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:	Ros Mhuire
Name of provider:	Sunbeam House Services CLG
Address of centre:	Wicklow
Type of inspection:	Unannounced
Date of inspection:	03 September 2025
Centre ID:	OSV-0001706
Fieldwork ID:	MON-0046791

About the designated centre

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

Ros Mhuire is a designated centre operated by Sunbeam House Services CLG located in a small town in County Wicklow. It provides a community residential services to four people, male and female, with intellectual disabilities. The designated centre consists of two sitting rooms, kitchen, dining room, four individual bedrooms, staff bedroom, office and a number of shared bathrooms. The centre is staffed by a person in charge, a deputy manager and social care workers. The person in charge works in a full time capacity and they are also responsible for a 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 3 September 2025	09:30hrs to 17:30hrs	Jacqueline Joynt	Lead

What residents told us and what inspectors observed

The purpose of this inspection was to monitor compliance with the regulations. 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 person in charge and deputy manager were not working on the day of the inspection, so the inspection was facilitated by a 'supporting person in charge' who worked in another designated centre run by the provider.

The inspector found that residents in the centre were supported to enjoy a good quality and meaningful life in their community. The residents independence was promoted through education, training, employment and goals that were important to them. Feedback provided on day by residents about their home and their life was very positive. Residents spoke enthusiastically with the inspector about current projects, upcoming training courses and events and future holidays away.

The centre was a large detached building consisting of four bedrooms and a staff sleepover room, a sitting room, a kitchen, a dining room and a living room. There was a large wet room facility, a bathroom and a toilet. There was also a laundry area and a staff office. For the most part, the internal spaces in the house were observed to be homely with lots of framed pictures, painted by residents, throughout the halls of the house. The sitting and living rooms included large soft couches and soft furnishes as well as colourful armchairs that had been chosen by residents.

There were four residents living in the centre and the inspector was provided with the opportunity to meet with all of the residents during different times of the day. Residents relayed their views verbally to the inspector, some residents spoke independently with the inspector and some required the support of their staff members.

One resident, who enjoyed participating in chores, showed the inspector around centre and discussed the household jobs they enjoyed doing.

As they walked around they pointed out all the framed artwork on the walls of the house that they had painted. The resident also showed the inspector the external areas of the house. They pointed out the garden table and chairs and barbeque (BBQ) and told the inspector about the birthday BBQ they enjoyed during the summertime. They also pointed out the colourful plants in pots around the seating area as well as the flower boxes at the front of the house. They told the inspector that they and their house mate enjoyed gardening and had planted all the flowers.

The resident was very eager to talk about all jobs and activities they were involved in the outside areas of their home. The resident brought the inspector to the large

concrete shed at the side of the house. The area inside was disorganised and required some upkeep. Previous to this inspection, the provider had put actions in place to maintain and upkeep this area however, the inspector saw that this had not been sustained.

The resident pointed out the garden tools and products they used for their gardening projects. They also showed the inspector the bags of coal and said that in the winter they filled coal bunkers, which were situated beside the house. The inspector observed the middle of the cement floor in the shed was raised with a deep crack in it and posed a potential trip hazard.

The resident brought the inspector to the front of the house using the external pathways and showed the inspector where they wheeled the refuse bins from the side to the front of the house on a weekly basis. This was a household chore the resident enjoyed being responsible for. There was one handrail to the front of the house, which the inspector observed the resident to grab hold of as they walked down that section of the pathway.

The resident told the inspector that they had recently recently re-painted a statue which was located in a pleasant rockery at the front of the house. There was a bench beside the statue where the resident liked to spend time. On walking around the paths of the house, the inspector observed the resident to walk slowly and was regularly prompted by their staff member to be careful and walk slowly.

It was evident that the resident enjoyed being responsible for these important household chores but the external pathways, which were uneven and cracked in a number of areas, and outside buildings to the centre such, as the concrete shed, posed potential trip hazards which they needed to be mindful of when engaging in their chores and activities outside the house.

All residents were happy to show the inspector their bedrooms. One resident showed the inspector all their art and craft work that was displayed on their bedrooms shelves. The had purchased a new double bed which they had been supported by their key worker to go to the shop to pick it out. They told the inspector that they were going to purchase a bedside table and were considering their options. They had visited a shop, priced it and taken a photograph of the side-table to compare against prices in other shops. The residents appeared happy and proud about their purchases and planned purchases.

The resident pointed out an area on their bedroom wall that had chipped paint. They seemed disappointed at this and said it needed to be repaired. Staff informed the inspector that the resident had raised this issue at the residents' household meeting. The required repair work had been included on the maintenance system with a number of reminders submitted. However, as of the day of inspection, the task remained outstanding.

Later in the day, the resident met again with the inspector for a chat. The residents talked enthusiastically about their health and fitness classes which they travelled to and attended, independently. The resident told the inspector about a new computer course they were looking forward to commencing in the autumn time. They also told

the inspector about their employment and how it was a very busy in the summer time. The resident appeared proud when talking about their achievements and smiled on occasions when relaying their accomplishments.

Another resident spoke with the inspector about their advocacy work. They were involved in the organisation's advocacy group. They told the inspector that they were attending an online meeting in the morning with the advocacy group. The resident seemed very focused and passionate about the work with this group. Later in the afternoon, they met with the inspector again and told them how they had enjoyed a music class in their local community. They told the inspector of their plan to relax for the evening and watch videos of online games.

Later in the day, another resident showed the inspector their bedroom, and the new storage they had purchased since the last inspection. The resident had memorabilia from their favourite football club displayed all around the room and appeared proud and happy showing it to the inspector.

Overall, on speaking with all residents, the inspectors found that they lived active lives. Residents independence was promoted at all times and there were adequate levels of staffing to support them when needed. Residents told the inspector that the recent staffing increase meant they got to spend more time with staff and enjoy more community activities.

The inspector found that residents were facilitated to exercise choice across a range of therapeutic and social activities and to have their choices and decisions respected. Residents were provided meaningful activities in the community to ensure positive outcomes for them in terms of the their wellbeing and development. On the day of the inspection, residents participated in their community through different activities such as, going to their local shop for their daily newspaper, going to the library to return a book, going swimming in the local pool, going to music and exercises classes. Some residents were supported to take part and travel to these activities independently and some were driven to the activities by their staff members.

The inspector observed that the residents seemed relaxed and happy in the company of staff and that staff were respectful towards the residents through positive, mindful and supportive interactions. Residents talked to the inspector about their planned goals and how their staff were supporting them. For example two residents talked about their goal to go on overnight stays, one in Belfast and one in Rome. They told the inspector that they were supported by their keyworker to research they places they wanted to go, to look up prices and different activities and shows they could visit while there.

In summary, the inspector found that there was a strong and visible person-centred culture within the designated centre. The residents independence and personal development was promoted which saw them participate in their community to the best of their ability. Residents relayed to the inspector that they were happy in their home, liked who they were living with and enjoyed life.

However, the overall findings of the inspection saw a decrease in compliance levels in the centre since the last two inspections and in particular, in the area of protection and positive behaviour supports. In addition, actions to bring Regulation 17: Premises back into compliance had not been completed within the time frame the provider had committed to in their compliance plan response to the previous inspection. The inspector was informed the expected date for completion was March 2026. This premises issue had been ongoing for some time and was impacting on residents, in particular when using the external parts of the centre.

These are discussed further in the next two sections of the report which present the findings of this inspection in relation to the governance and management arrangements in place in the centre and how these arrangements impacted on the quality and safety of the service being delivered to each resident living in the centre.

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 a number of quality improvements made in the centre, overall a review of the pace of implementation of the improvement plan in this designated centre was required. This was to ensure that it was progressing at the same pace as most of the recently inspected centres run by the provider.

Since the last inspection of this centre, while there had been significant improvements to the fire safety systems in place, outstanding actions remained in relation to the premises, and in particular, external parts of the premises.

The person in charge was not available on the day of the inspection as they were on planned leave. A person in charge from another designated centre, operated by the provider, facilitated the inspection. They had been nominated as the 'support person in charge' for the centre during a period that the person in charge and deputy manager were both on leave. They facilitated the inspection to the best of their ability however, due to minimal handover, they were not able to access all information required on the day.

The provider had ensured that an annual review and six monthly unannounced visits had taken place of the quality of care and support provided to resident in the centre and there was evidence to demonstrate that residents and where appropriate, their family had been consulted in the process.

The inspector found that for the most part, there were suitably qualified, competent and experienced staff employed in the centre to meet residents' current assessed needs.

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 made some positive reforms to staffing arrangements in an effort to mitigate safeguarding incidents in the centre as well as supporting resident's changing behavioural needs both during the daytime and night-time.

For example, the staffing levels had increased from one staff working a twelve hour shift to two staff working this shift. In addition, a waking night staff was also employed, as well as the sleepover staff that was already in place.

The provider had submitted a business plan for funding for the additional staffing hours. In the meant time, to cover gaps, one staff member hours increased to full-time residential hours. The organisation's relief staff were employed as well as agency staff.

The person in charge was endeavouring to ensure continuity of care and for the most part, the same two agency staff were employed and the same four to five relief staff on a regular basis. However, this arrangement could not always be ensured.

In addition, the inspector saw that when an agency staff was employed there was also a permanent member of staff on shift. However, this did always mean that staff worked together when supporting residents. On the day of the inspection, the agency staff supported two residents in the community while the other permanent staff supported the residents in the house. Later in the afternoon the agency staff supported residents in the house and permanent staff in the community. This arrangement required review taking in to considering that not all agency staff had completed the centre's mandatory training in order to meet the assessed needs of residents.

The person in charge appropriately maintained both planned and actual staff rosters. The rosters clearly reflected the staffing arrangements in the centre, including the full names of staff on duty during both day and night shifts. The working hours of the person in charge was also noted on the roster and when the

person in charge worked in this centre as well as the other centre they were responsible for.

Residents told the inspector that they were happy with the increase of staffing, they said it meant that they got to spend more time with their staff and go on more community activities.

Overall, the inspector found that while the provider had responded promptly in increasing staffing levels to support residents changing needs, some improvements were needed to ensure continuity of care and also that all staff supporting the residents had the necessary skills and experience to meet the needs of residents at all times.

The inspector found that the provider's plans for bringing Regulation 15 into compliance across their organisation required some improvements in this centre. Many actions that had been completed in other centres, operated by the provider, had not yet commenced in this centre.

Some examples are listed below:

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 no evidence to demonstrate that agency staff had been provided with an appropriate induction. On speaking with a regular agency staff they advised the inspector they had received an induction with the person in charge, however, no documentation or checklist was used at the time. On review of documents in the centre there were no completed agency induction checklists in place.

Not all agency staff had completed all the required mandatory training in advance of working in the centre. On speaking with one of the regular agency staff members they advised the inspector that they did not have safe medication training completed.

The inspector found that not all agency staff were provided with access to the organisations information technology (IT) systems. As such, not all agency workers were 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. On speaking with staff the inspector was advised that other staff would record the information on the computer system for them or agency workers would hand-write a report which in turn would need to be typed up onto system by permanent staff workers when they had time to do so or were next on shift.

Judgment: Substantially compliant

Regulation 16: Training and staff development

On the day of the inspection, the inspector saw that the person in charge had good systems in place to evaluate staff training needs and to ensure that adequate training levels were maintained.

On review of the staff training records in the designated centre, the inspector saw that staff had completed or were scheduled to complete the organisation's mandatory training such as manual handling, safeguarding, human rights, fire safety, infection and prevention and control.

The person in charge had ensured that one-to-one, supervision meetings, that support staff in their role when providing care and support to residents, were scheduled for all staff and had completed all part one of staff supervision with part two progress and on line to be completed by the end of September 2025.

Staff who spoke with the inspector noted that they found the supervision meetings to be supportive and beneficial to their practice.

As part of the provider's organisation improvement plan, the provider had developed and was rolling out a number of training courses to better support management and staff carry out their roles to the best of their ability.

The inspector found that there was some progress made on the delivery of training programmes, which were due to be completed by December 2025.

Some of the examples included:

- Five out of nine staff had completed the specialised person-centred positive behaviour supports training.
- All staff members, bar one, had completed the restrictive practice training course. Four out of nine staff were due to complete eLearning training regarding the provider's updated restrictive practice policy.
- The key working training programme had been completed by one key working staff member with three other key working staff booked to attend training in September 2025.
- The person in charge had completed additional in-house safeguarding training in February 2025, which was provided by the National Safeguarding Team and the provider's Senior Social Work Safeguarding Liaison Office.
- All but two staff members had completed eLearning training relating to the provider's updated safeguarding policy.

Judgment: Compliant

Regulation 23: Governance and management

For the most part, the inspector found that there was a defined management structure that identified the lines of authority and accountability, and staff had specific roles and responsibilities in relation to the day-to-day running of the centre. The person in charge was supported by a deputy manager and person participating in management to carry out their role in this centre.

On the day of the inspection the person in charge was on annual leave. During times when the person in charge was on leave, the deputy manager normally took on the person in charge duties. However, on this occasion it was not possible as the deputy had gone on extended leave from the previous week.

A person in charge from another designated centre, also operated by the provider, was acting as 'support person in charge'. While this was for one week and only until another deputy manager returned, the handover to the 'support person in charge' was not comprehensive or sufficient enough to ensure the most optimum continuity of service in the centre. This impacted on the inspector being able to access some information that was required for the inspection, for example the centre specific monthly house audits, which provides information on the local governance, administration and operation of the centre, were not available for the inspector to review.

Two unannounced six monthly visits had taken place in October 2024 and April 2025 to review the quality and safety of care and the support provided to residents. An associated action plan with allocated actions and time scales was included. However, the most up-to-date information to demonstrate what actions had been completed could not be accessed or provided to the inspector on the day of the inspection.

In April 2025, the provider had completed an annual review of the quality and safety of care and support in the designated centre during 2024. There was evidence to demonstrate that residents and their families and or representatives, had been consulted in the review.

The person in charge carried out regular team meetings with staff. Overall, the inspector found that the meetings promoted shared learning and supported an environment where staff could raise concerns about the quality and safety of the care and support provided to residents. On speaking with staff about the meetings, they told the inspector that they were very beneficial for sharing information and updates.

The provider was endeavouring to ensure that the centre had sufficient access to Internet services however, to date access to the Internet was at times intermittent. This issue was ongoing for some time and was impacting on management and staff using the provider's online oversight systems. It was also impacting accessing and recording information on the organisation's online system relating to the care and support of residents. For example, one staff member told the inspector that safeguarding plans had not been printed due to the Internet issue. Another staff member advised that, at times, they were handwriting daily logs as poor Internet

impacted on recording them on the online system. One residents, who enjoyed availing of the Internet, had also logged a complaint about the issue.

At the end of the inspection, at the feedback meeting, the inspector was told that the provider was addressing the ongoing poor Internet quality in the designated centre and that the issue had been escalated to the appropriate department to find a solution.

In relation to the ongoing issues regarding the premises and in particular, the external areas of the house, the provider had not ensured that all actions were completed as per their original compliance plan time frames. A new time frame for March 2026 was put in place for the most recent updated compliance plan. However, while a number of business cases had been submitted to the provider's funder, there remained no outcome or plan to upgrade external areas of house.

On review of documentation and from speaking with management the inspector found that the provider's plans for bringing Regulation 23 into compliance, across their organisation, had been partially completed in this centre with evidence of some progress being made.

Some examples of progress are listed below:

As discussed under Regulation 16: Training and Development, staff training in areas of safeguarding, person-centred specialised positive behaviour supports, restrictive practices, and key working training programmes that were due for completion by December 2025 were underway.

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.

The provider had rolled out a resilience 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 but the inspector was told they were likely be included on phase 2.

However, some areas required review to ensure continuous traction and progress of other sections of the provider's improvement plan related to Regulation 23, for example:

The provider's organisational priority traffic light system used to identify and prioritise positive behaviour supports required review to ensure its effectiveness in this centre. Two residents' positive behaviour support status was recorded were highlighted in 'green' which meant their behaviour support arrangements in terms of support and plans were in place. However, when the inspector reviewed this matter, one resident's behaviour support plan was out-of-date and the other resident with an identified behaviour support need had no plan. This meant the provider's

oversight strategy was not entirely effective in being able to provide accurate assurances that resident's assessed needs were being met.

The person in charge handover document the provider had developed as part of the overall service improvement plan to enhance continuity of services, was not put into practice during a period when handing over responsibilities of the centre to the 'support person in charge'.

The inspector was advised that the person in charge was unable to attend the recent manager morning breakfast meeting with the organisation's CEO where information, shared learning and updates are relayed. The inspector was informed the reason was the centre's staff meeting had been planned for the same day.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

The inspector found that incidents were appropriately managed and reviewed as part of the continuous quality improvement to enable effective learning and reduce recurrence. There were effective arrangements in place to ensure that the designated centre complied with notification requirements.

Judgment: Compliant

Quality and safety

This section of the report details the quality and safety of the service for the residents who live in the designated centre.

Overall, the inspector found that the provider and person in charge were endeavouring to ensure that residents well-being and welfare was maintained to a good standard.

There was a strong and visible person-centred culture within the centre. Residents were supported to live as independently as they were capable of. Residents were facilitated to exercise choice across a range of therapeutic and social activities and to have their choices and decisions respected.

Residents told the inspector that they enjoyed living in their home and were happy with who they shared their home with. Residents talked to the inspector about their meaningful participation in the community and of their upcoming goals, that supported their wellbeing and personal development.

However, improvements were needed to a number of areas to ensure that residents were in receipt of a safe service at all times. In particular to areas regarding protection, positive behaviour supports and external areas of the premises.

Each resident was provided with a personal plan and they were reviewed annually, in consultation with the resident, and more regularly if required.

Every effort had been made to ensure that residents could receive information in a way that they could understand. Most residents had been provided with a communication support plan and a personal communication passport.

Management and staff had been provided with training in safeguarding vulnerable adults. There was an up-to-date safeguarding policy in place in the centre. However, improvements were needed to ensure that residents were protected by appropriate safeguarding arrangements at all times.

The management and staff team promoted a positive approach in responding to behaviours that challenge. However, improvements were needed to ensure evidence-based specialist and therapeutic interventions were implemented in a timely manner for all residents who required them.

The physical environment of the inside of the house was observed to be clean and overall, in good decorative and structural repair. The design and layout of the internal parts of the premises ensured that each resident could enjoy living in a safe, comfortable and homely environment. This enabled the promotion of independence, recreation and leisure and enabled a good quality of life for the residents living in the centre.

However, since the last inspection, upgrades to improve external pathways around the house, including the flooring in the centre's large shed, which was used by residents and staff, had not been completed. These areas had gone into further disrepair and presented as an ongoing potential trip and fall risk to all who used it.

Regulation 10: Communication

Overall, the inspector found that for the most part, communication access was facilitated for residents in this centre in accordance with their needs and wishes however, some improvements were needed.

Residents were provided and received information in a way that they understood. Residents in this centre used verbal communication and where appropriate also used easy-to-read information and in some cases, picture format information.

The inspector observed examples of easy-to-read format information in residents' personal plans as well as information that was of interest to residents on their notice boards. Residents were also provided with a photographic roster. Information was

relayed this way (as well as verbally) to support residents' understanding of the information in line with their needs, likes and preferences.

There was a culture of listening to, and respecting residents' views in the service. Residents were provided with weekly house meetings where each of their views were taken into account and listened to. Residents were supported to make complaints about matters they were not happy with and in a format that they understood.

There was an in-house advocacy group that included residents as part of the group. The group empowered residents to advocate for themselves and other individuals living in designated centres. One of the residents living in this centre was a member of the group. They talked to the inspector about their advocacy work, how it was meaningful to them and beneficial to others. The resident had an on-line meeting with the advocacy group that morning and seemed excited about it.

The inspector saw that residents were provided with televisions in communal areas and in their own bedrooms. Residents were also supported to access news through local newspapers and radio. Where residents wished, they were provided with their own mobile telephones and electronic tablets. However, due to the ongoing issue with Internet access in the house, residents were not able to avail of an optimum service. As a result, one resident had lodged a complaint with the provider about it.

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 and personal communication passport. Communication passports are a practical communication profiling tool to help convey each residents unique identity, specifically in relation to their communication profile and are a particularly useful tool for unfamiliar or irregular staff, to refer to when support residents with bespoke communication needs.

However, on review of one resident's personal plan, the inspector saw that they had not been provided with a communication passport which would better assist staff and provide optimum guidance when supporting the resident to manage their behaviours as well as staying safe.

Judgment: Substantially compliant

Regulation 17: Premises

There had been some improvements to premises since the last inspection where Regulation 17 was found non-compliant, however, the potential risks related to the poor upkeep and repair of the external pathways around the house, as well as the raised cracked floor in the shed, remained. This was impacting on residents and staff safety when using these areas.

An inspection carried out in the centre in 2023 found that major works to the footpaths throughout the front and back garden was needed. At the time it was found that the work had been identified since 2019 and since that time the paths had gone into further disrepair. On the day of this inspection, the inspector observed that there was further disrepair and in particular, to the shed building.

The shed was observed to be in poor upkeep and poorly organised and laid out. However, of most risk was the large raised crack in the middle of the cement flooring. The shed stored coal, salt for icy conditions, festival decorations and gardening equipment which residents and staff used. The inspector was informed that one resident in particular enjoyed spending time in this building. The resident brought the coal to the bunkers, used the gardening equipment and products and as well as taking time out to potter in it.

Pathways, used to bring refuse and recycling bins out to the front gate, were observed badly cracked and uneven. As described, the inspector observed the impact of the uneven pathways and external surfaces on a resident as they showed them around the external areas. The resident was regularly prompted by their staff member to be careful and take at easy when walking on the pathways due to the evidential potential slip, trip and fall hazards the uneven surface areas posed.

As of the day of the inspection, while there was a proposed completion date of March 2026 for addressing the required upkeep works. However, there was no funding secured for the work, no schedule of work documents or commencement of work dates identified.

In addition to the above, some areas of the internal premises were observed to require upkeep and repair work such as:

- The kick board under the kitchen cupboards was in poor repair with cracks and areas broken in sections of it.
- Extractor fans in two bathrooms were observed to be unclean with a build-up of dust and fluff.
- Radiators in two bathrooms were observed to have rust. A radiator in the hallway had chipped paint across the top of it. This meant they could not be cleaned effectively in terms of infection prevention and control.
- In one bathroom there was in-built black grime behind toilet between the floor and wall and required addressing so that it could be cleaned effectively.
- There was a large chip on one of the walls in a resident's bedroom. The resident pointed this out to the inspector and appeared upset at the poor upkeep of the wall. The resident who took great pride in the upkeep of their room, told the inspector that "the wall needed to be fixed properly".
- In addition to external works above an iron railing at the side of the house was observed to have significant peeling paint over the entire rail.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

On the day of the inspection the inspector reviewed a sample of three residents personal plans. The residents had individualised holistic assessment and care plans which were part of everyday life that endeavoured to ensure that residents were provided a person centred service. The needs assessment outlined the support required to maximise each resident's personal development in accordance with their wishes, individual needs and choices.

The inspector found that residents had up to date personal plans which were continuously developed and reviewed in consultation with the resident, relevant keyworker, and where appropriate, allied health care professionals and family members. Where there were gaps relating to communication, safeguarding and positive behaviour supports, these are addressed under the individual regulations concerned.

The inspector saw that residents were supported to choose goals that encouraged their independence and personal development. Some of the residents goals included, attending a garden workshop, attending a computer class, a trip away to Rome, an overnight trip to Belfast included an craft exhibition.

On speaking with staff, the inspector was informed that residents were supported to progress their goals and were involved and consulted through the process. The inspector saw that the progress of residents' goals was regularly updated by each residents' keyworker in consultation with each resident and where goals were achieved these were acknowledged and celebrated.

On speaking with residents about their travelling goals, they told the inspector how they had sat with their keyworker to discuss plans. They said they had researched information about where they were travelling to and looked at options for dates and compared prices. Both residents seemed very excited about their trip away and were smiling throughout as they talked to the inspector about their goal.

On review of documentation and from speaking with staff and management, the inspector found that a number of the provider's plans for bringing Regulation 5 into compliance across their organisation had been partially completed in this centre.

Some of the examples are listed below:

Key worker training programme was rolled out in 2025. One staff member had completed the training with three other staff members identified to complete it.

While there were personal plan profiles in each resident's personal plan, that were checked on a quarterly basis, they were not yet in line with the provider's new version of the document that was used for auditing residents' personal plans. As such the profiles in place did not include a section regarding actions required, status

update and completion dates and overall, which meant they were not as effective as the most up-to-date version.

Judgment: Compliant

Regulation 7: Positive behavioural support

On the day of the inspection the inspector found that residents who were assessed to need behavioural supports, were not provided with an up-to-date plan. This was despite referrals to the provider's behaviour support department submitted in March and April 2025 as well as changes in behaviours for some residents, that led to safeguarding incidents.

On review of one resident's positive behaviour support plan it was last reviewed by an appropriate health professional in December 2022. The plan had since been reviewed in 2025, however, the review was by the resident's keyworker which included some handwritten notes and updates on the document. This meant that changes to the resident's plan had no oversight by an appropriate health professional and overall, was not in line with best practice.

For one resident, regular meetings were due to take place during 2024 between the resident and the behavioural support therapist however, the meetings did not take place. The inspector was informed that the resident had met with the organisation's new positive behaviour support therapist during 2025 and in addition underwent a forensic assessment however, an updated positive behaviour support plan, to guide staff when supporting the resident to manage their behaviours was not yet completed.

On review of another resident's personal plan folder, the inspector saw that there was no current positive behaviour support plan in place for them. On the day of the inspection, the 'support person in charge' endeavoured to find details of the resident's positive behaviour support plan on the computer system however, there was limited information.

The inspector was informed that the organisation's positive behaviour support specialist had met with this resident also and had spoken with the person in charge on several occasions as a way of collating information. At the end of August 2025, the resident's key worker submitted forms and information to the specialist to enable them develop the resident's plan. However, as on the day of the inspection there was no current positive behaviour support plan in place for the resident or interim directions or plans for staff to follow while the resident's formal behaviour support plan was being collated. This meant that there was limited information in place to guide staff when supporting the resident to manage their behaviours in the intervening period.

On review of documentation and from speaking with management, the inspector found that the provider's plans for bringing Regulation 7 into compliance across their organisation required review in this centre and in particular, for their effectiveness.

Some examples are listed below:

The newly implemented traffic light system, to identify and prioritise positive behavioural support needs in the organisation, was not effective in this centre. The traffic light system had rated two residents positive behaviours supports as green indicating they had the necessary supports in place. The inspector found this was not an accurate rating considering neither resident had been provided with an up-to-date plan.

The restrictive practice policy had been reviewed in September 2024. There was an eLearning programme in place to ensure staff had read and understood the policy. Four staff members were yet to complete the eLearning training.

Additional positive behaviour support training was being rolled out within the organisation throughout 2025. Five of this designated centre's staff members had completed the programme to date. Four staff were due to complete it, however no training date was provided.

Three staff were due to complete a training course relating to autism.

Judgment: Not compliant

Regulation 8: Protection

There were three safeguarding concerns that required monitoring and management at the time of inspection.

All three safeguarding concerns had been followed up, screened and submitted to the relevant external agencies. Measures to mitigate the risk of recurrence of similar incidents included the development and implementation of interim safeguarding plans.

In response to all three incidents grounds for concern were noted due to the negative impact the incidents had on residents. The provider was advised, by the national safeguarding team, that the safeguarding referrals they had received would be closed on the basis that the interim safeguarding plans remained active in the centre.

However, for two of the concerns, no interim safeguarding plans were available within residents' personal plan folders to guide staff in what to do or how to support residents. This meant that the safeguarding guidance and directions were not readily available to staff to ensure they were implemented and overall, ensure the residents safety. This was particularly necessary as agency workers were regularly

employed to work in the centre and the issues with consistent Internet access impacting on staff being able to access the electronic version of residents' plans.

On the day of the inspection, the 'support person in charge', was able to access some information about two incidents from the provider's computer system. On review of this information the inspector saw that not all measures that were due to be completed had been. For example, one of the measures included completing relationship training with residents. The inspector was informed that the training had not yet commenced.

In relation to one of the concerns, additional support plans and risk assessments had been put in place however, these guided staff to follow the resident's positive behaviour support plan, which was out of date, and to follow their interim safeguarding plan, which was not in place.

In addition, these where such plans were in place those documents were only available on the provider's computerised system which not all staff had access to, for example, agency staff. In addition, intermittent Internet access issues in the location, meant that access to the electronically stored plans could be limited at times.

To ensure residents were safeguarded, improvements were needed so that all staff had access to residents' safeguarding plans at all times and that plans were reviewed and updated on a regular basis to ensure all measures were in place. In addition, where external relevant agencies had provided directions and advised keeping interim safeguarding plans active, adherence to these directives required improvement.

On review of documentation and from speaking with management, the inspectors found that number of the provider’s plans for bringing Regulation 8 into compliance across their organisation had been completed or partially completed in this centre.

Some examples are listed below:

The inspector was informed that the person in charge informed had attended the one day training provided by the National Safeguarding Team and the provider's Senior Social Work Safeguarding liaison office.

The organisation's safeguarding policy had been reviewed October 2024 by the provider. A copy was made available to staff. All staff, bar two, had completed eLearning training to demonstrate they had read and understood the policy

The provider's Senior Social Work Safeguarding Liaison Officer had communicated with designated office and or persons in charge to assure that they had registered on the National Safeguarding portal.

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	Substantially compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 10: Communication	Substantially compliant
Regulation 17: Premises	Not compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Not compliant

Compliance Plan for Ros Mhuire OSV-0001706

Inspection ID: MON-0046791

Date of inspection: 03/09/2025

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • Agency staff have completed safe medication training on the 8th & 9th of September 2025. • There is an induction checklist on location that is completed by all new staff including agency staff. On completion this is signed by the staff and the PIC. Completed 11/9/25 • Agency staff have now been given access to the provider electronic information systems and has access to all SHS policies and procedures. This is included in the induction checklist in the induction folder. The PIC renews access every 21 days. Completed 11/9/25	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • Provider audits will be printed and kept up to date in an audit folder. Should there be any further problem with wifi access any required documents/ information will be printed promptly and made available at the centre. Completed 26/09/25. • An engineer has installed an AP device to boost the internet connections and this has resulted in a more reliable internet connection. Completed 22/9/25 • Positive Behaviour Support Plan for one resident has been reviewed. Completed 13/10/25	

• Another resident's positive behaviour support plan is being drafted and will be completed by 31/12/25. In the interim there are current guidelines in place for staff to follow. Safeguarding and positive behaviour support plans are a standing agenda at team meeting which occur every 6 weeks or sooner if required.

• The provider's organisational priority traffic light system used to identify and prioritise positive behaviour supports has been reviewed and updated by the PIC. This now reflects current status. Completed 23/9/25

• The PIC will continue to monitor the traffic light system and review quarterly or as the residents needs change.

• It is the normal circumstance that the DSM covers while the PIC is on leave, however should there be an occurrence where the DSM is unavailable to cover another PIC will cover and a handover document will be used to hand over priority issues.

• The schedule for breakfast meetings is circulated to all staff via the provider's newsletter two months prior to a breakfast meeting. On foot of this information, the PIC will schedule staff meetings to afford the PIC and staff to attend breakfast meetings.

Regulation 10: Communication	Substantially Compliant

Outline how you are going to come into compliance with Regulation 10: Communication:
• A communication passport has been completed for the resident to assist staff and provide optimum guidance when supporting the resident. Completed on 24/09/25

• An engineer has installed an AP device to boost the internet connection. This now provides more reliable access for residents to use electronic devices. Completed 22/09/25.

• Resident is now happy with internet access. The complaint is now closed. Completed 25/8/2

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• A business case has been submitted to our funders for repair work to be completed to the paths and shed, A review by facialities department on the works required was carried out 29/9/25. Plan in place for works to be completed- works to start are scheduled for

01/03/2026, This is to allow for the frosty weather to pass.

• The shed has been emptied of items such as fuel and stored in bunkers closer to the house, therefore eliminating the risk of slips and trips to the shed until repairs are completed.

• The current risk assessment was reviewed. The Bins are now kept to the front of the house. This will reduce the risk of potential slip, trip and fall hazards the uneven surface areas pose to residents.

• The kick board under the kitchen cupboards was in poor repair with cracks and areas broken in sections of it. Kick boards were replaced. Completed 23/10/25

• Extractor fans in two bathrooms were observed to be unclean with a build-up of dust and fluff. Both areas are included on the cleaning checklist. Completed on 24/9/25

• Radiators in the two bathrooms completed works on 16/10/25.

• Area behind the toilet has been cleaned and added to the cleaning checklist. Completed on the 24/09/25

• Damage to the wall in a resident's bedroom will be repaired by the 30/11/25

• The external rail was treated on the 26/09/25

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
• Hard copies of support Plans for each residents have been printed and are in their personal folders. Completed on the 26/9/2
• Positive behaviour support plan for one resident has been reviewed. Completed 13/10/25.

• The Positive Behavior Support Plan for other residents is currently being drafted and is scheduled for completion by 31/12/2025. In the interim, all existing measures are being actively followed, including: The current Support Plan and Safeguarding Plan, Regular team meetings to discuss residents progress and needs, Exploration of counselling options for one resident, Implementation of an activity schedule tailored to the residents, Ongoing key working sessions to provide consistent support and engagement
• All staff have completed the restrictive practice policy on eLearning. Completed

23/10/25

• All staff are scheduled to have positive support training completed by 31/12/2

• PIC has scheduled staff to complete autism training by the 30/11/25.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
• All safeguarding plans have now been printed and inputted into resident's personal folder. - completed 26/9/25

• Time to Talk Resource site and tool kit has been rolled out to PIC's. This resource was shared with the team at the team meeting on 02/10/25.
• Dates for training is scheduled to start 31/10/25. Residents will be offered this training.

• Positive behaviour support plans for one resident was reviewed. Completed 13/10/25
• The Positive Behaviour Support Plan for another residents are currently being drafted and is scheduled for completion by 31/12/2025. In the interim, all existing measures are being actively followed, including: The current Support Plan and Safeguarding Plan, Regular team meetings to discuss residents progress and needs, Exploration of counselling options for one resident, Implementation of an activity schedule tailored to the residents, Ongoing key working sessions to provide consistent support and engagement.

• Current support plans are in place to guide staff and the interim safeguarding plan is now available to all staff to follow. - completed 26/9/25
• Staff have completed Safeguarding and Protection ELearning training - 23/10/25
• Should there be any further problem with wifi access any required documents/ information will be printed promptly and made available at the centre.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 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	02/10/2025
Regulation 10(3)(a)	The registered provider shall ensure that each resident has access to a telephone and appropriate media, such as television, radio, newspapers and internet.	Substantially Compliant	Yellow	02/10/2025
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	Substantially Compliant	Yellow	02/10/2025

	statement of purpose and the size and layout of the designated centre.			
Regulation 15(3)	The registered provider shall ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.	Substantially Compliant	Yellow	02/10/2025
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.	Not Compliant	Orange	31/03/2026
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	31/12/2025
Regulation 07(3)	The registered provider shall ensure that where required, therapeutic interventions are implemented with	Not Compliant	Orange	31/12/2025

	the informed consent of each resident, or his or her representative, and are reviewed as part of the personal planning process.			
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	31/12/2025