Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Disabilities (Adults).

Issued by the Chief Inspector

Name of designated centre:	Helensburgh
Name of provider:	Sunbeam House Services CLG
Address of centre:	Wicklow
Type of inspection:	Unannounced
Date of inspection:	29 October 2025
Centre ID:	OSV-0001703
Fieldwork ID:	MON-0047661

About the designated centre

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

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

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
Wednesday 29 October 2025	09:40hrs to 17:20hrs	Jacqueline Joynt	Lead

What residents told us and what inspectors observed

This unannounced inspection was carried out as part of the regulatory monitoring of the centre. It particularly focused on how the provider safeguarded residents from abuse, promoted their human rights, and empowered them to exercise choice and have control in their lives. As part of the inspection, the inspector also assessed aspects of the provider's implementation of their organisation's improvement plan which was a response to an overview report published in February 2025.

The inspector used observations, conversations with the person in charge, the deputy manager and staff members as well as engagements with residents, and a review of documentation to form judgments on compliance with the regulations inspected.

The designated centre was registered for six residents. On the day of the inspection, there were four residents living in the centre. All residents were living in the downstairs section of the house and did not access the upstairs facilities in the premise. Due to residents physical and aging support needs, they were unable to avail of this area of their home independently. On the previous inspection of the centre in 2024, concerns had been raised in relation to the ageing resident group in the designated centre and their changing mobility needs.

The inspector was provided with the opportunity to meet and speak with all four residents. On the day of the inspection, one resident attended their day service, two residents went out with their staff for a walk and lunch in a local café and one resident, who has retired, relaxed in the sitting room chatting to staff members and watching television.

The inspector met the residents as a group and also throughout different times in the day, on a one to one basis. Where appropriate, staff supported the resident with the conversation and provided prompts, in line with their communication needs, to support them relay their views. One of the residents, who met with the inspector independently, told the inspector that they were “fed up” of the way their peer shouted at them. They said they did not want to live with them anymore as they were making them feel upset. The resident was visibly upset when relying their views to the inspector.

Another resident told the inspector that they "loved living in their home" and "loved who they lived with". However, they told the inspector that they did not like it when their housemates were shouting at each other. They said that when there was shouting between their housemates they would leave the room and go to their bedroom as it was upsetting to listen to.

The resident spoke to the inspector about their housemate who had recently passed away. They expressed how much they missed their friend and in particular, how they missed the conversations they had with them when they called into their room.

The resident said that staff had been very supportive and that, they and their housemates, had been provided with counselling to support them with their grief.

All residents were happy to show the inspector their bedrooms. Residents told the inspector that they had been consulted in the layout and décor or their room. One resident had recently moved from an upstairs room to a ground floor room which better met their accessibility needs. This was also part of the recommendations from an occupational therapist report.

The resident relayed their happiness with their new bed, new arm chair and new large television. The inspector observed that there was ample storage space in the room and it was filled with family photographs, an array of soft toys and memorabilia that was important to the resident. There was a table and chair in the room which was used in the evenings for the resident to eat their dinner at. This meal time arrangement was one safeguarding measure in place to manage the environment at mealtimes and to reduce the risk of peer-to-peer incidents occurring. It was also recognised as a rights restriction, as, although it provided a safer environment for residents, it was impacting on their choice of where they ate their evening meal.

Communal areas in the house presented as welcoming and homely. There was a large sitting room to the front of the house that contained a couch, arm chairs as well as a television and a table and chair by the bay window. The room including pictures on the walls, paintings and photographs. There was a fish tank that was well maintained and provided a relaxing ambiance to the room.

The kitchen was located to the rear of the house and included a dining area with tables. The inspector was informed by staff, that for the most part, this space was residents preferred area to spend time in and the inspector observed residents move between the dining area and sitting room and their own rooms throughout the day. There was an accessible bathroom on the ground floor however, due to its size some residents could not be accommodated to have a bath as there was insufficient room for a manual handling hoist to support them to do so.

The inspector observed the entrance and hallway into the house to be clean, bright and welcoming and included murals of trees on the walls which the residents had been involved in decorating. The house was decorated in a Halloween theme from outside the front door right through to the hallway and provided a jovial and seasonal theme to the residents' home. There was also a notice board that provided a lot of easy-to-read and picture format information for residents. The information related to safeguarding, advocacy, the designated officer and other information that kept residents informed about their home and service.

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

and caring interactions. However, there was a high number of agency staff that worked in the centre which meant that continuity of care to residents could not always be ensured. On speaking with one resident about a staff member who was supporting them that morning, the resident struggled to remember the staff member's name and referred to the staff member on a number of occasions as, "the agency staff".

The provider and local management had implemented arrangements to support residents to make choices and decisions, and consulted with them about their care and support, and on matters related to their home. The residents communicated using primarily verbal communication however, they were also provided with a selection of easy reads to support and enhance their understanding of matters that were important to them. Communication passports were in place to guide staff on communicating effectively with residents to ensure that they were understood.

Overall, this inspection found a notable decrease in compliance since the last inspection of the centre in 2024. The provider had recently self-identified deficits in local governance and management systems of the designated centre and, in response to this, the provider had already created an improvement plan to address these deficits, the plan outlined a high number of actions requiring completion. This plan was at it's initial stages of implementation at the time of the inspection.

In summary, incompatibility issues, as well as the layout of the premises, were negatively impacting on residents' lived experience. Some of the measures implemented to reduce the risk of safeguarding incidents were effective but, in turn, had resulted in additional restrictive measures being implemented which not only infringed upon the resident's autonomy but also restricted their freedom of movement within their own home. In addition, high use of agency staff meant that residents were not always in receipt of consistent support and care by staff who were familiar to them.

In response to the levels of non-compliance found on inspection, the Office of the Chief Inspector of Social Services invited the provider to attend an escalation meeting requiring the provider to bring the centre back into compliance.

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

Capacity and capability

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 an organisation improvement plan from the provider that outlined its actions to address the poor findings and to come into compliance. This inspection formed part of the Chief Inspector's overall assessment of the provider's implementation of the provider's plan and its effectiveness in driving improvements.

While there had been some traction on this plan, a number of areas required review and consideration by the provider.

For example;

Key worker training programmes for staff, due for completion by December 2025, were underway. Seven staff had completed the training, two staff were booked on training the following week and four staff including, the person in charge and deputy manager, had yet to complete the training.

Personal plan profiles had been recently implemented in each resident's personal plan, and there was a checking system in place for them to be audited on a quarterly basis.

As part of the enhancement of person participating in management (PPIM) governance and management oversight arrangements for the provider's designated centres, quarterly governance and assurances and business support meetings between the person in charge and person participating in management were in place. However, only one meeting had been completed with the person in charge and previous PPIM. Since September, a meeting had taken place with the interim PPIM and the deputy manager.

The provider had also rolled out a resilience training programme for persons in charge. Phase one of the programme commenced in July 2024 with 35 participants on the course. The person in charge for this centre was not included on phase 1 and there had been no update about the roll-out of the second phase.

There was an induction folder for agency staff in place and this was available for agency staff to review. The folder included pertinent information for staff to familiarise themselves with residents' support needs and other service delivery matters. However, there was insufficient evidence in place to demonstrate that all of the thirteen agency staff who worked in the centre between September and October had been provided with an appropriate induction.

Not all agency staff were provided with access to the organisations information technology (IT) systems which contained important information about residents. As such, agency workers were not being provided with the opportunity to be able to review recorded resident reports and plans or to be able log incident reports for residents ensure accurate and important information relating to residents was passed on.

The findings from this inspection demonstrated the following:

Since the previous inspection, there had been a decrease in the level of compliance. Prior to the inspection, the provider had self-identified the decrease in compliance and the need for enhanced governance and oversight of the centre and had assigned an interim person participating in management of the centre. The provider and the interim person participating in management had developed a centre-specific service improvement plan in an effort to bring the centre back into compliance and ensure a quality and safe service was provided to the residents living in the centre.

The plan was reviewed on a weekly basis by the by the interim person participating in management and the deputy manager. On the day of the inspection, the inspector saw that there had been good progress on a number of actions over a short period of time. However, there still remained several actions to be completed. In addition, deficits relating to premises, safeguarding, residents' rights and staffing all required addressing and significant input at provider level.

The provider had ensured that an annual review and a six monthly unannounced visit had taken place of the quality of care and support provided to residents in the centre. However, improvements were needed to ensure the effectiveness of the associated action plans.

The inspector found that, while there was a core team of suitably qualified, competent and experienced staff employed in the centre, there was a high reliance on agency staff. The staffing arrangements meant that continuity of care could not always be ensured. In addition, improvements were warranted to the accessibility of the providers computer systems which contained pertinent information about the support needs of residents.

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

Regulation 15: Staffing

The provider had not ensured that residents were provided continuity of care at all times.

There was a high use of agency staff in the centre and while efforts were being made to employ the same agency staff as much as possible this was not always possible. On a review of the actual and planned staff roster for September and October 2025 the inspector saw that during these two months 13 difference agency staff were employed.

There was an induction folder in place in the centre and this was available for agency staff to review. The folder included pertinent information for staff to familiarise themselves with residents' support needs and other service delivery

matters. The folder included completed induction forms for agency staff members however, on the day of the inspection only five inductions forms were contained within the folder and it was unknown if all thirteen agency staff had received an induction.

In addition, two of the induction forms noted that members of the core staff team had completed the inductions with the agency staff; There was no evidence of managerial oversight of the two inductions or the related forms. There was a note on two of the induction forms that the agency staff had not been provided with access to the centre's computer systems. This meant that agency staff could not record or read all information related to the care and support needs of residents or access organisational policies and procedures that was in place to guide and support staff in their roles.

Furthermore, on speaking with an agency staff member on the day, while they told the inspector they had received an induction, they said that they had not been provided access to the centre's computer systems. They told the inspector that they had worked seven shifts in the centre and that at the end of each shift they gave a verbal handover of the care and support provided to residents to another staff member. In addition, when asked how they would report a safeguarding concern, they informed the inspector that they would tell another staff member or manager, as they had no access to record it on the computer system.

This meant that there were times when residents were being supported by staff members who had not been provided with all information about their care and support needs or with access to policies and procedures to guide them in their practice. It also meant that where information was not directory recorded on to the provider's computer system, there was a potential risk of information, relating to the care and support of residents, being missed, misinterpreted or not recorded correctly.

There was one full-time social care worker vacancy in the centre.

Judgment: Not compliant

Regulation 16: Training and staff development

The provider had put arrangements in place to evaluate the provision of training to their staff and through these oversight arrangements had identified deficits and put in place actions to address this prior to the inspection.

Training deficits had been identified by the provider through their own provider-led six monthly audits, annual report and recent review of the actions. Since the implementation of the centre's service improvement plan in September, there had been significant progress on ensuring all staff had received required training and refresher training as required.

On review of the staff training records the inspector saw that the majority of staff had completed all training and where training was outstanding, a date had been booked for the training or staff were put on a waiting list.

The records demonstrated that training on safeguarding of vulnerable adults training, communicating with people with intellectual disabilities, infection prevention and control, feeding eating drinking and swallow (FEDS) and human rights were up to date. Most staff had completed positive behaviour support training, with three staff on the organisation's waiting list to complete it.

All members of the core staff team had completed eLearning training related to the positive behaviour support and safeguarding policies and procedures. This ensured that staff were up-to-date, knowledgeable and provided with sufficient guidance when delivering safe and appropriate care to residents living in the centre.

There had also been improvements to the area of staff one-to-one supervision meetings. The deputy manager had provided all staff with their mid-year supervision meeting and there were plans in place to carry out a further meeting at the end of the year.

Judgment: Compliant

Regulation 23: Governance and management

Improvements were needed to the governance and management systems in place in the designated centre. The provider had self-identified a number of deficits with some that required immediate attention. As a result the provider had developed a service improvement plan which they were implementing with an incorporated a weekly review of their progress in completing the required actions.

One of the areas that the provider had identified that required immediate improvements related to the recording and oversight systems in place for the management of residents' finances. Following the completion of a residents' finances audit in September, the provider had implemented measures to ensure appropriate systems were in place for monitoring and overseeing the management of residents' finances.

Senior management had also ensured there was shared learning across the organisation regarding the deficits so that improvements could be implemented across designated centres. The most recent staff meeting an agenda item had been dedicated to discuss, review and implement appropriate money management systems relating to resident finances in the centre. On speaking with a staff member during the inspection, they demonstrated they were aware and knowledgeable of the record keeping systems and procedures in place to ensure the safety and protection of all residents' finances.

Overall, on review of the centre-specific service improvement plan and its weekly review, the inspector saw that there had been satisfactory progress being made on actions relating to staff training and supervision, residents care and support plans, medication audits, positive behaviour supports, restrictive practices and cleaning audits. However, a number of the actions were a work in progress, and it was acknowledged by senior and local management on the day, that there was a lot more work to be completed to ensure the centre's compliance with all regulations.

The inspector reviewed the centre's most recent annual report and six monthly review of the quality of care and support provided to resident in the centre. Both these audits had been completed in May 2025. These reviews took into account how residents were safeguarded and reviewed the measures in place for their effectiveness.

On observing the action plans for each of these audits, the inspector saw that many of the actions were overdue for completion.

While the new centre-specific service improvement plan showed that many of the overdue actions had been completed or were in progress, this had not been updated on either of these two audit action plans.

As such there were inconsistencies in progress made in the centre within the providers oversight and monitoring systems. A review was needed to ensure consistency among the audits so that they were effective in driving quality improvements for residents living in the centre.

Judgment: Substantially compliant

Quality and safety

Overall, the inspector found that many of the principles outlined in the National Standards for Adult Safeguarding were not fully promoted in this service. This meant that the provider had failed to ensure that residents were receiving a service which promoted and upheld their rights and kept them safeguarded at all times.

There were compatibility issues in the centre which were resulting in a high number of safeguarding incident amongst peers. The provider and local management were endeavouring to reduce the risk of ongoing incidents and had put a number of strategies in place. However, as the incidents were continuous, not all strategies were proving to be effective. In addition some strategies were resulting in a more restrictive environment for residents to live in.

The premise was not meeting residents' assessed and aging needs and in particular, in relation to accessibility and safeguarding. Overall, the layout of the house was

impacting negatively on residents' lived experience in their own home as well as their rights, safety and freedom of movement in their home.

The provider and person in charge promoted a proactive and positive approach to managing behaviours that challenge. Where appropriate residents had been provided with a positive behaviour support plan. Two plans had been updated in September and October and were part of the measures in place to reduce the risk of ongoing safeguarding incidents.

Where safeguarding or potential safeguarding incidents occurred these were screened, investigated and reported in line with the centre's and national policy. There were arrangements in place to ensure that there was shared learning and reflective practice after each incident.

Overall, significant improvements were required to ensure that all residents were in receipt of a safe and quality service at all times. The ongoing risk of safeguarding incidents as well as the layout of the premises was infringing on residents' rights and in particular, accessibility, autonomy and safety.

Regulation 10: Communication

The provider, local management and staff had ensured that residents were provided information in a way that they understood. The inspector observed examples of easy-to-read format information in residents' personal plan and on residents' notice boards. This was to support residents' understanding of the information in line with their needs, likes and preferences.

In addition, there was easy-to-read information on safeguarding, on the designated officer, on the organisations' complaints procedures, on advocacy and rights but to mention a few. Residents were also provided with an easy-to-read booklet about bereavement as part of the supports put in place after the passing of one of their fellow residents.

To support residents to understand the information provided to them and to be supported to communicate their choices and decisions about their care and their lives, each resident was provided with communication support plan. On the day of the inspection, with the support of the centre-specific service improvement plan, all residents' personal plans included a communication passport. Communication passports were in place for each resident as a practical communication profiling tool to help convey each residents unique identity, specifically in relation to their communication profile.

Residents were communicated with about important matters in their life and were empowered to communication their decisions. The inspector was informed by the person in charge that one of the residents had been consulted on, and was involved in, developing their own safeguarding plan. For example, the resident relayed what measures they were willing to follow when their peer shouted at them. For example,

leaving the communal space and go to their bedroom. The consultation process empowered the resident to be involved in decision-making on a matter that was very important to them.

Judgment: Compliant

Regulation 17: Premises

The provider had failed to ensure that the premise was meeting residents' assessed and aging needs and in particular, in relation to accessibility and safeguarding. The current layout of the environment was not meeting the aims and objectives of the service and was not effective in reducing on-going compatibility issues in the house.

Since the last inspection of the centre, a resident was supported to move from an upstairs bedroom to a ground floor room which better met their physical needs as well as being in line with allied health care recommendations. As of the day of the inspection, all four residents' bedrooms were located on the ground floor. Due to all residents' physical support needs, they were not availing of the upstairs section of the house which included a bathroom, toilet room, TV room and other bedrooms.

The overall layout of the house was not suitable to the residents living in the centre and prohibited their choice and right to be able to move around all areas of their home independently. There was one bathroom downstairs for all residents to use. One resident was restricted in the use of the bath due to insufficient room for a hoist.

Furthermore, the layout of the environment and its limitations was impacting on the safety of residents. One of the measures attempting to reduce the risk of ongoing safeguarding incidents included 'staff managing the environment'. However, this had resulted in a more restrictive environment for a resident. For example, one resident was required to eat their evening meals in their bedroom.

As residents were unable to independently avail of all areas of the house, when a peer to peer safeguarding incident occurred, there was limited communal rooms for them to go to. For example, they could go to their own bedroom or the sitting room at the front of the house.

Overall, the inspector found that the provider was not operating in a manner that ensured residents were living in a suitable environment to meet their assessed needs or were safe at all times and this was impacting negatively on the lived experience of residents.

Judgment: Not compliant

Regulation 26: Risk management procedures

The provider had ensured that the centre's risk management policy met the requirements as set out in the regulations. The policy had been reviewed and updated in April 2024.

On review of the risk register, the inspector saw that there was a range of risk assessments with control measures that were specific to residents' individual health, safety and personal support needs. There were also centre-related risk assessments completed with control measures in place.

A review of incidents and accidents, alongside risks and measures in place, was included as a standing agenda item at staff meetings. This supported shared learning, awareness and where possible, reduce the risk of recurrence.

In October 2025 there had been a review of the risks in the centre including the measures in place to try reduce the risks. There were a number of orange rated risks identified, including the risk of choking, risk of falls and risk of emotional abuse arising from incompatibility of residents resulting in an increase of safeguarding incidents towards peers. There were measures in place for each of the risks and the provider and local management team were endeavouring to ensure these measures were effective. For example:

Where there was a risk of falls for one resident, some of the measures in place included carrying out a falls risk assessment tool (FRAT assessment), a safety plan, ensuring clutter-free ramps and walkways, and the use of a motion monitor at night-time.

Where there was a risk of choking for another resident, some of the measures included, staff following FEDS plans, staff training in FEDs, staff supervising residents during mealtimes and automated external defibrillators (AED) machine on site.

Where there was a risk of emotional abuse arising from incompatibility of residents resulting in an increase of safeguarding incidents, some of the measures included providing residents with positive behaviour support plans, staff training in safeguarding, managing the environment to minimise the risk of incidents occurring, positive behaviour support specialist and social worker input, and the use of rights restrictions.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The inspector reviewed a sample of two residents' care and support person plans. This included a hardcopy folder as well as information contained on the provider's computer systems.

The folders had been recently provided with a personal profile checklist as well as a quarterly audit for the checklist. This was to ensure that residents' personal plans were regularly reviewed and kept up-to-date with pertinent information about the resident.

Plans viewed included support plans relating to each resident's safety, health and wellbeing, money management, medication, risks and communication but to mention a few. In addition, where appropriate, personal plans included positive behaviour support plans and safeguarding plans.

The provider's recent annual and six monthly audits had identified that residents' assessment of needs required review. In addition, information pertaining to residents' goals and the progress and completion of their goals also required review and improvements. On the day of the inspection, the inspector was informed by management, that the staff team were working on addressing the deficit and good progress had been made in these areas.

All residents were provided with an easy-to-read format of their personal plan which residents liked to keep in their bedrooms. One resident's accessible plan was observed to be contained within their personal plan folder. It included an array of photographs of the resident enjoying activities in their home and community with their peers, staff and family. The resident had being consulted in, and was part of, the development of the accessible plan.

Residents had been provided with an annual review of their plan however, review meetings had only included the keyworker and the resident. There was no evidence to demonstrate that residents had been offered the choice of inviting others to the review, such as family, friends and where appropriate, allied health professionals. The inclusion of people who have significant input into residents' lives has the potential to support and enhance each resident's experience of their review and provide a space for them to show off and celebrate their progress and achievements during the year.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

On the day of the inspection, all residents who required positive behaviours support plans, had been provided with an up-to-date plan.

One resident's plan had been due review in June 2025 noting the time frame had elapsed the local management then made a referral which in turn prompted the provider's live traffic light system to move the urgency for the plan to a red risk

rating meaning a high risk was presenting as there was no plan in place. This in turn elicited a prompt to action and the plan was was completed shortly thereafter. This demonstrated the effectiveness of the provider's new positive behaviour support referral system in this centre.

In October, as part of the development of one resident's positive behaviour support plan, the organisation's behaviour support specialist visited the residents' home. They met and spoke with the resident, including their staff, as part of the consultation process and gathering of information.

Overall, on review of a sample of two residents' positive behaviour support plans the inspector found them to be clear and concise and included pertinent information to clearly guide staff on how to support residents manage their behaviours. Staff members spoken with were knowledgeable about the supports the resident required and were observed to implement these supports on the day of inspection.

There were a number of restrictive practices in place in the designated centre. Some of these included the use of lap-belts for wheelchair users in the community, money management supports, management of environment during mealtimes, motion detectors and limited access to bathroom facilities.

The restrictive practice policy had been reviewed in September 2024 and there was an eLearning programme in place to ensure staff had read and understood the policy. All core staff members had completed the eLearning course.

There was a human rights committee in the organisation where restrictive practice referrals were submitted for consideration to ensure the least restrictive option was in place as well as ensuring the rationale for their implementation was underpinned by a rights based approach. In addition, the inspector was informed of plans for the development of a centre-specific restrictive practice group.

Judgment: Compliant

Regulation 8: Protection

There were compatibility issues between some of the residents living in the centre and this was impacting on their quality of life as well as the quality of life for other residents living in the centre. The compatibility issues were resulting in behavioural incidents, many of which were resulting in safeguarding concerns. Overall strategies in place had not been fully effective in reducing incidents occur in the residents' home which meant there was on ongoing risk of further safeguarding incidents occurring.

In addition, the layout and limited access of the house was further impacting on managing safeguarding concerns. There were limited spaces for residents to take time out in or gather in smaller groups. This was primarily due to the fact that

residents could not avail of the upstairs areas of the premises due to their physical support needs.

As of the day of the inspection, there had been 24 safeguarding notifications submitted to the Office of the Chief inspector during 2025. 20 of these were related to peer-to -peer incidents of which 13 had occurred during August to October 2025. On the day of the inspection, two behavioural incidents occurred between peers which resulted in safeguarding concerns.

One resident had made a compliant about their unhappiness regarding their peer's behaviour towards them. The same resident spoke with the inspector on the day about their upset, unhappiness and frustration of the situation. On speaking with the resident about an incident that occurred that afternoon, the inspector found that the experience had left the resident feeling angry, upset and tearful.

On review of a sample of behavioural incidents records, the inspector saw that staff were adhering to residents safeguarding plans when de-escalating or pre-empting an incident. Some of the strategies within the plans included managing the environment, such as the separation of one resident at meal times, staff supervision of residents in communal areas and supporting residents to move from one communal area of the house to another, or to their bedroom. One resident who talked with the inspector, told them that when there was shouting they moved from the area to either their bedroom or the front sitting room.

Although these strategies were more likely to keep residents safe in their home, this resulted in a more restrictive living environment for residents and impacted negatively on their lived experience in their own home.

Overall, the inspector found that, while the current living arrangements were in place, the risk of continued behavioural incidents remained and as such, the provider could not be assured that residents were protected from all forms of abuse at all times.

Judgment: Not compliant

Regulation 9: Residents' rights

Overall, the ongoing risk of safeguarding incidents occurring and layout of the internal environment was infringing on residents' rights and in particular, accessibility, autonomy and safety.

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 negatively impacting on the residents' lived experience in their home.

Residents were not provided with the right to live in a safe and supportive living environment at all times. Frequent safeguarding incidents between peers were having negative impacts on their lives as well as other residents living in the house.

Rights restrictions were implemented to try reduce the risk of ongoing incidents however, this impacted on the freedom and choice of residents to enjoy meals together and led to a managed environment.

The layout of the premises was not promoting residents right to freedom of movement, accessibility and autonomy. It was also impacting on their safety. Residents were unable to independently access all areas of their home, for example, due to the physical support needs of residents, they were unable to access the upstairs area of their home. This resulted in four residents having to share one bathroom as well as one resident not being able to access a bath in their home.

The limited access to spaces in the residents home also impacted on their right to feel safe in their home as it meant there were fewer accessible communal spaces within their home to take time out in, or gather in smaller amicable groups, should peer to peer incidents occur.

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

Compliance Plan for Helensburgh OSV-0001703

Inspection ID: MON-0047661

Date of inspection: 29/10/2025

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	Not Compliant

Outline how you are going to come into compliance with Regulation 15: Staffing:
The Provider is currently reviewing the staff roster. The first consultation with staff took place on 11/09/2025 with further consultations to be scheduled. The proposed roster will include waking nights, long days (8am to 8pm) and also full-time staff contracts in order to give residents continuity of care and meet their changing needs. Draft rosters were submitted to the organisation's Financial Department for costings on 25/11/2025. On receipt of the costings, the PPIM and PIC will submit a Business Case. Recruitment for vacant posts remains ongoing.
Completion Date: 31/01/2026

The PIC ensures that all new staff and agency staff read, understand and sign the induction folder before commencing duties. If a new agency staff starts during the weekend or after PIC working hours, regular staff will provide induction, where possible, or arrangements will be put in place to ensure the required action is completed. The PIC reviews and signs off on the induction folder on their return as evidence of compliance. The PIC has a Governance Monthly Checklist to remind them to complete actions outstanding. Completion Date: 05/12/2025

The induction folder has been reviewed and now contains clear guidance for agency staff on how to use CID. Regular agency staff already use CID. However, if the PIC is absent and a new agency staff is employed, staff can contact another nominated PIC/DSM and request them to give the required access to CID. All staff have been made aware of this arrangement and instructions are contained in the induction folder.
Completion Date: 25/11/2025

Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The Provider has carried out a restructuring plan for the location. From 1st December 2025, there will be a new PIC and PPIM. The PIC will have only one location to manage. The PPIM will carry out a Governance & Management meeting and a Business Support Meeting with the PIC every quarter as well as unannounced visits to the location. A Service Improvement Plan is in place to address actions and monitor progress. The PIC has a Governance Monthly Checklist to remind them to complete actions outstanding. All actions will be reviewed and actioned by end January 2026.
Completion Date: 31/01/2026

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
The Provider acknowledges that the premises is not suitable for current residents. A Business Plan will be submitted for the de-congregation of the location. This will include a compatibility assessment for each resident, roster requirements, residents meetings and family meetings. Also, details of the type of accommodation that will meet the needs of the residents.

The previous SHS Project Manager created a folder with all the relevant documents for the decongregation of units and transitions.

Timeline for Actions:
(a) Meetings with staff Completion Date: 31/01/2026
(b) Meetings with family Completion Date: 31/01/2026
(c) Referrals Committee notified Completion Date: 31/01/2026
(d) Housing Department notified Completion Date: 31/01/2026
(e) Business Case to be submitted Completion Date: 28/02/2026

Residents will be informed at a later stage as there is no need to create unnecessary anxiety until the pathway is clear.

Completion Date: 28/02/2026

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:
The PIC is currently reviewing the residents' personal plans which will include meaningful goals identified by the residents. Family members and members of the MDT will be consulted, where necessary.
Completion Date: 31/01/2026

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
The PIC and the PPIM had a meeting on 12/11/2025 with the Clinical Practice Director, the Senior Social Worker and the Positive Behaviour Support Specialist (PBSS) to discuss peer to peer interaction on the location. It was recommended that staggered mealtimes are introduced. Clients could take their meals separately by using both the dining room and the sitting room.

One resident's plan has been reviewed by the PBSS and measures include extra guidance and support for about how to be more proactive rather than reactive to adverse peer to peer interaction. Also a bigger focus on meaningful goals for residents.

The staff team have been informed of these strategies and a full staff meeting is scheduled to take place on 16/12/2025 to discuss these plans in much more detail.

Rights restrictions were submitted to the Human Rights Committee on 01/10/2025.

Completion Date: 31/12/2025

The Provider acknowledges that the premises is not suitable for current residents. A Business Plan will be submitted for the de-congregation of the location. This will include a compatibility assessment for each resident, roster requirements, residents meetings and family meetings. Also, details of the type of accommodation that will meet the needs of the residents.

Timeline for Actions:
(a) Meetings with staff Completion Date: 31/01/2026
(b) Meetings with family Completion Date: 31/01/2026
(c) Referrals Committee notified Completion Date: 31/01/2026
(d) Housing Department notified Completion Date: 31/01/2026
(e) Business Case to be submitted Completion Date: 28/02/2026

Residents will be informed at a later stage as there is no need to create unnecessary anxiety until the pathway is clear.

Completion Date: 28/02/2026

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
A meeting took place on 12/11/2025 with the Clinical Practice Director, the Senior Social Worker and the Positive Behaviour Support Specialist (PBSS) to discuss peer to peer interaction on the location. It was recommended that staggered mealtimes are introduced. Clients could take their meals separately by using both the dining room and the sitting room.

One resident's plan has been reviewed by the PBSS and measures include extra guidance and support for about how to be more proactive rather than reactive to adverse peer to peer interaction. Also a bigger focus on meaning goals for residents.

The staff team have been informed of these strategies and a full staff meeting is scheduled to discuss these plans in much more detail.

Rights restrictions have been submitted to the Human Rights Committee.
Completion Date: 31/12/2025

The Provider acknowledges that the premises is not suitable for current residents. A Business Plan will be submitted for the de-congregation of the location. This will include a compatibility assessment for each resident, roster requirements, residents' meetings and family meetings. Also, details of the type of accommodation that will meet the needs of the residents.

Timeline for Actions:
(a) Meetings with staff Completion Date: 31/01/2026
(b) Meetings with family Completion Date: 31/01/2026
(c) Referrals Committee notified Completion Date: 31/01/2026
(d) Housing Department notified Completion Date: 31/01/2026
(e) Business Case to be submitted Completion Date: 28/02/2026

Residents will be informed at a later stage as there is no need to create unnecessary anxiety until the pathway is clear.

Completion Date: 28/02/2026

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	31/01/2026
Regulation 15(3)	The registered provider shall ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.	Not Compliant	Orange	31/01/2026
Regulation 17(1)(a)	The registered provider shall ensure the premises of the	Not Compliant	Orange	28/02/2026

	designated centre are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.			
Regulation 17(6)	The registered provider shall ensure that the designated centre adheres to best practice in achieving and promoting accessibility. He. she, regularly reviews its accessibility with reference to the statement of purpose and carries out any required alterations to the premises of the designated centre to ensure it is accessible to all.	Substantially Compliant	Yellow	28/02/2026
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Not Compliant	Orange	28/02/2026
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Substantially Compliant	Yellow	31/01/2026

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.	Substantially Compliant	Yellow	31/01/2026
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	28/02/2026
Regulation 09(1)	The registered provider shall ensure that the designated centre is operated in a manner that respects the age, gender, sexual orientation, disability, family status, civil status, race, religious beliefs and ethnic and cultural background of each resident.	Not Compliant	Orange	28/02/2026
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,	Not Compliant	Orange	28/02/2026

	intimate and personal care, professional consultations and personal information.			