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:	Rosewood
Name of provider:	Sunbeam House Services CLG
Address of centre:	Wicklow
Type of inspection:	Unannounced
Date of inspection:	29 April 2025
Centre ID:	OSV-0007932
Fieldwork ID:	MON-0046335

About the designated centre

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

Rosewood is a designated centre operated by Sunbeam House Services CLG. The centre is located in a busy town in county Wicklow. It accommodates two adults with intellectual disabilities. The centre provides residents with residential support in a safe, secure, and stimulating environment, and is committed to supporting residents to live a life of their choosing as independently as possible. Residents are supported by a key worker and are facilitated to avail of additional organisational and community multidisciplinary supports. The centre is managed by a full-time person in charge with support from a deputy manager, and the staff team consists of social care workers and a dedicated day services facilitator.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	2

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
Tuesday 29 April 2025	09:45hrs to 17:10hrs	Michael Muldowney	Lead

What residents told us and what inspectors observed

This unannounced inspection was carried out as part of the ongoing regulatory monitoring of the centre. The inspector used observations, conversations with staff and residents, and a review of documentation to form judgments on the effectiveness of the provider's arrangements to safeguard and protect residents from abuse, and how they ensured that residents' rights were being promoted and upheld in the centre. As part of the inspection, the inspector also assessed aspects of the provider's implementation of its improvement plan which was a response to an overview report published by HIQA in February 2025.

The previous inspection of the centre in July 2024 found that residents were experiencing a poor quality service with recurring safeguarding issues and insufficient oversight of restrictions on residents' rights.

This inspection found improvements under some of the regulations inspected; for example, there was a full staff team in place to support residents. However, the inspector found that the safeguarding issues had not been mitigated, and this was resulting in ongoing risks to residents' safety, wellbeing, rights and overall quality of life. Residents told the inspector that they experienced physical and verbal aggression, and did not feel safe or happy in their home. The inspector also found that the governance and monitoring of the centre required improvement to ensure that actions to drive improvements were being monitored and progressed.

There were two residents living in the centre. The residents were supported by staff to engage in separate social activities. The inspector spoke with both residents separately at different times.

One resident told the inspector that they did not like loud noises, and said that property in the house was damaged by the other resident. They showed the inspector around their home, and said that they enjoyed grocery shopping and doing some cooking and baking with staff support. They had enjoyed a recent day trip with staff, and said that they visited their family regularly. They were also planning their birthday party, and spoke about the presents they planned to buy. The resident had complex communication means, and used gestures and some words. The resident shared jokes with staff. However, the inspector observed that staff could not always understand the resident, and at times when they incorrectly interpreted what they were saying, the resident said "no, no" and appeared frustrated. This issue was also found during the previous inspection of the centre, and while the resident's communication needs had been recently assessed, there was no communication plan for staff to follow, and they had not received associated training (except for staff). The resident also raised a potential safeguarding concern outside of the centre, and the inspector brought this to the attention of the person in charge for them to assess.

The other resident told the inspector that they experienced regular peer-to-peer

abuse, including being intimidated, and verbally and physically assaulted (resulting in injuries). The resident said that they wanted to move out and live happily alone. The inspector also observed the resident speaking with the person in charge and deputy manager. The resident was very worried about their own safety and for the safety of staff if the other resident displayed aggressive behaviour. The local management team tried to alleviate the resident's concerns by providing verbal reassurances.

The resident also said that they did not get on with some staff and made an allegation against one staff. The management team said that they would report the allegation. The resident said that they got on with the rest of the staff, and wanted them to continue supporting them when they moved out of the centre. They told the inspector that they liked to go out shopping and walking independently, visiting their family, and going to the cinema with staff. They liked animals, and had their own pet cat and fish; and said that they would like to start dog walking. They showed the inspector their bedroom and some of their possessions, and pointed out damage to their door frame. The resident also said that they consented to having restricted access to certain property.

The centre comprises a spacious two-storey house in a large town. A wide range of amenities and services are within a very short walking distance of the house. There is a separate residential service attached to the house; however, it is not managed as part of the centre's remit. The inspector walked around the house with the person in charge and the residents at different times during the inspection. The house comprised residents' bedrooms, bathrooms, a utility room, a kitchen and dining room, two sitting rooms, a sun room, offices, storage rooms, and a nice garden. The inspector observed that three fire doors (including a bedroom door) did not close fully when released, and that upkeep was required throughout the house. For example, walls needed to be repainted, and some door frames were damaged. The premises are discussed further under regulation 17.

The inspector also observed notice boards with information for residents on infection prevention and control (IPC), complaints and safeguarding, and information on staff, activities and the menu in the kitchen-dining room. However, the menu was from the previous week. IPC information related to a certain type of personal protective equipment that was used during outbreaks of infection. The purpose of displaying this information was unclear as there were no recent suspected or confirmed outbreaks in the centre. The inspector also observed personal information about a resident displayed in the kitchen-dining room that posed a risk to their privacy (this matter is discussed further under regulation 9).

The inspection was facilitated by the deputy manager and person in charge. They commenced in their roles in September 2024 and January 2025. They said that while the residents were happy at times, overall they were not compatible to live together and this was resulting in frequent incidents of abuse. They endeavoured to manage the safeguarding risks through planned holidays, timetables of separate activities, and the implementation of support plans. However, the interventions were not fully effective, and they said that the incidents could be unpredictable and difficult to manage. They said that both residents want to move out, and that it is

upsetting for staff to see residents being distressed. The provider's senior management and multidisciplinary team were meeting regularly to review the known safeguarding risks, and a formal steering group was formed to lead the transition of both residents to more suitable homes. Both residents were on the provider's internal transfer list, but suitable homes were not available. One potential home had been identified for one resident to potentially move to; however, the transition has not been confirmed yet.

The local management team also told the inspector that improvements were needed to the quality of residents' personal plans and key worker meetings, the upkeep of the premises, recording of incidents, and the implementation of quality improvement actions. They were satisfied with the staffing arrangements, and had made some improvements to the management of restrictive practices. The local management team demonstrated a good understanding of the residents' needs and individual personalities. The residents also appeared comfortable and familiar with them.

Overall, the inspector found that the centre was not fully meeting the residents' assessed needs, and that the provider had not mitigated known risks to their safety and wellbeing. Residents communicated that they were not fully happy in the centre, felt unsafe at times, and were experiencing ongoing abuse. Additionally, the provider's oversight of quality improvement actions required improvement to ensure that actions were being monitored and progressed to contribute to a safer and better quality service for residents.

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 provided in the centre. This inspection reviewed the provider's arrangements for safeguarding adults from abuse and ensuring that their rights were promoted and protected.

In February 2025, HIQA published an overview report of governance and safeguarding in designated centres operated by the provider. The report incorporated the findings of 34 inspections carried out in 2024; and focused on five regulations (Regulation 5: Individualised assessment and personal plans, Regulation 7: Positive behaviour support, Regulation 8: Protection, Regulation 15: Staffing, and Regulation 23: Governance and Management). The provider was found to be not-compliant under those regulations. The report included a compliance plan from the provider that outlined its actions to address the poor findings and to come into compliance.

This inspection also formed part of the Chief Inspector’s overall assessment of the provider’s implementation of the compliance plan and its effectiveness in driving improvements. The inspector reviewed a sample of the compliance plan actions, and found that they had been achieved and were contributing to an improved quality of

service. However, the implementation of some actions required monitoring by the provider to ensure that they were sustained.

There were some good oversight and monitoring systems in place. For example; annual reviews (which consulted with residents) and six-monthly unannounced visit reports had been carried out and identified clear actions for improvement. However, the inspector found that not all actions outlined in a provider assurance report, dated October 2024, had been implemented. Additionally, local audits, such as on personal plans, were incomplete, which limited their effectiveness.

The provider planned for the residents to move to more appropriate homes to mitigate the ongoing incompatibility issues. However, the associated transition plan had not been finalised and the steering group formed to oversee the transitions had not yet met.

The inspector found that aspects of the centre were well resourced, such as staffing arrangements and residents' access to certain multidisciplinary services. The staff skill-mix comprised social care workers, and there were no vacancies. The management team were satisfied that the arrangements were appropriate to the residents' needs. The management structure included a deputy manager, a person in charge, a senior services manager, an operations director, and a chief executive officer; and there were systems for them to communicate.

The inspector reviewed the recent staff rotas. Minor improvements were required to some of the rotas, and were made by the person in charge during the inspection. The rotas also showed that two agency staff had worked in the centre in recent months. There was an agency induction folder with pertinent information for them to review, and a signature sheet for them to sign to confirm that they received an induction. However, one agency staff had not signed the induction sheet to show that they had received an induction.

The inspector reviewed the staff training log, and found that not all staff had completed necessary training. These deficits posed a risk to the quality and safety of care they provided to residents.

The inspector reviewed formal supervision records for six staff. Supervision was overdue for two staff; it was last done in September 2024. However, the deputy manager and person in charge were present in the centre on a regular basis to provide informal support and supervision.

Regulation 15: Staffing

The staff skill-mix comprises social care workers, a deputy manager and the person in charge. Two social care workers worked during the day, and one social care worker worked at night. The local management team were satisfied that the staff skill-mix and complement was appropriate. There were no vacancies, and staff leave

was covered by agency and relief staff.

The inspector reviewed the February, March and April 2025 planned and actual staff rotas. The rotas showed that planned staffing levels were in place. Generally, the rotas were well maintained, but the full names of all staff were not recorded on two dates. The person in charge rectified this during the inspection by adding the staff full names.

The inspector did not review staff Schedule 2 files as part of the inspection.

Judgment: Compliant

Regulation 16: Training and staff development

Staff were required to complete training as part of their professional development and to support them in the delivery of appropriate care and support to residents. The training included safeguarding of residents, first aid, positive behaviour support, communication, complaints, and de-escalation of challenging behaviour.

The inspector reviewed the staff training log with the person in charge and deputy manager. The log listed eight staff, and showed that all staff had completed safeguarding and complaints management training. However;

- One staff required de-escalation training (they were on a waiting list for the training)
- Two staff required first aid training (which was booked for them to attend)
- Two staff required 'do the right thing' training
- Three staff required online human rights training
- Five staff required positive behaviour support (which was booked for July and September 2025)
- Seven staff required communication training (which was booked for May 2025)

The deficits in staff training posed a risk to the quality and safety of the care and support provided to residents and their wellbeing. For example, as discussed in the first section of the report, the inspector observed that at times staff had difficulties in understanding a resident's communication. The outstanding training in de-escalation and positive behaviour support also posed a to how effectively all could respond to the recurring physical and verbal aggression in the centre that impacted staff and residents.

There were also plans for staff to complete trauma-informed care; however, the dates of the training had not been confirmed.

Judgment: Not compliant

Regulation 23: Governance and management

The provider had not ensured that their management systems were fully effective in ensuring that the service provided in the centre was safe, appropriate to residents' needs or effectively monitored.

The management structure included a deputy manager and person in charge. They also had responsibility for another centre and reported to a senior services manager. The senior services manager reported to an operations manager. There were systems for them to communicate, including business and governance meetings.

The provider's plans to transition residents to more appropriate homes also required progression. For example, while a steering group had formed to oversee the process, the group had not yet met, and the written transition plan for residents had not been finalised.

The provider had implemented systems to monitor the quality and safety of the service, including detailed annual reviews, unannounced visit reports, and other audits. However, the inspector found that the implementation of some audits needed improvement. For example, recent personal plan audits in February 2025 had not been completed in full (inspection findings in relation to personal plans are discussed in more detail in the quality and safety section of the report). Additionally, not all the actions from the recent annual review had been addressed.

The inspector also reviewed the implementation of the improvement actions outlined in a written provider assurance report submitted to the Chief Inspector in October 2024 in response to their concerns about residents' safety in the centre. The inspector found that the not all actions had been completed or sustained. For example, key worker meetings were not taking place in the manner specified. This demonstrated poor oversight from the provider to ensure that actions to improve the service provided to residents in the centre were fulfilled.

The inspector also reviewed the implementation of aspects of the provider's compliance plan (in response to the overview report published in February 2025). The inspector found examples of actions implemented, such as:

- The person in charge received additional training in safeguarding reporting
- The person in charge attended a governance workshop on best practice that was delivered by the chief executive officer
- An induction folder was in place for agency staff working in the centre
- The positive behaviour support plan traffic light system was in place
- The visitor’s book relayed that the person participating in management had visited the centre unannounced in January 2025

However, the implementation of the actions required review by the provider to ensure that they were sustained; for example:

- The aforementioned traffic light system in the centre required updating
- Induction records were only completed for one of the two agency staff who had recently worked in the centre

Judgment: Substantially compliant

Quality and safety

This section of report focuses on regulations related to the quality and safety of the care and support provided to residents in the centre and how it affects residents' safety and wellbeing. The inspector found that residents were incompatible to live together and this was leading to them experiencing ongoing physical and verbal abuse and intimidation, which was adversely impacting on their safety, quality of life and wellbeing. Residents told the inspector that they were upset and worried about their safety and the safety of staff.

The provider had determined that residents were not compatible to live together however, the associated compatibility assessment was not available during the inspection for the inspector to read. The inspector found that safeguarding incidents had been reported, and safeguarding plans were in place. However, the safeguarding arrangements were not effective, and this was seen through recurring incidents and ongoing concerns expressed by staff, the management team, and residents.

The ongoing incompatibility issues also adversely impacted on residents' rights and dignity in their home. The inspector found that the provider's arrangements to ensure that residents' concerns were escalated and that they were consulted with required improvement. Complaints had not been raised in line with the provider's policy, despite residents expressing unhappiness in their home, and key worker meetings were not being carried out in the manner specified by the provider. However, residents had been supported to access independent advocacy services in the past, and a new referral had been recently submitted for one resident.

The maintenance of residents' personal plan was found to require improvement and better oversight. The inspector found that some residents' care needs did not have an associated care plan to guide staff practice, which posed a risk to their care. The review and updating of residents' personal goals was particularly poor. The inspector found that goals made by residents in 2021 and 2023, such as getting paid work and going on particular social and leisure activities, had not been reviewed since then.

Additionally, there was an absence of communication plans from an appropriate multidisciplinary team member for staff to follow. While assessments had been carried out, the associated care plans had not yet been prepared. Only one staff member had completed training in communication, and overall it was not

demonstrated during the inspection that residents' communication needs were fully supported.

Residents required support to manage their behaviours of concern. Up-to-date support plans had been prepared by the provider's multidisciplinary team and were available to guide staff practice. The inspector also reviewed the arrangements for the management of restrictive practices in the centre, and found that some minor improvements were required to ensure that all restrictions were identified, reviewed and applied in line with evidence-based practice.

There was a risk management policy, and the risks pertaining to the centre were reflected on an associated risk register. However, the inspector found that not all risk presenting in the centre (such as a particular infection risk) had been assessed, and some of the control measures listed in risk assessments were not fully in place such as staff training.

The premises comprise a large two-storey house. The house comprises individual resident bedrooms, sitting rooms, an open-plan kitchen and dining room, a small utility room, a sun room, a staff room and office, storage rooms, and a rear garden. The premises required upkeep and maintenance throughout, and these matters had been reported by the management team to the provider's maintenance department.

Regulation 10: Communication

The provider had not ensured that residents were assisted and supported at all times to communicate in accordance with their needs and right to express themselves.

Communication assessments by the provider's speech and language therapy service had been recently completed for both resident; however, updated associated communication plans had not yet been prepared to guide staff practice.

The inspector observed one resident having difficulty at times being understood by staff. The resident used a combination of manual signs, gestures and words when communicating with staff and the inspector, and said "no, no" when staff incorrectly interpreted what they were saying. The resident had a communication device; however, staff had not been trained in using it, and the device was currently with the provider's communication team for updating.

One staff had completed manual sign communication training, and the rest of the staff team were due to attend the training in May 2025.

Judgment: Substantially compliant

Regulation 17: Premises

The premises comprised a large two-storey house with a front driveway and nice rear garden. Within the premises, there are two resident's bedrooms, an open-plan kitchen and dining room, sitting rooms, a utility room, storage rooms, offices, bathrooms, and a sun room.

The facilities appeared to be in good working order and there was sufficient space and storage for residents' belongings. The premises were bright and there was comfortable furniture. Efforts had been made to make the house homely; for example, photos of residents were on display. Parts of the house required upkeep and maintenance. For example:

- Three fire doors did not close fully when released. This issue had been risk assessed by the local management team.
- The glass in the front door was broken and covered with hard plastic
- Repainting was required throughout the house, including the dining room, banisters, and a sitting room
- Some door frames were damaged, including a resident's bedroom door frame

The above matters had been raised with the provider's maintenance department by the local management team.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

The provider had prepared a written risk management policy that outlined how risks were identified, assessed, controlled and monitored. The inspector reviewed a sample of the risk assessments relevant to the centre and individual residents.

The assessments related to a wide range of risks, including violence and aggression, self-injurious behaviour, choking, and the premises' hazards. The risk assessments were up-to-date and outlined the measures to be in place to reduce and mitigate the risks. However, the inspector found that some of the measures were not in place; for example, certain staff training. This posed a risk that the assessment of those risks was not accurate.

Additionally, the inspector found that not all risks presenting in the centre had been identified and assessed; for example, a particular infection prevention and control risk from residents' behaviours of concern. Therefore, it was not demonstrated that appropriate measures were in place to reduce and mitigate this risk.

Incidents were recorded on the provider's electronic information system, and reviewed by the management team. However, the inspector found that appropriate

arrangements for the recording of incidents were not fully in place. The inspector read multidisciplinary team meeting minutes from January 2025 which noted that improvements were needed in the recording of behavioural incidents using a particular form. However, the deputy manager told the inspector that while incidents had occurred since then, only one form had been completed.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

The provider had not ensured that the centre was suitable for meeting the needs of the residents and the ongoing safeguarding issues were adversely impacting on residents' safety and wellbeing. Additionally, the inspector found that the maintenance of residents' personal plans was poor and required improvement.

The provider had determined that the residents were not suitable to live together and required sole occupancy homes. However, alternative homes had not yet been sourced and residents continued to experience an unsafe service in the centre. This is discussed further under regulation 8.

The inspector reviewed both residents' assessments of need and personal plans. The deputy manager told the inspector that a compatibility assessment outlining the residents' accommodation needs had been completed; however, it could not be found during the inspection (a copy of the assessment shown to the inspector was incomplete). The care plans viewed by the inspector included health, personal and social care plans. The plans were poorly maintained and required improvement, particularly in relation to social and personal goals. For example:

- The safety plans did not refer to the ongoing peer-to-peer risks
- There were no plans for a particular health care need and self-injurious behaviour
- A budget plan, dated September 2024, required revision as it noted incorrect figures
- A shared spaces plan referred to the use of visual schedules, this intervention was not being implemented at the time of the inspection
- Two personal goals, made in 2021, had not been reviewed. Another three goals made in 2021 were last reviewed in 2023. Three goals made in 2023 had not been reviewed

Judgment: Not compliant

Regulation 7: Positive behavioural support

The provider had implemented systems to ensure that residents received support to manage their behaviours of concern. The inspector reviewed both residents' behaviour support plans. The plans were up-to-date, had been prepared with input from the provider's multidisciplinary team, and were available to guide staff practice.

Members of the provider's multidisciplinary team had attended team meetings to guide staff on the implementation of the plans, and staff were also required to complete relevant training in this area. However, as detailed under regulation 16, not all staff had completed this training, and this posed a risk to the quality of the care and support provided to residents.

Restrictive practices implemented in the centre included the use of psychotropic medicines, locked vehicle doors, and restricted access to sharps and residents' property and money. The restrictions had been submitted to the provider's rights committee for oversight, and were recorded on a register. Easy-to-read information had also been prepared on the restrictions to help residents understand how they were used. The inspector spoke with one resident about a restriction affecting them, and they said that they agreed to it.

However, some improvements were required. The restrictive practice register did not include a restriction identified during the inspection: a vehicle seating plan.

Judgment: Substantially compliant

Regulation 8: Protection

The registered provider had implemented systems to safeguard residents from abuse, which were underpinned by a written policy. However, these systems were not fully effective, and the ongoing incompatibility issues were impacting on residents' safety, wellbeing and overall quality of life.

Residents and staff told the inspector that the incidents were frequent, and residents expressed upset and worry about their safety. The recent annual review (March 2025) also noted that residents were unhappy in the centre, a resident's assessment of need (October 2024) noted that they were unhappy and did not feel safe in the centre, a safeguarding plan (March 2025) noted that residents did not feel safe, and recent multidisciplinary team meeting minutes (January 2025) noted that the residents were not suitable to live together.

Since the previous inspection of the centre 29 July 2024, 17 notifications of allegations of peer-to-peer abuse had been submitted to the Chief Inspector. These notifications included allegations of intimidation (such as residents being chased around the house and threatened), physical (including residents being hit with closed fists and table legs, and spat at) and verbal abuse. Some of the incidents had resulted in physical injuries such as bruising on 16 April 2025. Another recent notification, 17 April 2025, noted that one resident appeared upset and frustrated after an incident, and told staff that they wanted to end their life. Additionally,

during another incident, 17 October 2024, a resident contacted the Garda Síochána for help.

The inspector reviewed a sample (three) of the notified incidents to verify that they were reported to the national safeguarding office, and found that they had been. Associated plans had also been prepared which outlined the measures to protect residents from abuse. Measures included support from multidisciplinary team services, individualised time tables for residents, and separate holidays. However, the measures were not fully effective, and this was seen through recurring incidents.

Judgment: Not compliant

Regulation 9: Residents' rights

The provider had not ensured that residents' rights were promoted and protected within the centre. As discussed throughout the report, ongoing safeguarding concerns had not been mitigated and were adversely impacting on the residents' quality of life, wellbeing, and right to dignity.

The provider's systems for residents to escalate their concerns about their safety and living arrangements were not being fully utilised. Staff had received in-person complaints training; however, complaints had not been raised on residents' behalf in relation to their known dissatisfaction with their living arrangements and the incidents of abuse they were experiencing.

The arrangements for ensuring that residents were consulted with and participated in decisions about their care and the organisation of the centre were poor. The provider submitted written assurances to the Chief Inspector in October 2024 in relation to how they would ensure that residents' rights were protected in the centre. Part of the assurances included that monthly key working sessions would take place and discuss rights, consent and restrictive practices. However, the inspector reviewed the meeting records with the person in charge and found that only two meetings were recorded for one resident, and only one meeting for the other resident.

The inspector observed personal information about a resident displayed in the kitchen-dining room. This posed a risk to the resident's privacy. The person in charge removed the information during the inspection.

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

Compliance Plan for Rosewood OSV-0007932

Inspection ID: MON-0046335

Date of inspection: 29/04/2025

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 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
The service's training matrix has been updated and now it records both completed training dates and upcoming bookings.

All staff have been informed of the outstanding mandatory training modules they are required to complete. To facilitate this, some staff have been allocated dedicated administration time outside of their regular on location shifts. The expected completion date for all mandatory training is 30/09/2025 due to place availability.

The current status of staff training is as follows:

• All staff have now completed CPI Crisis Intervention Training or De-escalation Training.

• All staff have now completed the provider's mandatory training in rights "Understanding & Promoting Rights" (Long Version) in Open Future Learning.

• First Aid Training: Two staff members are required to repeat first aid training and are currently booked for sessions from June 10th to 12th and July 15th to 17th. Full completion for all staff is expected on the 17/07/2025.

Other Non-Mandatory Trainings:

• Specialised Person-Centred Positive Behaviour Supports Training: Three staff members have completed this training and five staff members are booked to attend. All staff are expected to have this completed by 13/06/2026. PBS specialist willl provide a de-briefing session with the staff team on the 13/06/2025.

• Additional to all staff having completed the mandatory training "Understanding & Promoting Rights (Long Version)" in Open Future Learning.

• All current staff in the location have completed HSE human rights training.

• All staff have completed Do the Right Thing: HSE Risk and Incident Management in HSEland training.

• Communication Training: All staff have completed communication with adults with an ID on HSE land. All staff will have in-person communication training completed by the 30th of July 2025.

• Three staff members have currently completed manual sign communication/lamh training. The remaining five staff members will have this completed by the 8th of September due to availability.

• Staff will complete communication device training by 30th of June 2025.

• Trauma-informed Care Training will be completed by all staff by the 24th of June 2025.

All staff will have completed behaviour support training by the 13th of June 2025.

Regulation 23: Governance and management	Substantially Compliant

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

• New project manager to lead the transition process began on 13/05/2025. PPIM had a handover meeting to discuss priorities and needs of the clients on the 20/05/2025.

• First steering group meeting to oversee transition process met on 16/05/2025. Regular meetings scheduled.

• Transition plan for residents was completed on the 23/05/2025. This is updated as required.

• A suitable local property has been identified for one resident. We have commenced the necessary processes, including occupational therapy and physio assessments, to further support the transition.

• In order to mitigate incompatibility concerns in the designated centre, extra staffing is being sourced to better support the residents and promote independence from each other.

• Full personal plan audits have been completed 29.05.2025.

• The PIC/Deputy will complete full audits on personal plans on a quarterly basis.

• Care plans for COPD and separate risk assessments related to escalation in behaviours, communication and mental health concerns have been completed.

• Personal goals have been on updated on 29/05/2025 And will be reviewed weekly.

• The PIC/DSM will review that this is being completed monthly.

• Communication plans for both residents have been completed. 13.05.2025.

• Communication passports for both clients have been completed 28.05.2025.

• Annual review actions will be completed by the 30.09.2025. However, actions will be update monthly by PIC/DSM as they are completed.

• The traffic light system in the centre has been updated. 15.05.2025.

• Induction records is being completed by PIC/Deputy or regular staff in their absence. PIC/Deputy review it as required.

• Supervision has now been completed with all staff.

Regulation 10: Communication	Substantially Compliant

Outline how you are going to come into compliance with Regulation 10: Communication:
• Three staff members have currently completed manual sign communication/lamh training. The remaining five staff members will have this completed by 6th of September 2025.

• All staff have completed online training in communicating with people with an ID online and in person training will be completed by the 30/07/2025.

• All staff will complete communication device training by 30/06/2025.

• Communication plans for both residents have been completed. 13.05.2025.

• Communication passports for both clients have been completed 28/05/2025.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
Management acknowledges that the premises are in need of upkeep and maintenance. These concerns were reported to the provider's maintenance department prior to the inspection, and there has been ongoing communication between both parties to address these issues.
In relation to the front door, the glass in the same was broken and has been replaced with hard plastic for health and safety reasons. This change was made due to repeated incidents where clients have struck the door against the stair post, as noted in multiple reports of concern.
The door will be replaced by the 30th of June.
Below is an update on the current status and planned actions related to the pending maintenance works in the premises.
• Fire Doors: This issue was assessed presviously by the local management team and a risk assessment was put in place following concerns about some fire doors not fully closing when released. External fire specialist visited the location on the 13th of May to assess the damage in the fire doors and maintenance is awaiting a quote. Once this is received, a plan of action will be finalized and implemented.

• Repainting throughout the house (including the dining room, banisters, and a sitting room) will be completed by the 30/06/2025. Banister was repainted on the 16/06/2025.

• Damaged door frames (including a resident's bedroom door frame. External specialist visited the location on the 13th of May to assess the damage in the fire doors and maintenance is awaiting a quote. Once this is received, a plan of action will be finalized and implemented.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
• All risks have been reviewed and updated to ensure an accurate reflection of control measures and risk rating. 30.05.2025

• Risk assessment for infection prevention and control was completed on the 01.04.2025 and present in IPC folder.

• Health and safety statement which includes risk of accidental injury is in place since March 2023 in the health and safety folder. This updated every 3 years or when required.

• ABC form completion was discussed with staff at team meeting on 16/05/2025. These are now being completed following behavioural incidents and PIC/Deputy will be reviewing that ABC forms are completed each week.

Regulation 5: Individual assessment and personal plan	Not Compliant

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

• Full personal plan audits have been completed 29.05.2025.

• The PIC/Deputy will complete full audits on personal plans on a quarterly basis.

• Care plans for COPD, skin picking and separate risk assessment related to escalation in behaviours, communication and mental health concerns have been completed.

• Personal goals have been on updated on 29/05/2026 and will be reviewed weekly.

• The PIC/DSM will review that this is being completed monthly.

• A second keyworker has been assigned to each of the residents, with the agreement of both the residents and the staff members. This will support more consistent keyworking and timely updates to individual plans.

• Keyworking Training Programme: Three key workers completed this training on 08/04/2025 and 27/05/2025. The remaining keyworker will complete this training on the 17th of June 2025.

• All the keyworkers have been informed about the need to update clients' personal plans and current goals. Key working notes are now updated monthly to accurately reflect resident's progress. This is regularly monitored by the PIC/Deputy. Completed.

• Quarterly audits of each resident's personal profile documentation, which commenced in May 2025, will continue and be carried out by the manager or deputy.

• Key worker notes and client's goals will be reviewed every three months. Any inconsistencies or outdated content will be flagged and followed up with the key workers.

• The PIC will meet biweekly with the PPIM for the next 8 weeks and will provide updates on the progress made and any challenges identified.

• The PPIM completes a governance and management review of the location quarterly.

• PPIM completes an unannounced visit at least quarterly.

• Compatibility assessment completed on the 25/05/2025.

• Budget plan for one resident has been reviewed to reflect the increase of cigarette prices 28/05/2025.

• Safety plans now reflect peer to peer issues for both residents. 26/05/2025/

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
• All staff have now completed CPI Crisis Intervention Training or De-escalation Training.

• Specialised Person-Centred Positive Behaviour Supports Training: Three staff members have completed this training and five staff members are booked to attend 13/05/2025.

• Restriction involving the use of vehicle/seating plan has been updated on restrictive register accordingly 23/05/2025.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
In order to address current safeguarding concerns in the designated centre and incompatibilities, the provider has put the following actions in place:

• Ongoing support by a Behaviour Specialist.

• Positive behaviour support plans are present for both clients.

• Regular reviews by Mental Health and Intellectual Disabilities (MHID) teams and GP. One resident has been attending MHID on a monthly basis with the most recent review taking place on the 08/05/2025 and next review appointment on the 12/06/2025. The second resident attends on a 6 monthly basis or sooner if required. The most recent appointments occurred on the 07/02/25 and 22/05/25.

• One resident is attending Psychology appointments on a biweekly basis which commenced on the 27/05/25 and the next appointment to occur on the 11/06/2025.

• Ongoing medication and MDT Client Case reviews.

• Engagement with independent advocates. One resident met with his advocate on the 29/08/24, and 29/05/2025.

• Regular breaks away from home for both residents to provide respite. The last holiday for one resident took place on the 19/05/2025.

• Introduction of day services for one resident which will commence on the 04/06/2025.

• New homes being sourced for both residents.

• New project manager to lead the transition process began on 13/05/2025. PPIM had a handover meeting to discuss priorities and needs of the clients on the 20/05/2025.

• The first steering group meeting to oversee transition process met on 16/05/2025. Regular meetings scheduled.

• Transition plan for residents was completed on the 23/05/2025. This is updated as required.

• A suitable local property has been identified for one resident. We have commenced the necessary processes, including occupational therapy and physio assessments, to further support the transition.

• In order to mitigate incompatibility concerns in the designated centre, extra staffing is being sourced to better support the residents and promote independence from each other.

To address concerns where one resident voiced that they wanted to end their lives, there is a risk assessment in place. All staff have completed "Let's talk about suicide" HSE online training. A safe talk in person training is taking place on the 16/06/2025 for staff to further upskill them.

As one resident has a history of making allegations regarding events and staff, two risk assessments are in place. One for allegations due to events in the community and a second risk assessment addressing allegations against staff and peers.

Additionally, an allegations tracker sheet have been implemented in the location due to the frequency of allegations made by one resident. This is monitored by the PIC/Deputy and shared with the provider's behaviour specialist.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights: In order to address current safeguarding concerns in the designated centre and incompatibilities, the provider has put the following actions in place:

• Ongoing support by a Behaviour Specialist the most recent visit with the recents occurred on the 17/04/25, 22/05/25 and 28/05/25.

• Positive behaviour support plans are present for both clients.

• Regular reviews by Mental Health and Intellectual Disabilities (MHID) teams and GP. One resident has been attending MHID on a monthly basis with the most recent review taking place on the 08/05/2025 and next review appointment on the 12/06/2025. The second resident attends on a 6 monthly basis or sooner if required. The most recent appointments occurred on the 07/02/25 and 22/05/25.

• Ongoing medication and MDT Client Case reviews.

• One resident is attending Psychology appointments on a biweekly basis which commenced on the 27/05/25 and the next appointment to occur on the 11/06/2025.

• Residents are supported to engage with an independent advocate One resident avails of this option and has met with them on 29/08/24, and 29/05/2025.

• Regular breaks away from home for both residents to provide respite. The last holiday for one resident took place on the 19/05/2025.

• Introduction of day services for one resident which will commence on the 04/06/2025.

• New homes being sourced for both residents.

• New project manager to lead the transition process began on 13/05/2025. PPIM had a handover meeting to discuss priorities and needs of the clients on the 20/05/2025.

• The first steering group meeting to oversee transition process met on 16/05/2025. Regular meetings scheduled.

• Transition plan for residents was completed on the 23/05/2025. This is updated as required.

• A suitable local property has been identified for one resident. We have commenced the

necessary processes, including occupational therapy and physio assessments, to further support the transition.

• In order to mitigate incompatibility concerns in the designated centre, extra staffing is being sourced to better support the residents and promote independence from each other.

A complaint is now logged for one resident in relation to their wish to move from their current home. Another advocate meeting has been scheduled for the 29/05/2025 to discuss it.

To ensure that residents are consulted with and participating in the decisions about their care, the following actions are being implemented:

• A second keyworker has been assigned to each of the residents, with the agreement of both the residents and the staff members. This will support more consistent keyworking and timely updates to individual plans.

• Keyworking Training Programme: Three key workers completed this training on 08/04/2025 and 27/05/2025. The remaining keyworker will complete this training on the 17th of June 2025
• All the keyworkers have been informed about the need to update clients' personal plans and current goals. Key working notes are now updated monthly to accurately reflect resident's progress. This is regularly monitored by the PIC/Deputy. Completed.

• Quarterly audits of each resident's personal profile documentation, which commenced in May 2025, will continue and be carried out by the manager or deputy.

• Key worker notes and client's goals will be reviewed every three months. Any inconsistencies or outdated content will be flagged and followed up with the key workers.

• The PPIM completes a governance and management review of the location quarterly.

• The PIC will meet biweekly with the PPIM for the next 8 weeks and will provide updates on the progress made and any challenges identified.

• PPIM completes an unannounced visit at least quarterly.

• Actions previously agreed on Provider Assurance Report 16/10/2024 are addressed in this compliance report and will be reviewed monthly by PIC/Deputy until full completion.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 10(1)	The registered provider shall ensure that each resident is assisted and supported at all times to communicate in accordance with the residents' needs and wishes.	Substantially Compliant	Yellow	30/07/2025
Regulation 10(2)	The person in charge shall ensure that staff are aware of any particular or individual communication supports required by each resident as outlined in his or her personal plan.	Substantially Compliant	Yellow	30/07/2025
Regulation 10(3)(c)	The registered provider shall ensure that where required residents are supported to use assistive technology and aids and appliances.	Substantially Compliant	Yellow	30/07/2025
Regulation	The person in	Not Compliant	Orange	30/09/2025

16(1)(a)	charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.			
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	30/09/2025
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	16/06/2025
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Substantially Compliant	Yellow	16/06/2025
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	29/05/2025
Regulation 26(1)(c)(ii)	The registered provider shall ensure that the	Substantially Compliant	Yellow	30/05/2025

	risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: the measures and actions in place to control the following specified risks: accidental injury to residents, visitors or staff.			
Regulation 26(1)(d)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: arrangements for the identification, recording and investigation of, and learning from, serious incidents or adverse events involving residents.	Substantially Compliant	Yellow	30/05/2025
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Substantially Compliant	Yellow	30/05/2025
Regulation 05(2)	The registered provider shall ensure, insofar as is reasonably practicable, that	Substantially Compliant	Yellow	29/05/2025

	arrangements are in place to meet the needs of each resident, as assessed in accordance with paragraph (1).			
Regulation 05(3)	The person in charge shall ensure that the designated centre is suitable for the purposes of meeting the needs of each resident, as assessed in accordance with paragraph (1).	Not Compliant	Orange	29/05/2025
Regulation 05(4)(a)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which reflects the resident's needs, as assessed in accordance with paragraph (1).	Substantially Compliant	Yellow	29/05/2025
Regulation 05(6)(a)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall be multidisciplinary.	Substantially Compliant	Yellow	29/05/2025
Regulation 05(6)(b)	The person in charge shall ensure that the	Not Compliant	Orange	29/05/2025

	personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall be conducted in a manner that ensures the maximum participation of each resident, and where appropriate his or her representative, in accordance with the resident's wishes, age and the nature of his or her disability.			
Regulation 05(6)(c)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall assess the effectiveness of the plan.	Not Compliant	Orange	29/05/2025
Regulation 05(6)(d)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances,	Not Compliant	Orange	29/05/2025

	which review shall take into account changes in circumstances and new developments.			
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	23/05/2025
Regulation 07(2)	The person in charge shall ensure that staff receive training in the management of behaviour that is challenging including de-escalation and intervention techniques.	Substantially Compliant	Yellow	23/05/2025
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.	Substantially Compliant	Yellow	23/05/2025
Regulation 07(5)(c)	The person in charge shall ensure that, where a resident's	Substantially Compliant	Yellow	23/05/2025

	behaviour necessitates intervention under this Regulation the least restrictive procedure, for the shortest duration necessary, is used.			
Regulation 08(1)	The registered provider shall ensure that each resident is assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection.	Substantially Compliant	Yellow	16/06/2025
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	16/06/2025
Regulation 09(2)(a)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability participates in and consents, with supports where necessary, to decisions about his or her care and support.	Substantially Compliant	Yellow	11/06/2025
Regulation 09(2)(b)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her	Substantially Compliant	Yellow	11/06/2025

	disability has the freedom to exercise choice and control in his or her daily life.			
Regulation 09(2)(c)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability can exercise his or her civil, political and legal rights.	Substantially Compliant	Yellow	11/06/2025
Regulation 09(2)(e)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability is consulted and participates in the organisation of the designated centre.	Substantially Compliant	Yellow	11/06/2025
Regulation 09(3)	The registered provider shall ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.	Not Compliant	Orange	11/06/2025