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

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| Name of designated centre: | Rosanna Gardens |
| Name of provider: | Sunbeam House Services CLG |
| Address of centre: | Wicklow |
| Type of inspection: | Announced |
| Date of inspection: | 29 May 2025 |
| Centre ID: | OSV-0001711 |
| Fieldwork ID: | MON-0038362 |

## About the designated centre

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

Rosanna Gardens is a designated centre operated by Sunbeam House Services located in Co. Wicklow. The centre can provide support for up to five adult residents. This designated centre offers support to men and women with mild to moderate intellectual disability and who may display responsive behaviour. Residents living in this designated centre are generally independent in their personal care or require a low level of support. The designated centre comprises of two units located beside each other. One unit is divided into two individual living apartments with their own front entrance. The second unit is for three residents with a shared kitchen, dining and living room and accessible bathroom and each resident has their own individual bedroom with en-suite facilities and a private sitting room area also. The centre has a large garden area. The staff team working in this designated centre consist of nursing staff, social care workers, day service staff, and care assistants. The centre is managed by a full-time person in charge, who has support from a deputy manager.

**The following information outlines some additional data on this centre.**

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| Number of residents on the date of inspection: | 5 |

## 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 |
|---|---|---|---|
| Thursday 29 May 2025 | 09:30hrs to 18:45hrs | Jacqueline Joynt | Lead |

## What residents told us and what inspectors observed

The purpose of this inspection was to monitor regulatory 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.

From speaking with the person in charge, the deputy manager, two staff members and five residents, as well as a review of documentation and observations on the day, the inspector found that there was sufficient evidence to demonstrate satisfactory levels of progress of the implementation of the provider's compliance improvement plan. In addition, there had been improvements to a number of areas in this designated centre since the last inspection, including fire safety, premises, positive behaviour supports and reduction in restrictive practices. The improvements were resulting in positive outcomes for residents living in the centre and providing a better lived experience for them in their home.

The person in charge and staff team were endeavouring to ensure that residents received the care and support they required and to ensure the service delivery was person-centred and included a rights-based focus. The person in charge was familiar with the needs of the residents and supports required to meet their needs. They spoke about the good standard of care provided to residents and of ensuring that changes in residents needs were addressed and potential future changes were also reviewed. Through observations and speaking with staff as well as a review of the documentation, the inspector found that there was suitable evidence to support this.

Staff who spoke with the inspector were familiar with residents' assessed needs and supports in place to meet those needs. They were also aware of low arousal approaches to support residents when they were feeling anxious or displaying behaviours that challenge. The inspector observed interactions between residents and staff to be kind, supportive and friendly. It was evident that staff knew how to communicate with residents in a way that they understood and were aware of each residents' likes and interests.

There was a level of incompatibility issues between some residents in the centre which in turn had resulted in safeguarding incidents. However, on speaking with the person in charge and staff, a move towards positive engagement between residents, rather than avoiding engagement, was starting to result in a reduction of incidents and better relationships between residents. This was further supported with recent visits and input from the organisation's positive behaviour support specialist and newly updated positive behaviours support plans for residents.

The designated centre comprised two separate single-floor buildings located on grounds shared with another designated centre operated by the provider. One of the buildings included two self-contained single occupancy apartments that each consisted of a bedroom, en-suite bathroom, kitchen, dining area and sitting room.

The other building provided accommodation for three residents. In this building, each resident was provided their own bedroom, en-suite and small sitting room. In the communal areas of the house, there was a large kitchen, a dining room and sitting room.

There was a separate building to the side of the centre which had been added to the centre's floor plan since the last inspection. This was used as an activity room for residents. The room was warm and colourful in design and consisted of different areas within the space to relax and enjoy activities. There was a table in the room with a large amount of paint and craft equipment for residents to use. The room also contained two comfortable couches with colourful soft furnishing and a large television was also available for residents. The room also contained patterned bunting, musical instruments and an array of indoor activity games. The inspector was informed that in the summer months, the double doors were opened out for resident to relax on the couches and look out at the sunshine.

On walking around the designated centre, the inspector saw that one of the apartments was clean, in good upkeep and repair and laid out to meet the needs of the resident and decorated in line with their tastes, interests and preference. The resident enjoyed making jigsaws and there was a number of large framed completed jigsaws hung up on the sitting room walls. There was a table and chair in place to support the resident engage in this activity. The inspector met the resident on the day and they told the inspector that they 'really liked" their apartment and were "very happy" living there.

The other apartment, was observed to be bright and airy and included lots of personalised memorabilia such as large canvas family photographs, music and film DVD's in the resident's bedroom, hallway and sitting room. The apartment was homely and personal to the resident however, the kitchen required a lot of upkeep and repair. The poor state of repair required attention as it was impacting on the effectiveness of the infection prevention and control measures.

On walking around the main building, the inspector saw there had been significant improvements to the communal areas and in particular, the layout and décor of the sitting room and dining room. These rooms had previously been observed as presenting an institutional aesthetic. The rooms had been painted with a number of newly purchased soft furnishings such as cushions, new curtains, floor mats and lamps, but to mention a few. The two rooms presented as homely, warm and relaxing.

On speaking with residents and staff the inspector was informed that residents were consulted in the décor and chose a number of soft furnishings. However, the communal kitchen in this house remained in poor upkeep and repair and the ceiling to floor length metal shutter between the kitchen and dining room remained in place, taking away from the homeliness of this section of the room. Since the last inspection, a refurbishment plan was put in place for the kitchen to be completed in May 2025. However, as on the day of the inspection, there was no funding sought or approved for the refurbishment.

Other areas of the house was observed to have poor upkeep and repair and required a deep clean, painting, removal of items. The inspector observed that a laundry room was also shared with an office space. The office space was located inside an airing cupboard. Inside this space there was a medicine cabinet, residents money and files. There was no room for a desk or chair. When preparing residents' medication, wooden slatted shelving in the cupboard was used as a table top surface. The layout and location of this area was not conducive to a suitable office space for practical, security and infection prevention control reasons.

Residents were supported to be kept informed and aware of matters that were important to them and matters to keep them safe. All residents' homes included notice boards with information in a format that was accessible to them. For example, the inspector observed that there was information and photographs about the organisation's social work team and the complaints officer and procedures. On the day of the inspection, the person in charge added information on the organisation's in-house advocacy group for residents, on the notice boards.

There was a large garden to the back of the centre. Since the last inspection there had been improvements to the garden. The inspector saw that there was a new vegetable patch with a large number of produce growing. The inspector was informed that it was the gardens first yield and residents liked this area and enjoyed spending time with staff in this part of the garden. There were a number of garden table and seats however, these were badly worn and needed replacing. The inspector was told by staff that when residents sit out in this area then had to use chairs from the activity room. Other large timber flower boxes had been painted different colours with a selection of wild flowers growing in them.

There was another designated centre located within the grounds of this centre and April 2025, five residents moved in to the other designated centre on a temporary basis. Compatibility assessments were completed for all residents to ensure there would be no risk for any resident regarding the occupancy of the centre. While the residents in each designated centre had separate services, a BBQ was arranged for the Friday evening for the residents to welcome their new neighbors. Posters had been designed and were on display in residents apartments and the main house.

Residents who spoke to the inspector about it, expressed happiness and excitement about the BBQ and in particular, they were looking forward to the burgers. There was one shared communal entrance between the two centres where there was a staff bathroom and laundry room. The person in charge's office was also in this areas. The inspector found that to ensure appropriate and safe use of the shared area, further communication and boundary setting was needed.

Throughout the day the inspector was provided the opportunity to meet and speak with all five residents living in the centre. The inspector met one of the residents in the newly upgraded sitting room. When the inspector complimented the décor of the room, the resident appeared proud when they said they had shopped for, and picked out, a number of the soft furnishings.

The resident was happy to sit with the inspector and have a cup of tea and talk about the things they liked in their home. The resident said that they liked when their family came to visit and when they went to visit them. They liked the staff and said they could go to the person in charge if they were upset about anything. When asked about the noise levels in the centre, and in particular, about shouting in the sitting room, the resident seemed hesitant to respond. The person in charge prompted the resident to respond, assuring them that it was fine to talk about it. However, the resident chose not to respond to that conversation and talked about other things instead.

The inspector met with another resident in their own small sitting room, within the house. The room included 'a wall of achievements' which consisted of framed certificates of achievement, a large selection of medals and trophies. The resident appeared proud and happy when talking about all their achievements and the story behind the certificates and medals. The resident told the inspector that they liked most of their staff and that they could speak to them and the person in charge if they were unhappy about anything. The resident said that they liked their bedroom and the way it was decorated. They said they were happy to have their own sitting room and enjoyed watching their large television, that was in the room. The resident told the inspector that they enjoyed the meals that were provided to them and in particular, when one staff made a roast beef dinner.

The inspector met with another resident in their bedroom. The person in charge supported the conversation between the resident and the inspector. The resident was styling their hair with hair-bands and getting ready to go out on a community activity. They told the inspector that they really liked living in their home and in particular, liked their bedroom. The resident talked about a music activity they were looking forward to going to which was part of the preparation of an upcoming concert. While in the room the inspector observed the resident's en-suite bathroom. The inspector saw that it was in poor upkeep and repair with a lot of ingrained grime around the shower and sink unit. The inspector was informed by the person in charge that the layout of the en-suite was no longer meeting the residents needs and a referral had been submitted back in November 2024 for an occupational therapist to complete an environmental assessment of it. As of the day of inspection, no date had been confirmed.

The inspector met another resident in their bedroom. The resident lived in one of the single occupancy apartments. The resident had just returned from a community activity that was based in a club in a nearby town. They were relaxing on their bed watching some of their favourite DVDs. The inspector observed the room to be painted bright red and was informed that it was the resident's choice in line with the colours of the football club they supported.

Another resident visited the inspector in the staff office after returning from their day service. The resident appeared upbeat and happy and told the inspector about their day. The resident said that they were attending a work experience course where they got to try out a variety of different work experiences. They told the inspector that the course organisers were building a café. The resident said that when it was built that they were going to be employed part-time as a waitress. The

resident appeared happy and excited when speaking to the inspector about the job. They also told the inspector about a part they had in an upcoming musical. When asked about their apartment, the resident said that they were very happy living in their home. They said their neighbour was their friend and that they liked all the staff.

Overall from speaking with the person in charge, the deputy manager, staff, and residents, as well as from observations, it was evident that residents felt very much at home in the centre, and were able to live their lives and pursue their interests as they chose. The service was operated through a human rights-based approach to care and support, and residents were being supported to live their lives in a manner that was in line with their needs, wishes and personal preferences.

However, to ensure residents were provided a safe service at all times, improvement was needed to the upkeep and repair of areas of the centre, and in particular, to two kitchens and one resident's en-suite shower room. Improvements were also needed to some of the provider level governance and management systems, staffing levels, resident goal progression and protection.

These are discussed 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.

There had been a number of quality improvements made in the centre which demonstrated effective progress on the provider's implementation of the improvement plan and how it was impacting positively on the quality of life for the resident living in this centre.

On the day of the inspection the inspector found that there was a clearly defined management structure in place and staff were aware of their roles and responsibilities in relation to the day-to-day running of the centre

The service was led by a capable person in charge, supported by a staff team, who was knowledgeable about the support needs of the residents living in the centre. The person in charge worked full-time and was supported by a deputy manager and a person participating in management.

Overall, there were suitably qualified, competent and experienced staff on duty to meet residents' current assessed needs. The inspector observed that, for the most part the number and skill-mix of staff contributed to positive outcomes for residents using the service. A review of staffing levels during the daytime was required to ensure the daily pace of residents' day was in line with their support needs and preferences.

There were two staff vacancies in the centre and the person in charge was endeavouring to ensure continuity of care by employing staff who were familiar to residents to cover the gaps on the roster. Warm, kind and caring interactions were observed between residents and staff.

The education and training provided to staff enabled them to provide care that reflected up to date, evidence-based practice.

A supervision schedule and supervision records for all staff were maintained in the designated centre. The inspector found that staff were in receipt of regular, quality supervision, which covered topics relevant to service provision and their professional development.

The registered provider had implemented good governance management systems to monitor the quality and safety of service provided to residents. The provider had completed an annual report of the quality and safety of care and support during 2024 which included consultation with residents, their families and representatives. Some improvements were needed to the providers governance and management structure to ensure that where external funding was required, there was clarification of who was accountable for this area of work.

The registered provider had prepared a written statement of purpose that contained the information set out in Schedule 1. The statement of purpose clearly described the service and how it is delivered.

The provider had suitable arrangements in place for the management of complaints and an accessible complaints procedure was available for residents in a prominent place in the centre.

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

## Registration Regulation 5: Application for registration or renewal of registration

The application for registration renewal and all required information was submitted to the Office of the Chief Inspector within the required time-frame.

Judgment: Compliant

## Regulation 14: Persons in charge

The person in charge commenced their role in this centre in November 2024. They were employed full-time in this centre only. The inspector found that the person in charge was ensuring ensure effective governance, operational management and administration in the designated centre.

The person in charge was supported by a deputy manager, who commenced their role in February 2025. They were also supported by a person participating in management.

Documentation submitted to the office of the chief inspector, demonstrated that the person in charge had the appropriate qualifications and skills and sufficient practice and management experience to oversee the residential service to meet its stated purpose, aims and objectives.

The person in charge was familiar with residents' support needs and was endeavouring to ensure that they were met in practice. The person in charge informed the inspector, that where there were compatibility issues in one house, they were endeavouring to promote positive engagements between residents. This was further supported by the positive behaviour support specialist and the newly updated support care plans in place.

The inspector found that the person in charge had a clear understanding and vision of the service to be provided and supported by the provider, fostered a culture that promoted the individual and collective rights of residents living in this centre. The person in charge informed the inspector that they were part of the organisation's special interest group for de-congregation. They also provided input for the organisation's quality assurance framework.

Staff who spoke with the inspector, said that the person in charge was very supportive to staff, and person-centred in their approach towards residents. Staff acknowledged some of the changes the person in charge had made and in particular, how promoting positive engagement between residents was having a positive impact on residents' lived experience in their home.

Judgment: Compliant

## Regulation 15: Staffing

On review of documentation and from speaking with management the inspector found that a number of the provider's plans for bringing regulation 15 into compliance, across their organisation, had been completed or partially completed in this centre with evidence of good progress being made.

Some examples are listed below (additional examples can be found under regulation 16);

Where agency staff were employed in the centre, they had been provided with an appropriate induction. There was an induction folder for agency staff in place and it was available for agency staff to review. The folder included pertinent information for staff to familiarised them with residents' support needs and other service delivery matters.

The person in charge ensured that agency staff had completed mandatory training and where additional training was required, the person in charge was in the process of organisation the training.

On the day of the inspection, agency staff had not been provided with access to the organisation's Information Technology (IT) systems. While agency staff were employed in the centre, it was not on a regular basis. The person in charge advised the inspector that they would ensure access when agency staff were next employed in the centre. This was to ensure agency staff were provided access to recorded reports and incident for residents and to ensure accurate information was passed on.

There were two vacancies in the centre, the local management had developed a bespoke advertisement poster specific to the designated centre and support needs of residents living in the centre. This was in an effort to ensure that individuals applying for the post were knowledgeable about the requirements and expectations of the role before applying and overall, providing a more effective recruitment campaign. As there was a recent change in role for one of the vacancies, the poster had yet to be advertised.

Overall, the inspector found that, the provider and person in charge were endeavouring to ensure that there were sufficient staffing levels with the appropriate skills, qualifications, and experience to meet the assessed needs of the residents at all times, in accordance with the statement of purpose and the size and layout of the designated centre.

The statement of purpose noted that an absolute minimum number of staff required to work in the centre in case of emergency included three daytime staff and two night time staff. On review of the centre's roster, the person in charge was endeavouring to roster four staff per day. However, the inspector saw that since May 2025 there were a lot of days where three staff were employed per day rather

than four. At times, this ratio of staff was impacting on the quality of care and support provided to residents. On speaking with staff, the inspector was informed that where there were days that only three staff were employed, staff found themselves rushing from place to place to try accommodate residents' choices of attending different activities and outings. Staff expressed that this was impacting on the quality of service provided to residents and in particular, that the pace was not in line with some of the residents' likes or preferences.

The staff team consisted of the person in charge, a deputy manager and 14 permanent staff (social care workers and care assistants). There were two full-time care assistant vacancies. There had been an instructor vacancy (Monday to Friday) however, to better meet the needs of residents and to provide better cover at weekends, this role had been changed to a care assistant role.

Staffing arrangements in place were ensuring continuity of care and promoting the development and maintenance of positive relationships. On review of the roster, the inspector saw that for the most part, the person in charge had employed the same two agency staff to cover shifts. Permanent staff were also covering shifts which meant that residents were being supported and cared for by staff who were familiar to them.

During the inspection, the inspector spoke and observed a number of staff members on duty. The inspector spoke in detail with two staff and found that they were very knowledgeable about residents' support needs and their responsibilities in providing care. On speaking to residents about their staff, they relayed very positive feedback about the care and support they received. Resident told the inspector, that they could speak with their staff if they were unhappy about anything and that staff would support them to address the matter.

Overall, planned and actual staff rosters were appropriately maintained by the person in charge. For the most part, rosters clearly reflected the staffing arrangements in the centre. The working hours of the person in charge and deputy manager were also noted on the roster. However, some improvements were needed to ensure that all staff names on the roster were accurate and that they were listed in full. For example, the inspector saw where three staff had not being named in full on the roster.

On review of a sample of five staff files (records), the inspector found that for the most part, they contained the required information as per Schedule 2. However, some gaps were found in some of the records. For example, there were small gaps in dates of employment on two records and no evidence of one staff's qualification in one record.

Judgment: Substantially compliant

## Regulation 16: Training and staff development

As part of the provider's improvement plan, the provider had developed and was rolling out a number of training courses to better support management and staff carry out their role to the best of their ability. The inspector found that there was good progress being made on the delivery of training programmes in this centre, which were due to be completed by December 2025.

Some of the examples include;

The roll out of a specialised person centred positive behaviour supports training saw that, five of the staff had completed the training with nine other staff due to complete it.

Thirteen staff had completed the restrictive practice training course, with one staff yet to compete it.

The person in charge had booked 14 staff on the key working training programme. Seven staff had completed the on-line section of it with seven staff yet to complete this section. All fourteen staff had been provided dates to complete the face to face section of the report in 2025.

Staff had not completed training relating to Autism however, on the day of the inspection, the person in charge showed the inspector training dates with availability and advised that they would commence booking staff on these courses that day.

The person in charge had completed the new in-house safeguarding training in February 2025 which was provided by the National safeguarding team and the provider's senior social work safeguarding liaison officer.

All staff had completed eLearning training relating to updated safeguarding policy and restrictive practice policy.

A specific person in charge resilience training programme, which included topics such as enhanced decision making, effective communication, conflict resolution, team building, adaptability and wellbeing impact, had commenced with phase one rolled out in July 2024 with 35 participants. The inspector was informed that the person in charge of this centre was one of the participants on phase 1. The person in charge informed the inspector that they found they course to be beneficial and supportive.

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

On review of the staff training records the inspector saw that all staff had been provided with the organisation's mandatory training as well as specific training to meet the needs of residents living in the centre. For example, staff had been provided training in manual handling, safeguarding, human rights, fire safety, feeding, eating, drinking and swallow (FEDS), communication, first aid and infection, prevention and control, but to mention a few.

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 completed with staff and in a timely manner. All staff had been provided a meeting in quarter one of 2025 and there was a schedule in place for meetings in July and August 2025. On speaking with staff, they informed the inspector that they found their supervision meetings to be supportive and helpful to their practice.

Judgment: Compliant

## Regulation 19: Directory of residents

The person in charge had established and maintained a directory of residents in the designated centre. The directory had elements of the information specified in paragraph three of schedule three of the regulations.

Judgment: Compliant

## Regulation 22: Insurance

The registered provider had valid insurance cover for the centre, in line with the requirements of the regulation.

The service was adequately insured in the event of an accident or incident. The required documentation in relation to insurance was submitted as part of the application to renew the registration of the centre.

The inspector reviewed the insurance submitted to the chief inspector and found that it ensured that the building and all contents, including residents' property, were appropriately insured. In addition, the insurance in place also covered against risks in the centre, including injury to residents.

Judgment: Compliant

## Regulation 23: Governance and management

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

Some examples are listed below;

Training in areas of safeguarding, person centred specialised positive behaviour supports, restrictive practices, and key working training programmes that was due for completion by December 2025 were well underway.

There was evidence to demonstrate that the traffic light plan, to identify and prioritise positive behaviour supports needs, was in place in the centre. Residents' positive behaviour support status were recorded on the live system as 'green'.

As part of the enhancement of person participating in management (PPIM) governance and management oversight, information for quarterly governance and assurances and business support meetings had been collated. The person in charge showed the inspector minutes from one of the governance assurance meetings that had occurred between them and the PPIM in April 2025. Matters discussed and reviewed at the meeting included the centre's statement of purpose, residents' medication, housekeeping inspections, staff training, health and safety, residents' files, inductions, actions from six monthly review and the quality improvement actions plan action updates.

The person in charge had created a folder for staff with bullet points relating to the centre’s recent overview report action plans. This was to ensure that all staff were kept informed of the status of quality improvements to be completed in the organisation. For example, some of the items included in the folder included, breakdown of action plan (per regulation), clinical case review flow chart poster, occupational therapist process, positive behaviour supports strategy and the organisation's safeguarding pathways procedures.

On review of the designated centre's visitor’s book, the inspector saw that the person participating in management had called to the centre unannounced on at least five occasions between November 2024 to the day of the inspection.

The provider had commenced roll out a resilience programme for persons in charge. The programme commence in July with 35 participants on the course. The person in charge of this centre informed the inspector that they were a participant on the course.

The person in charge spoke to the inspector about the restrictive practice in house regulatory themed self-audits and had a template printed in the local audit folder. They advised the inspector that they were endeavouring to have it complete by end of quarter two.

On the day of the inspection, the inspector found the governance and management systems in place to operate to a good standard in this centre. For the most part, there was a clearly defined management structure that identified the lines of authority and accountability, specifies roles and details responsibilities for all areas of service provision.

However, some improvement was needed.

For example, there was an outstanding action from the last inspection regarding the refurbishment of the kitchen in the main building. There had been some progress in securing quotes, design and contractors however, funding had not been secured. On the day of the inspection, the inspector found that there was uncertainty as to who was accountable for submitting the funding business case. This meant that there was likely a further delay in completing the refurbishment of the residents' kitchen to enhance the lived experience of residents and mitigate any IPC risks presenting.

The provider was required to review their arrangements for whom was responsible for coordinating business plans, overseeing their progress and implementing project oversight to see such plans come to fruition.

The person in charge was supported by a deputy manager and person participating in management to carry out their role in this centre. Staff had specific roles and responsibilities in relation to the day-to-day running of the centre with systems in place that ensured effective oversight by the person in charge.

The provider had completed an annual review of the quality and safety of care and support in the designated centre between 01 December 2023 to 11 November 2024. There was evidence to demonstrate that residents, and where appropriate, their families and/or representatives, had been consulted in the review.

In addition, to the annual review an unannounced six monthly review had been completed in December 2024 to review the quality and safety of care and support provided to the resident and an action plan with allocated actions and time scales was in place. The next six monthly was due in June 2025.

The person in charge carried out regular team meetings with staff. On review of the most recent meeting in May 2025, the inspector saw that the behaviour specialist has joined the meeting to talk with staff about residents' updated positive behaviour support plans in place.

On speaking with staff about the meetings they told the inspector that they were very beneficial for sharing information and learning. They also said that it was a place where staff could raise any concerns or issues they had and that it would be addressed on the day or thereafter.

Judgment: Substantially compliant

## Regulation 3: Statement of purpose

The provider had submitted a statement of purpose which outlined the service provided and met the requirements of the regulations. The statement of purpose had been reviewed an updated on 14 April 2025.

The statement of purpose described the model of care and support delivered to residents in the service and the day-to-day operation of the designated centre. The

statement of purpose was available to residents and their representatives and was available in communal areas of the centre.

In addition, a walk around of the designated centre confirmed that the statement of purpose accurately described the facilities available including room function.

The person in charge was aware of their legal remit to review and update the statement of purpose on an annual basis (or sooner) as required by S.I. No. 367/2013 - Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (the regulations).

Judgment: Compliant

## Regulation 31: Notification of incidents

The inspector found that the person in charge had ensured that there were effective information governance arrangements in place to ensure that the designated centre complied with notification requirements.

For the most part, all adverse incidents and accidents in the designated centre, required to be notified to the Chief Inspector of social services, had been notified and within the required time frames as required by S.I. No. 367/2013 - Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (the regulations).

The inspector found that incidents were managed and reviewed as part of the continuous quality improvement to enable effective learning and reduce recurrence. Where there had been behavioural or safeguarding incidents, the incident and learning from the incident, had been discussed at staff team meetings.

Where a notification had not been submitted, this has been discussed under Regulation 8.

Judgment: Compliant

## Regulation 34: Complaints procedure

The provider had established and implemented effective complaint handling processes. For example, there was a complaints and compliments policy in place. In addition, staff were provided with the appropriate skills and resources to deal with a complaint and staff spoken to on the day, had a full understanding of the complaint's policy and procedures.

The inspector observed that the complaint's procedure was accessible to residents and in a format that they could understand. On speaking with the person in charge and staff, the inspector was informed that the complaints process is discussed with residents during monthly key working sessions on a regular basis.

On the day of the inspection, the person in charge placed a copy of the organisation's own advocacy group (which residents are part of) booklet in each of the centre's buildings.

There was one open complaint on the day of the inspection. The complaint was in relations to peer to peer incidents that had occurred in one of the houses. The person in charge was in regular contact with the complainant and provided assurances of steps that had been put in place to try resolve the matter. The person in charge informed the inspector that the complaint would remain open until updated behavioural support plans were fully embedded and a reduction in behavioural incidents was evident.

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.

The inspector found that, overall, residents' well-being and welfare was maintained by a good standard of evidence-based care and support. It was evident that the person in charge and staff were aware of residents' needs and knowledgeable in the person-centred care practices required to meet those needs. Care and support provided to residents was of good quality.

Since the previous inspection there had been a number of improvements in the centre resulting in positive outcomes for residents. However, to ensure continued positive outcomes for residents, improvements were needed to the upkeep and repair of areas of the premises to ensure the effectiveness of infection prevention and control measures in place and overall, to ensure the health and safety of residents and staff. In addition, some small improvements were needed to the areas of protection and residents' personal plans.

The person in charge ensured that there was a comprehensive assessment for each resident, taking into account their changing needs. The assessment informed residents' personal plans which guided the staff team in supporting residents with identified needs and supports. Plans were reviewed annually, in consultation with each resident, and more regularly if required. Some improvements were needed to ensure that residents were supported to engage in meaningful goals and were provided steps to empower them achieve and celebrate personal achievements.

Every effort had been made to ensure that residents could receive information in a way that they could understand. Each resident was provided with a communication support plan and a personal communication passport. These were reviewed on a yearly basis or sooner if required.

There were systems in place to manage and mitigate risks and keep residents and staff members safe in the centre. There was a risk register specific to the centre that was reviewed regularly. Individual and location risk assessments were in place to ensure the safe care and support was provided to residents.

Overall, residents living in the designated centre were protected by appropriate safeguarding arrangements. Staff were provided with appropriate training relating to keeping residents safeguarded. The provider, person in charge and staff demonstrated a high level of understanding of the need to ensure each resident's safety. However, a review of some incidents of concern was needed to ensure that they were followed up in line with the organisation's and national policy.

Since the last inspection, there were some improvements found to the systems in place that better ensured the effectiveness of the infection, prevention and control measures in the house. However, the poor condition and state of repair in areas of the centre meant that the arrangements put in place by the person in charge and staff team could not always be entirely effective in the promotion of good infection prevention and control at all times.

The design and layout of the premises of the designated centre was in line with the statement of purpose and for the most part met the needs of residents living in the centre. There had been a number of improvements to areas of the main house in the centre so that it now provided a more pleasant, comfortable and homely environment for residents.

The provider and person in charge promoted a positive approach in responding to behaviours that challenge and ensured evidence-based specialist and therapeutic interventions were implemented. The inspector saw evidence that there was clear, correct and positive communications which helped residents understand their own behaviour and how to behave in a manner that respects the rights of others and supports their development.

There was a number of environmental and rights restrictive practices used in the centre. Primarily the restriction were in place to support the health, safety and well-being of residents during their respite stays. Where applied, the restrictive practices were clearly documented and were subject to review by the appropriate professionals. The restrictive practices were supported by appropriate risk assessments which were reviewed on a regular basis. The person in charge regularly reviewed restrictions in an effort to reduce them as much as possible.

The inspectors found that the systems in place for the prevention and detection of fire were observed to be satisfactory. There was suitable fire safety equipment in place and systems in place to ensure it was serviced and maintained. There was

emergency lighting and signage at fire exit doors. Local fire safety checks took place regularly and were recorded and fire drills were taking place at suitable intervals.

## Regulation 10: Communication

Overall, the inspector found that communication access was facilitated for residents in this centre in accordance with their needs and wishes.

The person in charge had ensured that residents were provided information in a way that they understood. The inspector observed examples of easy read format 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. For example, the complaints procedure, which was placed on all residents' notice boards, was written in easy to read format.

There was a culture of listening to and respecting residents' views in the service. Staff also advocated for residents, and residents were facilitated and supported to access advocates when requested or when required. 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. On the day of the inspection, a copy of the advocacy's group booklet was placed in residents' homes. The booklet contained easy to read information relating to the group and the service it provided.

The inspector found that the provider and person in charge understood that the ability to communicate needs and wishes and to be understood was a core value as a human being. In respecting this principle, they were endeavouring to ensure that residents were supported to understand the information provided to them and to be supported to communicate their choices and decisions about their care and their lives.

To support this, residents were provided with communication support plans and personal communication passports. 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.

In addition, the provider's April 2025 newsletter had included information regarding communication passports, explaining what they were, why communication passports are important, who has one, where it is used and how residents are consulted about it. The article also included residents' views and feedback, as well as the in-house advocacy group's feedback on the communication passport, which overall, was found to be very positive.

Through conversations with staff, the inspector found that they were aware of each resident's communication support needs and were knowledgeable on how to communicate with residents. On observing staff interact with residents, it was clear they understood what residents were saying and that the residents understood what

staff were saying to them. Engagement between staff and residents was observed to be kind, supportive and caring

Judgment: Compliant

## Regulation 17: Premises

Overall, the physical environment of the house was observed to be clean and tidy. There were a number of upkeep and decorative repairs required which were impacting on the effectiveness of infection prevention and control measures. These have been addressed under regulation 27.

The inspector observed the design and layout of the premises ensured that each resident could enjoy living in a comfortable and homely environment. This enabled the promotion of independence, recreation and leisure and overall enabled a good quality of life for residents living in the designated centre.

During the walk around of the centre, including the two self-contained apartments and the main house, the inspector observed residents' personal living spaces and bedrooms to be personal to each resident and relayed their likes and interests.

While there was some outstanding works to be completed, there had been a number of improvements to the designated centre since the last inspection and in particular, to the main building where three residents lived.

The dining room and sitting room had a complete make-over that resulted in a homely and warm feeling to the areas. New furniture, fixtures and soft furnishing were all in place in the rooms. The inspector was informed by staff and residents that residents had been consulted in the make-over and their opinion was taken into account. When talking to a resident who was watching television and relaxing in the newly improved sitting room, they told the inspector that they 'loved' being in that particular sitting room. The also said that they had been part of choosing the soft furnishing for the room and pointed to the new curtains which they had picked out.

There had also been significant improvements made to the external room to side of house. The room was used as a residents' activity room. It presented as a bright and colourful room with spaces to enjoy art and crafts, board games and puzzles and seating areas to relax, listen to music or watch television.

There had also been improvement to the external areas of the centre. There was a large garden area to the side and back of the house. A new vegetable patch had been developed with lots of fresh salad ready for picking. Staff informed the inspector that residents enjoyed this space and often sat with staff and chatted while the garden was been tended to. The space was observed to be a relaxing and calm environment for resident to enjoy.

The provider had a maintenance system in place and where there were maintenance issues the person in charge and staff team would notify the maintenance team via an IT system. The notification would be responded to and a date of when the works were due to be completed would be relayed through the system.

Judgment: Compliant

## Regulation 20: Information for residents

The registered provider had prepared a guide for residents which met the requirements of regulation 20. For example, on review of the guide, the inspector saw that information in the residents' guide aligned with the requirements of associated regulations, specifically the statement of purpose, residents' rights, communication, visits, admissions and contract for the provision of services, and the complaints procedure.

The guide was written in easy to read language and was available to everyone in the designated centre.

Judgment: Compliant

## Regulation 26: Risk management procedures

The inspector reviewed the centre's risk management policy and found that the provider had ensured that the policy met the requirements as set out in the regulations. The policy was last updated in April 2024 and was due for renewal in 2027.

Where there were identified risks in the centre, the person in charge ensured appropriate control measures were in place to reduce or mitigate any potential risks.

The person in charge had completed a range of risk assessments with appropriate control measures, that were specific to residents' individual health, safety and personal support needs.

For example;

Where there was a risk of psychological harm to residents from peers 'display of verbal aggression', there were measures in place to reduce the risk. These included staff training, positive behaviour support plans, safeguarding policy and residents having their own private living spaces.

Where there was a risk of serious illness or poor health to a resident due to non-compliance with feeding eating drinking and swallow (FEDS) plans, there were a

number of measures in place to reduce the risk of it occurring. Measures included, staff adhering to residents' FEDS plans, staff awareness of signs of aspiration, recording instances of non-compliance with FEDS and following up with a SALT review.

Where there was a risk of residents losing a number of, or all, teeth due to poor hygiene, control measures included, education piece on oral hygiene during key working sessions, three monthly visits to hygienists, new antibiotic toothpaste and six monthly visits to dentist.

There were also centre-related risk assessments completed with appropriate control measures in place.

Judgment: Compliant

## Regulation 27: Protection against infection

The previous inspection found this regulation to be non-compliant however, many of the findings had related to staff knowledge, local checks and ineffective oversight of infection prevention control measures. On the day of this inspection, it was evident from speaking with the person in charge and staff, as well as a review of related records, that there had been improvements in this area of infection prevention and control.

However, there were a number of upkeep and repair works required that were impacting on the effectiveness of cleaning which in turn impacted on the arrangements for ensuring the best possible infection, prevention and control arrangements, and this required improvement.

During the last inspection it was identified that the kitchen in the main building required significant upkeep and repair. In particular, it had been identified that the kitchen counters and cupboards were damaged posing a risk of bacteria harbouring. The provider submitted a compliance plan with an action to complete a kitchen refurbishment by May 2025. In advance of the inspection, the inspector was informed that there was a delay on the works and that it would be completed by August 2025. However, due to lack of coordination of a funding application it was now likely these dates were not achievable. This meant that the infection prevention control risk, for the residents living in this premises, was ongoing.

In addition, another kitchen in one of the apartments, which was of similar layout and design to the above mentioned kitchen, was observed to have many of the same upkeep and repair requirements as the kitchen in the main building. However, this kitchen had not been identified to be part of the kitchen refurbishment with no plan or date in place to address the deficits.

Furthermore, during a walk around of the premises the inspector observed the following areas that required action to mitigate health and safety risks;

A number of areas in the centre were observed to require a deep clean where dirt, grime and grease was visible; for example, inside surround of kitchen fire shutters, inside exit door frames, shower surrounds and tiling area and areas of a floor at base of a kitchen fridge.

In the back hallway of the centre, there was flaking and peeling paint on the ceiling surrounding an old fire alarm that was no longer in use. There was ingrained dirt on the external exit door frame as well as large chips of plaster on wall surrounding the door.

In the archive storage room there was a large amount of boxes and bags on the floor and overall, the room was observed to be cluttered and untidy and there was insufficient shelving to store boxes in a hygienic manner.

In one of the resident's apartments there was chipped paint on the sitting room wall. In the kitchen area the inspector observed a number of cracked tiles and ingrained dirt and grease inside the large kitchen shutters. There was a gaps in the lino in front of fridge, it was observed dirty and difficult to clean due to the surface. The kitchen counter top was worn and cracked in areas. A large drawer that contained a bin was in disrepair; the surface of the timber drawer was peeling and blistered. The radiator in kitchen was stained and rusty in areas. There were gaps and cracks on the kick-boards under kitchen units. Tiles at end of the kitchen unit beside fridge were broken and coarsely cut and could not be cleaned effectively.

The laundry room, where residents and centre laundry was carried out, also included a space that was used as an office. A doubled door cupboard at one end of the room was set up as an office for staff to work in. The space was extremely small and had previously been used as a bathroom airing cupboard. The inspector observed a money safe, a medicine cabinet, a number of residents' folders, a first aid box and three office trays containing paperwork, stored in this area. The wooden slatted shelves in the cupboard were worn and stained. One of the staff demonstrated how the wooden slatted shelving was used as a table top when preparing residents' medication. This area was not an appropriate, safe or hygienic environment for a staff office or for dispensing medication.

In the main house, in addition to the ongoing poor upkeep and repair of the kitchen, a resident's en-suite shower room was observed to require a deep clean and upkeep and repair to the tiling and shower surround. The person in charge and staff told the inspector that the shower was currently not meeting the resident's mobility needs and a referral had been submitted for and occupational therapist to review the layout of the room back in November 2024.

There was a raised septic tank to the back of the garden that included a large metal ladder leading up to the top of the tank. It was shielded on one side by a large timber structure. The inspector was advised that every Friday morning at 6am, a lorry drives through the residents' garden to collect the contents from the tank. This situation had been in place for a number of years. There was no risk assessment in

place for the tank or much information available on the day about the arrangements in place for the upkeep and safety relating to the tank.

There were a number of small waste bins in the centre that were observed to have no lid on them. For example, in a resident's bedroom, a resident's en-suite and one of the kitchens.

There was a strong malodour in one of the resident's bedroom. On the day it was unclear as to what was causing it.

The floor behind the toilet in a resident's en-suite was observed to have a gap and be unclean. There was chipped paint and a lot of old sticky tape (unclean) on the wall of the room.

Garden furniture (two table and chair benches) were observed to be very old, worn and chipped in areas.

Judgment: Not compliant

## Regulation 28: Fire precautions

Since the last inspection, there had been improvements to the centre's fire precautions. In particular, to the containment measures, fire drills and fire evacuation plan. In addition, a fire door inspection had been carried out in 2024 and where remedial works were needed they had been completed. In early May 2025 another fire door assessment was carried out and the inspector was informed that there was a plan to commence any required remedial works in mid-June 2025.

Overall, the inspector found the registered provider had appropriate fire safety systems in place including fire detection, containment and fire fighting equipment.

There was adequate arrangements made for the maintenance of all fire equipment. All fire safety equipment was subject to regular checks and servicing with a fire specialist company. There was adequate means of escape and emergency lighting in place.

On review of fire safety records, the inspector saw that staff were carrying out daily, weekly and monthly fire safety checks. For example, daily checks on the magnetic door lock system, weekly checks on the fire alarm and monthly checks on evacuation routes and door closers (but to mention a few).

Regular fire drills were completed, and the person in charge had demonstrated that they could safely evacuate residents under day and night time circumstances.

All staff had completed fire safety training. On speaking with staff, the inspector found that they were knowledgeable in how to support residents evacuation from the centre in case of fire and keeping in mind their support needs.

The person in charge and staff team were endeavouring to make the centre look as homely as possible however, many of the fire extinguishers were stored in large red plastic boxes which took away from the homely feel to the centre. The inspector observed that some extinguishers were not stored in the large boxes and on speaking with local management, the inspector was informed that there was no known risk or need for the large boxes.

In addition, in one of the apartments and in the main building, large steel shutters (that were part of the fire containment system) were fitted in the kitchens. These presented as institutional in style and took away from the homeliness of the centre.

Overall, the inspector found that to support the recent improvements made to the aesthetics of centre, a review of the requirement for the large red plastic boxes and kitchen steel shutters, would likely enhance the homeliness of the centre.

Judgment: Compliant

## Regulation 5: Individual assessment and personal plan

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

Some of the examples are listed below;

Key worker training programme rolled out in 2025; Seven key workers had completed the on-line section of the programme. There were plans in place for all 14 staff to complete the face to face section on the course by end of 2025.

Audits of residents' personal profile documentation by the person in charge, using the person profile checklist, had been implemented with evidence of completion for second half of quarter one and quarter two. The audit included actions required, status update and completion dates that were signed by the person in charge.

The person in charge was aware of the newly developed clinical case review work flow chart and advised that it had been beneficial when recently referring a resident to a speech language therapist.

On the day of the inspection, the inspector reviewed a sample of three residents' personal plans and saw that they included an assessment of each resident's health, personal and social care needs and that arrangements were in place to meet those

needs. This ensured that the supports put in place maximised each resident's personal development in accordance to their wishes, individual needs and choices.

The inspector saw that residents' plans were regularly reviewed, and where appropriate, their family members were also consulted in the planning and review process of their personal plans. The multidisciplinary reviews were effective and took into account changes in circumstances and new developments in residents' lives. Residents' personal plans reflected the revised assessed needs of residents.

On review of the section of residents' personal plan that related to their personal goals and achievements, the inspector found that improvements were needed.

For example, improvements were needed in supporting residents' choose goals that were meaningful to them, specific, and achievable. On review of a sample of residents' goals the inspector found that some goals in place for residents related more to activities they enjoyed rather than meaningful goals to achieve.

Steps to breakdown and support residents achieve their goals were not clear and in some cases, not in place at all. Some residents' goals had already been achieved however, there was nothing recorded to demonstrate the achievement had been acknowledged. In some cases, the same goal was repeated the following year.

Recording the progress of goals also required review to ensure that they related to the specific goal rather than listing daily community or in-house activities.

Overall, a review of residents goals, the progress of them and how residents' achievements are acknowledged, required review. This was to ensure that residents were supported to engage in meaningful goals and were provided steps to empower them achieve and celebrate personal achievements.

Judgment: Substantially compliant

## Regulation 7: Positive behavioural support

On review of documentation and from speaking with management the inspector found that number of the provider's plans for bringing regulation 7 into compliance across their organisation had been completed or partially completed in this centre.

Some examples are listed below

Where appropriate, all residents were provided with a positive behaviour support plan which had been reviewed in April 2025 by an appropriate professional. The inspector saw that residents' plans had been included in the newly implemented traffic light system (to identify and prioritise positive behavioural support needs in the organisation) and all were currently live rated as green. The inspector found that

this was an accurate rating considering residents' plans were up to date and there was no referral outstanding.

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. All staff had completed the eLearning course.

Additional positive behaviour support training was being rolled out within the organisation throughout 2025; Five of this designated centre's staff members had commenced the programme to date. Nine staff were due to commence the training and the person in charge had booked dates for staff to attend the training.

A new positive behavioural specialist had joined the positive behaviour support department. The person in charge and deputy were aware of the names of the behaviour support specialist team and told the inspector that one of the specialists recently attended their staff meeting to discuss residents' support plans.

On the day of the inspection, the inspector reviewed a sample of three residents' positive behaviour support plans. The inspector saw that the plans were up-to-date (reviewed in April 2025) and provided satisfactory guidance to staff in supporting residents' manage their behaviours. The plans included appropriate clinical oversight, both in the development and review of the plan.

Overall, there had been significant improvement in positive behaviour supports in the centre since the last inspection. The inspector was informed that the provider's positive support specialist had visited the centre on a least five occasions as part of the review of residents' positive behaviour support plans. The specialist met with residents in their home and met with staff in advance of reviewing and updating plans. The specialist also attended the centre's staff meeting in May 2025 to talk through the strategies in residents' plans with the staff team.

On speaking with the person in charge and staff, positive feedback was relayed about the positive support behaviour specialist. In particular, positive feedback related to the specialist's engagement with residents, with staff and the newly updated plans. The person in charge and staff told the inspector that they were seeing positive changes between residents (were there was compatibility issues) and that the plans provided good support with implementing the change.

Staff who spoke with the inspector demonstrated that they had appropriate knowledge and skills to respond to behaviour that is challenging and to support residents to manage their behaviour.

The inspector saw there where restrictive procedures were being used, they were based on centre and national policies. Where applied, the restrictive practices were clearly documented and were subject to review by the appropriate professionals involved in the assessment and interventions with the individual.

Restrictive practices were regularly reviewed by the person in charge and they were committed to reducing and removing restrictions where possible. There was a good oversight system in place where new and existing restrictions were required to be

approved by the provider's rights restrictions group. Restrictive practices in use at time of inspection were deemed to be the least restrictive possible for the least duration possible.

Judgment: Compliant

## Regulation 8: Protection

On review of documentation and from speaking with management the inspector 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 person in charge informed the inspector that they had attended the one day training provided by the national safeguarding team and the provider's senior social work safeguarding liaison officer.

The organisation's safeguarding policy had been reviewed October 2024 by the provider. A copy was made available to staff. All staff in this centre 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/persons in charge to assure that they had registered on the National safeguarding portal. The person in charge informed the inspector that they had registered on the portal.

The person in charge and deputy were aware of the name of the second social worker who was recently employed to the organisation's social work department.

On the day of the inspection, the inspector saw that all residents were provided with safeguarding passports which were included in each resident's personal plan folder.

The training matrix demonstrated that all staff had been provided training in safeguarding of vulnerable adults and all training was up-to-date. In addition, all staff had completed the eLearning training on the centre's safeguarding policy.

On review of staff meetings' minutes, the inspector saw that safeguarding was discussed at team meetings on a regular basis.

From reviewing a sample of five staff files, with regard to Schedule 2 of the regulations, all five staff had appropriate vetting in place.

Information on how to contact the social work team, complaints officer and as well the organisations own advocacy group, was on display in a number of areas in the designated centre. In addition there was a copy of the organisation's 'safeguarding pathways procedures' booklet available in the staff induction folder. The booklet

provided clear guidance and steps for staff on how to report a concern as well as the time frames for different steps to be completed by.

On speaking with staff, the inspector found them to be knowledgeable about their safeguarding remit; Staff understood their role in adult protection and were knowledgeable of the appropriate procedures that needed to be put into practice when necessary. Both staff spoken to were aware of the different forms of abuse and what to do should they have a concern. Staff were aware what to do and how to report it, if they observed one resident's behaviour impact negatively on another resident.

Overall from a review of notifications submitted to the chief inspector, relating to safeguarding allegations, the inspector found that on the most part, the person in charge had followed up, reviewed, screened, and reported the incident in accordance with national policy and regulatory requirements.

However, some improvement was needed as not all peer to peer incidents had been identified as safeguarding incidents. On review of three 'issues of concern' incident reports, the inspector saw that where there had been a behavioural incident (shouting at staff, kicking doors, vocalising loudly) the impact on residents witnessing the incident, had not been followed up in line with the provider's safeguarding policy.

Incident reports relayed that other residents were present and had to be removed to their room for safety or had to remain in their room for safety. Overall, the inspector found from reading the reports that it was evident that one incident clearly demonstrated a safeguarding incident had occurred. However, the other two incident reports, were not very clear and required further investigation to deem if they were a safeguarding incident or inadequate recording of the incident.

Judgment: Substantially compliant

## Appendix 1 - Full list of regulations considered under each dimension

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

| Regulation Title | Judgment |
|---|---|
| **Capacity and capability** | |
| Registration Regulation 5: Application for registration or renewal of registration | Compliant |
| Regulation 14: Persons in charge | Compliant |
| Regulation 15: Staffing | Substantially compliant |
| Regulation 16: Training and staff development | Compliant |
| Regulation 19: Directory of residents | Compliant |
| Regulation 22: Insurance | Compliant |
| Regulation 23: Governance and management | Substantially compliant |
| Regulation 3: Statement of purpose | Compliant |
| Regulation 31: Notification of incidents | Compliant |
| Regulation 34: Complaints procedure | Compliant |
| **Quality and safety** | |
| Regulation 10: Communication | Compliant |
| Regulation 17: Premises | Compliant |
| Regulation 20: Information for residents | Compliant |
| Regulation 26: Risk management procedures | Compliant |
| Regulation 27: Protection against infection | Not compliant |
| Regulation 28: Fire precautions | Compliant |
| Regulation 5: Individual assessment and personal plan | Substantially compliant |
| Regulation 7: Positive behavioural support | Compliant |
| Regulation 8: Protection | Substantially compliant |

# Compliance Plan for Rosanna Gardens OSV-0001711

## Inspection ID: MON-0038362

## Date of inspection: 29/05/2025

**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:<br>• Agency staff have been provided with log on for Organisation's Information Technoical System (from 30/05/25. This will be renewed by PIC/DSM after the allotted time is up.<br>• Agency staff have been provided with access to mandatory policies to the companies 'e-learning' system.<br>• PIC developed a Risk assessment on 12/06/25 for instances where minimum number of staff (3) on shift. Control measures include sourcing regular agency staff and PIC/DSM to provide support and ensure client activities are prioritised. PIC will review the staff roster at the end of each month to monitor the number of times this occurs and update risk assessment controls accordingly.<br>• PIC held a meeting with recruitment on 12/06/25 to discuss efforts to fill two current vacancies.<br>• PIC has completed the roster for July and August 2025 to ensure sufficient time to fill gaps with familiar staff.<br>• The Roster has been amended to reflect correct and full names of staff on shift, only PIC and DSM are authorised to make changes or add to the roster to ensure it remains accurate.<br>• Gaps in employment records on HR files have been rectified on 10/06/2025. | |
| Regulation 23: Governance and management | Substantially Compliant |
| Outline how you are going to come into compliance with Regulation 23: Governance and management: | |

• Clear boundaries have been set in relation to the neighbouring designated centre. The office and bathroom described in the report will no longer be shared with second location. Meeting took place on week of 16/06/25 to confirm no further actions required by Rosanna PIC.

• The provider has developed a clear workflow and user-friendly guidance document to inform the operations team the new procedure related to business cases on 23/06/2025.

| | |
|---|---|
| Regulation 27: Protection against infection | Not Compliant |

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
• All upkeep and repair works have been added to the maintenance system on 02/06/2025 with a completion date of the 31/07/2025 for the following areas:

o Repainting of client spaces where chipped paint has been identified.
o Storage solutions for archive room.
o Painting the hallways entrance.
o Purchase of a new desk for staff.
o Repair of cracked tiles in one bathroom.
o Metal fire shutters are required as part of the existing fire certification and cannot be removed. They will be deep cleaned and greased with food grade grease to comply with IPC.
o Bin replaced in the bedroom with malodour.

• Deep clean of areas identified during inspection will be carried out by the 30th of June 2025. This will be documented on the weekly housekeeping checklist and verified by PIC.

• The Area being used as laundry room/office has been reviewed and this will now be used as laundry room only, the items in the office space will be moved to another location in the designated centre and this will be the space used by staff supporting that area of the centre. This will be completed by the 30th of July.

• Pedal bins were purchased week of 09/06/2025 to replace open bins identified during the inspection.

• The Replacement of garden furniture was requested on 01/06/25 and will be in place by 31/07/2025.

• An OT assessment was carried out on 20/06/25 regarding resident ensuite – following this, a business case will be submitted for upgrade of the ensuite.

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| • A Business case was completed by SOM on 05/06/2025 to request funding for two kitchens. The business case has been submitted to the funders; this will be reviewed and escalated by the provider should this not be completed by March 2026.<br>• The PIC will develop a risk assessment for the above ground septic tank with support from facilities PIC. This will include arrangements for upkeep and safety. This risk assessment will be complete by 01/07/2025. |

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| 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:<br>A Full review of all client goals by a member of the quality and compliance team will be completed on the 23/06/2026. PIC to carry out information session with staff team on 24/06/25 around logging discussions about meaningful goals and tracking progress. All client goals will be updated as required by the 30/07/2025. | |
| Regulation 8: Protection | Substantially Compliant |
| Outline how you are going to come into compliance with Regulation 8: Protection:<br>The PIC has reviewed the three incidents identified by the inspector. Of the three, one has been confirmed as a safeguarding concern and correct protocol has been followed. This was completed on 12/06/25. Two incidents were confirmed as inaccurate reporting and not safeguarding. PIC to discuss accurate recording and reporting during team meeting on 24/06/25. | |

## 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 |
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| Regulation 15(1) | The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre. | Substantially Compliant | Yellow | 30/08/2025 |
| Regulation 15(4) | The person in charge shall ensure that there is a planned and actual staff rota, showing staff on duty during the day and night and that it is properly maintained. | Substantially Compliant | Yellow | 30/08/2025 |
| Regulation 23(1)(c) | The registered provider shall ensure that management systems are in place in the designated centre | Substantially Compliant | Yellow | 30/07/2025 |

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| | to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored. | | | |
| Regulation 27 | The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority. | Not Compliant | Orange | 30/03/2026 |
| 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 | 30/07/2025 |
| Regulation 08(3) | The person in charge shall initiate and put in place an Investigation in relation to any incident, allegation | Substantially Compliant | Yellow | 12/06/2025 |

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| | or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse. | | | |