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: | Ocean House |
| Name of provider: | Sunbeam House Services CLG |
| Address of centre: | Wicklow |
| Type of inspection: | Announced |
| Date of inspection: | 14 October 2025 |
| Centre ID: | OSV-0007912 |
| Fieldwork ID: | MON-0042009 |

## About the designated centre

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

Ocean House is a designated centre operated by Sunbeam House Services CLG. The designated centre provides full-time residential services for adults with a mild or moderate level of intellectual disability. The maximum number of residents who can reside in the centre is two. The centre is made up of one semi-detached two story house located in a large town in Co. Wicklow. It comprises a communal sitting room leading to an adjoined kitchen/dining room with a large sunroom/conservatory at the rear with access to the back garden. There is a toilet/shower room downs stairs and a garage to the side of the house. Upstairs there are four rooms, three bedrooms and a storage room and staff office. There is also a communal toilet/bathroom on this floor also. The centre is managed by a full-time person in charge who is responsible for this and two other locations. The residents are supported by a nurse, social care workers with a sleep over staff arrangement in place at night.

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

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| Number of residents on the date of inspection: | 2 |

## How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

**1. Capacity and capability of the service:**

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

**2. Quality and safety of the service:**

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

**This inspection was carried out during the following times:**

| Date | Times of Inspection | Inspector | Role |
|---|---|---|---|
| Tuesday 14 October 2025 | 09:30hrs to 16:10hrs | Kieran McCullagh | Lead |

## What residents told us and what inspectors observed

This was an announced inspection, completed to monitor the provider's compliance with the regulations and to inform the decision in relation to renewing the registration of the designated centre. Overall, this inspection found that there were serious risks to the safety of the residents and management systems in place failed to ensure the safety and wellbeing of both residents living here.

In February 2025, the Health Information and Quality Authority (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 contained a compliance plan from the provider, which detailed a number of actions intended to address the identified concerns and achieve compliance. This inspection was a component of the Chief Inspector of Social Service's comprehensive evaluation of the provider's plan and its effectiveness in driving improvements.

The inspection was conducted by one inspector over the course of one day and was facilitated by the person in charge and deputy client service manager. The inspector also met with the senior operations manager, and the quality, compliance and training (QCT) manager. The inspector used observations and conversations and interactions with residents, in addition to a review of documentation and conversations with key staff, to form judgments on the residents' quality of life.

The designated centre is currently registered to accommodate two residents. On the day of the inspection, the inspector had the opportunity to briefly meet and talk with both residents. Residents had been made aware of the upcoming inspection and appeared comfortable with the presence of the inspector in their home. In advance of the inspection, residents had been sent Health Information and Quality Authority (HIQA) surveys. These surveys sought information and residents' feedback about what it was like to live in this designated centre. However, copies of residents' surveys were not made available for the inspector to review.

One resident spent some time speaking with the inspector at the kitchen table. They told the inspector that they did not get along with their housemate and that they did not always enjoy living in their home. They reported to the inspector that they had a fall earlier that morning and that they had made an appointment with their general practitioner (GP) for later that day. Staff had prepared breakfast for the resident and the inspector observed a positive and engaging rapport between the resident and staff on shift.

The inspector also briefly met the other resident who was spending time with staff in the office upstairs. The inspector observed the resident smiling and waving and they appeared happy and content in the presence of staff. The resident spent the rest of the day outside of the designated centre engaging in community activities and their volunteer job.

The inspector completed a walk through of the designated centre in the company of the person in charge. While the centre presented as homely, certain rooms had been designated for the exclusive use of one resident due to ongoing incompatibility concerns. The inspector noted that residents did not interact or spend time with each other while the inspector was present. The person in charge and deputy manager reported that residents could spend time with other but close staff supervision was required at all times due to ongoing peer-to-peer incompatibility concerns.

There were a number of restrictive practices in place in order to mitigate ongoing safeguarding and peer-to- peer related incidents. However, these restrictive practices in place were not notified to the Chief Inspector of Social Services in line with Regulation 31: Notification of incidents.

The inspector also identified further restrictive practices in use which had not been appropriately risk assessed, documented or approved by the provider's human rights committee. The inspector requested that all restrictive practices be retrospectively submitted to the Chief Inspector. However, at the time of drafting this report the required retrospective notifications had not been submitted.

Ongoing concerns related to safeguarding and residents' rights, which had been identified on the previous inspection, remained. The inspector was informed that the provider had an action plan in place to address this. The provider had identified a new property for one resident to move into. Remedial premises works were due for completion in October 2025. However, ongoing incompatibility issues and safeguarding concerns, known to the provider, continued to negatively impact on residents' lived experience and their rights. For example, one resident was prevented by their housemate from using the bathroom at night on a number of occasions. This resulted in additional restrictive measures being implemented which not only infringed upon the resident's personal dignity but also restricted their freedom of movement within their own home.

Although this was an announced inspection, the inspector noted continued delays in accessing required information and documentation. There was a number of occasions in which the inspector requested important required documentation for review which was not be provided in a timely way or retrievable by the local management team during the course of the inspection. This did not assure the inspector that effective governance and oversight arrangements were in place for the designated centre. A review of the care and support for 2024 evidenced that both residents and their family members had raised concerns regarding resident incompatibility and use of agency workers. Following a review of staff rosters, the inspector also found that there was an over reliance on agency and relief staff to

cover vacant shifts.

In summary, the provider had failed to ensure their management systems were providing a service that was safe, appropriate to residents' needs, consistent, and effectively monitored at all times. Strategies to support residents were not effective and there remained an ongoing risk to residents of further safeguarding incidents occurring and negatively impacting on their lived experience and their human rights.

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

The next two sections of the report 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

This section of the report presents the inspection findings regarding the leadership and management of the service, and evaluates how effectively it ensured the provision of a high-quality and safe service. Overall, it was determined that the provider had failed to ensure that management systems in place in the designated centre were effective in providing a service that was safe, appropriate to residents' needs, consistent, and effectively monitored at all times.

The inspector found that deficits relating to staffing, governance and management, protection, and residents' rights were of particular concern. Overall, the lack of improvement to the lived experience of residents living in this designated centre since the previous inspection in June 2023 meant that there was an ongoing risk to their safety, and wellbeing and overall was resulting in negative outcomes for them. This is discussed further in the main body of this report.

The provider had not ensured that the centre was adequately resourced to ensure the effective delivery of care and support. The provider failed to put in place suitable contingency arrangements to respond to residents' assessed and known behavioural support needs, incompatibility and ongoing safeguarding concerns. The heavy reliance on relief and agency staff meant there was no continuity of staffing which supported the building of relationships between staff and the residents who relied on staff support.

The provider and the person in charge did not have effective systems in place to assure them that all agency and relief staff employed to work in the designated centre had the required mandatory or additional training in order to full support residents living in this designated centre. Agency and relief staff members' training was not recorded or incorporated into the centre's staff training records. The

absence of documentation further highlighted the inadequate oversight and review of staff training by the provider and the person in charge. This was particularly concerning considering the safeguarding concerns in the home.

The provider had not ensured appropriate oversight and monitoring of the designated centre. The provider had assigned a person in charge and deputy client service manager for the designated centre that also managed two other services in addition to being responsible for a regulated designated centre. Given the ongoing and persistent safety and quality of life issues for residents in this designated centre, the inspector found that the provider had not put adequate governance arrangements in place, but also extended the responsibilities of the person in charge to other disability support services, putting further pressure on the ability of the person in charge to effectively manage this centre, and meet their regulatory responsibilities.

## Regulation 15: Staffing

Overall, improvements were required to the oversight of staff rosters, and staffing arrangements to ensure continuity of care for all residents residing in the designated centre.

There was one part-time care support worker position vacant in the designated centre. Although the provider was endeavouring to back fill vacant shifts, it was found that there was an over reliance on agency and relief staff to cover vacant shifts, which was having a negative impact on both residents.

For example, following a review of the planned and actual rosters maintained in the designated centre for the months of August, September and October 2025 it was found that;

- 15 shifts were covered by six different agency staff across the month of August 2025
- 16 shifts were covered by five different agency staff across the month of September 2025
- Five different agency staff had covered or were planned to cover a total of 14 shifts across the month of October 2025
- A further 14 shifts had also been covered by eight different relief staff.

The provider had not ensured that suitable contingency arrangements were in place to ensure continuity of care for residents. This was of concern given the incompatibility and safeguarding risks in the designated centre, and required comprehensive review by the provider.

Improvements were also required to the recording of agency and relief staff used to back fill vacant shifts. For example, there were numerous occasions in which the full name of the relief and agency staff or the agency used was not recorded. This required enhancement to ensure the provider and person in charge had easy access

to accurate and up-to-date staff rosters.

Judgment: Not compliant

## Regulation 16: Training and staff development

Systems for recording and monitoring staff training were in place, ensuring that core staff had completed all mandatory training. However, improvements were required to ensure that all agency and relief staff were well-equipped to provide quality care, and had completed all necessary mandatory training.

Examination of the staff training matrix evidenced that all all core staff members had completed a diverse range of training courses, enhancing their ability to best support the residents. This included mandatory training in fire safety, and safeguarding of vulnerable adults.

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

For example, staff members had completed eLearning training relating to updated safeguarding policy and restrictive practice policy, and key working training. The inspector saw evidence that staff had been booked to complete specialised person-centred positive behaviour supports training sessions in October 2025.

During this inspection, the training records for relief and agency staff were unavailable for the inspector's review. These records were not reflected in the designated centre's training records, which was important in documenting that all staff have completed both mandatory and additional training to effectively support residents. Although the senior operations manager had brought this to the attention of the local management team on 06 October 2025, necessary corrective actions had not been completed by the time of this inspection.

The provider and person in charge had appropriate supervision arrangements in place for all staff. All staff received support and supervision relevant to their roles from appropriately qualified and experienced personnel in line with the provider's policy. The inspector reviewed four one staff members' supervision records, which included a review of staff members' personal development and provided an opportunity for them to raise any concerns.

Judgment: Substantially compliant

## Regulation 23: Governance and management

Improvements were required to ensure the provider and person in charge had suitable oversight of the centre and that effective governance arrangements were in place to ensure the service was safely and effectively managed.

The provider had assigned a person in charge and deputy client service manager for Ocean House designated centre. However, they were also assigned to manage two other services. Given the extent of the person in charges remit, the inspector found that the person in charge did not have capacity to effectively oversee the quality of support and care to residents on a consistent basis. This was a concerning management arrangement, given the ongoing incompatibility and safeguarding concerns for both residents living in the centre, and required review by the provider.

This inspection highlighted that the governance and management practices had not effectively addressed previously identified issues. Specifically, the concerns pertaining to the incompatibility of residents and residents' rights, as well as incident notification, persisted from the June 2023 inspection. Despite a senior operations manager's review of the centre that resulted in required actions for the local management team to address prior to this announced inspection, the required corrective actions remained incomplete at the time of this inspection, further highlighting gaps in the management's follow-through and risk mitigation where deficits were identified.

The inspector found that increased oversight arrangements between the person in charge and deputy manager was required in order to establish delegated responsibilities, identify timelines for actions to be complete, and ensure that appropriate regulatory oversight was maintained for the designated centre. While staff team meetings occurred every eight weeks, there was an absence of regular, dedicated management meetings between the person in charge and deputy manager specifically focused on reviewing and tracking identified tasks and progress.

In addition, the provider had not ensured that the deputy manager had access to relevant IT systems to record appropriate and accurate details of residents' safeguarding concerns. Specifically, on the day of this inspection they had restricted access to the safeguarding portal meaning they were unable to access important updates or review ongoing safeguarding concerns.

Overall, the provider's governance and management of the centre had not considered the potential risks or impact the reduction in oversight over a centre where high levels of support was required for ongoing safeguarding concerns, and the provider was not ensuring the centre was resourced or monitored in a way that ensured effective delivery of care and support to residents at all times.

Judgment: Not compliant

## Regulation 31: Notification of incidents

Improvements were required to the centre's information governance arrangements to ensure compliance with regulatory notification requirements at all times. This deficit had been identified during the last inspection also

Prior to the inspection, it was identified that the required notifications to the Chief Inspector of Social Services were not submitted as mandated. Specifically, the person in charge failed to report incidents involving the use of restrictive procedures such as chemical or environmental restraints during quarters one and two of 2025, as required by Regulation 31(3)(a). The inspector requested that these were notified to the Chief Inspector retrospectively. At the time of writing this report, these had not been notified to the Chief Inspector.

This required consideration and review by the provider and person in charge to ensure that good reporting practices were adopted and all necessary information was submitted as required in a comprehensive, accurate and concise way.

Judgment: Not compliant

## Quality and safety

The provider did not demonstrate the capacity or capability to operate the service in compliance with the regulations and in a manner which ensured safe good quality care to residents. Overall, strategies in place to support residents were not effective and there remained an ongoing risk to residents of further safeguarding incidents occurring and negatively impacting on their lived experience and their human rights.

Residents with an assessed need pertaining to positive behavioural support had comprehensive support plans in place. These plans effectively guided staff in delivering the necessary support, and during the inspection, staff demonstrated a strong understanding of these plans. However, enhancements and improvements were required in the documentation and recording of restrictive practices used within the designated centre. Specifically, the restrictive practice register was found to be inaccurate and needed updating. For instance, some practices currently in use were not documented, while others that were no longer in use remained on the register. A thorough review by the person in charge was required to ensure accurate monitoring and documentation of all restrictive practices. Additionally, it was noted that restrictive practices in use had not been reported to the Chief Inspector, in line with Regulation 31: Notification of incidents.

The provider lacked sufficient systems and processes to guarantee that residents were adequately protected and safe from harm. The existing safeguarding measures in the designated centre were ineffective in promoting and protecting residents'

human rights, and wellbeing, as well as empowering them to safeguard themselves. Ongoing incompatibility issues and safeguarding concerns compromised residents' sense o security and their right to a safe environment. Additionally, the absence of formal safeguarding plans failed to provide the inspector with confidence that proper scrutiny and oversight were in place to ensure residents' safety and welfare. This called for a thorough review and action by both the provider and person in charge.

The provider had not ensured the centre was operated in a manner which was respectful to the rights of all residents, and ongoing incompatibility issues adversely impacted on residents' rights and dignity in their home. These compatibility issues impeded the overall quality and safety within the centre, with both residents experiencing limitations in accessing shared areas comfortably. Furthermore, one resident's dignity was continually compromised which ultimately restricted them from using the bathroom during the night. Restrictive practices implemented failed to mitigate concerns and impinged on the resident's basic human rights.

Overall, strategies in place to support residents were not effective and there remained an ongoing risk to residents of further safeguarding incidents occurring and negatively impacting on their lived experience and their human rights.

## Regulation 7: Positive behavioural support

The inspector found that effective arrangements were in place to provide positive behaviour support to residents with assessed needs in this area. However, improvements were necessary pertaining to the oversight, and monitoring of restrictive practises used within the designated centre.

Residents had up-to-date positive behaviour support plans on file. The inspector reviewed one resident's plan and found that it was detailed, comprehensive, and developed by an appropriately qualified person. The positive behaviour support plan incorporated proactive and preventative strategies aimed at minimising the risk of behaviours that challenge from occurring. All core staff team members had read and signed the support plan.

As previously reported under Regulation 16: Training and staff development, and as per the provider's compliance plan all core staff had completed or had been booked to complete specialised person-centred positive behaviour supports training sessions in October 2025. Staff spoken with on the day of this inspection were knowledgeable of positive behaviour support plans in place and the inspector observed positive communications and interactions between residents and staff.

Prior to this inspection, a comprehensive review of all restrictive practices notified to the Chief Inspector on a quarterly basis was undertaken. As previously reported the person in charge had not notified the Chief Inspector of restrictive practises in use in quarter one or quarter two of 2025. Previous notifications identified a total of four restrictive practises, encompassing environmental, financial, and chemical restraints. The inspector confirmed that these had been appropriately risk assessed, in

accordance with the provider's established policy, and were subject to regular review by the provider's human rights committee.

However, during the inspection the inspector identified one further restrictive practice in use which had not been identified by the provider, risk assessed, approved by the provider's human rights committee, or notified to the Chief Inspector. For example, both residents required staff presence and supervision whenever they were together, thereby limiting their freedom of movement within their own home.

Further improvements were also required in the oversight and monitoring of restrictive practices within the designated centre, For instance, a review of the restrictive practice register maintained by the person in charge revealed that it was neither routinely updated nor adequately monitored. A number of restrictive practices listed had not been in use for some time, and those that were in effect were not properly recorded. This lack of accurate documentation hindered the ability to analyse trends and develop effective reduction strategies.

Judgment: Substantially compliant

## Regulation 8: Protection

This inspection found evidence that there was inadequate and ineffective arrangements in place to protect residents from all forms of abuse. For instance, over the past 12 months, a total of 16 safeguarding concerns were reported to the Chief Inspector. Upon review, the inspector found that 14 of these concerns were directly related to peer-to-peer incidents.

Resident surveys revealed a general dissatisfaction with the current living arrangement, which also resulted in a formal complaint being lodged by a resident's family member. Additionally, the provider's annual review of the care and support of residents also acknowledged that despite additional control measures in place such as one-to-one staffing, and increased staff supervision, one resident was still at high risk of exposure to negative experiences arising from the behaviour of the other resident.

The provider acknowledged that the current living arrangement for one resident was not suitable, and had made a decision in order to address this issue. For instance, a more appropriate residence was identified with works to the premises due for completion by the end of October 2025. However, this incompatibility among residents highlighted ongoing safeguarding issues, which ultimately compromised residents' right to feel secure and free from harm in their own home.

The inspector conducted a comprehensive review of all safeguarding concerns within the designated centre. While it was evident that these concerns had been reported in accordance with the provider's established policy, it was clear that the person in charge lacked the necessary oversight to guarantee residents' safety and

wellbeing, and to fully implement national safeguarding policies and procedures. For instance, no formal safeguarding plans were in place for residents. Despite multiple requests to review these plans on the day of inspection, neither the person in charge or deputy client service manager could provide them. This absence of documented procedures raised serious concerns about the effectiveness of the designated centre's safeguards against harm or abuse, and required comprehensive review from the provider.

Judgment: Not compliant

## Regulation 9: Residents' rights

This inspection found that residents lived in a restrictive environment, which the provider had assessed as a requirement for their care and support needs. However, the provider had not ensured that residents' rights were promoted and protected within the centre. As discussed throughout the report, ongoing safeguarding concerns had not been mitigated and were adversely impacting on the residents' quality of life, wellbeing, and right to dignity.

Evidence highlighted that residents' right to a safe and supportive living environment was compromised. Specific instances included residents' reluctance to engage in communal spaces or avoid certain areas when another resident was present, indicating a lack of freedom and choice and hindered their autonomy. Instances where residents were in each others company required close staff supervision of two staff members at all times.

The dignity of one resident was being compromised due to the inadequate arrangements that hindered their ability to safely and freely use the bathroom at night. For instance, on multiple occasions, the resident was prevented from accessing the bathroom, leading to incidents of incontinence. During the inspection. the person in charge and the deputy client service manager advised that mitigating measures had been put in place to address this. However, these measures included the resident wearing incontinence products, despite a GP and a urology nurse confirming that there was no known medical necessity for such measures. Additionally, a bedroom door alarm was installed to alert staff whenever the resident tried to leave their room at night.

These interventions not only infringed upon the resident's basic human rights but also restricted their freedom of movement within their own home. This required consideration and a comprehensive review by the provider.

Judgment: Not compliant

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

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

| Regulation Title | Judgment |
|---|---|
| **Capacity and capability** | |
| Regulation 15: Staffing | Not compliant |
| Regulation 16: Training and staff development | Substantially compliant |
| Regulation 23: Governance and management | Not compliant |
| Regulation 31: Notification of incidents | Not compliant |
| **Quality and safety** | |
| Regulation 7: Positive behavioural support | Substantially compliant |
| Regulation 8: Protection | Not compliant |
| Regulation 9: Residents' rights | Not compliant |

# Compliance Plan for Ocean House OSV-0007912

## Inspection ID: MON-0042009

## Date of inspection: 14/10/2025

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

This document is divided into two sections:

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

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

A finding of:

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

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

## Section 1

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

**Compliance plan provider's response:**

| **Regulation Heading** | **Judgment** |
|---|---|
| Regulation 15: Staffing | Not Compliant |

Outline how you are going to come into compliance with Regulation 15: Staffing:

1. The roster has been reviewed and will continue to receive monthly oversight to ensure adequate staffing levels and continuity of care are maintained. Vacancies and outstanding shifts are now covered by two regular agency staff, where possible, promoting consistency and stability within the team.
Completion date: 13/11/25

2. The Person in Charge has ensured that all staff rosters now include full names, agency/relief staff and the agency providing the staff. This provides transparency and accountability in staffing records.
Completion date: 14/11/2025

3. The PIC or DSM ensures that all new staff and agency staff read, understand, and sign the induction folder before commencing duties. If a new agency staff starts during the weekend or after PIC or DSM working hours, regular staff will provide induction, where possible, or arrangements will be in place to ensure the required action is completed. On call information is displayed in the office for easy access. The PIC or DSM reviews and signs off on the induction folder on their return as evidence of compliance. Completion date 13/11/25

4. All safeguarding plans are included in the induction folder, as well as the clients' folders, where required, which is accessible to all staff (including agency staff) on site.
Completion date 25/11/25

5. The roster is structured to ensure that, wherever possible, the DSM and/or Person in Charge (PIC) are present on-site Monday to Friday. However, due to operational demands, there may be occasions when neither is present on location. In such cases, cover arrangements will be communicated to staff in advance whenever feasible. Additionally, the PPIM will be accessible by phone for support to provide additional oversight. 13/11/25

6. Recruitment for the vacant post remains ongoing. As candidates are identified by HR, shortlisting and interviews will be scheduled.
Completion date: 31/01/2026.

7. To address compatibility issues in the location, one resident is scheduled to transition to a new centre in the coming months. The provider is progressing actions under the Service Improvement Plan and a Steering group has been set up with regular meetings with all relevant stakeholders involved to monitor progress and delegation of actions.

8. A property has been identified for one resident. A meeting will be scheduled by 28.11.2025 for the resident to view the house following required completion of works on the property.

9. The Person in Charge has implemented a clear protocol for sourcing cover. Cover will be sought first within the current team, followed by regular agency staff, and only if necessary, last-resort agency cover. This protocol has been shared with the staff team and added to the location induction folder to ensure a consistent approach going forward. Completion date: 14/11/2025

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|---|---|
| Regulation 16: Training and staff development | Substantially Compliant |

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
1. Core mandatory training requirements and any location-specific training have been clearly defined and communicated to agencies, ensuring consistent understanding of training expectations and compliance.
Completion date: 14/11/2025

2. All regular agency and relief staff have completed mandatory and location-specific training or are scheduled.
Completion date: 14/11/2025

3. Training records for all agency and relief staff will be maintained on-site. The Person in Charge or Deputy requests these records from the agency each time a staff member is booked to work, ensuring that all staff on duty have completed up-to-date mandatory and role-specific training.
Completion date: 25/11/2025

4. The majority of shifts are now covered by two regular agency staff, which supports continuity of care and allows for effective ongoing monitoring of training compliance.
Completion date: 14/11/2025

5. Staff training needs records have been updated to include agency staff. The Person in Charge will review the training monthly, including all agency and relief staff, to ensure ongoing compliance with mandatory and location-specific training requirements. Any gaps identified will be addressed promptly. Commencement date: 30/11/2025

| | |
|---|---|
| Regulation 23: Governance and management | Not Compliant |

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

1. The provider has completed a resource review and developed a restructuring plan as follows:

• Phase 1 -the reduction of the PIC having three locations to two locations 14th November.

• Phase 2 –The Centre will be re clustered- 1st December 2025.

2. As part of the management and oversight of the location, the PPIM will complete one governance and management meeting with the PIC each quarter to review, assign and document actions arising from audits, resident's needs, documentation, staffing, safeguarding, restrictions and regulatory compliance needs of the designated centre. At least, quarterly 1:1 meeting with the PIC and one unannounced visit to the location.

3. Additional supports have been temporarily introduced to the local managerial structures to strengthen day-to-day oversight and leadership presence as well as to implement required identified actions until full restructuring plan is completed. 30/10/2025

4. A Service Improvement Plan is in place to address identified actions and monitor progress. The PIC oversees this process, and any concerns are reported to the Senior Operations Manager. 30/10/2025

5. To address compatibility issues in the location, one resident is scheduled to transition to a new centre. The provider is progressing actions under the Service Improvement Plan and a Steering group has been set up with regular meetings with all relevant stakeholders involved to monitor progress and delegation of actions.

6. A property has been identified for one resident. A meeting will be scheduled by by 28.11.2025 for the resident to view the house following required completion of works on the property.

7. The Deputy Manager now has full IT access to safeguarding documentation, resolving the access issue identified during inspection. Completion date: 11/11/2025

8. A full review of rights restrictions has been completed by members of the Human Rights Committee (HRC). Corrective actions have been identified to address undocumented restrictions and gaps in supporting documentation. All rights restrictions, including those identified by the inspector, have now been submitted to the HRC. All related actions will be completed by 30/11/2025.

9. A comprehensive review of all safeguarding incidents has been completed by the Safeguarding Officer to ensure all matters are appropriately managed and recorded. All corrective action arising from the review will be completed by Completion date: 25/11/2025

10. A full review of all 2025 incident notifications has been completed. The NF39 quarterly notification and NF40 nil return have been submitted retrospectively to ensure all statutory reporting requirements are met.
Completion date: 07/11/2025

11. The SHS Social Worker visited the location on 21/10/2025 to review resident well-being, staff morale, and the implementation of safeguarding processes. A review of the 15 most recent safeguarding reports confirmed consistent communication with the Safeguarding Protection Team (SGPT) and prompt reporting. Three minor delays were noted at management level and have been addressed. The formal safeguarding plan, initially submitted 19/03/2025, has been updated following inspection and will be resubmitted to CH06 by 14/11/2025.

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| Regulation 31: Notification of incidents | Not Compliant |

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
1. A full review of all 2025 incident notifications has been completed to ensure compliance with reporting requirements. The NF39 quarterly notification and NF40 nil return have been submitted retrospectively to ensure all incidents are appropriately captured and reported.
Completion date: 07/11/2025

2. Ongoing monitoring of notification compliance will be carried out through provider audits and governance and management meetings with PPIM. The Person in Charge and Deputy Service Manager are tasked to ensure timely and accurate submissions and will notify the PPIM of submissions going forward.
Completion date: 31/12/25

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| Regulation 7: Positive behavioural support | Substantially Compliant |

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
1. A full review of rights restrictions has been completed by members of the Human Rights Committee (HRC). Corrective actions were identified to address undocumented restrictions and gaps in supporting documentation. All rights restrictions, including those identified by the inspector, have now been submitted to the HRC. All actions relating to supporting documentation will be completed by 30/11/2025.

2. The Restrictive Practice Register has been updated to reflect all current rights restrictions in place within the location.
Completion date: 14/11/2025

3. The Person in Charge will update and monitor the Restrictive Practice Register on a monthly basis in line with organisational policy. This process will be overseen by the PPIM during governance visits to ensure ongoing compliance and accurate recording.
Completion date: Ongoing – first review due 30/11/2025

4. A review group will be established to review all rights restrictions in the location and explore areas for reduction. The Person in Charge has developed Terms of reference and initial meeting is scheduled for 02/12/25 to be Completion date 31/12/2025.

| Regulation 8: Protection | Not Compliant |
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Outline how you are going to come into compliance with Regulation 8: Protection:
1. To address compatibility issues in the location, one resident is scheduled to transition to a new centre. The provider is progressing actions under the Service Improvement Plan and a Steering group has been set up with regular meetings with all relevant stakeholders involved to monitor progress and delegation of actions.

2. A property has been identified for one resident. A meeting will be scheduled by 28.11.2025 for the resident to view the house following required completion of works on the property.

3. The SHS Social Worker visited the location on 21/10/2025 to review resident well-being, staff morale, and the implementation of safeguarding processes. A review of the 15 most recent safeguarding reports confirmed consistent communication with the Safeguarding Protection Team (SGPT) and prompt reporting. Three minor delays were noted at management level and have been addressed. The formal safeguarding plan, initially submitted 19/03/2025, has been updated following inspection and will be resubmitted to CH06 by 14/11/2025.

4. In response to ongoing peer-to-peer safeguarding concerns, a revised formal safeguarding plan has been submitted to CH06. In addition, localised safeguarding support plans have been developed to guide staff in managing peer interactions within the location. These plans are available on file in the centre.
Completion date: 17/11/2025

5. The Social Worker met with the staff team to provide guidance and support in managing peer-to-peer safeguarding concerns
Completion date: 27/11/2025

| Regulation 9: Residents' rights | Not Compliant |
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Outline how you are going to come into compliance with Regulation 9: Residents' rights:
1. To address compatibility issues in the location, one resident is scheduled to transition to a new centre. The provider is progressing actions under the Service Improvement Plan and a Steering group has been set up with regular meetings with all relevant stakeholders involved to monitor progress and delegation of actions.

2. A property has been identified for one resident. A meeting will be scheduled by 28.11.2025 for the resident to view the house following required completion of works on the property.

3. The SHS Social Worker visited the location on 21/10/2025 to review resident well-being, staff morale, and the implementation of safeguarding processes. A review of the

15 most recent safeguarding reports confirmed consistent communication with the Safeguarding Protection Team (SGPT) and prompt reporting. Three minor delays were noted at management level and have been addressed. The formal safeguarding plan, initially submitted 19/03/2025, has been updated following inspection and will be resubmitted to CH06 by 14/11/2025.

4. In response to ongoing peer-to-peer safeguarding concerns, a revised formal safeguarding plan has been submitted to CH06. In addition, localised safeguarding support plans have been developed to guide staff in managing peer interactions within the location. These plans are available on file in the centre.
Completion date: 17/11/2025

5. The Social Worker met with the staff team to provide guidance and support in managing peer-to-peer safeguarding concerns
Completion date: 27/11/2025

6. A tracker has been introduced to document any instances of the resident waking overnight to ensure appropriate monitoring and support. The resident is not restricted from leaving their room at night and the existing door alarm provides safeguarding oversight when the resident exits. The tracker will clearly evidence any such instances and inform ongoing care planning.
Completion date: 31/12/2025.

7. A full review of residents' intimate care plans will be conducted in consultation with allied health care professionals. 31/12/20025.

## 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(3) | The registered provider shall ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis. | Not Compliant | Orange | 31/01/2026 |
| Regulation 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. | Not Compliant | Orange | 31/01/2026 |
| Regulation 16(1)(a) | The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional | Substantially Compliant | Yellow | 30/11/2025 |

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| | development programme. | | | |
| Regulation 23(1)(b) | The registered provider shall ensure that there is a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision. | Not Compliant | Orange | 01/12/2025 |
| Regulation 23(1)(c) | The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored. | Not Compliant | Orange | 01/12/2025 |
| Regulation 31(3)(a) | The person in charge shall ensure that a written report is provided to the chief inspector at the end of each quarter of each calendar year in relation to and of the following incidents occurring in the designated centre: any occasion on which a restrictive procedure including physical, | Not Compliant | Orange | 31/12/2025 |

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| | chemical or environmental restraint was used. | | | |
| Regulation 07(4) | The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice. | Substantially Compliant | Yellow | 31/12/2025 |
| Regulation 08(2) | The registered provider shall protect residents from all forms of abuse. | Not Compliant | Orange | 28/11/2025 |
| Regulation 08(3) | The person in charge shall initiate and put in place an Investigation in relation to any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse. | Not Compliant | Orange | 28/11/2025 |
| Regulation 09(2)(b) | The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability has the freedom to exercise choice and control in his or her daily life. | Not Compliant | Orange | 31/12/2025 |

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| Regulation 09(3) | The registered provider shall ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information. | Not Compliant | Orange | 31/12/2025 |