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:	Orchid Lane
Name of provider:	Sunbeam House Services CLG
Address of centre:	Wicklow
Type of inspection:	Announced
Date of inspection:	03 March 2025
Centre ID:	OSV-0005052
Fieldwork ID:	MON-0038142

About the designated centre

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

Orchid Lane is a designated centre for people with intellectual disabilities and is operated by Sunbeam House Services Company Limited by Guarantee. The centre is located in a town in County Wicklow. The centre comprises of four single occupancy apartments within a residential complex that also consists of other apartments and day services. The centre is managed by a full time person in charge who also has responsibility for another designated centre. The person in charge reports to a senior services manager who has operational oversight of a number of designated centres and other support services within Sunbeam House Services. The staff-skill mix comprises social care workers, social care assistants, and an instructor.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	4

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Monday 3 March 2025	10:00hrs to 18:00hrs	Michael Muldowney	Lead

What residents told us and what inspectors observed

This announced inspection was carried out as part of the regulatory monitoring of the centre and to help inform a decision on the provider's application to renew the centre's registration. The inspector used observations, conversations with residents and members of the management team, and a review of documentation to form judgments on the quality and safety of the care and support provided to residents in the centre.

The inspector found some examples of compliance. However, improvements were required under many of the regulations inspected including in relation to residents' assessments of need, positive behaviour support plans, contracts of care, risk assessments, the premises, fire safety, the notification of incidents, and the governance and management of the centre. The inspector also found that residents' concerns regarding their current and future living arrangements had not been effectively managed by the provider to alleviate their concerns, and there was an absence of a cohesive plan or strategy to support residents to move out of the centre.

The centre comprises four individual apartments on a large complex that also contains day services and other apartments operated by different providers. The complex has numerous entrance points and exit gates around the grounds, which are located within a larger setting with other external companies also located within it. The staff office of the designated centre is located in a separate building to the apartments across a courtyard which is shared with day services.

Residents were told in 2023 that the lease for the centre would expire in August 2025, and that they would have to move out. During the previous inspection of the centre in July 2024, residents told inspectors that they were anxious, worried and upset about moving out, and inspectors found that the provider had failed to give their concerns sufficient regard.

During this inspection, the inspector met all four residents. They were still concerned about moving out of the centre and the lack of information provided to them. They asked the inspector for information and an update about their moves. For example, some residents asked where and when they would move, if staff from the centre would be moving with them, and if they could bring their pets with them. The inspector was unable to provide them with any answers as this information was privy to the provider and the senior management team that were responsible for residents' transition planning.

One resident said that they had known since January 2023 that the centre was to close, and they were ready to move out now, but that there was no update from the provider. They said that they wanted to stay within their current area to be close to their family, friends, and day service. They had an active life, and told the inspector that they enjoyed their day service, going to the gym, and spending time with their

family.

Another resident was also keen to move out. They told the inspector that they had not been happy in the centre for a long time. They said that their sleep was adversely affected due to the noise from other apartments, and that they did not get on with some of the other residents. They said that these issues were "going on a long time". They had previously made complaints about these issues, but they had not been resolved. The resident was happy with the support they received from staff, but said that they wanted to move out due to the close proximity of their day service and their ongoing issues with other residents. They told the inspector about some of the requirements that they would need for a new home, such a ground floor property that would allow pets and be close to their current home. They had submitted a referral for an external advocate, and said that they was keen to meet with an advocate to help them plan for their future as they do not know what will happen when the lease expires in August 2025.

They also told the inspector that they no longer enjoyed their day service, and wanted to pursue paid employment. They had completed work experience and was attending an employment course to help them achieve their goal. They also attended local community groups, and enjoyed going on outings with staff, and meeting friends and family. They told the inspector that staff helped them in many ways, including to clean their apartment and cook meals. Staff were also helping the resident to plan a big celebration party, and the resident showed the inspector some of the decorations that had been purchased. They were also looking forward to an upcoming hotel break with staff.

Another resident briefly spoke with the inspector. They said that everything in the centre was "good", but some times they were lonely and bored in their apartment. They told the inspector about some of their hobbies, such as swimming and playing sports.

One resident told the inspector that had lived alone in their apartment for a long time, and they were upset, worried, and sad at the prospect of moving out. They said that they did not know where or when they would move. However, a potential move to another of the provider's centres had been discussed with them. That move would involve sharing a house with another two residents. The resident said they liked the location of the house, but was unsure about how they would find living with other people as they preferred their own space. They had also been supported to apply for an advocate, and was awaiting a meeting. They told the inspector that they felt safe in their apartment, and showed the inspector the mobility aids and equipment that they used. They said that the staff were "great" and provided sufficient support.

In advance of the inspection, residents completed Health Information and Quality Authority (HIQA) feedback surveys on what it was like to live in the centre. Generally, the feedback was positive, and indicated that residents were safe, liked the staff, and received good care. Their comments included "I have visitors when I want", and "the staff are helpful" and "very nice". However, they also expressed concern about the staffing arrangements (commenting that there are "too many

different staff") and their future living arrangements. One resident said that they are "very sad" as they liked living on their own, and others said "hopefully [I can] get my own apartment and stay in [current area]" and "when I move I want my own place for me and my [pet]".

The inspector observed staff, including a social care worker, the person in charge and the deputy manager, engaging with residents in a very warm and respectful manner. They responded to residents with kindness, and residents appeared very comfortable with them. For example, some residents hugged staff when they saw them, joked, and chatted about everyday life.

The person in charge and deputy manager facilitated the inspection. It was clear that they were endeavouring to response to residents' needs and concerns. They spoke warmly about the residents and it was clear that they had a good understanding of their individual personalities.

The person in charge and deputy manager told the inspector that residents ask them daily about their future living arrangements, and when and where they will move to. They provided verbal reassurances to residents, and had delivered information sessions for them and their families on moving out of the centre. However, they could not fully alleviate the residents' concerns as there were no confirmed plans for the residents. They showed the inspector email correspondence, dated 12 February 2025, from the landlord that indicated that the lease would be extended for another three years; however, this information had not been shared with the residents. They told the inspector that the current centre was not meeting all of the residents' needs, and even if an extension is granted, moving to a more appropriate home would benefit their quality of life.

The person in charge and deputy manager also told the inspector about some of the positive changes since the previous inspection, such as a reduction in behavioural incidents and safeguarding concerns. They also spoke about some of the current challenges, including staffing deficits, incompatibility issues, overdue assessments of residents' need, the high workload they managed, and their concern about a lack of direction for the residents to move out of the centre. These matters are discussed further in the report.

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

Capacity and capability

This announced inspection was carried out as part of the provider's application to renew the registration of the centre. The application included an up-to-date statement of purpose, residents' guide, and copy of the centre's insurance contract. Overall, the inspector found the provider's governance and management of the

centre required improvement to ensure that residents were in receipt of effective care and support, and that the provider's systems were being implemented and monitored.

The management structure included the full-time person in charge and deputy manager. They also managed another centre, and described the challenges they faced in effectively managing two busy centres. The person in charge had escalated their concerns about their workload, and the provider was recruiting an additional deputy manager to alleviate the management team's workload.

There were oversight systems, including provider-led and local management audits, to monitor the service provided in the centre. However, the findings under many of the regulations inspected in this report, demonstrate that the provider's monitoring of the centre requires improvement to ensure that residents' concerns, complaints, and findings from audits are adequately addressed.

The staff skill-mix in the centre was found to be appropriate to the residents' needs; however, there were three full-time vacancies which posed a risk to residents' consistency of care. Recent staff rotas showed a high reliance on agency staff to cover the vacancies, and residents expressed concern that there were too many different staff working in the centre. The provider's arrangements for inducting agency staff and ensuring that they had appropriate training also required more consideration.

The person in charge had ensured that permanent staff members received appropriate training as part of their professional development, and that they received regular informal and formal support and supervision.

The provider had prepared a complaints procedure that was in an accessible format for residents. Some residents told the inspector that they were unhappy about their living situations and access to day services. These issues were well known in the centre, but had not been recorded as complaints in line with the provider's procedure.

The inspector found that the maintenance of residents' contracts of care required improvement, as three required updating.

The inspector also found that not all incidents and events, as specified under regulation 31, had been notified to the Chief Inspector of Social Services.

Regulation 14: Persons in charge

The registered provider had appointed a full-time person in charge. They are suitably skilled and experienced for the role, and possess relevant qualifications in social care and management. They commenced in their role in September 2024 and prior to that had worked as a person in charge in other centres operated by the

provider.

Judgment: Compliant

Regulation 15: Staffing

The staff skill-mix comprised a deputy manager, social care workers, a social care assistant, and an instructor. There were three full-time vacancies which were filled by relief and agency staff. The inspector reviewed the planned and actual staff rotas for January, February and March 2025, and found that there was a high reliance on agency staff. For example, 64 shifts were covered by agency staff in January, 40 shifts were covered by agency staff in February, and 34 shifts were to be covered by agency staff in March. The high use of agency staff posed a risk to residents' consistency of care. However, the provider had recruited for two of the vacant posts, and those staff were due to start working in the centre in April 2025; this would reduce the need for agency staff and promote better consistency of care.

The inspector found that the maintenance of rotas required improvement as the full names of all agency staff working in the centre were not recorded. The person in charge rectified this matter during the inspection.

The inspector also found that the induction systems for agency staff required improvement. The inspector checked the induction records for nine agency working in the centre during one week in January, and found that induction sheets had only been completed for two staff. The person in charge told the inspector that some of the other agency staff had received an induction, but that it was not documented. The systems for inducting agency staff requires more consideration from the provider to ensure that the staff are adequately informed on the centre and the support needs of the residents.

The person in charge and deputy manager told the inspector about the challenges in acquiring assurances from staff agencies that staff are trained in all areas necessary to work in the centre such on the safeguarding of residents from abuse. The person in charge and deputy manager contacted the agencies for these assurances, and had also booked agency staff to attend the provider's internal training programmes. This was time consuming, and the matter requires better oversight and management at a provider level.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Permanent staff were required to complete training as part of their professional

development and to support them in the delivery of appropriate care and support to residents. The training included safeguarding of residents, first aid, manual handling, medication administration, complaints, infection prevention and control, positive behaviour support, and fire safety. Some staff had also attended supplementary training in trauma informed care and human rights.

The inspector reviewed the most recent training log with the person in charge and deputy manager. The log showed that most staff were up to date with their training, and that any outstanding training was booked for them to attend.

The person in charge ensured that staff were supported in their roles. The inspector review three staff formal supervision records, and found that they had received supervision in line with the provider's policy. The person in charge and deputy manager also provided informal supervision to staff while present in the centre.

Judgment: Compliant

Regulation 22: Insurance

The registered provider had effected a contract of insurance against injury to residents and other risks in the centre including property damage.

Judgment: Compliant

Regulation 23: Governance and management

The inspector found that the provider's governance and management systems were not fully effective and required improvement to ensure that the service provided to residents in the centre was responsive and appropriate to their needs.

As detailed in the first section of the report and under regulation 25, the arrangements to support residents to move out of the centre require more consideration, formulation, and attention from the provider.

The management structure for the centre includes a deputy manager, person in charge, and senior services manager. The deputy manager and person in charge also have responsibility for another centre. They told the inspector that it is challenging to effectively manage both centres due to the work loads that they both centres present. The person in charge escalated their concerns to the senior services manager and the provider is recruiting for an additional deputy manager to ease the work loads. However, there is no time frame for when the deputy manager will be recruited.

The provider has implemented some good systems to monitor and oversee the

quality and safety of care and support provided to residents in the centre. Comprehensive six-monthly unannounced visit reports and annual reviews had been carried out by the provider, and they had consulted with residents and their representatives. Audits had also been carried out in relation to health and safety, documentation, and medication management. However, the findings of this report demonstrate that enhanced monitoring of the centre is required to address areas of concern.

The provider's resourcing of the centre also required improvement. As discussed under regulation 15, there was a high reliance on agency staff, and vacancies in their multidisciplinary team, such as occupational therapy, have not been filled which is impacting on how residents' needs are being assessed.

Judgment: Substantially compliant

Regulation 24: Admissions and contract for the provision of services

The inspector reviewed all four residents' contracts of care. The contracts were signed by the relevant parties; however, the fees to be charged were not correctly detailed. The fees in two contracts were not listed, and in another contract the fee needs to be updated to reflect the actual fees that the resident was paying.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The registered provider had prepared a written statement of purpose containing the information set out in Schedule 1. It was up to date, and available in the centre for residents and their representatives.

Judgment: Compliant

Regulation 31: Notification of incidents

The person in charge had not ensured that incidents, as detailed under this regulation, which had occurred in the centre were notified to the Chief Inspector.

The provider's recent unannounced visit report from November 2024 had noted that three incidents in 2024 had not been notified to the Chief Inspector. However, the incidents had not been submitted at the time of the inspection. The incidents included the unexplained absence of a resident, an unplanned evacuation of the

centre, and a minor injury. The person in charge submitted the notifications before the inspection concluded.

The inspector also read a recent safeguarding incident report from October 2024 that had not been notified to the Chief Inspector.

Judgment: Not compliant

Regulation 34: Complaints procedure

The registered provider had implemented a complaints procedure for residents, which was underpinned by a written policy. The policy outlined the processes for managing complaints including the stages of resolution, the associated roles and responsibilities, and how residents could access advocacy services. The procedure had been prepared in an easy-to-read format for residents and their representatives. It was on display in the residents' apartments, and had been discussed with them during their house meetings to help them understand it.

The most recent complaint from a resident, dated 2 March 2025, related to the behaviour of another resident. The inspector read previous complaints from residents and their representatives that had been made in 2024 and since closed. However, some residents told the inspector that they were unhappy with their living situations and day services, and while these concerns were well known in the centre, they had not been reported as complaints. Therefore, it was not demonstrated that the complaints procedure was being utilised to support residents to escalate their concerns.

Judgment: Substantially compliant

Quality and safety

There were systems in place to support the delivery of quality and safe care for resident. However, the inspector found that improvements were required under regulations in relation the premises, fire safety precautions, the arrangements for assessing residents' needs, and residents' behaviour support plans. The inspector also found that residents' concerns about moving out of the centre had not been given sufficient regard, and that there was an absence of a consolidated plan to ensure that their current and future living arrangements were suitable.

The residents were informed in 2023 that the lease for the centre would expire in August 2025. This has caused anxiety and stress for them which has been communicated to the provider. However, the inspector found that there was an absence of a comprehensive plan for the residents' future living arrangements.

While actions were being taken by the provider and the management team, they were not been consolidated and it was unclear who was responsible to drive progression of the residents' moves. The inspector was informed that the lease had been extended for another three years; however, this information had not been shared with the residents. Furthermore, the inspector found that the residents' accommodation needs and preferences had not been detailed in a working document to inform the provider on the type of home and service they required. These issues had also been identified during the July 2024 inspection of the centre.

The premises comprised four individual apartments and a separate office on a large complex that was shared with other residential and day services. The residents were happy to show the inspector around their apartments. The apartments contained a bedroom, bathroom, and living space. The apartments were decorated to the residents' individual tastes, and provided space for them to receive visitors. Some minor upkeep was needed, and had been reported to the provider's maintenance department.

The inspector observed good fire safety systems, such as fire detection and fighting equipment in the apartments. Staff had completed fire safety training, and the topic was discussed with residents during their house meetings. However, improvements were required to the systems, as one night-time drill was overdue and the most servicing records of the fire alarms and emergency lights were not maintained in the centre or made available to the inspector.

The inspector observed a washing machine in a walk-in closet in a resident's bedroom. The closet door did not appear to be a fire door, and this arrangement required assessment by the provider to ensure that any associated risks were mitigated. The person in charge planned to escalate this issue to the provider's fire safety expert.

There were arrangements to safeguard residents from abuse. Staff completed safeguarding training, and there was a policy to guide their practices. The inspector reviewed three safeguarding incidents that had been reported to the Chief Inspector in 2024. The incidents had been managed in line with the provider's policy and safeguarding plans had been put in place. However, there remained a residual risk to residents' wellbeing due to the incompatibility issues in the centre, and this risk required ongoing monitoring by the provider.

The person in charge and staff team had completed assessments of the residents' needs which they used to inform care plans. However, some residents were awaiting multidisciplinary team assessments to determine their full needs.

There were arrangements to support residents to manage their behaviours of concern. However, two positive behaviour support plans were overdue review to ensure that they were still effective.

Regulation 11: Visits

The registered provider had ensured that residents could receive visitors as they wished. There was private space and facilities for visitors to be received as each resident had their own private apartment. Residents told the inspector that they enjoyed when their families and friends visited.

Judgment: Compliant

Regulation 17: Premises

The premises comprised four individual apartments on a large complex that also contained day services and other apartments that were not within the designated centre.

The apartments contained a bedroom, bathroom, and a kitchen and living space. The apartments were personalised and decorated in line with the residents' individual tastes. The facilities were in good working order. However, some upkeep was required. For example, in one apartment the veneer on some of the kitchen cabinets had detached, and in another apartment a bathroom door was water damaged. These matters had been noted in a recent health and safety audit, and had been reported to the provider's maintenance department.

Judgment: Substantially compliant

Regulation 20: Information for residents

The registered provider has prepared a residents' guide. The guide was up to date, available in the centre to residents, and included the required information such as the terms and conditions relating to residency

Judgment: Compliant

Regulation 25: Temporary absence, transition and discharge of residents

The provider was aware since 2023 that the lease of the centre would expire in August in 2025; however, they had not ensured that residents' transition from the centre was taking place in an appropriately planned manner.

Residents were informed in 2023 that the centre would close in August 2025, and this has caused stress, sadness, worry and anxiety for them. During the inspection, residents sought answers from the inspector which he could not provide. For

example, they asked if they could bring their pets with them when they moved out, and they said that they did not know when or where they would move to. The person in charge and deputy manager told the inspector that the residents also ask them every day for updates, and they are limited on what assurances they can provide. Residents concerns were also noted in the recent audits, and residents' house meeting and keyworker meeting minutes. However, it was not demonstrated that the provider has met with the residents to try and alleviate their worries. The inspector viewed correspondence from the landlord which stated that the lease would be extended for another three years, and before the inspection concluded was shown a new lease with the extension detailed. However, this information had not been shared with the residents.

While some actions had taken place to support the residents to move out (such as applications to the local county council for housing), there was an absence of a cohesive plan or strategy for the centre and the residents' accommodation needs. There was no identified person to lead the actions, and while actions were being taken by the provider and local management team, it was unclear how the actions were being delegated, implemented, and monitored.

The senior services manager had prepared a transition plan; however, the provider could not give the inspector an update on some of the actions listed such as one resident possibly availing of an alternative service provider. The plan also referred to a 'steering group' that had not yet been established. The inspector also read 'decongregation' meeting minutes; however, the meetings were very infrequent; for example, meetings took place in January and December 2024, and January 2025. Furthermore, the local management team had begun completing transition plan templates for residents, but the templates were not fully applicable, and it was unclear how they were to be used or who they would inform.

Additionally, residents needs had not been fully assessed as multidisciplinary team assessments were outstanding, and compatibility assessments were outstanding. Therefore, it was not demonstrated that the residents' accommodation needs had been determined. Residents and staff also told the inspector about some of their preferences and needs, but the inspector found that this information was not recorded.

Judgment: Not compliant

Regulation 26: Risk management procedures

The provider had prepared a written risk management policy which outlined the arrangements for identifying and managing risks that may present in the centre.

The person in charge had prepared risk assessments relevant to the centre and specific residents. The risk assessments were up to date and included risks related to abuse, incompatibility issues, infection prevention and control, fire, falls, and

health conditions. However, the risks related to the security of the centre's lease and the associated impact on the residents' wellbeing, the management arrangements, and the high use of agency staff in the centre had not been risk assessed.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The registered provider had implemented some good fire safety precautions in the centre. However, improvements were required to ensure that the precautions were being effectively implemented.

There was fire detection and fighting equipment throughout the centre, including fire alarms, fire extinguishers and blankets, fire doors, and emergency lights. Staff completed daily, weekly, and monthly checks of the equipment. There were also arrangements to service the equipment. The inspector found that the fire extinguishers were up to date with their serving requirements. However, the records made available to the inspector showed that the alarms and lights were overdue servicing.

The person in charge had prepared up-to-date individual evacuation plans which outlined the supports required by residents to evacuate the centre. The plans were to be tested during fire drills. The recent unannounced visit report of the centre noted that there had not been a night-time drill in 2024. The inspector found that a night-time drill was still outstanding; however, had been scheduled for May 2025.

Staff had completed fire safety training, and residents were reminded of fire safety during residents' meetings. Residents spoken with told the inspector that they would evacuate the centre if the fire alarm sounded.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

The inspector reviewed two residents' files. The files included assessments of need that had been completed by the staff, and care plans. The assessments and care plans were up to date and readily available to guide staff on the residents' care and support needs. Some of the documents had been prepared in an easy-to-read format to be more accessible to residents.

However, some residents had been referred for multidisciplinary team assessments, and were awaiting to be seen. For example, three residents were awaiting occupational therapy assessments. The absence of comprehensive multidisciplinary team assessments meant that all of the residents' potential needs had not been

determined.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

There were arrangements to support residents to manage their behaviours of concerns. Staff were required to complete positive behaviour support training, and care plans had been prepared by behaviour specialists to guide staff on the strategies needed by residents. Members of the provider's multidisciplinary team were also available to give guidance and support to residents.

The inspector reviewed three residents positive behaviour support plans. Some of the plans incorporated easy-to-read information such as 'social stories' to help residents to understand and manage their behaviours.

Two plans had been referred to the provider's behaviour support team as they required review and updating to ensure that they were still appropriate.

Restrictive practices were not reviewed as part of this inspection.

Judgment: Substantially compliant

Regulation 8: Protection

The registered provider and person in charge had implemented systems to safeguard residents from abuse. Staff working in the centre completed safeguarding training to support them in the prevention, detection, and response to safeguarding concerns, and there was guidance for them in the centre to refer to. The person in charge had also arranged for an external party to deliver a safeguarding information session for staff in November 2024.

The inspector reviewed the records of three safeguarding incidents reported in 2024, and found that they had been appropriately reported and managed to promote the residents' safety. However, there remained a residual risk to residents' safety and wellbeing in the centre due to the incompatibility issues. This risk required closed monitoring by the provider.

The person in charge had ensured that intimate care plans had been prepared to guide staff in delivering care to residents in a manner that respected their dignity and bodily integrity. The inspectors reviewed three resident’s intimate care plans and found that they were up to date and readily available to staff to guide their practice (one plan required more detail under a specific area).

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 24: Admissions and contract for the provision of services	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 20: Information for residents	Compliant
Regulation 25: Temporary absence, transition and discharge of residents	Not compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Compliant

Compliance Plan for Orchid Lane OSV-0005052

Inspection ID: MON-0038142

Date of inspection: 03/03/2025

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Substantially Compliant

Outline how you are going to come into compliance with Regulation 15: Staffing:

• The current PIC and their Deputy Manager are providing temporary cover for Orchid Lane and one other Centre with 2 residents in close proximity as the regular PIC was on leave. Ard Na Greine's regular PIC is scheduled to return on the 18.04.2025. The temporary cover was in place from Sept 2024 to April 2025.

• A recruitment initiative began on the 25.11.2024 to implement an additional Deputy Manager position for the other Centre during the temporary arrangement, the post was filled for a short period however this role remained open at the time of the inspection and continues to be advertised.

• There are currently 3 frontline staff vacancies in the designated centre. 2 WTE are going through the compliance stage of the process. There remains 1 WTE which is currently advertised, reducing the need for agency staff. To ensure consistency in client support, a familiar agency is being used to cover the position in the interim.

• There is an Agency induction sheet and folder in place and completed with new agency staff by PIC/Deputy manager or regular staff in their absence when starting in the designated centre.

• PIC/Deputy review signed agency induction sheet bi-weekly to check that the process is adhered to.

• There is a Handover communication book in place to ensure written and verbal handovers are documented.

• There is an Appointment diary in place in the staff office for all staff to be aware of scheduled appointments.

• There are daily tasks sheet for each resident with their supports detailed for staff to

complete on each shift and reviewed weekly by management.

• There are currently 3 regular agency staff working in the designated centre. Their training records are available on the providers data base.

• Training records for new agency staff are requested prior to their first shift. Only staff with completed compulsory training will be offered shifts at this location.

Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:

In order to address communication needs regarding the transition, the following actions have been put in place:

• At a minimum monthly resident meetings have been scheduled for the remainder of 2025, where residents can voice concerns, ask questions, and receive up-to-date information regarding their transition. These meetings occur on an individual basis if that is the resident's will and preference. These meetings will be facilitated by the PIC/Deputy Manager and with the support of the PPIM as required.

• To alleviate concerns, more regular communication is in place via visual aids to afford a resident the autonomy to write any concerns or queries and they are addressed on a weekly basis.

• Another resident likes to receive information on transition process using photographic steps

• Overall educational information in the form of visual presentations and have been scheduled monthly to provide updates on the transition in an accessible format for the residents. A visual presentation was completed on 21.02.2025. The next session is scheduled for 25.03.2025.

• Despite these measures, one resident may seek regular reassurance from people external to the designated centre. A risk assessment and support plan are in place to address this concern.

• Residents' families are updated monthly by the PIC/Deputy manager and invited to family meetings to discuss any ongoing concerns and provide further support if they wish. A meeting was recently held on 29.01.2025 and 31.01.2025. Written communication was also submitted to all families and residents to inform them of the lease renewal on the 10.02.2025.

• All residents were referred for advocacy on 22.01.2025, with an independent advocate assigned to each resident on 11.03.2025. The first meetings with an external advocate is scheduled for 01.04.2025.

Actions completed regarding the transition:

• All residents are on the priority housing list for the provider's Internal Referral's Committee 15.06.2023.

• All residents are on the local County Council housing list. The county council acknowledged the residents applications in January and February 2024.

• The provider contacted the funder to inform them of the upcoming need for alternative housing for the four residents. A request was made that they be considered for any suitable property that may become available within the funder's remit 21.06.2023.

• The provider held meetings to discuss the overall property plans for the location on the 30.08.2023, 12.10.2023, 11.01.2024, 29.01.2025.

• A follow up meeting took place to discuss current vacancies within the organisation that may be suitable. Following this meeting, a detailed plan was developed 12/12/2024.

• Subsequently, and in collaboration with residents, the viability of 2 residents transitioning to internal vacancies is being explored. Compatibility assessments have been completed for the two residents 12.02.2025 and 10.03.2025.

• A single occupancy property is being sourced for one resident. Further discussions are taking place for the 4th resident to determine their will and preference.

• Support Needs Forms are in place for all residents and updated as required.

• Outstanding MDT assessments are being pursued. A Referral has been submitted to funder's Occupational Therapist.

• A meeting with behavioural specialists took place on 13.03.2025 to discuss the two residents. The behavioural specialist will meet both residents on 03.04.2025 and a positive behaviour support plan will be completed. There is currently an interim behavioural support plan in place to guide staff.

• Recruitment for the Transition Project Manager has commenced on 04.02.2025.

• A Steering Group, led by the PPIM on an interim basis until the Project Manager is recruited, has been established to oversee the entire transition. The group will meet regularly to monitor progress and address any challenges.

• A comprehensive transition plan template is in place for each resident, detailing their individual needs and outlining the specific actions required during the transition process. It includes dates of completed actions and serves as a guide for the service regarding the necessary information and next steps. This document remains active until each resident's transition is fully completed, with the PIC/Deputy Manager reviewing and updating it weekly. The plan has been successfully used in similar transitions in the past.

• The current PIC and their Deputy Manager are providing temporary cover for Orchid Lane and one other Centre with 2 residents in close proximity as the regular PIC was on

leave. Ard Na Greine's regular PIC is scheduled to return on the 18.04.2025. The temporary cover was in place from Sept 2024 to April 2025.

• A recruitment initiative began on the 25.11.2024 to implement an additional Deputy Manager position for the other Centre during the temporary arrangement, the post was filled for a short period however it remained open at the time of the inspection.

• There are bi-weekly 1:1 business meetings in place between PPIM and PIC to provide additional oversight and support to the PIC.

Regarding staffing concerns:

• There are currently 3 frontline staff vacancies in the designated centre. 2 WTE are going through the compliance stage of the process.

• There remains 1 WTE which is currently advertised, reducing the need for agency staff. To ensure consistency in client support, a familiar agency is being used to cover the position in the interim.

• There is an Agency induction sheet and folder in place and completed with new agency staff by PIC/Deputy manager or regular staff in their absence when starting in the designated centre.

• PIC/Deputy review signed agency induction sheet bi-weekly to check that the process is adhered to.

• There is a Handover communication book in place to ensure written and verbal handovers are documented.

• There is an Appointment diary in place in the staff office for all staff to be aware of scheduled appointments.

• There are daily tasks sheet for each resident with their supports detailed for staff to complete on each shift and reviewed weekly by management.

• There are currently 3 regular agency staff working in the designated centre. Their training records are available on the providers data base.

• Training records for new agency staff are requested prior to their first shift. Only staff with completed compulsory training will be offered shifts at this location.

Regulation 24: Admissions and contract for the provision of services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 24: Admissions and contract for the provision of services:

Contracts of care have been updated to reflect the amount of rent each resident is paying 17.03.2025.

Contracts of care will be reviewed quarterly to ensure that they are up to date.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:

Notifications for an unexplained absence of a resident, and unplanned evacuation of the centre, and a minor injury were submitted retrospectively on the day of inspection. Notifications submission requirements will be discussed with PIC at bi-weekly 1:1 Support meetings.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:

On the day of inspection one resident made 3 complaints to the inspector. These have been recorded and are going through the providers' complaints process. The providers complaints officer will complete an information session with the staff in the designated centre by 30.04.2025.

The PIC will follow the referral procedure regarding the resident's request to transfer to day services. In the interim, activities in alternative day services that the resident may wish to take part in on an ad-hoc basis were explored on 21.03.2025. The resident will be regularly updated on any available activities.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:

Veneer on some kitchen cabinets for one apartment will be repaired by 06.06.2025. The damage does not present an immediate risk to the resident and has been temporarily secured in place until the repair is completed.

A business case will be submitted to the funder to replace the bathroom door in the second apartment. Completion is expected by the 31.12.2025 pending approval.

An assessment of the washing machine in the walk-in closet was completed by an external fire safety company on 25.03.2025. It was determined that although a fire door is not required, there is an alarm in place which mitigates risks. A risk assessment will be completed to address the concern by 27.03.2025.

Regulation 25: Temporary absence, transition and discharge of residents	Not Compliant

Outline how you are going to come into compliance with Regulation 25: Temporary absence, transition and discharge of residents:

The PIC and PPIM will ensure that all residents' transition plans are in place and updated to reflect their current situation. These plans will include roles and responsibilities, along with dates for the completion of actions.

Updates will be provided to the referrals committee monthly.

The PPIM is the lead, supported by the PIC and DSM. The referrals committee receives updates and reviews the process. A new role of Project Manager will be introduced to oversee the transition stages, communications, stakeholders, risks, and timelines.

In order to address communication needs regarding the transition, the following actions have been put in place:

• At a minimum monthly resident meetings have been scheduled for the remainder of 2025, where residents can voice concerns, ask questions, and receive up-to-date information regarding their transition. These meetings occur on an individual basis if that is the resident's will and preference. These meetings will be facilitated by the PIC/Deputy Manager and with the support of the PPIM as required.

• To alleviate concerns, more regular communication is in place via visual aids to afford a resident the autonomy to write any concerns or queries and they are addressed on a weekly basis.

• Another resident likes to receive information on transition process using photographic steps

• Overall educational information in the form of visual presentations and have been scheduled monthly to provide updates on the transition in an accessible format for the residents. A visual presentation was completed on 21.02.2025. The next session is scheduled for 25.03.2025.

• Despite these measures, one resident may seek regular reassurance from people external to the designated centre. A risk assessment and support plan are in place to address this concern.

• Residents' families are updated monthly by the PIC/Deputy manager and invited to family meetings to discuss any ongoing concerns and provide further support if they wish. A meeting was recently held on 29.01.2025 and 31.01.2025. Written communication was also submitted to all families and residents to inform them of the lease renewal on the 10.02.2025.

• All residents were referred for advocacy on 22.01.2025, with an independent advocate assigned to each resident on 11.03.2025. The first meetings with an external advocate is scheduled for 01.04.2025.

Actions completed regarding the transition:

• All residents are on the priority housing list for the provider's Internal Referral's Committee 15.06.2023.

• All residents are on the local County Council housing list. The county council acknowledged the residents applications in January and February 2024.

• The provider contacted the funder to inform them of the upcoming need for alternative housing for the four residents. A request was made that they be considered for any suitable property that may become available within the funder's remit 21.06.2023.

• The provider held meetings to discuss the overall property plans for the location on the 30.08.2023, 12.10.2023, 11.01.2024, 29.01.2025.

• A follow up meeting took place to discuss current vacancies within the organisation that may be suitable. Following this meeting, a detailed plan was developed 12/12/2024.

• Subsequently, and in collaboration with residents, the viability of 2 residents transitioning to internal vacancies is being explored. Compatibility assessments have been completed for the two residents 12.02.2025 and 10.03.2025.

• A single occupancy property is being sourced for one resident. Further discussions are taking place for the 4th resident to determine their will and preference.

• Support Needs Forms are in place for all residents and updated as required.

• Outstanding MDT assessments are being pursued. Referral submitted to funder's Occupational Therapist, currently awaiting date.

• A meeting with behavioural specialists took place on 13.03.2025 to discuss the two residents. The behavioural specialist will meet both residents on 03.04.2025 and a positive behaviour support plan will be completed. There is currently an interim behavioural support plan in place to guide staff.

• Recruitment for the Transition Project Manager has commenced on 04.02.2025.

• A Steering Group, led by the PPIM on an interim basis until the Project Manager is recruited, has been established to oversee the entire transition. The group will meet regularly to monitor progress and address any challenges.

• A comprehensive transition plan template is in place for each resident, detailing their individual needs and outlining the specific actions required during the transition process. It includes dates of completed actions and serves as a guide for the service regarding the necessary information and next steps. This document remains active until each resident's transition is fully completed, with the PIC/Deputy Manager reviewing and updating it weekly. The plan has been successfully used in similar transitions in the past.

• The current PIC and their Deputy Manager are providing temporary cover for Orchid Lane and one other Centre with 2 residents in close proximity as the regular PIC was on leave. Ard Na Greine's regular PIC is scheduled to return on the 18.04.2025. The

temporary cover was in place from Sept 2024 to April 2025.

• A recruitment initiative began on the 25.11.2024 to implement an additional Deputy Manager position for the other Centre during the temporary arrangement, the post was filled for a short period however it remained open at the time of the inspection.

• There are bi-weekly 1:1 business meetings in place between PPIM and PIC to provide additional oversight and support to the PIC.

Regulation 26: Risk management procedures	Substantially Compliant

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

• A risk assessment was completed to address the impact the transition has on residents' wellbeing 05.03.2025.

• A risk assessment was completed to address the high use of agency staff 05.03.2025

• Any risks identified that may affect the residents' experience will be added to the risk register and monitored as part of the transition process.

Regulation 28: Fire precautions	Substantially Compliant

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

Six required fire evacuations have been scheduled for 2025.
1. 31.01.2025 – Completed
2. 21.03.2025 - Completed
3. 12.05.2025 (Deep Sleep)
4. 30.07.2025
5. 25.09.2025
6. 24.11.2025

Servicing report obtained from external fire safety company. A servicing report was obtained from the external fire safety company. Reports are now requested during each servicing and are kept on file

External fire safety company completed the service of emergency lights, fire alarms, fire extinguishers on 18.03.2025.

An assessment of the washing machine in the walk-in closet was completed by an external fire safety company on 25.03.2025. It was determined that although a fire door is not required, there is an alarm in place which mitigates risks. A risk assessment has been completed to address the concern.

Regulation 5: Individual assessment and personal plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:

• Outstanding OT assessments are being pursued. Referral submitted to funder's Occupational Therapist, currently awaiting date. • A meeting with behavioural specialists took place on 13.03.2025 to discuss the two residents. The behavioural specialist will meet both residents on 03.04.2025 and a positive behaviour support plan will be completed. There is currently an interim behavioural support plan in place to guide staff.

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support: • A meeting with behavioural specialists took place on 13.03.2025 to discuss the two residents. The behavioural specialist will meet both residents on 03.04.2025 and a positive behaviour support plan will be completed. There is currently an interim behavioural support plan in place to guide staff.

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Substantially Compliant	Yellow	30/06/2025
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	30/06/2025
Regulation 15(4)	The person in charge shall ensure that there is a planned and actual staff rota,	Substantially Compliant	Yellow	30/06/2025

	showing staff on duty during the day and night and that it is properly maintained.			
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Substantially Compliant	Yellow	31/12/2025
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.	Substantially Compliant	Yellow	30/06/2025
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Substantially Compliant	Yellow	30/06/2025
Regulation 24(4)(a)	The agreement referred to in paragraph (3) shall include the support, care and welfare of the resident in the	Substantially Compliant	Yellow	17/03/2025

	designated centre and details of the services to be provided for that resident and, where appropriate, the fees to be charged.			
Regulation 25(3)(a)	The person in charge shall ensure that residents receive support as they transition between residential services or leave residential services through:the provision of information on the services and supports available.	Substantially Compliant	Yellow	30/06/2025
Regulation 25(4)(b)	The person in charge shall ensure that the discharge of a resident from the designated centre take place in a planned and safe manner.	Not Compliant	Orange	30/06/2025
Regulation 25(4)(c)	The person in charge shall ensure that the discharge of a resident from the designated centre is in accordance with the resident's needs as assessed in accordance with Regulation 5(1) and the resident's personal plans.	Substantially Compliant	Yellow	30/06/2025
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the	Substantially Compliant	Yellow	05/03/2025

	designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.			
Regulation 28(2)(b)(iii)	The registered provider shall make adequate arrangements for testing fire equipment.	Substantially Compliant	Yellow	04/03/2025
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	04/03/2025
Regulation 31(1)(c)	The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: any fire, any loss of power, heating or water, and any incident where an unplanned evacuation of the centre took place.	Not Compliant	Orange	03/03/2025
Regulation	The person in	Not Compliant	Orange	03/03/2025

31(1)(e)	charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: any unexplained absence of a resident from the designated centre.			
Regulation 31(1)(f)	The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: any allegation, suspected or confirmed, of abuse of any resident.	Not Compliant	Orange	03/03/2025
Regulation 31(3)(d)	The person in charge shall ensure that a written report is provided to the chief inspector at the end of each quarter of each calendar year in relation to and of the following incidents occurring in the designated centre: any injury to a resident not required to be notified under paragraph (1)(d).	Not Compliant	Orange	03/03/2025
Regulation 34(2)(b)	The registered provider shall ensure that all	Substantially Compliant	Yellow	03/03/2025

	complaints are investigated promptly.			
Regulation 05(1)(b)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out subsequently as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.	Substantially Compliant	Yellow	30/06/2025
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.	Substantially Compliant	Yellow	30/04/2025