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:	Beechhaven
Name of provider:	Co Wexford Community Workshop (Enniscorthy) CLG
Address of centre:	Wexford
Type of inspection:	Unannounced
Date of inspection:	19 June 2026
Centre ID:	OSV-0002121
Fieldwork ID:	MON-0049735

About the designated centre

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

This designated centre is a large purpose built, detached bungalow set in an elevated site on the outskirts of a busy town in Co. Wexford. It has seven bedrooms for residents, five of which are en-suite, a large and small living room, large kitchen and dining room as well as well appointed bathrooms and a well maintained outdoor space. Residents can access day services if they wish either on site or in other locations, and residents are also facilitated to stay in the centre if they prefer. Residents are supported at all times by a staff team, comprising of nurses, social care workers and healthcare assistants. This centre provides full-time residential care for residents with varying degrees of intellectual disability and specific high support needs due to changing health and the process of aging.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	6

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Friday 19 June 2026	09:15hrs to 18:00hrs	Lisa Walsh	Lead

What residents told us and what inspectors observed

This was an unannounced inspection carried out to assess the provider's compliance with the regulations. It particularly focused on how the provider safeguarded residents from abuse, promoted their human rights, and empowered them to exercise choice and have control in their lives.

From residents' feedback, and what the inspector observed, it was evident that residents living in the centre were leading busy lives and engaging in activities of their choosing. Overall, the inspection found that the provider had taken a number of responsive steps to meet the identified changing needs of residents and was making efforts to bring about change to meet the needs of residents. The service was provided by a dedicated staff team who were very familiar with the resident's needs. However, improvements were required in several areas to ensure safe, quality care was provided and that all residents were protected from peer to peer safeguarding concerns. Some other improvements were also required to the governance and management systems in place and risk management arrangements in place.

For a significant period of time some residents have been experiencing difficulties sharing their home, which has resulted in peer-to-peer safeguarding concerns that have been notified to the Chief Inspector of Social Services. Since the last inspection in September 2025 there had been an increase in safeguarding concerns which had been notified. The majority of incidents related to negative verbal interactions and the corresponding impact for residents. On review of documentation and from speaking to staff there had been a change in presentation for some of the residents with an increase in responsive behaviours towards staff also. These incidents were now impacting all of the residents in the centre. Staff spoken with detailed how two residents would not come out of their bedrooms due incidents they had witnessed. Staff also spoke about another resident becoming distressed when witnessing incidents. Residents had also made multiple complaints about incidents that had occurred and how they were impacted by them.

On arrival to the centre, the inspector was greeted by the person participating in management (PPIM). The person in charge was on planned leave, and the PPIM was supporting the staff team in their absence. There were six residents residing in the centre, with one vacancy. This had been a reduction in the number of residents living in the centre since the last inspection.

One resident had already left to go to their day service themselves when the inspector arrived. The remaining residents were either getting ready for the day or up and sitting in the dining room having drinks of tea and breakfast. It was observed to be a very busy and noisy house at times. Throughout the day, the inspector met with all the residents. For the residents who could not verbally

communicate their views on living in the centre, the inspector spent time observing their daily lives and staff interactions.

When the inspector arrived, they sat with the residents at the dining room table. Some of the residents chatted with them while they were waiting for transport to arrive to take them to their day services. They spoke about their plans for the day, one resident was going to the beauticians, and another said they would go for a walk. Residents spoken with said they liked living in Beachhaven, with one saying they 'loved living there'. However, the same resident also said they do not get along with another resident who lives in the centre. The PPIM went to sit at the dining room table to join the conversation, and a resident told them they could not sit in the chosen seat as it belonged to another resident who would be upset if they found out that they sat there.

While residents were getting ready to leave it was very busy and one resident became anxious. Staff asked everyone in the dining room to leave so they could support the resident to continue to get ready for their day service, which they did once they were in a quieter environment and left shortly after.

Another resident remained in the hall area until some of the residents left for their day service. Staff said they preferred when there were less people. The resident chatted to the inspector and was excitedly talking about their plans for the day and weekend. They spoke about enjoying their independence and liked living in the centre. They showed the inspector their bedroom and some items of significance to them and left for their day service shortly after.

A second resident showed the inspector their bedroom before heading to their day service. They chatted about their rights and how every resident has rights. They also spoke about making a complaint and said they had done this with the support of staff. The resident talked about learning how to budget and took the inspector to meet the dog that lived in the centre too.

Once all the residents had left for day service, the inspector completed a walk around of the centre with the PPIM. The centre comprised of a large, detached bungalow located in Co. Wexford. The premises were well-maintained and had a homely atmosphere. Communal space consisted of a dining room, large kitchen which opened out onto a garden patio area, a large sitting room and a smaller snug room. The snug was used by one resident in particular who liked to listen to classical music and played the keyboard there.

Each resident had their own bedroom, one of which had been fitted with a tracking hoist which ran between both the bedroom and the en-suite. Residents had televisions in their bedrooms and those who showed the inspector around their bedroom said they were happy with their bedrooms and had decorated it themselves.

There were a small number of restrictive practices in place throughout the centre such as a locked front door and gates. These were in place due to identified risks and supporting risk management documentation evidenced rationale for their use. Residents had free access around their home, meaning there were no restrictive

practices like internal locked doors that would prevent them accessing areas of their home.

There had been a reduction in the number of residents living in the centre since the last inspection in September 2025. This had positively impacted the residents living in the centre. There were now sufficient staff supports available to ensure that residents could chose the activities they wanted to do on a particular day.

Residents were supported to keep in contact with family members and some of them went to stay with family overnight. One resident had recently begun travelling to visit their family independently on the bus or train and said they really enjoyed this. Staff spoke about how they supported the resident to work towards achieving this goal and it was evident that they were familiar with their needs.

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

Capacity and capability

Overall, the inspector found that there was a clearly defined management structure in the centre. While there were some good practices identified, the inspector found that some improvements were required to ensure all aspects of the service met residents needs and were in line with the regulations. For example, improvements were required in relation to protection, risk management, positive behavioural support, staffing, and training and development.

There were clear lines of authority and accountability in this service. The centre had a clearly defined management structure in place which was led by a person in charge. They were supported in their role by an experienced clinical nurse manager 3 (CNM 3) who was a person participating in management (PPIM). While the person in charge was on planned leave during the inspection, the PPIM was present in the centre to ensure staff were supported and management oversight was in place.

There was a person in charge employed in a full-time capacity, who had the necessary experience and qualifications to effectively manage the service. They had oversight of three centres and divided their time between them. They also had a team leader in the centre to support them in their role. The person in charge regularly met with staff to ensure that any issues were raised and responded to effectively.

Regulation 15: Staffing

Since the last inspection in September 2025 the number of residents living in the centre had reduced from seven to six. This reduction in the number of residents ensured that there were sufficient numbers of staff to meet the number and changing needs of the residents in the centre. The number of staff on duty each weekend had increased from three to four, which had allowed for residents to engage in meaningful activities outside of their home if they wished.

From a review of records and speaking with staff, those who were on sleepover shift were no longer being regularly woken to support residents with their care needs during the night.

From a review of rosters for April and May 2026, it was evident that the provider was trying to ensure continuity of care for residents. There was one social care worker vacancy on the day of inspection. The required number of staff was in place each day, however there remained a significant number of relief staff in use within the centre. For the period reviewed, 109 shifts were covered by relief staff and six shifts covered by agency staff. The provider had tried to ensure that regular relief staff were used where possible. However, given the number of peer-to-peer safeguarding concerns within the centre a more consistent staff team was required to ensure continuity of care.

Judgment: Substantially compliant

Regulation 16: Training and staff development

The oversight systems in place for staff training, required review. On the day of inspection, the inspector was unable to review staff training records as management and staff present were unable to access these. These were submitted the following working date for the inspector to review.

Staff were provided with a range of training as part of their professional development and to support them in the delivery of appropriate safe care and support to the residents living in the designated centre.

On review of the training records, the inspector saw that most of the staff training was up-to-date. However, two staff had not completed patient handling training, with a resident who required this support. This was scheduled to be completed in September 2026. One staff also had not completed safeguarding training, and no date was scheduled for when this would be completed.

Other relevant training like fire safety, emergency first aid, safety interventions and children's first had been completed by all staff.

There were effective arrangements for the support and supervision of staff. The person in charge provided formal supervision meetings, which were scheduled in line with the provider's policy.

Staff spoken with said that they would have no concern raising any issue they might have about the safety and welfare of the residents with the person in charge.

Judgment: Substantially compliant

Regulation 23: Governance and management

While the registered provider had implemented management systems to monitor the quality and safety of service provided to residents, this was not always effective. Compatibility and safeguarding concerns had been identified for the residents, but the systems had not identified that safeguarding plans were not in place to support the residents on a day-to-day basis while these safeguarding concerns remained. There were a significant number of peer-to-peer safeguarding concerns which had been increasing since the previous inspection in September 2025. These were ongoing and continued to impact the residents at the time of inspection.

Good record-keeping is a fundamental part of good practice and an integral part of safe and effective care and support. On the day of inspection, there were several documents which the inspector was unable to review as the management, and staff present did not have access to these. For example, staff training records and the person in charge monthly reports. In addition, the registered provider had implemented a new online record management system. This impacted the availability of records on the day of inspection and led to delays in accessing some records.

The inspector had requested a copy of the six-monthly unannounced visits to the centre and the annual review of the quality and safety of care for the previous year; however, these were not available on the day of inspection for review. The inspector was informed that the annual review was completed but not signed off by the provider. It reported on the previous year from January 2025 to January 2026. This was submitted to the inspector the following working day. On review, it contained limited information to evidence compliance, to highlight areas of good practice or areas in which opportunities for improvements were identified.

A six-monthly unannounced report was also submitted to the inspector the following working day. However, this was completed in July 2025 and there was no evidence provided that a more recent six-monthly unannounced visit had been completed. Without this audit being completed, the inspector was not assured that the provider was fully aware of the safety and quality of care and support being provided in the centre. It also meant that in the absence of this report there had been no plans in place to address any concerns in the centre.

Judgment: Not compliant

Quality and safety

Residents care and support was provided by a consistent staff team who were familiar with their needs and were striving to provide person-centred care to the residents in this centre. This meant that residents were able to express their views, were supported to make decisions about their care and that the staff team listened to these views. However, improvements were required in safeguarding residents, risk management and positive behavioural support.

Residents were leading busy and active lives and doing activities of their choosing at times which suited them. Resident's rights were recognised and promoted, and they were supported to engage in shared decision-making about their care and support.

Safeguarding concerns were being identified, reported to the relevant authorities and some measures were being put in place to try managed these concerns. However, these peer-to-peer safeguarding concerns remained and were continuing to impact residents.

The inspector saw that systems were in place to manage risks associated with the quality of care and the safety of the residents. However, the systems were not always effective and required a review.

Regulation 10: Communication

The residents living in the centre presented with a variety of communication support needs. Residents' communication needs were outlined in their personal plans. Staff were familiar with their communication requirements, and this was observed by the inspector on the day of inspection.

Overall, the inspector found that the person in charge was ensuring that residents received information in a way that they understood. Information was provided to residents verbally and through easy-to-read format, pictures, photographs and social stories.

Residents were supported to understand information provided to them and supported to communicate their choices and decisions about their care and their lives. Staff also had regular meetings called key worker meetings, with the residents where they could communicate, discuss and address any issues they may have in the centre.

The inspector observed a number of interactions between staff and residents on the day of inspection, and these were found to be respectful, familiar and in line with the resident's communication needs.

Residents also had access to television, radio, and Internet in their home.

Judgment: Compliant

Regulation 17: Premises

The premises were laid out to meet the assessed needs of the residents and were kept in a good state of repair, to ensure a comfortable and safe living environment for the residents.

Each resident had their own bedroom with televisions in them. These were decorated to their individual style and preference. Their rooms provided a safe and private space for them to relax in and spend some time by themselves, when they so wished. For one resident who required the use of a hoist, their bedroom and en-suite had been adapted to ensure that the necessary equipment was in place to meet their needs.

There was also adequate communal space available to the residents in the centre, which was important for their overall well-being.

The garden areas to the front and rear of the property were well maintained. The front garden led out onto a busy road and had a secure gate to ensure the safety of residents. The back garden had a patio area with garden furniture for residents to relax in whenever they wished.

Judgment: Compliant

Regulation 26: Risk management procedures

The inspector reviewed the centre’s risk management policy and found that the provider had ensured that it met the requirements as set out in the regulations and included information pertaining to safeguarding.

There was a risk register in place which was maintained by the person in charge. Risk management documentation and assessments required review. There appeared to be two different systems in operation, some risk assessments were handwritten, and others were on an electronic system. The handwritten risk assessments were difficult to read and at times differed from the risk assessments on the electronic

system with different risk scores. In some cases, it was also difficult to locate the residents' individual risk assessments.

The inspector also found that risk ratings were not reflective of the level of risk identified on inspection. For example, a risk assessment in place for one resident following safeguarding concerns was scored as one, this was not reflective of the actual risk. Some risk ratings were also not revised following the implementation of control measures and some risk assessments were also not reviewed regularly or as required. This meant that it was not clearly documented whether the risk had been reduced or mitigated following the implementation of control measures and whether these were effective.

While each resident had several individual risk assessment management plans in place, not all risks were identified. This meant that for some risks there was no mitigating actions in place to reduce the risk. For example, there was no risk assessment in place to manage ongoing risk of peer-to-peer safeguarding concerns and compatibility issues found on inspection for all residents who were impacted.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

The inspector reviewed a sample of residents' personal plans. The person in charge had ensured that a comprehensive assessment of each resident's health, personal, and social care needs had been carried out. This also included assessing the safeguarding needs of the resident. On review of the assessments the inspector found that these were reviewed on an annual basis or more frequently if required.

The inspector found that personal plans were developed and reviewed in consultation with the residents and where required, included multidisciplinary professional input. The plan was informed by the assessments and reflected the support required to meet residents' needs. On review of the sample of resident's plans the inspector found that they were up-to-date and readily available to guide staff in the appropriate delivery of care and support interventions.

Residents were provided with an assessable format of their personal plan that included easy-to-read information and photographs about their goals and the progress of their goals. This meant that residents were provided with a plan that they understood and that was in a communication format that was of preference to them.

Judgment: Compliant

Regulation 7: Positive behavioural support

Some residents presented with responsive behaviours in the centre. Two residents had positive behaviour support plans in place; however they had not been reviewed in a year. For another resident whose changing needs meant that they required a positive behaviour support plan, there was no plan in place. The inspector was informed that the provider has not had access to positive behaviour support therapy and was seeking this input. Referrals had been made for the resident with no support plan in place and for the other residents to have their plans reviewed.

There were minimal restrictive practices in use in the centre. Each resident had a risk management plan in place which outlined clear rationale for the use of any restrictive practices. A restrictive practice log was maintained to record any use of a restrictive practice. All restrictive practices were reviewed regularly.

Judgment: Substantially compliant

Regulation 8: Protection

While the registered provider had measures in place to protect residents from abuse, the inspector found that there had been a significant number of allegations of peer-to-peer abuse between some residents, which was impacting all residents in the centre.

The inspector found that allegations between residents and negative interactions had been increasing since the previous inspection in September 2025, with an increased number of notifications received by the Chief Inspector. There had been no compatibility assessments completed for any of the residents prior to admission and none completed since the increase in negative peer-to-peer interactions.

On arrival to the centre the inspector met with a resident who clearly stated they did not like one of the other residents in the house. Other residents were observed to not enter a room while some other residents were present in the room. Staff also communicated compatibility issues and noted two of the residents would not leave their bedroom on occasions due to another resident. Staff also noted residents are fearful to sit on specific seats in the centre as they said this may upset a resident who will respond negatively. The inspector also observed the PPIM going to sit in this seat and a resident became visibly anxious repeatedly telling them they could not sit there as it was another resident's seat. Several residents had also made complaints about the impact of living with their peers was having on them.

While there were safeguarding plans put in place to manage a specific incident that had occurred, there were no safeguarding plans in place to manage the ongoing concerns of compatibility and safeguarding concerns between residents. This meant residents were at risk of experiencing further peer-to-peer safeguarding incidents without mitigating actions in place. One resident had a safeguarding plan in place;

however it had not been reviewed since October 2025 and some information in it was outdated.

The provider had escalated their concerns and appropriate representatives were informed. The inspector was informed that a meeting was scheduled to discuss the safeguarding concerns in the centre.

Judgment: Not compliant

Regulation 9: Residents' rights

Notwithstanding, the ongoing safeguarding concerns in the centre, which could negatively impact on the residents in the centre, the inspector found examples of residents' rights being respected. Care and support provided appeared to be led by the residents and the residents were supported to exercise their choice on a daily basis. This was seen in examples reviewed of the residents' daily records and meal options where choice and control were offered to them. For one resident, they had been supported to travel independently and said they enjoyed taking both the bus and the train.

Residents were supported to make complaints and observed to use this system. Residents were informed about independent advocacy services and supported to access these services when they wished.

Residents attended weekly residents' meetings where they had the opportunity to make decisions about things they would like to do for the week ahead. This included planning activities or what meals they wanted to have, and residents were informed about updates in relation to the centre. Topics such as advocacy, safeguarding, complaints were also discussed to given residents an opportunity to raise any concerns. There was also a residents' forum which met monthly to discuss topics like human-rights and advocacy and allowed residents to raise issues they wanted discussed.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Beechhaven OSV-0002121

Inspection ID: MON-0049735

Date of inspection: 19/06/2026

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:
Since the previous inspection, the Person in Charge, PPIM and Provider have implemented measures to strengthen staffing arrangements within the centre. Staffing levels were increased from three to four staff on duty seven days a week, ensuring that there are sufficient staff available to meet the residents' assessed, safeguarding concerns and changing needs. This has supported improved resident outcomes, including increased opportunities for meaningful community participation and enhanced continuity of care.
At the time of inspection, there remained one whole-time equivalent (WTE) vacancy and one maternity leave position, they are currently being covered by consistent core staff who are rostered on a month-to-month basis till January 2027. Ongoing recruitment efforts for the vacant line have been undertaken to fill this position; however, despite continued advertising and recruitment campaigns, the vacancy has not yet been successfully filled. To maintain safe staffing levels and continuity of care, the Team Leader has arranged for regular core staff member to be block-booked into these lines. During this time for April and May 2026 we had a total of 364 shifts in those two months average of 6 shifts a day,94% (343 shifts) by the same 17 trained core staff.
• These staff members have completed the required mandatory training, are familiar with the residents' support needs, routines, and safeguarding plans, and provide continuity within the staff team.
• The Provider and Human Resources Department will continue to actively recruit for the vacant position through ongoing advertising and recruitment initiatives, with the aim of establishing a fully permanent and consistent staffing team within the Centre.

Regulation 16: Training and staff development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
The registered provider has established systems to ensure staff receive the training required to meet the assessed needs of residents and to support the delivery of safe, effective, and person-centred care.
A designated member of the administration team is responsible for the oversight and coordination of all mandatory and refresher training. This includes maintaining a comprehensive training matrix, booking staff onto required training programmes, issuing advance notification of upcoming training, and sending reminder emails prior to scheduled training dates. The same process is in place for all HSE Land training requirements. The PIC, PPIM and team leaders have access to the training matrix.
Where a staff member is unable to attend scheduled training, alternative arrangements are made and the staff member is rebooked on the next available course to ensure compliance is maintained. Team Leaders and the HR department also actively monitor training compliance and provide reminders to staff regarding upcoming training requirements.
An annual training schedule is developed and circulated to all staff at the beginning of each year. This schedule outlines mandatory training, refresher training, and in-service training days to support continuous professional development and ensure staff maintain the knowledge and skills required to meet residents' needs.
In relation to the specific findings of this inspection:
• The two staff members identified as requiring Patient Handling refresher training have now been completed on the 04.08.2026.
• The staff member requiring Safeguarding HSE land Training has completed the safeguarding programme on the 05.08.2026.
• The PIC, PPIM and team leaders have access to the training matrix for staff in their own areas on soft works and there is a detailed manual on how to access this.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The registered provider acknowledges the findings of the inspection and remains committed to ensuring the delivery of a safe, high-quality, person-centred service. While the inspection identified areas requiring improvement in governance systems, it is important to note that the provider, Person in Charge, and Person Participating in Management have maintained oversight of safeguarding concerns and have consistently

escalated all safeguarding incidents to the appropriate authorities and notified HIQA within the required timeframes.
Since 2025, the provider has actively engaged with the relevant external stakeholders, advocacy services, residents, families, and multidisciplinary teams through regular meetings to address compatibility concerns and enhance the overall quality and safety of the service. The provider has consistently sought external support and guidance to ensure residents' rights, safety, and welfare are upheld.
Recognising the ongoing challenges associated with compatibility concerns, residents were offered alternative accommodation within the organisation during 2025. The residents declined these options following discussions and review meetings. The provider has continued to review options with residents and relevant stakeholders while respecting residents' wishes and rights regarding where they choose to live.
The provider engaged on two occasions in 2025 and 2026 with two external Behaviour Support Specialists to review residents' needs, support staff practice, and make recommendations to improve quality of life outcomes. A resident declined to engage in the behavioural support process during 2025; however, the provider continued to offer opportunities for engagement and support. Since the inspection, an external Behaviour Specialist has reviewed Positive Behaviour Support Plans that were overdue for review, and additional Positive Behaviour Support Plans have now been developed for residents identified as requiring them as identified by the inspector.
The provider, PIC, and PPIM have also engaged extensively with relevant stakeholders, including residents, families, advocates, multidisciplinary team members, and disability service personnel to explore alternative supports and service options. Additional respite opportunities outside of the organisation were offered however, these offers were declined. The provider has continued to advocate on behalf of all residents and has submitted multiple business cases seeking additional resources and supports to address changing needs and improve compatibility outcomes. The service did seek a compatibility assessment over the years and had a challenge to find a document re same. Any new admissions would have a comprehensive pre-admission assessment and compatibility would be considered.
The service has also sought guidance from the Assisted Decision-Making (Capacity) framework and the organisation’s Human Rights Committee. Human rights focused training and guidance were provided to staff during 2025 and 2026 to support rights-based decision making and promote positive outcomes for residents.
To further address compatibility concerns, a comprehensive compatibility assessment process has commenced and is currently being completed by the external Behaviour Specialist in consultation with residents, families, staff, advocates, and multidisciplinary professionals. The outcomes of these assessments will inform future safeguarding strategies and service planning.
Additional staffing resources remain in place to provide increased opportunities for residents to access individualised activities, community participation, and one-to-one support away from situations that may negatively impact on their well-being. Since a resident vacancy arose within the centre in April 2026, the provider has made the decision not to fill this placement until there is clear evidence of a sustained reduction in safeguarding incidents and improved compatibility among residents.
The provider acknowledges the findings relating to governance documentation and record accessibility during the inspection. Measures have now been implemented to ensure key governance records, including six-monthly unannounced visits, annual reviews, monthly PIC reports, and staff training records, are readily accessible at all

times and all staff have access to these documents.
The provider has completed an internal updated six-monthly unannounced visit process, and will strengthen the annual review to ensure it evidences compliance, identifies areas for improvement, and includes clear quality improvement actions. Governance systems will be reviewed quarterly by the PIC, PPIM, and senior management team to ensure ongoing oversight of safeguarding, compatibility, risk management, staffing, quality assurance, and residents' outcomes.
The provider remains concerned that the availability of suitable alternative disability residential placements within County Wexford continues to be limited. Despite these challenges, the provider will continue to work collaboratively with all relevant stakeholders to identify appropriate solutions that uphold residents' rights, dignity, safety, and quality of life.
The six-monthly unannounced reports completed by the PPIM for 2025 were available within the designated centre and were maintained with the PIC and team leader audit reports. The most recent 2026 PPIM six-monthly audit had been completed and was held within the main service administration office. It was intended that this document, would be forwarded to the inspector on the first working day following the inspection. Unfortunately, due to an administrative error, the July 2025 six-monthly unannounced report was submitted to the inspector instead of the completed 2026 report. As a result, the inspector was not provided with the most up-to-date evidence of provider oversight and quality monitoring activities within the centre. In the future, the Annual Review and six-monthly provider reports will contain significantly more detailed analysis than is reflected in our current report. These documents identify the current safeguarding and compatibility concerns within the centre, outline the impact of these concerns on residents, and clearly document the actions implemented and planned by the provider to mitigate risks and improve outcomes for residents.
Actions to Achieve Compliance:
• Compatibility assessments for all six residents will be completed by the external Behaviour Specialist, with recommendations implemented and reviewed through the multidisciplinary process.
• All safeguarding plans that are in place will be reviewed and updated to ensure they clearly outline day-to-day control measures and support arrangements for residents impacted by safeguarding concerns and new plans implemented.
• Positive Behaviour Support Plans will be maintained and reviewed in line with residents' assessed needs and reviewed yearly by the behaviour therapist.
• Governance audits, six-monthly unannounced visits, annual reviews, and monthly oversight reports will be completed within required timeframes and made readily accessible.
• The current resident vacancy within the centre will remain unfilled pending review of safeguarding outcomes and compatibility assessments.
• The provider will continue engagement with the safeguarding services, multidisciplinary professionals, families, and residents to identify and implement sustainable long-term solutions.

Regulation 26: Risk management procedures	Not Compliant

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

The Person in Charge and provider acknowledge the number of elements to the risk management procedure. The provider will ensure that systems are in place for the assessment, management, ongoing review and oversight of risks within the designated centre. Risks are written and scored in the risk assessment book and a copy is kept in the risk register folder, all risks are logged on an excel sheet on Microsoft teams and all staff will have read only access. There was a risk assessment completed on the impact of peer-on-peer verbal abuse.

The service maintains a central Risk Assessment Register where all original risk assessments are recorded. Each risk is assessed using the HSE risk matrix to ensure consistent scoring and evaluation of risk levels. All risk assessments are reviewed and signed by the staff member completing the assessment and subsequently approved by the Team Leader, Manager and/or Person in Charge

• A comprehensive review of all existing risk assessments and risk management documentation will be completed, and training will be provided for all staff. There was a risk assessment completed for all residents re the impact of the peer-on-peer abuse.

• Risk scores will be amended accordingly to reflect the effectiveness of control measures and any reduction or escalation in risk.

• The original white sheet of the risk assessment will be stored in the designated centre.

• Specific risk assessments and corresponding control measures will be developed to address ongoing peer-to-peer safeguarding and compatibility concerns within the centre. These assessments will identify risks to residents, outline clear mitigating actions and support staff in managing identified concerns in a consistent manner.

• To further strengthen practice, the provider is exploring additional risk management training from the HSE for staff and management to enhance knowledge and ensure a consistent approach to risk identification, assessment and review.

The provider maintains oversight of risk management through regular Management Meetings and weekly updates from the Manager of Day Residential Services who is the PPIM. The red-rated risks as per the excel spreadsheet are reported to the Board of Directors under the Risk & Quality Agenda item at the Monthly Board Meetings. In addition, significant risks and safeguarding concerns are discussed as part of the quarterly Service Level Agreement (SLA) meetings with the relevant external stakeholders to ensure appropriate external oversight and monitoring.

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
The provider has ensured that positive behavioural support (PBS) arrangements are in place for residents who require them. At the time of inspection, two residents had PBS plans in place; however, these had not been reviewed within the required timeframe. This occurred because the external Behaviour Therapist engaged by the service reviewed and signed off PBS plans on a six-monthly schedule rather than the annual review cycle required by the service.
To address this, the provider sourced a new external Behaviour Therapist. Prior to the inspection, the existing PBS plans had already been forwarded to the newly appointed therapist for review. The revised PBS plans for the residents identified during the inspection have since been completed and submitted to the external Behaviour Therapist for final review and sign-off. The service is currently awaiting their return.
In addition, a PBS plan has now been developed for the residents identified during the inspection as requiring a positive behavioural support plan. This plan has also been forwarded to the external Behaviour Therapist for review and sign-off.
The provider has implemented a system to ensure all PBS plans are reviewed annually, or sooner where there is a change in presentation, support needs, or following behavioural incidents that indicate a review is required. The Person in Charge and team leaders will monitor review dates through the centre's governance and oversight systems to ensure plans remain current, reflective of residents' needs, and are effectively guiding staff practice. Two of these staff are also trained Mapa instructors and provide support to staff. There are five internal trained staff in 'Meeting the challenge of challenging behaviour' level 8 and they will oversee the internal behaviour plans and support staff when completing them for review.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
Since 2025, the provider has actively engaged with the relevant external stakeholders, advocacy services, residents, families, and multidisciplinary teams through regular meetings to address the ongoing safeguarding and compatibility concerns within the centre. Concerns have been escalated appropriately, and the provider has consistently sought external guidance and support from behaviour therapist and human rights and restrictive practice trainer to ensure that resident's rights, safety and welfare are protected.
The provider recognises that peer-to-peer of verbal safeguarding incidents and compatibility concerns have had a significant impact on residents' quality of life. In

response, safeguarding concerns have remained under ongoing review with relevant stakeholders, and measures have been implemented to minimise risks and support residents. Safeguarding plans are being reviewed and updated to ensure they accurately reflect residents' current needs, identified risks and agreed control measures. A schedule of regular reviews has been implemented to ensure plans remain current and effective.
Recognising the ongoing compatibility challenges within the centre, residents involved were offered alternative accommodation options during 2025 and 2026. Following consultation and review meetings, the residents chose to remain living in the centre. The provider continues to work collaboratively with residents, families, advocates and multidisciplinary teams to identify and explore suitable options while respecting residents' rights and preferences regarding where they choose to live.
To further address these concerns, the provider engaged external Behaviour Support Specialists to review residents' support needs, provide guidance to staff and make recommendations aimed at improving residents' quality of life and reducing safeguarding risks. Positive Behaviour Support Plans have been reviewed and updated where required, and additional plans have been developed for residents identified as requiring enhanced behavioural support.
A centre-wide compatibility assessment process is currently underway for all residents within the designated centre and is being completed by an external Behaviour Support Specialist in consultation with residents, families, staff, advocates and relevant multidisciplinary professionals. The provider is awaiting the outcome and recommendations of these assessments in the coming months. On receipt of the findings, the provider will implement and monitor all appropriate actions and recommendations to strengthen safeguarding arrangements, improve resident compatibility, reduce the impact of peer-to-peer incidents and ensure residents can live in a safe, supportive and person-centred environment.
Additional staffing resources continue to be maintained within the centre, providing increased opportunities for one-to-one supports, community participation and individualised activities. These residential supports allow residents greater choice and opportunities to spend time away from situations that may negatively impact their wellbeing. Furthermore, since a resident vacancy arose within the centre in April 2026, the provider has made the decision not to fill this placement until there is evidence of a sustained reduction in safeguarding incidents and improved compatibility outcomes for existing residents.
The provider remains committed to ongoing engagement with all relevant stakeholders and will continue to review safeguarding arrangements, compatibility outcomes and support requirements to ensure that residents are protected from abuse and supported to achieve the best possible quality of life within the centre.

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(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	19/12/2026
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.	Substantially Compliant	Yellow	06/08/2026
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the	Not Compliant	Orange	30/09/2026

	service provided is safe, appropriate to residents' needs, consistent and effectively monitored.			
Regulation 23(1)(d)	The registered provider shall ensure that there is an annual review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards.	Substantially Compliant	Yellow	22/06/2026
Regulation 23(1)(f)	The registered provider shall ensure that a copy of the review referred to in subparagraph (d) is made available to residents and, if requested, to the chief inspector.	Substantially Compliant	Yellow	22/06/2026
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place	Not Compliant	Orange	22/06/2026

	to address any concerns regarding the standard of care and support.			
Regulation 23(2)(b)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall maintain a copy of the report made under subparagraph (a) and make it available on request to residents and their representatives and the chief inspector.	Substantially Compliant	Yellow	22/06/2026
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Not Compliant	Orange	30/09/2026
Regulation 07(3)	The registered provider shall ensure that where required, therapeutic interventions are	Substantially Compliant	Yellow	30/09/2026

	implemented with the informed consent of each resident, or his or her representative, and are reviewed as part of the personal planning process.			
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	30/09/2026