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

Issued by the Chief Inspector

Name of designated centre:	Beechview House (Orchard)
Name of provider:	Autism Initiatives Ireland Company Limited By Guarantee
Address of centre:	Co. Dublin
Type of inspection:	Unannounced
Date of inspection:	11 February 2026
Centre ID:	OSV-0002060
Fieldwork ID:	MON-0045647

About the designated centre

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

Beechview House (Orchard) is a designated centre operated by Autism Initiatives Ireland Company Limited. It provides community residential services to up to three adult residents with an Autism Spectrum Disorder and other associated conditions. The centre comprises of a large apartment which consists of an open plan kitchen/living/dining room, utility room and a shared bathroom. There is a second communal space that is used as a sitting room and activity room. Each resident has their own bedroom with en-suite. The centre is situated in a suburban area of County Dublin with access to a variety of local amenities such as shops, train stations, bus routes and the city centre. The centre is staffed by a area manager, team leaders, social care workers and support workers.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	3

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 11 February 2026	10:00hrs to 18:15hrs	Jacqueline Joynt	Lead

What residents told us and what inspectors observed

This was an unannounced inspection. The purpose of the inspection was to monitor ongoing regulatory compliance in the designated centre. Through speaking with the person in charge, staff members and all residents, the inspector found that residents were empowered to live life as independently as they were capable of.

Overall, the inspector found that that the person in charge and staff were striving to ensure that, residents living in the designated centre, were provided with a quality and safe service.

However, the inspector found that some improvements were needed to local oversight systems, maintenance of rosters, risk management and infection prevention and control. In addition, further action was needed to resolve the high frequency of false fire alarm activations, which had been ongoing since the last inspection, and overall were impacting negatively on the lived experience of residents.

The inspection was facilitated by the person in charge, the team leader and the person participating in management for the duration of the inspection. The inspector used observations and discussions with residents, in addition to a review of documentation and conversations with key staff and management, to inform judgments on the residents' quality of life.

There were three residents living in the centre and on the day of the inspection, the inspector was provided with the opportunity to meet with two of the residents. One resident was living in the centre from Friday to Tuesday only and the inspector did not get the opportunity to meet with them.

On day of the inspection, residents were supported to engage in activities in their home and community that were of preference to them. For example, one resident, supported by their staff member, baked a cake in the morning and later in the day travelled to Gorey to have lunch and go for a walk. Another resident spent the day in Bray with their staff member where they participated in bowling and ate lunch in a café.

The centre comprised of a large ground floor apartment which was located in an apartment complex of three floors. The last inspection of the centre found that there were high number of false fire alarm activations. This inspection found that a similar trend had emerged during 2025 and moving in to 2026. The inspector was informed by management that the alarms were activated as a result of minor cooking incidents in upper floor apartments.

Overall, residents in the designated centre were evacuating promptly every time the alarm was activated except for one recent occasion in January 2026, where a

resident refused to evacuation as they believed it to be a false alarm. A record of the evacuations, show that the fire alarm was being activated during the day, evening and night-times and were impacting negatively on the lived experience of residents.

On speaking with residents and staff, the inspector found that this situation was impacting on residents' routine, sleep and anxieties. The inspector was informed that other residents from neighboring designated centres gathered at the same fire evacuation meeting point. Some of the behaviours and vocalisations from these residents had led to upset and anxieties for the residents of this centre. On two occasions during 2025, this had resulted in safeguarding concerns.

On speaking with one resident about the frequency of the fire alarm activation, they expressed their dissatisfaction. The resident said that it was not right and the issue was upsetting to them and their friend who lived with them. They said it was going on for a long time. The resident also spoke to the inspector about other things and matters that they enjoyed and were happy about however, returned to the issue of the frequency of the fire alarm activations at the end of the conversation. The resident told the inspector that they would speak to staff about it. Overall, the inspector observed the resident to appear frustrated and annoyed at the impact of this situation and was seemed keen for it to be dealt with. This issue is discussed further under Regulation 23 and 26.

The person in charge showed the inspector around the residents' home. The apartment consisted of an open plan kitchen/living/dining room, a separate communal sitting room, a utility room, staff office and a shared bathroom. The inspector observed that two of the shower facilities were in poor upkeep and decorative repair. This is further addressed in the quality and care section of the report.

Each resident was provided with their own private bedroom which was decorated to their individual style and choice. One of the resident's chose to show the inspector their bedroom. They pointed out all their favourite items such as books, DVDs and computer games. The told the inspector they liked their bedroom and had everything they needed in it.

On speaking with another resident, they also told the inspector that they were very happy with their bedroom and that it contained everything they liked including a television. The resident expressed their happiness of living in the centre and said that they considered it to be their home.

On walking around the rest of the apartment, the inspector observed it to have a homely and welcoming feel. In the kitchen there was a large information board that supported residents in their everyday life. For example, there was a photograph-format of a daily staff roster. This was in place to support residents know who was working with them on a day-by-day basis. There were picture-format menu choice boards as well as daily activity boards. The inspector was informed that one of the residents enjoyed updating the notice board every week as part of their Friday evening routine.

The inspector also observed on the notice board a large birthday poster which included a number of photographs of the resident celebrating the day. There was colourful birthday bunting at the top of the poster and each member of staff had written a personalised birthday message to the resident on the poster.

The inspector observed respectful and caring engagements between residents and staff and management throughout the day. It was clear that staff knew what residents were communicating to them and that residents understood their staff. On speaking with two staff members in detail, they were aware of the needs of residents and how to support those needs.

Residents were consulted and involved in the running of their home. Residents told the inspector about their daily household tasks. One resident showed the inspector the different task they completed on different days for example, making their bed, cleaning their room and bringing their laundry to the utility room. Residents also attended weekly meetings to discuss topics about their home, activities, food menus as well as information on staying safe at home and in the community, their rights and other matters that were current at the time.

In summary, the inspector found that each resident’s well-being and welfare was maintained to a good standard and that there was a strong and visible person-centred culture within the designated centre with some improvements in the areas of staffing, risk management, and infection control. In addition, follow-up on the high number of false fire alarm activations was needed as this was upsetting and frustrating for residents.

These matters are discussed further in the next two sections of the report alongside the governance and management arrangements in place in the centre, and how these arrangements impact on the quality and safety of the service being delivered to each resident living in the centre.

Capacity and capability

This section of the report sets out the findings of the inspection in relation to the leadership and management of the service and how effective it was in ensuring that a good quality and safe service was being provided.

Overall, the inspector found that the care and support provided to residents was person-centred, and that residents' needs and wishes were taken into account. There had been improvements since the last inspection, and in particular in relation to infection, prevention and control, which had resulted in positive outcome for residents. However, some further improvements were needed to local oversight arrangements, staff rosters and the statement of purpose.

The centre had a clearly defined management structure in place. The person in charge was an experienced, qualified professional and demonstrated their knowledge of the residents' assessed needs and the supports required to meet those needs. However, a review of the person in charge's responsibilities was needed to ensure that they were in line with the statement of purpose and were within their capacity and capability.

The registered provider had completed an annual review regarding the quality of safe care and support provided to residents during 2024 and the review for 2025 was currently being completed. Six-monthly unannounced visits had also taken place in the centre and a suite of audits and checklist had been completed at local level in the centre. However, improvements were needed to ensure that there was appropriate oversight over all local audits so that they were escalated and actions completed within a timely manner.

The staff team working in the centre were aware of their responsibilities and who they were accountable to. There was one staff vacancy (social care worker) in the centre at the time of the inspection. The person in charge was endeavouring to provide continuity of care when filling the gaps on the roster, using familiar relief and agency staff.

The inspector spoke with staff members throughout the course of the inspection. The staff members were knowledgeable on the support needs of residents. On observing management and staff engage with residents, the inspector saw that interactions were positive, kind and caring.

Staff completed relevant training as part of their professional development and to support them in their delivery of appropriate care and support to residents. The person in charge regularly reviewed staff training needs and on the day, overall, staff training was found to be up-to-date.

There was appropriate information governance arrangements in place to ensure that the designated centre complied with all notification requirements.

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.

Regulation 14: Persons in charge

The person in charge had the appropriate qualifications and skills and sufficient practice and management experience in line with the regulatory requirement.

On speaking with the person in charge, the inspector found that they were familiar with residents' support needs and ensured that they were met in practice. In addition, 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 was responsible for three separate designated centres and divided their working time between the centres. The provider had employed a team leader per designated centre to support the person in charge in their role.

However, on the day of the inspection, the inspector was informed that the person in charge was also responsible for an additional service (Direct Support Living service). This meant that the person in charge's whole time working hours was further divided with less time allocated to each centre.

Overall, a review of the number of services allocated to the person in charge was required. This was to ensure that the person in charge had sufficient capacity to ensure effective governance, operational management and administration of the three designated centres they were appointed to.

Judgment: Substantially compliant

Regulation 15: Staffing

From speaking with staff, the inspector observed that there was a staff culture in place which promoted and protected the rights and dignity of residents through person-centred care and support.

The inspector spoke in detail with two staff members on the day as well as having general conversations with other staff and management. The inspector found staff team to be very knowledgeable of the residents' needs and the supports in place to meet those needs. Staff were invested in promoting each resident’s independence as much as they were capable of.

Residents were provided one-to-one support from staff during the day. Additional staffing (22 hours) was provided during times when the third resident was residing in the centre from Friday night until Tuesday morning.

At the time of the inspection the centre was operating with one staff vacancy for a social care worker post.

The person in charge was endeavouring to provide continuity of care to residents. From a review of the centre's roster for the months of January and February, the inspector observed that same four flex-time staff were employed to cover gaps on the roster. Where agency staff were required, the same three agency staff, who were familiar to the residents, were employed.

For the most part, the roster was maintained appropriately. The first page of the roster clearly laid out the full names of the core staff team, the flexi-time staff and

agency staff. The person in charge and team leader were also included. However, on the day of the inspection some areas for improvement were identified.

- The person in charge's hours required review so that they clearly demonstrated the days and times they were working on-site in this centre.
- Where staff were attending training, this had not been included clearly on the roster.
- Information that was not appropriate was included on the roster. For example, the roster included details of the days and times, when staff were employed to support a person who was not a resident in the designated centre.

Judgment: Substantially compliant

Regulation 16: Training and staff development

There was a colour coded staff training record in place that supported the person in charge to monitor, review and address the training needs of staff to ensure the delivery of quality, safe and effective service for the residents. Overall, staff training was up-to-date including refresher training.

On a review of the training records, the inspector saw that, staff were provided with training in, safeguarding and protection of vulnerable adults, fire safety, managing behaviours that challenge, safe medicine practices which included training in epilepsy and rescue medication. In addition, staff were provided training in food hygiene, feeding, manual handling infection prevention and control. Staff were also provided additional training in other area such as human rights, good autism practice, effective complaint handling and person-centred planning, but to mention a few.

Staff who spoke with the inspector were found to be knowledgeable of policies and procedures which related to the general welfare and protection of residents living in this centre.

One to one practice support meetings were provided for staff to support them perform their duties to the best of their ability.

There was a practice support meeting schedule in place and the inspector saw staff were provided the meetings in line with the providers policy. For example, all staff had received a one to one meeting in November 2025 and dates for March 2026 had been scheduled.

Judgment: Compliant

Regulation 23: Governance and management

Overall, the provider had put in place appropriate management and oversight arrangements to ensure a good quality service for residents. The person in charge was responsible for three designated centres. There was a team leader employed in each centre to support the person in charge in the governance operation management and administration of the centre. However, some improvements were required so that the oversight arrangements were effective at all times. In addition, further input by the provider regarding the high frequency of fire alarms falsely activated, was needed.

The monthly management report and management tasks audit had been completed and signed by the team leader. Some of the areas monitored by these tools related to rotas, training, team meetings, medication audits, medication sign off, manager weekly checklists, maintenance, incidents and accidents, HIQA notifications, safeguarding, personal planning working file audit, but to mention a few. Overall, on observing the documents, the inspector found that there was no clear evidence of oversight by the person in charge or provider of these monitoring tools.

On review of the January 2026 monthly manager task audit, the inspector found a number of areas had not been completed, with no explanation for the gaps. For example, tasks related to manager weekly checklists, quarterly returns, personal plan audit, person centred planning dates, household risk assessments and complaints, were observe as blank.

In addition, on review of the weekly Health and Safety checklists, which had been completed by staff members, the inspector observed that not all identified risks had been addressed or escalated. On two Health and Safety checklists dated 15 January and 07 February 2026, a risk had been identified. For example, the number of hazard signs available in the centre was unsafe. As of the day of the inspection, this risk had not been followed up or escalated to the appropriate person.

Overall, the inspector found that a review of the provider's arrangements for monitoring and evaluating the service at local level, was needed. This was to ensure that where there were risks or gaps in audits and checklists, that they were followed up by the appropriate person and actions completed in a timely manner.

The inspector reviewed a sample of a team meeting that took place in January 2026. Minutes of the meetings demonstrated, that overall, the person in charge and staff were striving for excellence through shared learning and reflective practices to ensure better outcomes for residents. Some of the matters discussed at the meetings related to updates on the care and support provided to residents living in in the centre, quality, rights of the month, person centred planning, safeguarding.

The provider had arranged for an annual review to be completed to assess the quality of care and support provided in the service between January to December 2024. Residents and their families had been consulted as part of the review. However, on the day of the inspection, a copy of the report was not available in the

centre for residents and their family. Senior management printed a copy on request. The person in charge informed the inspector that they were in the process of collating the information for the 2025 annual review.

Two six monthly unannounced reviews of the quality of care and support provided to residents living in the centre had been completed in April and October 2025. Where improvements were needed, an action plan was in place. The person in charge had completed most of the actions to date.

The last inspection in May 2024, highlighted an issue related to high frequency of fire alarm falsely activated as well as unplanned evacuation in the centre, and how it was impacting on residents. The provider's compliance plan actions to address this matter had been completed however, had not proved fully effective in rectifying the issue.

For example, on review and trending of notifications submitted to the Chief Inspector of Social Services from January 2025 to early February 2026, the inspector found that the number of incidents of fire alarm falsely activated and unplanned evacuations was of similar trend to that identified in 2024. In total, sixteen NF09s had been submitted and the four quarterly NF39Bs (during 2025); each included from two to four occasions on which the fire alarms were operated, other than for the purpose of fire practice, drill or test of equipment.

The inspector was informed that the fire alarm was being triggered by residents living in other apartments above the designated centre. The impact of the high number of false alarms meant that there was a potential risk that the seriousness of the alarm sounding might be diluted. In addition, on speaking with staff and residents the inspector found that the alarms were impacting on residents anxieties, sleep and routines.

There had been a number of meetings and engagements between the person in charge, areas manager and provider representation with the landlord about the issues however, no satisfactory resolution had been found to date and the issue remained on-going. Overall, the timeliness to resolve this matter, was not satisfactory and meant that the negative impacts were ongoing for residents.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The provider had ensured that there was a statement of purpose in place in the centre. For the most part, the statement adequately outlined the service provided however, to ensure the plan was in line with the requirements of the regulations, some improvements were needed.

For example, the centre's current statement of purpose had not accurately described the person in charge's whole time equivalent hours (WTE). On the day of the

inspection, the inspector was informed of an additional service that the person in charge was also responsible for.

This meant that the person in charge's whole time equivalent hours on the current statement of purpose was not reflective of the hours they were employed to work in the centre. In addition, the additional service was not part of the function of the designated centre. This issue is addressed in detail under Regulation 14.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

Overall, there were effective information governance arrangements in place to ensure that the designated centre complied with notification requirements.

The person in charge was endeavouring to ensure that all adverse incidents and accidents in the designated centre, required to be notified to the Chief Inspector of social services, had been notified 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).

Overall, 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 incidents of concern, the incident and learning from the incident, had been discussed at staff team meetings.

To enhance the learning and outcomes arising from notifications, the inspector found that a review of the detail within notifications, relating to fire alarm false activations, was needed. This was to ensure that where this issue was impacting on residents' sleep, routines and upset, that this was acknowledged. For example, many of the notifications stated that there had been no impact on residents however, on speaking with residents on the day, this was not always the case.

Judgment: Compliant

Regulation 34: Complaints procedure

The registered provider had a complaints procedure in place that was easily accessible to residents and their family members. In addition, there was there was information regarding the national advocacy service displayed on a communal notice board in the residents' home.

Residents were supported to understand how to make a complaint. The inspector observed that there was an easy-to-read document on how to make a complaint and a diagram on how they are managed on the centre's notice board. On a review of residents' weekly house meetings and from speaking with staff, the inspector found that residents were provided information on how to make a complaint if they so wished.

There was one open complaint in process. The person in charge and area manager had promptly follow up with the complaint through emails, telephone calls and meetings to try resolve the issue. Changes to some visiting arrangements had been implemented which overall, resulted in positive outcomes for the complainant and a resident. The inspector found that the complaint was being managed appropriately and in a sensitive and understanding manner.

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.

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. Residents were supported and encouraged to have meaningful participation in their community. Overall, care and support provided to residents was of good quality however, some improvements were needed to the areas related to risk management, medicines and pharmaceutical services, and infection prevention and control.

The physical environment of designated centre was clean and tidy and for the most part, in good decorative and structural repair throughout. The design and layout of the premises ensured that each resident could enjoy living in an accessible, comfortable and homely environment. However, there were some areas in the apartment that required upkeep and repair and in particular, residents en-suite shower and toilet facilities. This meant that there were areas in the residents home could not be cleaned effectively and impacted on the effectiveness of the infection prevention and control measures in place.

The provider and person in charge were endeavouring to ensure that every effort was made to allow residents communicate in a way that was in line with their needs and preferences. On observing staff engagement with residents, the inspector saw that staff understood what residents were expressing.

Individual and location risk assessments were in place to ensure that safe care and support was provided to residents. Residents were supported to partake in activities they liked in an enjoyable but safe way. Some improvements were needed to ensure that where risks had been identified that they were assessed and provided measures to mitigate or reduce the risk.

The provider and person in charge promoted a positive approach in responding to behaviours that challenge. There were systems in place to ensure that where behaviour support practices were being used, they were clearly documented and reviewed by the appropriate professionals on a regular basis.

There were restrictive practices in use in the centre. Where applied, the restrictive practices were documented and subject to review by the organisation's positive approvals management group.

The person in charge and staff were endeavouring to facilitate a supportive environment which enabled residents to feel safe and protected from all forms of abuse. There was an atmosphere of friendliness, and the residents' modesty and privacy was observed to be respected.

The inspector found that for the most part, the medicine arrangements and practices were appropriate and in accordance with the provider's associated policy. The person in charge was endeavouring to ensure that the designated centre had appropriate and suitable practices relating to the ordering, receipt, prescribing, storing and disposal and administration of medicines. However, on the day of the inspection, improvements were required with regards to the labelling arrangements for some resident's medication as well as the effectiveness of the associated audits.

Regulation 10: Communication

Communication access and support arrangements were facilitated for residents in accordance with their assessed needs and wishes. Residents living in this centre used verbal communication however, required support with their communication needs.

The person in charge was striving to ensure that residents were provided information in a way that they understood. The inspector observed examples of easy-to-read formats in residents' personal plans and an array of easy-to-read, picture format and photographic forms of information displayed on the residents' kitchen notice board. For example, photographic daily staff rosters and picture meal planners. The inspector also observe picture poster format of resident's goals and achievements on two of the residents' bedroom walls.

Residents were also provided consultation meetings with their keying working staff members. There were a number of social stories to explain matter to residents

during the consultation process to ensure the resident could understand what was being discussed.

Residents' assessment of need included a communication assessment and from this a communication support plan was developed. The support care plan included the method of communication the resident used to express themselves. The information in the support plan provided guidance for staff on how to best communicate with each resident in line with their needs, wishes and preference.

Residents had access to television and Internet in their home. Residents were also supported to access computers and Internet in the community, such as at their local library. One resident, who showed the inspector their bedroom, pointed out their television, radio and electronic table devise that they enjoyed using.

Judgment: Compliant

Regulation 17: Premises

The physical environment of the house was observed to be clean and tidy. The design and layout of the premises ensured that each resident could enjoy living in an accessible, 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.

The residents' home was decorated to meet their needs and wishes. During the walk around of the centre, the inspector observed that communal spaces, such as the kitchen and dining area, were decorated in line with residents' likes and wishes. There were ample information posters and notice boards that were part of residents' everyday life in the apartment and as such, made it more individual to them. For example, there was a large birthday poster on the kitchen notice board that included photographs of the residents enjoying a birthday celebration together.

Residents' bedrooms were decorated in line with their needs, likes and preferences. The inspector observed two residents' bedrooms to have a lot of posters, pictures, books, videos and memorabilia that was important to them. For another resident, who preferred a minimalistic style, the inspector observed the décor of the room to be reflective of this and saw very little personal items or memorabilia included in the room.

All residents were provided their own en-suite shower and toilet. The inspector observed that some upkeep and repair was required to the showers and flooring in these rooms. One resident was provided the use of a small sitting room which was attached to their bedroom. In line with the residents support needs, this room provided an additional space for the resident to take time out and relax and supported them self-regulate when needed.

Overall, the apartment was observed to be clean and tidy. Where there were some improvements needed to the upkeep and repair of the premises, including the en-suites, these have been addressed under Regulation 27.

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 May 2023 and was due for renewal in May 2026.

Overall, where there were identified risks in the centre, the person in charge had included them on the risk registered. This was to ensure that appropriate control measures were in place to reduce or mitigate any potential risks.

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

However, improvements were needed to ensure that risks related to the high frequency of fire alarm false activations were reviewed so that appropriate measures were put in place. On speaking with residents and staff and a review of fire drills, the inspector found that there were a number of risks related to this issue and in particular, a resident's refusal to evacuation, increase risk of behaviours of concern, increase risk of anxieties , increase risk to resident health and wellbeing through lack of sleep and change in routine.

Judgment: Substantially compliant

Regulation 27: Protection against infection

Since the last inspection there had been improvements to the infection protection and control measures in the centre. Overall, the residents' apartment was observed as clean and tidy. There were a number of cleaning schedules in place and it was evident that they were being adhered to by staff.

However, there were areas in the residents' home that were in poor upkeep and repair and as such could not be clean effectively in terms of infection prevention and control.

For example, the inspector observed the following issues when walking around the centre:

- Two of the three residents' showers were observed as unclean. There was black grime on the grout between the lower tiles and on the base of the shower. Rust was also observed on parts of the showers. There was chipped paint and rust observed on the radiators. Due to the design of the floor tile it was difficult to clean and a build-up of grime was observed on both shower room floors.
- There was chipped paint observed on the walls in the residents sitting room and in two residents' bedrooms.
- There was a large crack observed on the skirting board in one resident's bedroom which could not be cleaned effectively.
- One resident's bedroom flooring had chips in it which made it difficult to clean.
- One of the resident's leather armchairs was observe to have tears and rips on it and made it hard to clean effectively.
- On the morning of the inspection, there was no paper towels in the communal bathroom and while there was toilet paper, it was not placed in the toilet roll holder provided, which potentially impacted on infection control measures. The toilet roll was also not placed in toilet roll holders in residents room. While this did not necessarily impact on infection prevention control, the type of holder was not meeting the residents' needs. On speaking with one resident they told the inspector that it was too difficult to put the paper in to the holder.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Overall, the registered provider had ensured that there was effective fire safety management systems in the centre that ensured the safety of residents in the event of a fire.

Staff had completed fire safety training and were knowledgeable in how to support residents evacuate the premises, in the event of a fire.

Staff completed daily, monthly and quarterly fire checks. The emergency lights, fire alarms, blankets and extinguishers were serviced by an external company within the required time frame.

The person in charge had prepared fire evacuation plans and resident personal evacuation plans. These were in place for staff to follow in the event of an evacuation. The plans provided clear guidance to staff to ensure a timely evacuation in the case of fire.

Daytime and night time fire drills, to test the effectiveness of the fire evacuation plans, had been carried out in January 2026. A drill that included the least amount of staff and the most amount of residents had been completed.

In relation to the high frequency of fire alarm false activations and the impact this had on residents, this has been addressed under Regulation 23 and Regulation 26.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

Medicines used in the designated centre were found to be used for their therapeutic benefits and to support and improve each resident's health and well-being.

Staff were competent in the administration of medicines and were in receipt of training and ongoing education in relation to medicine management. A member of the staff team showed the inspector the medication cupboard and the systems, protocols and processes in place for the safe management of medicine. The staff was knowledgeable on medicine management procedures and on the reasons medicines were prescribed. The medication administration records also indicated that medications were administered as prescribed.

Overall, the provider and the person in charge had ensured that appropriate systems were in place for the ordering, receipt, prescribing, disposal and administration of medicines. However, on observing the medication storage cupboard, the inspector observed that one resident's medication cream was out of date. In addition, where a resident's medical cream and liquid had been opened, it had not been provided a label to note the opening date. As such it was difficult to ascertain if the medication was still in date and safe to use. Overall, this posed a potential risk to the resident's health should it be administered.

For the most part, there were appropriate oversight systems in place to ensure safe medication practices and their effectiveness. All medicine errors and incidents were recorded, reported and analysed and learning was fed back to the staff team to improve each resident's safety and to mitigate against the risk of recurrence.

Medicines management was audited on monthly basis in order to provide appropriate oversight over medicine management. However, improvements were needed to ensure the effectiveness of the audits. For example, on review of the December 2025 audit, the inspector saw that it noted all medications were in date. In addition, the audit had not considering checking if creams and liquid medications were provided opening and out of date labels. Furthermore there was no record or evidence to demonstrate that there was adequate oversight of the audit. For the example, the audit had been completed by the team leader and staff member.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Residents were provided with a personal plan that was individual to them. The inspector reviewed a sample of residents' personal plans and saw that they included an assessment of each resident's health, personal and social care needs. However, two residents' assessment of needs had not been reviewed on an annual basis. For example, one resident's assessment of need was due an annual review in October 2025 and the other resident's assessment was due in November 2025.

A new personal plan template had been developed since the last inspection in 2024. The inspector was informed that a review of the new template had resulted in improved synchronisation of all parts of the plan. While this ensured the effectiveness of the plan it had resulted in the delay of two assessments of needs. On the day of the inspection, the inspector reviewed the schedule and saw that the two assessments were due to be completed by quarter one of 2026.

Residents were encouraged to choose goals that were meaningful to them and were supported to plan and achieve their goals using a step by step process. On a monthly basis, residents met with their keyworker for a one-to-one consultation meeting. At these meetings residents were encouraged to talk to their keyworker about their identified current goals and objectives and how they were progressing. The monthly meetings also included a review of residents' health needs and current support plans as well as discussing any issues that were important to them.

All residents were provided with an accessible form of their personal plans. One resident pointed out a poster on their wall that included pictures of their planned and achieved goals.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

Where appropriate, residents were provided with positive behavioural support plans. The inspector was advised that a new behaviour support therapist had been employed in the organisation since the last inspection.

On a review of a resident's positive behaviour support plan, the inspector found that the plan was up-to-date and included satisfactory guidance to enable staff support the resident manage their behaviours.

All plans were developed, written and had oversight by, an appropriate allied health professional or clinician. As such, the provider could be assured that evidence-based

specialist and therapeutic interventions were effectively implemented in line with national and centre policies.

All staff were provided with training in positive behaviour supports. On speaking with staff they were familiar with the content of the plans and how to support residents manage their behaviours.

In line with the organisation’s policy, the provider had a very clear restrictive practice assessment process in place. All restrictive practices were risk assessed. Where applied, the restrictive practices were clearly documented and were subject to approval and review by the organisation's restrictive practice group. Restrictive practices were regularly reviewed in an effort to find alternatives to reduce or cease some restrictions.

Judgment: Compliant

Regulation 8: Protection

The residents living in this centre were protected by practices that promoted their safety. There was an up-to-date safeguarding policy in the centre and it was made available for staff to review. The policy had been reviewed in February 2024 was due for the next review in February 2027.

Where appropriate, residents were provided with safeguarding plans in their personal plans which were reviewed on a regular basis. Residents were also assessed through a safeguarding screening tool to ensure that adequate supports were in place for them in their home and community.

All staff had received up-to-date training in the safeguarding and protection of vulnerable adults. On the day of the inspection, the inspector was informed by the person in charge and area manager that, two staff, were completing their safeguarding training on the day.

Staff spoken with, were familiar with the reporting systems in place, should a safeguarding concern arise. On speaking with a staff member they advised the inspector that as part of their probation, they had completed a safeguarding competency assessment. This was in place to access and ensure staff were familiar and knowledgeable on safeguarding policy and procedures.

Residents had been provided with easy-to-read materials regarding safeguarding and participated in key working consultation sessions with their staff to further explain them. In addition, keeping safe was included on the agenda during residents weekly household meetings. During conversations with the inspector two of the residents informed the inspector that they knew who they could go to if they had a concern or were upset.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Substantially compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Substantially compliant
Regulation 28: Fire precautions	Compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Beechview House (Orchard) OSV-0002060

Inspection ID: MON-0045647

Date of inspection: 11/02/2026

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 14: Persons in charge	Substantially Compliant
Outline how you are going to come into compliance with Regulation 14: Persons in charge: • A review of the number of services allocated to the person in charge has been undertaken by the provider and a decision to allocate this service to the community support services in Autism A Chara has been agreed. • A transition period will be facilitated by the Orchard staff team to ensure a smooth transition for this person to their new service and once completed the person in charge will no longer have this service under their remit, leaving the WTE split equally between three services as per Statement of Purpose.	
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • The rota will be updated to include the days and times when the person in charge is working on-site in this centre, so that the WTE hours is clearly shown to be in line with the Statement of Purpose. • The rota will be updated to reflect when staff are attending training and not working on-site in the service. • Information regarding the person no longer supported by the service will be removed from the rota once the transition to his new service is completed.	

Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
• The person in charge will ensure that their oversight is clearly evidenced on all the monitoring tools, audits and checklists used in the service and that actions identified in these audits are addressed in an effective and timely manner.
• The person in charge will complete the process of collating the information for the 2025 annual review of quality and care in the service and have this report available for inspection and for the people we support and their families.
• The provider will continue to follow up on the ongoing issue related to high frequency of fire alarm activations leading to unplanned evacuations in the centre. This is to include meeting with the service supporting the individual tenants living upstairs in the apartment block, meeting with the housing authority again and putting an agreement in place to get monthly reports from the fire alarm company identifying patterns of where and when these events are happening. This will inform where to target plans to put training in place for those tenants who may not understand the gravity of the situation.

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
• The person in charge will review the statement of purpose to ensure it accurately describes the person in charge's whole time equivalent hours (WTE) once the additional service has moved to community support services within Autism A Chara as described under Regulation 14

Judgment: Substantially compliant

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
• The person in charge will review the risks related to the high frequency of fire alarm false activations and put appropriate measures in place to reduce the frequency of same.
• The risk assessment will reflect the following: a resident's refusal to evacuate, increased risk of behaviors of concern, increased risk to residents' health and wellbeing, through lack of sleep and change in routine.

Regulation 27: Protection against infection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
• The provider will replace tiling and grouting on the floors of the two bathrooms identified in the inspection.
• Radiators will be repainted or replaced as needed.
• The residents sitting room and two residents' bedrooms will be repainted.
• The skirting board in one resident's bedroom will be replaced.
• The flooring in one resident's bedroom will be repaired.
• One resident's leather armchair will be replaced.
• The person in charge will review the toilet roll holders and ensure that they are appropriate to the needs of the residents and will ensure that paper hand towel is always available in the communal bathroom.

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
• The person in charge will maintain oversight of the medication audit to ensure it has been carried out correctly and that all actions are completed in a timely manner.
• The person in charge will ensure that all medications are correctly labelled and that open topical medications have been labelled when opened so that they can be discarded within the recommended timeframe.

Regulation 5: Individual assessment and personal plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
• The provider and person in charge will review the assessment of needs for two residents and ensure that they are reviewed annually and actions incorporated into their yearly person-centered planning meeting

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 14(4)	A person may be appointed as person in charge of more than one designated centre if the chief inspector is satisfied that he or she can ensure the effective governance, operational management and administration of the designated centres concerned.	Substantially Compliant	Yellow	30/04/2026
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	30/03/2026
Regulation 23(1)(b)	The registered provider shall ensure that there is a clearly defined management structure in the	Substantially Compliant	Yellow	30/03/2026

	designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.			
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Substantially Compliant	Yellow	30/03/2026
Regulation 23(1)(e)	The registered provider shall ensure that the review referred to in subparagraph (d) shall provide for consultation with residents and their representatives.	Substantially Compliant	Yellow	30/03/2026
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Substantially Compliant	Yellow	30/03/2026
Regulation 27	The registered provider shall	Substantially Compliant	Yellow	30/04/2026

	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.			
Regulation 29(4)(c)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that out of date or returned medicines are stored in a secure manner that is segregated from other medicinal products, and are disposed of and not further used as medicinal products in accordance with any relevant national legislation or guidance.	Substantially Compliant	Yellow	30/03/2026
Regulation 03(1)	The registered provider shall prepare in writing	Substantially Compliant	Yellow	30/03/2026

	a statement of purpose containing the information set out in Schedule 1.			
Regulation 05(6)(b)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall be conducted in a manner that ensures the maximum participation of each resident, and where appropriate his or her representative, in accordance with the resident's wishes, age and the nature of his or her disability.	Substantially Compliant	Yellow	30/03/2026