from the advocacy group and that these were relayed to residents in the house at monthly residents' meetings.

On review of residents' monthly meeting minutes the inspector saw that complaints, (and how to make a complaint), was one of the standing agenda items at meetings. On speaking with residents on the day, and on review of the annual review feedback forms, the inspector found that residents were aware of who to go to if they wished to make a complaint or wanted to raise an issue.

There were no open complaints on the day or since the last inspection in October 2025. However, the inspector found that the person in charge was knowledgeable and aware of the organisation's policy and procedures relating to complaints.

Judgment: Compliant

Quality and safety

This section of the report details the quality and safety of the service provided to residents who live in the designated centre.

The inspector found that since the last inspection, there had been a lot of improvements made to support residents live in an environment that was safe, consistent and promoted their rights. Residents who spoke with the inspector relayed positive feedback about their current lived experience, which was in contrast to their previous feedback in October 2025.

While compatibility issues in the centre were still in place, there had been a number of additional measures put in place that had been effective in reducing the high levels of safeguarding incidents amongst peers.

Residents were provided with positive behaviour support plans and safeguarding support plans that included clear and coherent guidance for staff on how to consistently and effectively support residents manage their behaviour.

While the entire premises was not meeting residents' assessed and aging needs the provider had initiated plans to find alternative accommodation for residents that would better meet their support needs. A number of steps within this process had been completed or were in progress. In the interim, staff were provided guidance

and support, on how to better manage the environment to ensure residents safety and physical needs were supported.

Due to changes in staffing levels and arrangements, residents were enjoying higher levels of community participation and engagement. This better supported residents to progress and achieve their individual goals and overall promoted meaningful and regular participation in their local community.

The management and person in charge were striving to ensure residents' rights were promoted. Where there were rights' restrictions in place, they were subject to approval by the organisation's rights committee as well as a risk assessment. Residents were supported to understand and be consulted about the restrictions through easy-to-read social stories, which was in line with their communication support needs and preferences.

Overall, while there were further improvements needed to the areas of premises and safeguarding, this inspection saw that improvements made since the previous inspection in October 2025 had led to positive outcomes in residents lives and in particular, a safer and more enjoyable lived experience in their home.

Regulation 10: Communication

The residents living in the centre presented with a variety of communication support needs. Communication access was facilitated for residents in this centre in a number of ways in accordance with each of their needs and wishes. The person in charge had ensured that residents were provided information in a way that they understood.

Information was provided to residents verbally but also through easy-to-read format, photographs and social story type information in their personal plans and on residents' notice boards. This supported residents' understand the information in line with their needs, likes and preferences.

During a walk around of the centre, the inspector observed easy-to-read information on safeguarding, on the designated officer, on the organisations' complaints procedures, on advocacy and rights. In addition, each resident was provided their own personal white board in their bedroom to support the planning of their daily and weekly activities in a format that met their communication needs and preferences. One of the residents went through their daily plan on the whiteboard and explained to the inspector what each of the photographic symbols represented. They said that they liked using the board for planning their activities.

There was also a photograph-style staff roster in place in the hallway of the house. The roster included photographs of staff who were on duty during day and night time shifts. The inspector was informed that this roster supported some residents with their anxieties in relation to unfamiliar staff.

To support residents to understand the information provided to them, and to be supported to communicate their choices and decisions about their care and their lives, each resident was provided with communication support plan which was included in their personal plan. Communication passports were in place for each resident as a practical communication profiling tool to help convey each residents unique identity, specifically in relation to their communication profile.

Judgment: Compliant

Regulation 17: Premises

Overall, the designated centre's premises was not meeting residents' assessed and aging needs and in particular, in relation to accessibility. All residents were living in the downstairs section of the house. For example, residents' bedrooms were all located on the ground floor. This was in line with their physical support needs as well as healthcare recommendations. As such, residents were unable to access all areas of their home, such as the upper floors that included a toilet and an accessible bath and shower room. This meant that resident were only able to avail of the accessible bath and shower room on the ground floor. The layout of the house, had also been identified as contributing to peer to peer safeguarding issues in the house.

However, since the last inspection, a number of improvements had occurred which overall, lessened the risk of safeguarding incidents occurring in the house. For example, staff were proactively managing the environment through supporting residents spend time in different spaces in their home. In addition, limited congregating in the kitchen was encouraged, as this was where most incidents occurred. Staff were also mindful to ensure that they were spaced out through the house when all residents were home. It had been identified that residents tended to gravitate to where staff located. Meal-times were staggered and residents were offered the choice of different places to enjoy their meal, such as the sitting room at the front of the house. In addition, new staff had been employed alongside changes in the roster, which allowed for increased meaningful community activity for residents on a one to one basis or in small amicable groups.

The provider and person in charge acknowledged that some of the measures impacted on residents' right of movement within their own home. The restrictive practices were reviewed by the organisation's rights committee on a regular basis. In addition, residents were consulted and informed about the restrictions in a communication format that was in line with their communication support needs.

The provider had commenced plans to find alternative accommodation for residents living in the house. A business plan had been submitted in February 2026 to the provider's funder for the de-congregation of the location. No further admissions were permitted and the provider's funder had been made aware of this. A folder had

been created with all the relevant documentation for the de-congregation of residents from their homes as well as transition information.

At the end of January 2026, a number of actions had been completed on the de-congregation plan. The provider, senior management and person in charge met with the staff team (in particular, with regard to the roster). In addition, meetings were held with residents' family members. The organisation's referral and housing committee had been notified and the centre was put at high priority (level one) for residents to move from the location. Residents were supported to complete local authority housing application forms and a referral had been sent to residents' occupational therapist in April for assessments to be completed and submitted with the application forms. There was also a plan in place to carry out specific compatibility assessments for each resident to ensure they were supported to transition to a location that ensured their safety. However, this item had not yet been completed. There was a plan in place to inform residents at a later stage which was in line with residents assessed needs, as well as limiting any unnecessary anxiety.

Overall, the inspector found that while there had been a lot of traction on compliance plan actions as well as on the provider's own service specific service improvement plan, further action was needed to progress the plan along so that residents were supported to move to alternative accommodation, that fully met their needs, within an appropriate timeframe.

In addition to the above, on an observational walk around of the house, the inspector saw that overall, the house was clean and tidy and for the most part in good upkeep and repair. Where there were chipped timber kitchen units and counter tops, door frames and doors, the provider had self-identified these and was in the progress of seeking funding for the works to be completed. However, the external parts of the house required review and in particular, the centre's back garden. The inspector observed the area to require some upkeep so that it provided a welcoming space for residents to sit out in during good weather. It also had the potential to be considered as an addition space to support the environmental safeguarding measures that were already in place.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

The inspector found that the provider had ensured that the organisation's risk management policy met the requirements as set out in the regulations.

Where there were identified risks in the centre, as well as risks that were specific to residents' individual health, safety and personal support needs the person in charge ensured appropriate control measures were in place to reduce or mitigate any potential risks.

For example;

Where there were potential safeguarding risks in the centre, due to compatibility issues, there were measures in place to reduce the risk. For example, some of the measures included, staff refer to positive behaviour support plans in place, use of rights restrictions, priority one on organisation's referrals list, ongoing recruitment of permanent staff, staff proactively management environment, mealtimes staggered, key working session and monthly meetings with residents to discuss safeguarding and respect and one to one support, where possible, to support residents engage in more community activities.

Where there were risks related to falls for one resident, some of the measures in place included the use of a motion sensor, use of a rollator-walker, provision of downstairs bedroom, access to occupational therapist, physiotherapy exercise and staff provided training in manual handling and first aid.

All residents' risk assessment were linked to a variety of support plans that provided guidance to staff on how to implements the measures and mitigate or reduce the risk in place.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

Information associated with each residents' personal plan was recorded in a hardcopy folder as well as on the provider's computer system. There was an auditing system in place that ensured personal plans were reviewed on a regular basis, by the person in charge and staff team, to make sure all information was up-to-date and relevant to each resident. For example, resident's personal plans included a personal profile checklist as well as a quarterly audit for the checklist. This was to ensure that residents' personal plans were regularly reviewed and kept up-to-date with pertinent information about the resident.

The person in charge, went through a number of care and supports plans with the inspector, that were recorded on the provider's computer system. The inspector saw that they provided adequate guidance to staff on how to support residents with their assessed needs. There were care and support plans relating residents' safety, health and well-being, money management, medication, risks and communication but to mention a few. n addition, where appropriate, residents' personal plans included positive behaviour support plans and safeguarding plans.

All residents were provided with an easy-to-read format of their personal plans. This meant that residents could understand what was contained with their own plan and in a way that met their communication needs and preferences.

Since the last inspection, all residents had been provided a review of their plan and their family, as well as where appropriate multi-disciplinary team were involved in

the review. This improvement meant that people who have significant input into residents' lives were provided the opportunity to support and enhance residents' experiences of their review and provided a space for residents to show off and celebrate their progress and achievements during the year.

Residents were supported to engage in goals that were meaningful to them. Two residents were planning to go abroad to a theme park in France. The residents were supported by their keyworker to progress these goals. For example, the inspector was informed that staff were supporting residents with accessing the appropriate documentation required to go abroad. Once this had been completed, the booking of flights and accommodation would follow. One resident informed the inspector that one of their goals was to spend an overnight in a hotel in Wexford. They told the inspector that the hotel was booked and they were looking forward to the trip.

Judgment: Compliant

Regulation 7: Positive behavioural support

The inspector found that there were arrangements in place to provide positive behaviour support to residents with an assessed need in this area. Residents' positive behaviour support plans were observed to be detailed, comprehensive and developed by an appropriately qualified person. In addition, plans included proactive and preventive strategies in order to reduce the risk of behaviours of concern from occurring. Where there were changes in residents' behavioural needs, the person in charge communicated these changes to the appropriate clinician to ensure plans were updated in a timely manner.

The provider ensured that staff had received training positive behaviour supports and received regular refresher training in line with best practice. Staff spoken with were knowledgeable of support plans in place and in particular, of each residents' triggers as well as the proactive support strategies in place to support residents manage their behaviours.

There were a number of restrictive practices in place in the designated centre. Some of these included money management supports, management of environment during mealtimes, motion detectors and limited access to bathroom facilities and freedom of movement.

Restrictive practice referrals were submitted for consideration to the centre's human rights committee to ensure the least restrictive option was in place as well as ensuring the rationale for their implementation was underpinned by a rights based approach.

In addition, the person in charge was endeavouring to ensure restrictive practices were in place for the least amount of time. On review of documentation, the

inspector saw that one of the resident was being supported, through a reduction plan, to learn how to manage their money more independently.

Some of the rights restrictions, relating to mealtimes and movement within the environment were in place to support peer to peer safeguarding measures. This was in an effort to reduce the number of incidents that were occurring in the house due to compatibility issues. Since the last inspection, residents had been provided with an easy-to-read social story, explaining the restriction about movement within their own home when one of their fellow residents becomes upset. The document explained the rational for the restriction in a communication format that was in line with residents assessed needs and overall, supported the effectiveness of the measure.

Judgment: Compliant

Regulation 8: Protection

There were ongoing compatibility issues between some of the residents living in the centre which were resulting in behavioural incidents, many of which were resulting in safeguarding concerns. However, since the last inspection, there had been a number of measures and strategies implemented that were proving effective in reducing the number of safeguarding incidents. In addition, staff were supported to understand how to better de-escalate and pre-empt potential incidents, which also supported the reduction of peer to peer incidents.

The following are a number of measures and strategies implemented that were effective in reducing safeguarding incidents;

Staff were provided training in positive behaviour supports and in particular, were supported to be aware and knowledgeable about potential triggers, residents' communication preference, language usage, as well as the significance of proactive strategies within residents' supports plans. This aided and supported staff in pre-empting potential incidents.

Staff proactively managed the environment so that residents used different spaces throughout the house rather than always gathering in the one area (primarily the kitchen).

Residents' mealtimes were staggered so residents could enjoy their meals either in smaller amicable groups or by themselves.

Staff provided key working sessions to residents to better support their understanding of safeguarding. In addition, residents were provided monthly resident meetings that included information and discussion on safeguarding and respect of each other.

There was a staff ratio of one to one, where possible, so that residents could enjoy time in the community with their staff. This supported residents take time out away from their home and to enjoy meaningful activities in their local community.

A change to staffing levels and arrangements led to better levels of continuity of care that overall promoted consistency of care and in particular, when supporting residents manage their behaviours.

In addition, the person in charge reviewed incidents logs on a quarterly basis and analysed the number and types of adverse incidents that occurred so that trends could be identified and the effectiveness of strategies and measures reviewed. The tracker also monitored actions on interim safeguarding plans that had been submitted to the national safeguarding office. This was to ensure that actions were progress and completed within the stated time lines. In addition, a new safeguarding prevention support plan was implemented for two residents with plans to implement these for all residents. The plans included a root cause analysis and ways to prevent the incident recurring.

Overall, the inspector found that for the most part, strategies in place were effective in reducing incidents occur in the residents' home. However, the risk of safeguarding incidents remained in the centre due to compatibility issues and layout of premises. As such, further action was needed by the provider to ensure residents were kept safe at all times and in a way that fully promoted their rights. These are discussed further in regulation 15 and 17.

Judgment: Substantially compliant

Regulation 9: Residents' rights

The inspector found that due to improvements in the centre since the last inspection, that many of the areas of non-compliance that were infringing on residents rights, had been addressed. For the most part, residents rights were promoted, considered and respected as much as possible. Where there were some further actions relating to premises, staffing and safeguarding, these have been addressed in detail in regulation 8, 17 and 15.

Residents right to live in a safe environment, for the most part, was being promoted. There had been a decrease of peer to peer safeguarding incident occur in the house over the past six months. Changes in staffing levels and arrangements led to a decrease in the use of agency staff, and an increase of permanents staff which better supported continuity of care for residents. This also promoted consistency in approach when managing or pre-empting potential safeguarding incidents. In addition, an number of measures had been put in place to better manage areas within the residents current living environments. While two of these measures saw a rights' restrictions in place, this was a temporary measure, which residents and their families had been consulted about. Residents were provided an easy-to-read social

story to explain the rationale of the restriction and in particular, to let residents know that it was in place to keep them safe.

Resident were provided with support plans such as safeguarding plans and positive behaviour support plans for staff to support residents manage their behaviour and have autonomy in their own self-regulation.

Residents were provided with choice and control in their lives. Residents attended monthly resident meetings where a variety of topics relation to their care and support were discussed. Residents were also supported to discuss and have an understanding of the their rights, how to keep safe and who they could speak with if they were upset.

Information was accessible for residents; Information about residents' care and support was provided to them in easy-to-read format as well as social stories and verbally. This was in line with residents assessed communication needs and supported their understanding of information about them. Residents information was securely stored which promoted their right to privacy of personal information.

Staff had completed online training in human rights, which supported their knowledge and understanding of human rights practices when providing care and support to residents. On speaking with staff they were aware and knowledgeable of practices that promoted residents rights. For example, one staff member spoke to the inspector about a resident who was determined to manage areas of their own personal care, such as undressing themselves before taking a bath. The staff member advised that all staff were mindful of this, and shared this with new or temporary staff, so that the residents was not rushed and was able to go at their own pace. The staff relayed that this was very important to the resident, for their dignity and to support their independence in this area. Overall, the example demonstrated a person-centred and human rights focus when supporting the resident.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Helensburgh OSV-0001703

Inspection ID: MON-0049177

Date of inspection: 11/05/2026

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	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: The provider implemented a new roster on the 1st June 2026 designed to better meet the assessed needs of residents. This increased the WTE. There are currently four open vacancies. Following the interview process, three candidates have progressed to offer stage. The fourth vacancy post is currently advertised. Agency staff used in the interim will continue to have a comprehensive induction to the service. Completion date 30th September 2026.	
Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: The PIC will complete compatibility assessments for each resident in preparation for any transition to new accommodation. Will be Completed by the 30 September 2026. The provider, through the Housing Committee, will continue to source and secure alternative accommodation that fully meets each resident's assessed ageing, accessibility, and safeguarding needs. Residents remain on the organisation's Referrals Committee agenda. The provider will continue to engage with residents, families, funding bodies, and relevant professionals throughout the transition process. Completed 30 December 2027. Garden furniture ordered on 21 May 2026 and expected delivery date 30 June 2026. An external Company is scheduled to complete fortnightly visits for general upkeep and maintenance to include grass cutting and weeding of the garden during the summer months and Monthly visits in the winter months for hedging maintenance. Completion date 30 June 2026. A business case was submitted to the provider's funder for a new kitchen on 15/12/2025.	

Completion date 30 Dec 2026.

The PIC will continue to ensure oversight of current restrictive practices within the Centre with reviews through the Human Rights Committee.
The PIC will continue to implement interim safeguarding and environmental management measures until all clients have transitioned to a new home.
The first session of location specific Safeguarding training is scheduled for all on the 12th of June 26. Completion date 12th June 2026

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
The Provider will ensure that the following measures are implemented:
• Continue to review and carry out safeguarding measures to further reduce peer-to-peer incidents within the service.
• Ensure that safeguarding practices consistently promote and uphold residents' rights.
• Continue regular key-working sessions and resident meetings focused on safeguarding awareness and promoting mutual respect among residents.
• Ensure that all actions identified within interim safeguarding plans are completed within agreed timelines.
• Complete the additional location specific safeguarding training run by the Clinical Director in conjunction with the PIC for the staff team of this centre and ensure implementation of safeguarding prevention support plans for all residents.
• Continue to provide staff training in positive behaviour support and de-escalation strategies.
• Ensure that all staff consistently implement proactive behaviour support strategies and communication approaches as outlined in residents' support plans.
• Continue to foster a positive culture that promotes residents' rights and proactive measures to reduce the implementation of restrictive practices where possible.
• Continue to develop staff learning and knowledge through regular team meetings that promote reflection, discussion, and shared learning to further develop the team.
• Continue to promote continuity of care for residents through consistent staffing arrangements wherever possible.
• Continue to promote all the above until de-congregation is completed.

Completion 30 December 2027.

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 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.	Substantially Compliant	Yellow	30/09/2026
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.	Substantially Compliant	Yellow	01/06/2026
Regulation 17(1)(a)	The registered provider shall ensure the premises of the designated centre	Substantially Compliant	Yellow	30/12/2027

	are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.			
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Substantially Compliant	Yellow	30/12/2026
Regulation 17(6)	The registered provider shall ensure that the designated centre adheres to best practice in achieving and promoting accessibility. He. she, regularly reviews its accessibility with reference to the statement of purpose and carries out any required alterations to the premises of the designated centre to ensure it is accessible to all.	Substantially Compliant	Yellow	30/12/2027
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Substantially Compliant	Yellow	30/12/2027