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:	Sonas Bungalows - Sonas Residential Service
Name of provider:	Avista CLG
Address of centre:	Dublin 15
Type of inspection:	Announced
Date of inspection:	17 June 2026
Centre ID:	OSV-0003738
Fieldwork ID:	MON-0041348

About the designated centre

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

In Sonas bungalows, residential care and support is provided on a 24 hour basis for up to 18 residents over the age of 18 with an intellectual disability. The designated centre consists of three purpose built bungalows on a campus in an outer suburb of Dublin. Two of the house have six single bedrooms, and one of the houses has five single bedrooms, and a self-contained one bedroom apartment. Each of the houses has suitable private and communal space to meet the needs of up to six residents. Residents are supported by a person in charge, clinical nurse managers, healthcare staff, and household staff. Residents have the option to attend day activity sessions on the campus, or they are supported to partake in meaningful home or community based activities in line with their wishes.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	18

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
Wednesday 17 June 2026	09:00hrs to 17:00hrs	Kieran McCullagh	Lead
Wednesday 17 June 2026	09:00hrs to 17:00hrs	Brendan Kelly	Support

What residents told us and what inspectors observed

This announced inspection was conducted to assess the registered provider's compliance with regulations, and to inform the decision regarding the renewal of the designated centre's registration. This inspection determined that while in the main good practice was observed and residents enjoyed a good quality of life, improvements were necessary pertaining to a number of regulations including staffing, governance and management, food and nutrition, positive behavioural support, fire precautions, and medicines and pharmaceutical services.

The inspection was conducted over a single day by two inspectors. Inspectors informed their judgments through observations, conversations with residents, management, and staff, and a review of documentation about how care and support was provided to residents, and documentation which reflected actions taken since the previous inspection, completed 17 September 2025.

On arrival to the designated centre, the inspectors were greeted by the person in charge. The inspectors signed into the designated centre's visitors' book and had a discussion with the person in charge about the designated centre. The designated centre was located on a congregated mixed-use campus setting with five other bungalows, and an overall capacity of 72 residents. This designated centre was comprised of three purpose-built bungalows, which were located in close proximity of each other on the campus, and was registered for 18 adult residents. On the day of this inspection there were no resident vacancies in the designated centre. The designated centre provided services for adults with an intellectual disability with complex health and social care needs.

Two bungalows were comprised of six individual resident bedrooms, while the third bungalow was comprised of five individual bedrooms and one apartment. There were six residents living in each home that made up the designated centre. During the walk around of the first house, inspectors were introduced to staff members on duty, along with some residents who were up and ready for the day ahead or being supported to get ready for the day ahead. In the morning of the inspection some residents were supported to relax in bed longer as they had requested. Inspectors observed some residents relaxing in the sitting room watching television and listening to music. Residents were supported to engage with inspectors, and inspectors noted that residents living here appeared very happy, relaxed and content in the presence of the staff.

The inspectors visited the second house and met with all residents living there. One resident invited inspectors in to see their bedroom, which had been decorated to their own personal style and preference. The resident showed inspectors a book of photographs showcasing the resident's trip to a farm. The resident had a keen interest in animals and had recently set a goal of visiting a farm. They had been supported by their key worker to achieve this goal in recent weeks and were proud

to show inspectors photographs of their recent trip. Other residents met with were observed taking part in activities they enjoyed including knitting and arts and crafts.

Inspectors also visited the third house and met with residents living there. One resident was out for the day on a planned activity and other residents were being supported with their meals or relaxing. The staff discussed with the inspectors the residents' plans for the day ahead and the support needs of each of the residents. Staff were found to very knowledgeable of each resident's needs and were observed to be attentive and responsive to resident's requests.

All three houses were warm, homely and clean throughout. Each resident had their own bedroom, which were decorated with their own personal belongings and soft furnishings. Residents had access to a kitchen, a dining room, a living room, and a sun room in each house. The overall interior decor and furnishings were tasteful and well maintained, contributing to a warm and inviting environment.

Care and support to residents was provided by a team of nursing staff and healthcare assistants. At the time of this inspection, the designated centre had a number of staff vacancies. Although the registered provider was endeavouring to back fill vacant shifts, it was found that there was an over reliance on agency and relief staff to cover vacant shifts, which was having a negative impact on residents.

In advance of the inspection, residents had been sent Health Information and Quality Authority (HIQA) surveys. These surveys sought information and feedback about what it was like to live in this designated centre. Completed surveys were reviewed by one inspector following the inspection. The feedback in general was very positive, and indicated satisfaction with the service provided to them in the centre, including activities, food and choices and decisions.

Throughout the duration of this inspection, inspectors observed residents to be relaxed and comfortable in their homes, staff engaged with them in a very kind and friendly manner, and it was clear that they had a good working relationship. The staff team were attentive to residents' needs and responded quickly and professionally to residents' requests and support needs. At the time of this inspection there were no open complaints and residents spoken with informed inspectors they did not wish to change anything about their home.

The person in charge emphasised the high standard of care provided to all residents, expressing no concerns regarding their wellbeing. Staff spoke with inspectors regarding the residents' assessed needs and described training that they had received to be able to support such needs, including safeguarding, and feeding eating drinking and swallowing. Inspectors found that staff members on duty were very knowledgeable of residents’ needs and the supports in place to meet those needs. Staff were aware of residents' likes and dislikes and told the inspectors they enjoyed working in the designated centre.

The next two sections of the report present the findings of this inspection in relation to the governance and management arrangements in place in the designated

centre, and how these arrangements impacted on the quality and safety of the service being delivered to each resident.

Capacity and capability

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. Overall, it was determined that the registered provider had failed to ensure that management systems in place in the designated centre were effective in providing a service that was consistent and effectively monitored at all times.

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

The staff team were in receipt of regular support and supervision. They also had access to regular refresher training and there was a high level of compliance with mandatory training. Staff had received additional training in order to meet residents' assessed needs. Inspectors spoke with a number of staff over the course of this inspection and found that staff were well-informed regarding residents' individual needs and preferences in respect of their care.

The registered provider ensured that the directory of residents was readily available in the designated centre, in full compliance with regulatory requirements. It contained accurate and up-to-date information for each resident.

Inspectors found that a number of improvements were required to the governance and management systems in place at the time of this inspection. Specifically, the key issues identified related to staffing resources, and the effectiveness of the registered provider's auditing and oversight systems and arrangements. Overall, the registered provider was not ensuring the designated centre was resourced or monitored in a way that ensured effective delivery of care and support to residents at all times.

The registered provider had developed a comprehensive written statement of purpose which included all the information required under Schedule 1.

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

Registration Regulation 5: Application for registration or renewal of registration

The registered provider had submitted a complete application to the Chief Inspector of Social Services, requesting the renewal of the designated centre's registration.

One inspector reviewed the application prior to this inspection. All required information and documentation specified in Schedule 2, and Schedule 3 were included in the application.

Additionally, the registered provider ensured that the fee for renewing the registration of the designated centre, as outlined in Section 48 of the Health Act 2007 (as amended), was paid in full.

Judgment: Compliant

Regulation 15: Staffing

The registered provider did not at all times have the appropriate skill-mix or number of staff on duty. This meant that the registered provider could not provide continuity of care to residents living in the designated centre.

The person in charge told inspectors that the designated centre currently had 3.5 whole time equivalent (WTE) vacancies across clinical nurse manager, staff nurse, and healthcare assistant grades. The person in charge also told inspectors that the registered provider had been successful in recruiting staff for each of the vacancies. However, at the time of inspection there was no confirmed start date for any of the new recruits.

The registered provider had ensured that planned and actual rosters were held in the centre. The person in charge maintained the rosters as part of their oversight responsibilities. On the day of this inspection one inspector reviewed the rosters from the months of April and May 2026. In reviewing the rosters the inspector observed the following:

- The designated centre was staffed by a team of staff nurses and healthcare assistants
- Day shift patterns in the designated centre were a mix of 07:45-20:15, 08:00-20:00, 08:00-18:00, and 20:00-23:00
- Night duty shift patterns were 20:00-08:00.

The rosters evidenced that the registered provider had a reliance on agency and relief staff in each of the locations that made up the designated centre to backfill vacant shifts. In the two months of rosters reviewed by the inspector, it was observed that agency and relief staff were used each week. The inspector observed that the registered provider had rostered two nurses for waking night duties. In each of the weeks reviewed one of these nurses was always an agency or relief nurse. Furthermore, the inspector also observed that the registered provider had used multiple different staff to cover these shifts, which did not provide continuity of care for residents.

The registered provider had a system in place where agency and relief staff signed a sheet attached to the roster. One section to be completed was to identify if the staff were agency or relief, and in the case of agency staff, what agency they were associated with. While the staff signed in each shift, they were not always identifying if they were agency or relief. This meant that the registered provider nor the inspectors could identify exact numbers of agency or relief staff used to backfill vacant shifts. However, the inspector did note that a total of 182 shifts across April and May 2026 were covered by either agency or relief staff.

In addition, the inspector observed that the registered provider could not always fulfill the staffing arrangements as documented in the designated centre's statement of purpose or as informed by centre management on the morning of the inspection. For example, the staffing arrangements each day should have been three staff nurses with one nurse in each house. However, on review of the rosters the inspector noted that there was no week across April and May 2026 when three nurses were on duty each day. This required comprehensive review and consideration by the registered provider and the person in charge.

Judgment: Not compliant

Regulation 16: Training and staff development

Staff had received appropriate training and education, ensuring they had the necessary knowledge and skills to effectively meet the residents' assessed and changing needs.

One inspector reviewed the staff training matrix, concentrating on a sample of fifteen staff members. Each of these individuals had successfully completed a diverse range of training courses, ensuring they possessed all the essential knowledge and skills required to support residents. This included training in mandatory areas such as fire safety, managing behaviour that is challenging, and safeguarding, all of which contributed to a safe and supportive environment for the residents living in this designated centre.

In addition, and to enhance quality of care provided to residents, further training was completed, covering essential areas such as food safety, Children First, feeding,

eating, drinking, and swallowing (FEDS), infection prevention and control (IPC), and medication management. Since the previous inspection, the registered provider had ensured refresher training had been booked for healthcare assistants regarding epilepsy awareness and the administration of emergency medication.

The registered provider and person in charge had appropriate supervision arrangements in place for all staff. All staff received support and supervision relevant to their roles from appropriately qualified and experienced personnel in line with the registered provider's established policy. The person in charge maintained supervision records and schedules. The inspector reviewed a sample of staff members' supervision records, including five staff nurses and seven healthcare assistants, and found that each supervision meeting included a review of each staff members' personal development, and provided an opportunity for them to raise any concerns.

Judgment: Compliant

Regulation 19: Directory of residents

The registered provider and person in charge ensured that a directory of residents was available in the designated centre which met the requirements of the regulations. The directory of residents was made available for inspectors to complete a thorough review.

One inspector reviewed the directory of residents and found that it included accurate and up-to-date information in respect of each resident living in the designated centre. For example, information pertaining to the name, address and telephone number of each resident's general practitioner (GP), the date in which the resident first moved into the designated centre and the name, address and telephone number of each resident's next of kin were all recorded.

Judgment: Compliant

Regulation 23: Governance and management

Improvements were required to ensure the registered provider and person in charge had suitable oversight of the designated centre and that effective governance arrangements were in place to ensure the service was safely and effectively managed.

The registered provider did not ensure that the designated centre was resourced to ensure the effective delivery of care and support in accordance with the designated centre's statement of purpose. As previously discussed under Regulation 15:

Staffing, there was a heavy reliance on agency and relief staff to cover vacant shifts. The designated centre was operating with a 3.5 WTE deficit and while recruitment for vacant positions had been successful there was no official start date for any of the new recruits.

The inspectors observed that, while the registered provider had established a range of auditing mechanisms including an annual review of the care and support, six-monthly unannounced audits led by the registered provider, regular governance meetings, local team discussions, and targeted local audits, there was a need for further enhancement to ensure these systems were effective. For instance, one inspector examined a sample of local audits from the designated centre. A medication audit, carried out by frontline staff in May 2026, was supposed to cover all 18 residents as per the registered provider's own medication policy. However, the inspector found that only 12 audits were completed, and some residents were erroneously audited multiple times. Moreover, the audit outcomes were largely repetitive, with identical scores across all residents. Notably, the designated centre had one resident on a controlled drug, yet, the inspector observed that the section addressing controlled drugs was inaccurately scored on all audits, implying that all residents were prescribed them. This highlighted a critical need for substantial improvement and a thorough reassessment of the auditing process.

On reviewing local team meetings from April and May 2026 one inspector observed that key topics such as safeguarding, risk management, and incident reviews were not discussed. It was evident that there was no standing agenda for team meetings and there were no actions or timelines coming from discussions. It was also noted that not all staff were attending team meetings or reviewing the meeting minutes. For example, in the April 2026 meeting the inspector observed that three staff attended the meeting from a team of over 30. This did not provide sufficient assurance to inspectors that all staff were being adequately updated and informed about the evolving needs of residents within the service and this posed a risk to the staff members providing person-centred, safe, and effective support to residents.

In reviewing local governance meetings involving management from April and May 2026, the inspector observed that discussions from both meetings were frequently copied and pasted. Important topics such as resident updates were left blank and there was no evidence of actions or timelines coming from the governance meetings. Inspectors found that increased oversight arrangements was required in order to establish delegated responsibilities, identify timelines for actions to be complete, and ensure that appropriate regulatory oversight was maintained for the designated centre.

Judgment: Not compliant

Regulation 3: Statement of purpose

As part of the application to renew the registration of the designated centre, the registered provider submitted a statement of purpose that clearly described the services offered, and met the regulatory requirements.

One inspector reviewed the statement of purpose and found that it clearly outlined the care model and the support provided to residents, as well as the day-to-day operations of the designated centre. The statement of purpose was also made available to residents and their representatives in a format that suited their communication needs and preferences.

Additionally, a walk-around of the designated centre confirmed that the statement of purpose accurately reflected the available facilities, including room sizes, and their intended functions.

Judgment: Compliant

Quality and safety

This section of the report provides an overview of the quality and safety of the service provided to the residents living in the designated centre. Overall, inspectors found that the registered provider was endeavouring to support residents in a person-centred manner. However, improvements were necessary regarding Regulation 7: Positive behavioural support and Regulation 29: Medicines and pharmaceutical services. Further improvements were required regarding Regulation 18: Food and nutrition and Regulation 28: Fire precautions.

Inspectors observed a warm and relaxed atmosphere throughout the designated centre, with residents appearing content and comfortable with both their living environment and the support they received. After walking through the designated centre, it was found that the design and layout of the premises effectively ensured residents could enjoy an accessible, comfortable and homely setting. There was a good balance of private and communal spaces, and each resident had their own bedroom which was thoughtfully decorated to reflect their personal tastes and preferences.

There were arrangements in place that ensured residents were provided with adequate nutritious and wholesome food that was consistent with their dietary requirements and preferences. Residents were encouraged to eat a varied diet, and equally their choices regarding food and nutrition were respected. Residents were supported by a coordinated multidisciplinary team, such as medical, speech and language therapy, and during the inspection staff were observed to adhere to advice and expert opinion of specialist services. However, improvements were necessary to ensure that any food reaching its expiration was promptly and appropriately discarded.

The registered provider had mitigated against the risk of fire by implementing suitable fire prevention and oversight measures. There were suitable arrangements in place to detect, contain and extinguish fires within the designated centre. There was documentary evidence of servicing of equipment in line with the requirements of the regulations. However, improvements were required in resident personal emergency evacuation plans (PEEP), fire specific risk assessments, and the recording of the designated centre fire drills.

Inspectors noted that improvements were required to establish robust and consistent practices for the safe storage and management of all medicines within the designated centre. Specifically, inspectors observed recurring lapses, such as failure to sign for 10pm medicines on a number of occasions throughout 2026. In addition, the overall arrangements for storing residents' medicines required a thorough review to ensure both accuracy and safety in their administration.

The registered provider had failed to ensure that residents with identified positive behavioural support needs had access to appropriate and structured supports. As a result, some residents were exhibiting high-risk behaviours, including instances of self-injury, and staff were left without the vital guidance or tailored support strategies required to effectively intervene and promote safer, positive outcomes within the designated centre.

Regulation 17: Premises

The registered provider ensured that each of the homes that made up the designated centre was designed and arranged to align with the service's aims and objectives, as well as the number and needs of residents. The designated centre was well maintained, clean and appropriately decorated.

Each resident had their own bedroom, which was decorated according to their personal style and preferences. For example, bedrooms featured family photos, artwork, soft furnishings, and memorabilia that reflected their individual tastes and interests. This approach supported the residents' independence and dignity, while acknowledging their uniqueness. Additionally, every bedroom was provided with ample and secure storage for residents' personal belongings.

Residents were able to freely access and use the available spaces within the designated centre and its gardens. Inspectors noted that facilities were well maintained and in good working order. There was sufficient private and communal space for residents.

The equipment used by residents was both easily accessible and stored securely. Records reviewed by one inspector evidenced that the equipment was regularly serviced, with items such as high-low beds and overhead hoists undergoing annual servicing.

Judgment: Compliant

Regulation 18: Food and nutrition

The registered provider had adequate systems in place to ensure that residents had appropriate assessments in place regarding food and nutrition. However, improvements were required to ensure that any food reaching its expiration was promptly and appropriately discarded.

One inspector reviewed residents feeding, eating, drinking and swallowing (FEDS) plans and the contents of the fridge, cupboards and fruit bowls on the day of this inspection. Upon reviewing the FEDS plans, the inspector observed that staff were informed of the appropriate consistency of foods and fluids for each resident. The plans guided staff on how to safely modify the food and fluid for residents. Staff were also informed on the type of optimal environment for residents to eat in and how residents should be safely positioned to reduce the risk of choking.

All of the resident care plans observed by the inspector were reviewed by the registered provider's speech and language therapist (SLT) between September 2025 and May 2026. The inspector spoke with a staff member in one of the homes about a particular resident's care plan. The staff member demonstrated a good understanding of the care plan, including detailed adjustments to both the resident's diet and fluid intake.

Inspectors observed a diverse range of food and drinks, including fresh and perishable items, stored in kitchens for residents to select from. All items were stored in a hygienic manner. Kitchens were also well-equipped with high-quality cooking appliances and utensils, providing residents with everything needed to prepare their own meals. However, inspectors also observed a number of items that were either out of date or did not have labels detailing when the items had been opened. In addition, inspectors observed items in one fridge that had been opened and labelled, however, had not been disposed of past their use by dates.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The registered provider had adequate firefighting systems in place that included fire detection and alarm systems, fire doors, fire extinguishers, emergency lighting, and fire signage. However, improvements were required in resident personal emergency evacuation plans (PEEP), fire specific risk assessments, and the recording of the designated centre fire drills.

On the day of this inspection one inspector reviewed the designated centre's fire folder, servicing dates for firefighting and detection equipment, fire drill records, and fire safety checks completed by staff. The inspector observed the following:

- Firefighting equipment such as fire extinguishers and fire blankets had been serviced in March 2026
- The designated centre's fire detection and alarm system had been serviced in April 2026
- The designated centre's emergency lighting had last been serviced in April 2026.

The inspector also reviewed the daily, weekly, and monthly checks completed by the staff team for the month of May 2026. The inspector noted that all checks had been completed. The inspector also spoke with staff from each home that made up the designated centre regarding evacuation procedures. Staff spoke competently regarding how evacuation plans would be enacted in the event of an emergency.

The inspector observed that in one fire drill record completed in March 2026 it was documented that one resident failed to evacuate. On review of this resident's PEEP and fire specific risk assessment this risk had not been recorded and no identified actions were outlined for staff to follow in the event of a similar occurrence.

In reviewing the designated centre's fire drill records, the inspector noted that nighttime fire drills were not taking place as per the registered provider's established policy. For example, one nighttime drill had been completed in 2026, however, a nighttime fire drill had not been completed in 2025. Considering the specific profile of residents living in the designated centre, it was important that the registered provider ensured a robust and thorough evacuation procedure for nighttime conditions, so that all residents could be safely guided and evacuated if an emergency occurred after dark.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

Improvements were necessary to ensure the registered provider and person in charge had appropriate practices and arrangements in place for the management of medicines, including for the administration and storage of residents' medicines.

Inspectors noted that each residents' medicines were not administered and monitored in line with best practice as individually and clinically indicated at all times. Specifically, it was observed by one inspector that residents' 10pm medicines had not been signed for by the staff nurse on duty over a number of occasions across the months of January, May, and June 2026. This was brought to the attention of the person in charge and staff nurses on duty on the day of this

inspection, who were unable to provide sufficient assurances that residents had been administered medicines as prescribed on these dates.

The arrangements for storing residents' medicines required a thorough review. The inspector observed that a number of medicines, no longer prescribed, were being kept in the designated medicine storage units. Additionally, outdated equipment, such as blood sugar monitors, was also stored in these units. This posed a significant risk to the residents, as there was a possibility that staff nurses could mistakenly administer the wrong medicine or use inappropriate equipment. This necessitated a comprehensive review by both the person in charge and registered provider to ensure safe and effective practices moving forward.

Further improvements were also required to the safe storage of all medicines within the designated centre. For instance, one inspector noted that a resident's medicine, which required refrigeration, was stored in a Tupperware container in the kitchen fridge. This approach failed to align with the registered provider's established medication management policy in relation to safe storage of medication and posed a potential safety risk, and required improved and more secure storage arrangements.

Judgment: Not compliant

Regulation 7: Positive behavioural support

One inspector reviewed the arrangements in place to support residents' positive behaviour support needs and found that the registered provider had failed to provide all residents with timely and effective positive behavioural support in line with their assessed needs.

During the inspection, the inspector observed one resident with identified behavioural support needs who was loudly vocalising in the communal corridor of one house for a prolonged period. The resident appeared visibly distressed, repeatedly asking to go to bed. Despite the efforts of three staff members to support and engage with them, they were unable to calm the resident. The person in charge informed the inspector that the resident had not yet been referred to the registered provider's positive behaviour support specialist, and no specific guidance or strategies were in place for staff to implement. Staff also reported to the inspector that the resident's behaviours had escalated in recent weeks following a hospitalisation, with behaviours that challenge now occurring more frequently.

It was noted by the inspector that another resident with an assessed positive behavioural support need did not a formal positive behaviour support plan on file. The inspector noted that the staff team had been using antecedent-behaviour-consequence (ABC) charts to track incidents. The inspector noted that since the end of January 2026, there had been 12 recorded behavioural incidents, including a number of instances of self-injurious behaviour. While staff had received some guidance from the positive behaviour support specialist, such as a traffic light

system and other informal strategies, there was no formal positive behaviour support plan on file. As a result, staff lacked crucial information on antecedents, proactive and reactive strategies, and detailed background on the behaviours. This gap necessitated a comprehensive review and action by the registered provider and the person in charge.
Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 5: Application for registration or renewal of registration	Compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Compliant
Regulation 19: Directory of residents	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Compliant
Quality and safety	
Regulation 17: Premises	Compliant
Regulation 18: Food and nutrition	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 7: Positive behavioural support	Not compliant

Compliance Plan for Sonas Bungalows - Sonas Residential Service OSV-0003738

Inspection ID: MON-0041348

Date of inspection: 17/06/2026

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	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • Rosters have been reviewed, and all agency staff and relief staff are now clearly identified in all rosters. • Each house within the designated center will have a staff nurse present on day duty. • Staff nurse x 1 on boarding completed and awaiting confirmation of commencement date . • Graduate nurse to commence in Quarter 4 and same will be allocated to current vacancy. • Two care staff to commence on 2nd August and 30th August 2026. • Recruitment of staff continues on an ongoing basis to ensure continuity of care for all residents. • Currently, Service has engaged with agency to secure regular staff support vacancies during the onboarding stage for new employees.	
Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
• PIC reviewed audit on medication management. PIC scheduled a meeting with all the staff nurses to discuss the safe medication storage, medication management, and medication audit to ensure same aligns with the safe medication management process. PIC has put a system in place that a medication audit system has been reviewed. Every individual will have an individual audit completed weekly and monthly which will have governance by PIC. PIC will ensure any recommendations/actions will be identified to ensure effectiveness of audit and will ensure accuracy of scoring in relation to the audit process.
• PIC ensure medication audit for controlled medication will be accurately scored where relevant to ensure person covered care, and effective support to respective individuals.
• PIC has compiled a new agenda for local team meetings to ensure that appropriate regulatory oversight is maintained for the designated centre. The team meetings will include key topics re residents' updates, safeguarding, risk management, and incidents.
• All team meetings will be SMART, and action plans and timeline to be completed as discussed in the meetings. All staff day/night will be encouraged to attend local team meetings on site. Alternative provisions will be available to support via teams. All staff will receive information on Minutes of Team meetings and will sign to indicate they have read and understand the contents.
• Separate household meetings have been scheduled monthly.
• Night staff meetings have been scheduled monthly.

Regulation 18: Food and nutrition	Substantially Compliant

Outline how you are going to come into compliance with Regulation 18: Food and nutrition:
• PIC has ensured that all opened foods and drinks are clearly labelled detailing when item has been opened and consumed in accordance with manufacturers' instructions.
• PIC ensures that all consumable items and beverages are strictly and appropriately disposed of once reaching its expiration date.
• Education of staff in relation to the same has been provided via safety pause/ team meetings.

Regulation 28: Fire precautions	Substantially Compliant

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

• PIC has reviewed the PEEP and specific Fire Risk Assessment for all supported individuals. One risk rating has been adjusted and updated to reflect one resident who had failed to evacuate. All risk assessments will be updated and reflect the actions required following local fire drills. All staff will be informed of any additional control measures at daily safety pause, and staff meetings. Risk register will be updated to reflect any additional actions required as per service policy.
• Two Fire evacuation for Nighttime has been completed since Inspection. Nighttime Evacuation will be completed in line with the Service Policy and will also be completed in event there is any change to an individual assessed needs.
• PIC had obtained from the archive all fire evacuation drills that were completed for 2025 and these will be filed in the fire safety register folder under the Fire evacuation section. Going forward, all fire evacuation records from preceding 12 months will be filed and retained in the fire safety register folder

Regulation 29: Medicines and pharmaceutical services	Not Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:

• PIC conducted a thorough review of all medications in the MPAR. And three NIMS have been completed for unsigned medication administration errors on the identified dates in January, May, and June.
• All staff nurses are designated to check all MPAR are completed correctly after each medication round.
• PIC has implemented a weekly and monthly audit of all medication administration and all medications.
• All medication errors will be reported promptly and actioned.
• PIC has completed reviewing medication storage, and all medications no longer prescribed have been returned to the pharmacy and appropriately disposed of.
• PIC has reviewed arrangements for medication storage, and all medication equipment has been removed.
• A specialized medical refrigeration will be supplied to guarantee safe and compliant storage arrangements for all temperature-sensitive medications aligned with the safe medication management policy.

Regulation 7: Positive behavioural support	Not Compliant

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

• Two referrals have been sent to CNS Behavior Specialist to ensure both will have an up-to-date positive behavior support plan in situ. This will ensure clear guidance for all staff on antecedents, proactive and reactive strategies and will give a clear detailed account of all behaviors.
• PIC has an Interim Behavior Support Guidelines / Plans currently in place for both individuals until a formal positive behavior plan has been implemented. All staff have been informed and implementing guidelines.
• Any individual who has been identified to require a positive behavior plan will have the same implemented in a timely manner going forward in line with their assessed needs.

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.	Not Compliant	Orange	30/11/2026
Regulation 15(2)	The registered provider shall ensure that where nursing care is required, subject to the statement of purpose and the assessed needs of residents, it is provided.	Not Compliant	Orange	01/08/2026
Regulation 15(3)	The registered provider shall ensure that residents receive continuity of care and support, particularly in	Not Compliant	Orange	30/11/2026

	circumstances where staff are employed on a less than full-time basis.			
Regulation 15(4)	The person in charge shall ensure that there is a planned and actual staff rota, showing staff on duty during the day and night and that it is properly maintained.	Not Compliant	Orange	28/07/2026
Regulation 18(2)(a)	The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which are properly and safely prepared, cooked and served.	Substantially Compliant	Yellow	28/07/2026
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.	Not Compliant	Orange	30/11/2026
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate	Not Compliant	Orange	30/11/2026

	to residents' needs, consistent and effectively monitored.			
Regulation 28(2)(b)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Substantially Compliant	Yellow	28/07/2026
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.	Substantially Compliant	Yellow	28/07/2026
Regulation 28(4)(b)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Substantially Compliant	Yellow	30/12/2026
Regulation 29(4)(a)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration	Not Compliant	Orange	30/08/2026

	of medicines to ensure that any medicine that is kept in the designated centre is stored securely.			
Regulation 29(4)(b)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine which is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.	Not Compliant	Orange	30/12/2026
Regulation 29(4)(c)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that out of date or returned medicines are stored in a secure manner that is segregated from other medicinal products, and are	Not Compliant	Orange	30/08/2026

	disposed of and not further used as medicinal products in accordance with any relevant national legislation or guidance.			
Regulation 07(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.	Not Compliant	Orange	30/092026