Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Regulation and Monitoring of Social Care Services

Overview report of governance and safeguarding in designated centres operated by Sunbeam House Services CLG

February 2025

Safer Better Care

About the Health Information and Quality Authority

The Health Information and Quality Authority (HIQA) is an independent statutory body established to promote safety and quality in the provision of health and social care services for the benefit of the health and welfare of the public.

Reporting to the Minister for Health and engaging with relevant government Ministers and departments, HIQA has responsibility for the following:

- **Setting standards for health and social care services** — Developing person-centred standards and guidance, based on evidence and international best practice, for health and social care services in Ireland.
- **Regulating social care services** — The Chief Inspector of Social Services within HIQA is responsible for registering and inspecting residential services for older people and people with a disability, and children's special care units.
- **Regulating health services** — Regulating medical exposure to ionising radiation.
- **Monitoring services** — Monitoring the safety and quality of permanent international protection accommodation service centres, health services and children's social services against the national standards. Where necessary, HIQA investigates serious concerns about the health and welfare of people who use health services and children's social services.
- **Health technology assessment** — Evaluating the clinical and cost effectiveness of health programmes, policies, medicines, medical equipment, diagnostic and surgical techniques, health promotion and protection activities, and providing advice to enable the best use of resources and the best outcomes for people who use our health service.
- **Health information** — Advising on the efficient and secure collection and sharing of health information, setting standards, evaluating information resources and publishing information on the delivery and performance of Ireland's health and social care services.
- **National Care Experience Programme** — Carrying out national service-user experience surveys across a range of health and social care services, with the Department of Health and the HSE.

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Introduction

The Chief Inspector of Social Services in the Health Information and Quality Authority (HIQA) was established under the Health Act 2007 (as amended) ('the Act'). The Chief Inspector inspects and registers designated centres through assessing compliance with the regulations and nationally-mandated standards. Regulation provides assurance to the public that people living in designated centres are receiving a safe, high-quality service that meets the requirements of the regulations.

The Chief Inspector uses its regulatory powers and processes proportionately and fairly to ensure that residents and children are safeguarded and have a good quality of life. A human rights-based approach seeks to ensure that their rights are protected and promoted.

The Chief Inspector carries out regulatory monitoring, escalation and enforcement activities in line with HIQA's Monitoring Approach (AMA)[2] which strives to ensure a fair, proportionate and consistent approach to regulation.

Sunbeam House Services CLG is a registered provider of designated centres for adults with disabilities. It provides a wide range of services to adults with intellectual disabilities including residential and respite services and day services. As a registered provider under the regulations, Sunbeam House Services CLG must ensure that effective governance arrangements are in place which ensure that people living in its services have safe and good quality support and care.

Due to the consistently poor and very often serious inspection findings, increasing non-compliance and risk to residents, the Chief Inspector had concerns about the governance and management of Sunbeam House Services CLG designated centres, and in particular the safety and safeguarding of residents. Due to repeated poor findings on inspection, there was an increasing risk to the registration of a number of its residential centres. In 2024, the Chief Inspector decided to implement an escalated regulatory programme that focussed on improving governance and oversight of centres and achieving better outcomes for people with disabilities living in those centres.

This report sets out the findings from 34 inspections carried out of 28 centres operated by Sunbeam House Services CLG between 4 January to 14 August 2024. Thirteen of these 34 inspections were carried out between 30 July and 8 August as

[2] AMA is a standardised monitoring approach incorporating a range of procedures, protocols and tools to assist inspectors in carrying out their functions. Applying AMA ensures that providers are treated fairly and that the assessment of compliance is timely, consistent, proportionate and responsive.

part of that provider-level regulatory escalation programme in Sunbeam House Services CLG centres.

In response to this report, the provider submitted to the Chief Inspector a compliance improvement plan on how it intends to strengthen its oversight of centres, and how it intends to assure itself that these actions are effective in driving improvements in lives and experiences of residents.

Sunbeam House Services CLG as a registered provider

Sunbeam House Services CLG (referred to in this report as 'the provider') is a voluntary organisation, registered as a charity with the Revenue Commissioners, providing a wide range of services to adults with intellectual disabilities including residential and respite services, and day services. Sunbeam House Services is constituted as a company limited by guarantee, and is also a registered housing association. Sunbeam House Services CLG is funded by the Health Service Executive (HSE), the Department of Education and voluntary donations.

During the 2024 inspection programme (up to 14 August 2024), the provider operated 29 designated centres as set out in the table below.

Table 1. Designated centres provided by Sunbeam House Services CLG and date of 2024 inspections, as of 14 August 2024

OSV (Centre ID)	Designated Centre	2024 Inspections	Registered Beds
0001702	Appleview	11/04/2024 18/06/2024	4
0001689	Ard na Greine	27/03/2024 26/07/2024	4
0001710	Ard Na Mara	30/07/2024	4
0001700	Ardbrae	06/08/2024	4
0007795	Aubrey Respite	31/07/2024	3
0001701	Bellavista	23/05/2024	8
0003776	Claraville	30/07/2024	1
0004919	Drumcooley	07/08/2024	2
0001707	Dunavon	04/04/2024	6
0001709	Hall Lodge	04/01/2024 08/02/2024 11/07/2024	4

OSV (Centre ID)	Designated Centre	2024 Inspections	Registered Beds
0001703	Helensburgh	06/03/2024	6
0007757	Hillview	30/07/2024	4
0001708	Kilcarra	16/04/2024	4
0007912	Ocean House	06/08/2024	2
0005052	Orchid Lane	30/07/2024	4
0001691	Parknasilla	31/01/2024 30/04/2024	7
0001704	Parkview	19/03/2024	4
0008563	Primrose House	04/04/2024 14/08/2024	1
0008225	Redwood[4]	-	6
0001706	Ros Mhuire	06/08/2024	4
0001711	Rosanna Gardens	17/01/2024	5
0007932	Rosewood	31/07/2024	2
0005760	Suaimhneas Respite	05/03/2024	4
0005299	Sunny Gardens	07/08/2024	3
0003322	The Beeches	06/08/2024	4
0005415	Tús Nua	08/08/2024	4
0004458	Vale Lodge	13/02/2024	4
0001705	Valleyview	12/03/2024	8
0001686	Villa Maria	21/02/2024	6

[4] Redwood was vacant in 2024 and therefore not inspected.

In line with the regulations, Sunbeam House Services CLG appoints persons in charge to manage their centres. The persons in charge usually have responsibility for one to two designated centres and are supported by deputy managers. Persons in charge report to a senior service manager.

The senior service managers have responsibility for between six and eight designated centres each, and are named as persons participating in the management (PPIM) of those centres on the Chief Inspector's register of designated centres. In addition, they manage other services such as day services. They report directly to the Chief Executive Officer (CEO) along with other members of the provider's senior management team, such as the heads of finance, human resources, multidisciplinary services, facilities, information and communicative technology, and the quality manager. The CEO reports to the board of directors. Appendix 2 shows the provider's organisational structure as of July 2024.

Background: January 2022 – July 2024

In 2022 and 2023, inspections of the designated centres operated by Sunbeam House Services CLG found a concerning deterioration in compliance which was impacting on the safety and the quality of life of residents.

In response to the increasing non-compliance and risk to residents, a significant volume of regulatory escalation and enforcement activities were undertaken by the Chief Inspector which was outside of normal regulatory monitoring activities. This was necessary due to consistent, and often serious, poor inspection findings and the associated adverse impact on residents' rights, safety and wellbeing.

The provider's responses to inspection findings, provider assurance requests and regulatory escalation and enforcement actions were often not effective. In a range of centres, the provider failed to implement the improvement actions they had committed to. Inspectors often found similar non-compliance issues on follow-up inspections.

Between January 2022 and July 2024, a high number of regulatory escalation activities were carried out in relation to the provider's centres. These included 28 triggered inspections focused on risk which were carried out in response to information of concern that HIQA received. On five occasions, the provider was required to attend a warning meeting with the regulator due to poor inspection findings such as breaches of their registration conditions, ineffective governance and management systems, fire safety risks, and a failure to safeguard residents from abuse.

Between January 2022 and July 2024, the provider was also required to attend five cautionary meetings, and in response to immediate risks found during inspections, the provider was issued with a requirement to undertake eight urgent actions. Additionally, the provider was required to submit written assurance reports on matters related to risk in their centres on 27 occasions.

Six centres were issued with notices of proposed decision to cancel their registration due to significant risks to residents and the provider's failure to comply with the regulations. Two of these progressed to notices of decision to cancel the registration of the centres, which is the final decision of the Chief Inspector. The Health Service Executive (HSE) has taken over the operation of one of those centres under the Health Act 2007. At the time of this report, the other centre is still undergoing due process.

In addition to poor inspection findings, notifications that the provider is legally required to submit to the Chief Inspector gave rise to concerns about how residents were being safeguarded and protected.

Between January 2022 and July 2024, across all designated centres operated by the provider, 482 safeguarding notifications were submitted to the Chief Inspector. Of these, 375 notifications were received from 10 specific designated centres. These related primarily to the provider's failure to manage peer-to-peer incompatibility and conflict and its impact on the safety and welfare of residents.

The Chief Inspector also received concerns from members of the public through HIQA's Concerns Helpdesk, including information about the safeguarding arrangements for residents.

In response to the risk that a range of the provider's designated centres may have their registration cancelled, the Chief Inspector commenced an escalated regulatory programme for Sunbeam House Services CLG which is discussed in this report.

The Chief Inspector is mindful of the upset and distress that the cancellation of registration can cause for residents and their loved ones. This action is only taken as a last resort where a provider has repeatedly failed to improve the quality of support and safety for residents. When there is a risk that poor governance may result in a number of centres being cancelled, and where circumstances allow, the Chief Inspector has previously used an escalated regulatory programme to require providers to improve oversight, governance and safety of their centres and ensure improved outcomes for residents.

This report has consolidated the findings from all inspections carried out in 2024 of Sunbeam House Services CLG designated centres to provide an overview of governance and management of designated centres at provider level and the arrangements to safeguard residents from harm. The report relates only to the provider's registered designated centres.

The views of residents using the provider's designated centres, which are a crucial element of any inspection, have been collated and are also summarised later in the report. The provider's response to the report and their plan to address the areas of non-compliance are included at the end of the report.

Regulatory escalation programme

In July 2024, the Chief Inspector commenced a provider-level regulatory escalation programme due to a trend of deteriorating levels of compliance in designated centres. This deterioration in compliance was occurring despite a high frequency of regulatory monitoring activity, escalation and enforcement procedures being undertaken with the provider by the Chief Inspector at an individual designated centre level.

The provider, represented by the CEO and members of the board, attended a meeting with the Chief Inspector on 24 July 2024. The provider was informed about the regulatory escalation programme and the rationale for it was explained to them.

The programme included the inspection of 13 centres that had not previously been inspected in 2024 over a two-week period from 30 July to 8 August 2024. These inspections were undertaken in the following manner:

- 13 inspections were carried out by a team of six inspectors, two regional managers and the Deputy Chief Inspector of Social Services in HIQA. The outcome of those inspections have been incorporated into the findings contained in this report and there will not be an individual inspection report for each centre.

- the inspections focused on five regulations related to the theme of residents' safety. These regulations were chosen based on a pattern of repeated non-compliance found on previous inspections of the provider's centres. The regulations were:

Regulation 5: Individualised Assessment and Personal Plan
Regulation 7: Positive Behaviour Support
Regulation 8: Safeguarding
Regulation 15: Staffing
Regulation 23: Governance and Management

- during these 13 inspections, inspectors spoke with 36 residents, 28 members of staff, three residents' family members and 15 management staff including deputy managers, persons in charge, and senior service managers. Feedback on the inspection findings was given during the inspections.

- formal interviews were carried out by HIQA's Regional Manager and National Operations Manager (Disability) on 19 August 2024 with members of the provider's management team and board directors:
  - four senior service managers
  - Chief Executive Officer
  - two board directors
  - another board director responsible for the quality and risk sub-committee of the board.

Summary of the findings

This overview report incorporates the findings from 34 inspections carried out in 2024 of 28 centres operated by Sunbeam House Services CLG:

- 20 inspections were carried out from 4 January to 26 July,
- 13 inspections from 30 July to 8 August (as part of this regulatory escalation programme),
- One unannounced inspection on 14 August.

These judgments are based on the consolidated findings from those inspections, and are discussed further later in the report:

Dimension: Quality and Safety	Judgment
Regulation 5: Individualised assessment and personal plan	**Not Compliant**
Regulation 7: Positive behavioural support	**Not Compliant**
Regulation 8: Protection	**Not Compliant**
Dimension: Capacity and Capability	**Judgment**
Regulation 15: Staffing	**Not Compliant**
Regulation 23: Governance and Management	**Not Compliant**

Inspections of 11 centres found good levels of compliance and that residents were being supported to have a good quality of life.

However, non-compliance was found on 23 of the 34 inspections. Areas of non-compliance identified during these inspections often posed a significant risk to residents' safety, wellbeing and overall quality of life, which are discussed further in the regulatory findings section of this report. For example:

- residents in eight centres told inspectors that they were unhappy, did not feel safe, were upset at times and wished to move out of their homes due to the continuing risk of aggressive and upsetting behaviours from other residents. Following the inspection of two centres, inspectors made referrals to the National Safeguarding Office due to serious concerns identified on the inspection.

- inspectors saw instances where residents' needs had not been appropriately assessed with the input from relevant healthcare professionals. Inspectors also saw instances where residents' needs had been assessed, however adequate arrangements and supports were not in place to meet those needs. This posed a risk to the quality and safety of the care and support they received.
- in some centres the allocated staffing resources were insufficient, which adversely impacted on residents' quality of life. For example, some residents were not provided with continuity of care due to the provider's failure to supply a consistent and stable staff team that residents were familiar with.
- the provider had not ensured access to appropriate and timely positive behaviour support for residents and this was impacting on their safety and wellbeing. For example, residents engaging in significant behaviours of concerns, such as self-harm, were not being fully supported to manage these behaviours to reduce and mitigate potential harm to themselves and others.
- there was poor recognition and management of restrictive practices which impinged on residents' rights. Inspectors found examples of restrictions being implemented without a clear rationale and in a manner inconsistent with evidence-based practice. These practices, and the provider's poor oversight of them, posed a risk of residents experiencing institutional abuse.

Regulatory findings from inspections and interviews

Regulation 5: Individualised assessment and personal plan

The provider had not ensured that all residents' health, personal and social care needs had been adequately assessed with input from appropriate healthcare professionals. Furthermore, adequate arrangements were not in place to meet residents' needs, and in some cases the centres they resided in were unsuitable. These issues were not being identified and responded to by the provider through their own monitoring of their designated centres.

Where identified by inspectors, the provider acknowledged the deficits in their systems for assessing and ensuring that residents' needs were appropriately met. However, in subsequent inspections, inspectors found that they had not addressed these matters in a consistent or effective manner.

As part of each inspection, inspectors reviewed residents' assessments. In many instances, they found that residents did not have complete assessments, their assessments had not been reviewed or the residents had significantly changed support needs and the assessments had not been updated to reflect these changes.

Inspectors found examples of instances where recommendations from assessments had not been implemented in a timely manner. For example, during an inspection of a centre in July 2024, inspectors found that a recommendation from a health professional in 2019 to paint a resident's bedroom to support their sensory needs had not been implemented.

In another centre inspected during 2024, inspectors found that the provider had determined that the centre was unsuitable for residents to live in due to its physical design and layout and because the provider did not have the clinical resources to meet residents' complex needs. The issues impacting on residents included exhibiting serious self-injurious behaviours that required hospital treatment. This finding had also been made during inspections in 2022 and in 2023 and the provider had not taken adequate action to make the situation safer for residents.

Personal support plans for residents that were reviewed in other centres by inspectors were found to contain insufficient, out of date and inaccurate information which did not adequately guide or direct staff on the appropriate delivery of care and support. This issue was more acute in centres with an ongoing reliance of non-familiar agency staff who did not know the residents.

Inspectors also saw examples where the care and support of residents was not being assessed by relevant healthcare professionals. For example, in one centre, a resident required specific support around their communication needs. The communication

assessment and support plan had been prepared by front-line staff who did not have the appropriate training. The resident had been referred to the provider's own speech and language therapy services approximately 12 months prior, but had not yet been assessed and there had been no follow up. The resident had an assistive technology device to help them with communication but it was not in use and staff had not been trained to use it.

During an inspection of another centre, a resident said that they had ongoing pain. Staff told the inspector that the resident was prescribed pain medication, however there was no documented pain management plan for them to follow. This posed a risk of the resident's pain not being treated consistently and promptly.

Overall, across a range of centres, inspectors found evidence that the needs of residents were not being assessed and where they were assessed, many were out of date or had inaccurate information. They were not being updated when the needs of residents changed and were not being used to ensure that staff had clear directions on how to best meet residents' care and support needs.

Regulation	Judgment
Regulation 5: Individualised assessment and personal plan	Not compliant

Regulation 7: Positive behavioural support

This regulation requires providers to embed a positive approach in responding to behaviours of concern and ensure that evidence-based interventions and staff training are implemented.

Inspectors found that the provider had failed to provide residents with timely and effective behaviour support, and that restrictive practices were not being applied in line with the provider's own policy or evidence-based best practice. This impacted on residents' rights, including the right to be treated with dignity and respect.

In eight centres inspected in 2024, inspectors found that residents who required behaviour support to ensure their safety and their quality of life, were not being provided with that support. For example, in a centre where the behaviour of residents was placing themselves, other residents and staff at risk, residents did not have positive behaviour support plans in place to give direction to staff on how to prevent and reduce the level and intensity of incidents. A referral had been made to the provider's own positive behaviour support service in April 2023. However, on the day of inspection in April 2024, support plans were still not in place. This deficit was

concerning given the frequency and intensity of behavioural incidents which were having a negative impact on residents and their peers.

During an inspection of another centre in July 2024, inspectors read notes of a multidisciplinary team meeting from February 2024 which noted that risks for a resident were "high, and these included self-harm, attempting suicide, and risk to those they live with". However, inspectors found that the resident's behaviour support plan had not been updated to reflect the findings of the multidisciplinary team and, as a result, the support plan was inaccurate and ineffective in guiding staff on how to ensure best support and outcomes for the resident. An external specialist's report from May 2024 had made recommendations such as specific training for staff, however there were no plans in place to respond to those recommendations.

Inspectors saw correspondence where staff had escalated their concerns to the senior management team about a resident's self-injurious behaviour and a behavioural specialist had also communicated their concerns in February 2024. However, there was no positive behaviour support plan or guidelines in place and inspectors were informed that the resident had been hospitalised the night before the inspection due to a prolonged period of self-harm. The provider was failing to ensure residents' safety and management of known risks.

Additionally, in another centre, inspectors saw records of increased incidents of concern which impacted on the safety of residents. For one resident, a referral to the provider's own positive behavioural support service had been made in June 2023, however no review had taken place by the time of the inspection in May 2024. For another resident, while a referral had been made to the provider's positive behaviour support service, there was no record of when the referral had been made and staff informed the inspector that it was before 2022. The absence of timely support meant that residents were not properly supported to manage their behaviours, staff did not have adequate guidance on the best approach to support residents and behavioural incidents continued which negatively impacted on residents' wellbeing, and the wellbeing of those that they lived with.

Behaviour support plans reviewed by inspectors in three centres were dated as having being reviewed and updated within the past 12 months, as required by the regulations. However, inspectors found that those plans were being reviewed by staff in the centre without input from the behaviour support specialists who had developed the plans. Inspectors saw plans that were noted as having been reviewed and updated and yet there were no changes to the previous plan even though there continued to be recurring behaviour incidents.

In another centre, inspectors viewed a behaviour support plan that included directions to staff that were no longer being used with the resident and made reference to behaviours that the resident no longer displayed. The plan had been referred to the provider's behaviour support services for updating in 2023 but this had not yet happened when the centre was inspected in 2024. This was particularly concerning given the high use of agency staff. The failure to update these inaccuracies demonstrated that residents' information was not maintained in a manner that respected their dignity.

Appropriate training is fundamental in supporting staff to understand behaviours of concerns and promoting environments that respect residents' rights and dignity. The provider had not ensured that all staff who worked with residents who needed behaviour support had up-to-date skills or training in positive behaviour support. This was a recurrent finding that was not being addressed by the provider. For example, inspectors viewed training records and found that in five centres, staff had not received positive behaviour support training, and in four centres review of the training was overdue.

Restrictive practices can adversely impact on the rights of residents and where they are being used, providers must ensure that they are the least restrictive and used for the shortest duration. Inspectors found recurring examples across a range of centres where the provider's own policy on restrictive practices was not being implemented. For example, in one centre, the flush button on a toilet had been removed to prevent a resident from flushing it after use. This had not been reported to the provider's human rights committee to ensure that any impact on the resident's right to privacy and dignity had been assessed.

Inspectors also found that in three centres restrictions were being implemented without documented-informed consent from residents or their representatives to clearly show that they understood and agreed to the restrictions affecting them.

The provider had not ensured that sufficient efforts were made to reduce restrictions. For example, in a centre with locked doors, inspectors found that there were no restrictive practice reduction plans in place to consider other measures to reduce the need for the locked doors.

In another centre, one resident was only allowed to go for a walk on their own for a very short time, and was only given a very limited amount of their own money to spend each day. Inspectors reviewed the resident's personal plan and other records and spoke with staff. There was no rationale for these restrictions. This demonstrated the provider's failure to ensure that restrictive practices were proportionate, monitored, applied in line with evidence-based practice, and the practices could be viewed as institutional abuse.

In another example, regular night-checks of residents were being carried out where staff were going into the bedrooms of residents while they slept. While this may be a requirement in certain services, when the inspector reviewed residents' records and other centre documentation and spoke with staff, they found that this was an historical practice, that there was no clear rationale for it and staff were not clear about why these checks were taking place. The practice had not been identified as a potential rights and privacy restriction that required a rationale for its implementation.

Regulation	Judgment
Regulation 7: Positive behaviour support	Not compliant

Regulation 8: Protection

Every person has the right to feel protected and safe from all forms of abuse, including institutional abuse. Safeguarding is about proactively protecting people. Providers must ensure that robust policies and procedures are in place and implemented to protect residents, and to assist and support residents to develop the knowledge and understanding needed for self-care and protection.

Residents in some centres told inspectors that they felt safe in their homes. Inspectors also spoke with staff who were found to be knowledgeable on recognising, responding, and appropriately reporting safeguarding concerns in those centres.

However, other inspections found that the provider had failed to protect residents from aggressive behaviour of peers, and that their safeguarding practices and procedures were ineffective. For example, in eight centres, inspectors found that residents were not compatible to live together and this was contributing to incidents of aggression and harassment towards other residents. Inspectors saw examples of residents in distress and being very upset by this behaviour. The provider was failing to manage these situations and residents' sense of safety and their quality of life was negatively impacted.

In one of those centres, inspectors observed a resident displaying very loud behaviours that was very upsetting to another resident. Staff told the inspector that this was a frequent occurance and that the other resident was frequently upset. Inspectors reviewed the second resident's records and the assessments noted that the resident needed to live in a quiet environment. Staff told inspectors that these loud behaviours were frequent, however they were not being recorded or reported as potential safeguarding concerns. Furthermore, there was no evidence that the

provider had taken action to address this situation. The impact on the wellbeing of the second resident was significant and allowing this to continue on an ongoing basis could be considered institutional abuse.

In another centre, inspectors read daily notes which documented interactions between staff and residents. The daily notes described the use of coercive language by staff and threats to the residents' freedom of movement in their community. A resident living in the centre also told inspectors that they were not happy living in their home because of other residents' behaviours. They said that they had told staff about their concerns but that "they don't listen".

Inspectors saw in the resident's records that they had complained to staff and had told staff that they wanted to speak with an advocate. This had not been recorded as a complaint and had not been escalated to the provider. A referral had not been made to an advocate. The provider's own monitoring and review of this centre had not identified this failure to respond to a resident's complaint and nothing had been done to resolve the issue. Due to the nature of the concerns identified on this inspection, a safeguarding referral was made to the National Safeguarding Office.

Inspectors found that residents were also at continued risk of psychological abuse in another centre, and that strategies to reduce the incidents occurring were not effective. One resident engaged in aggressive behaviour that was distressing to other residents in the house. Inspectors read about a recent incident in the centre where staff were unable to keep other residents safe and had to contact their local Garda Síochána (police) station for assistance. A family member of one of the residents in this centre contacted inspectors and described the concerns they had for their family member's safety and mental health. They described getting frequent phonecalls from their family member late at night in a distressed and upset state.

Inspectors reviewed the safeguarding plans and directions for staff on how to manage such incidents and ensure the safety of residents in this centre. Inspectors found that the plans were out of date and contained inaccurate information. They did not give adequate guidance to staff on how to manage such incidents.

In another centre, the provider failed to take appropriate action and did not have plans in place to address ongoing issues, and failed to ensure that residents lived free from distress. Safeguarding plans were ineffective and did not prevent the reoccurrence of abuse. For example, one plan stated that the resident's home "has been deemed not suitable for the person causing harm for several years and as a result, a more suitable location has been identified for the resident to move into". However, the inspector was told that the relocation of this resident would not be proceeding.

Inspectors found inconsistencies and discrepancies in the implementation of the provider's safeguarding policy. For example, in one centre, inspectors found that while the preliminary screening of a safeguarding incident had been undertaken, the information was not comprehensive or sufficiently detailed. The reported safeguarding concerns had been closed and as a result, appropriate safeguarding plans were not in place to manage the actual level of risk. In another centre, inspectors saw correspondence from the National Safeguarding Office asking to be kept updated on any changes relating to a specific safeguarding issue. The provider had failed to submit updates of significant changes that had occurred. The Chief Inspector reported this finding to the National Safeguarding Office.

Overall, it was found that the provider was not adequately monitoring safeguarding and protection of residents from the risk of abuse in their designated centres. They had not put in place appropriate and effective arrangements to ensure the safety of all residents from abuse, and had not made adequate efforts to ensure that residents were afforded their right to feel safe and secure in their homes.

Regulation	Judgment
Regulation 8: Protection	Not compliant

Regulation 15: Staffing

The provider had failed to ensure that staffing arrangements were appropriate to the number and assessed needs of residents, with eight centres found to be not compliant under this regulation in 2024. This impacted on residents' continuity of care and the quality and safety of the service provided to them.

While using agency workers to manage staff resource limitations on a short-term basis is a suitable and often important resource arrangement for providers, there can be significant challenges that arise if providers depend on high levels and frequent use of agency staff in designated centres to support residents on a long-term and ongoing basis.

A consistent and persistent trend of non-compliance under this regulation related to the provider's ongoing and heavy reliance on agency workers to staff seven of their designated centres. Local managers endeavoured to minimise the adverse impact on residents by booking the same non-permanent staff. However, their endeavours were not always successful.

An inspection of a centre in April 2024 found that there were no permanent or full-time staff and the resident living there was being supported by agency workers only.

The resident required significant staff support in relation to their safety and wellbeing; however, the staffing arrangements were not meeting the resident's needs or preferences. The resident was continuously refusing to engage with many of the staff. Due to the frequent changes to staff, the resident had not had an opportunity to build trust with staff. This meant that the behavioural strategies that had been recommended had not been commenced and the resident regularly refused to engage in activities and support arrangements that were important for their personal wellbeing.

During a follow-up inspection in August 2024, a resident referred to night-time staff as 'strangers' and explained that they did not want to let unfamiliar staff into their home. The resident's behaviour support plan stated that it was a requirement for the wellbeing of this resident to have familiar staff working with them. However, the staffing arrangements were continuously not in line with the recommendations made by the behaviour support expert and with the resident's own preferences.

An inspection of another centre in 2024 found that during a two-week period in June 2024, 12 different agency staff supported one resident. The high use of agency staff did not ensure that residents received continuity of care.

Most residents praised the care and support they received from permanent staff, and said that they had a good relationship with them. However, this was in contrast to the feedback from residents living in centres with high use of agency staff where they expressed dissatisfaction and worry. One resident told inspectors that they did not know all staff supporting them, and their family had complained to the provider on their behalf.

The provider had also not ensured that all agency staff were adequately informed on residents' care and support needs. For example, inspectors met residents with specific care and support requirements to ensure their safety and wellbeing. Inspectors spoke with two of three agency staff in the centre and found that they were not aware of the guidance and direction outlined in a resident's wellbeing and support plan. On reviewing residents' records, inspectors found that staff in that centre required suitable training in necessary areas such as medication management and positive behaviour support. Inspectors found that the agency staff did not have the necessary training to support residents appropriately.

Staffing levels in some centres were not adequate to meet residents' needs or to ensure their safety. In one centre some residents were assessed as requiring support at night-time to prevent falls, when in a heightened and agitated state and for personal hygiene and intimate care. The provider had failed to put in place sufficient staffing arrangements and inspectors found that this was resulting in residents having increased incidents of incontinence, increased noise levels in the centre which

disturbed the sleep of other residents and inadequate supervision for residents who were at high risk of falls.

In another centre, inspectors found that because of inadequate staffing, there was very limited time to support residents individually and residents had to either forgo their planned activities or could only go out for group activities. This impacted on their freedom of movement and opportunities to engage in activities that were important to them.

Regulation	Judgment
Regulation 15: Stafffing	Not compliant

Regulation 23: Governance and management

Inspectors reviewed governance and management arrangements during each of the inspections, giving consideration to how the arrangements were impacting on the provider's ability to oversee their designated centres and ensure that residents were receiving the quality of care and support that they needed and that upheld their rights.

Following the completion of the programme of 13 inspections over two weeks, interviews were conducted with three members of the board of directors, as well as with senior managers within the organisation. In addition, inspectors reviewed the minutes of board of directors meetings.

Overall, inspectors found that there was evidence that the board of directors had taken actions with the intention of strengthening the functioning of the board such as recruiting new board members and establishing subcommittees of the board. However, inspectors found that these actions were not sufficiently effective, that there continued to be a disconnect between the board's oversight and what was happening in designated centres. The board oversight of designated centres was dependent on reports from management and the executive. The management structures within the organisation were not effective in ensuring good quality support for residents and in identifying and responding when issues arise that impact on the safety and quality of life of residents.

Board members described how the CEO reported to the board and provided the board with extensive information about the functioning of the organisation. They also described how they were in the process of recruiting new board members and were considering the competencies and skills that they needed to enhance the

capacity of the board. They expressed concern about poor inspection findings, but explained that they did not always have a clear understanding of the complex needs of residents or the services they may need to be provided with. They explained that they are reliant on the CEO to explain the complexities of some residents' needs.

Having intervewed board members and reviewed the minutes of board meetings, inspectors concluded that while the board were in receipt of a lot of information about the operation of designated centres, this information was not informing the board adequately about the management of risks and was not providing effective assurances about the safety and quality of support for residents.

Inspectors also reviewed the executive and senior management arrangements in the organisation. The CEO described how she reported to the board of directors and led the senior management team, which included senior service managers who oversaw the delivery of services and the heads of finance, human resources, multidisciplinary services, facilities, quality and risk and information technology.

During the inspections, inspectors spoke with senior service managers and they were also interviewed on completion of the 13 inspections carried out over two weeks. Senior service managers described how they were each responsible for a number of designated centres, and some also managed day-service provisions and self-directed living services. For example, one senior service manager was responsible for 15 locations which comprised of seven residential services, day services and self-directed living services.

Senior service managers spoke about the challenges they encountered and how it was difficult, stressful and hard at times to fulfil all of their responsibilities. They said that it was difficult to provide sufficient support to all of their areas due to competing demands. Another significant challenge that they identified was accessing resources, particulary finances, when needed. For example, to source appropriate properties that would better meet residents' needs and reduce the risks of incompatibility issues.

Senior service managers said that they met with the CEO every six to eight weeks, and described the systems to escalate risks to the CEO and, if appropriate, on to the board of directors. However, these were not always utilised effectively. For example, inspectors read minutes of a meeting between a senior service manager and the CEO in July 2024 with safeguarding listed as a standard agenda item. However, despite known safeguarding incidents, safeguarding was not recorded as being discussed. This showed that reporting systems were not effective or functioning as intended.

Senior service managers said that they were not always satisfied with the support from the board. They told inspectors that, when risks were escalated to the board, there was often no response. For example, challenges in sourcing resources had been escalated, but the managers did not know if and how the board responded.

Inspectors examined the board's arrangements for oversight of risk management. Inspectors also reviewed documents supplied by the board concerning the previous 12 months. The provider's corporate risk register, dated August 2024, showed seven open risks. Six of these were risk-rated 'high' and colour-coded red and one risk was rated as 'low' and colour-coded green. Five red-rated risks related to centres where the Chief Inspector was undertaking regulatory escalation and enforcement activities; the other red-rated risk was described as 'budget deficit'. Of particular note was a risk relating to the absence of a strategic plan for the organisation and this was described as 'green' low risk.

Inspectors also identified other significant risks that were not included in the provider's risk register. These included significant premises maintenance failings in some centres, staffing deficits and ongoing safeguarding issues experienced by residents in some centres. Inspectors saw that some of these issues were included in previous versions of the risk management reports but had appeared to be closed even though the risks continued to be present.

Another example of inadequate governance relates to a health and safety report to the board in 2023 which noted that some residents with a significant number of behavioural incidents required behavioural support input, and that a review of the behavioural supports should be completed. This recommendation was presented again in the 2024 quarter two report. The board was failing to get assurances that critical recommendations were being actioned in a timely manner in order to reduce and mitigate the risk of harm to residents.

Inspectors also read about other issues that were discussed by the board which required actions, but no one had been nominated to take responsibility for the action and there was no follow-up on the actions by the board. For example, thenotes of one board meeting noted that the board should develop strategic goals around clients' needs. However, the action was not defined, there was no identified person responsible for completing the action and there was no follow-up noted in the two subsequent meeting minutes.

Inspectors found that the provider's oversight and monitoring systems were not effective in identifying areas for improvement, responding to risks, and driving quality improvements for the safety and wellbeing of residents.

Providers are required by the regulations to carry out an annual review and complete unannounced visits to each centre every six months to consider the quality of care and support. Inspectors found that these audits were not identifying gaps in service provision that were impacting on residents' quality of life and risks to residents were also not being identified.

For example, during one inspection, the most recent six-monthly report had not identified numerous restrictive practices which were impacting on residents' rights. It found the centre to be "compliant" but it failed to identify gaps in residents' communication needs, such as outstanding assessments and training. The annual review found 'Theme 1 Individual care and support', which explored areas including residents' rights to be compliant. However, the inspector found that there were numerous rights infringements impacting residents.

In other centres, the monitoring visits had not taken place at least once every six months as required by the regulations. Inspectors saw where there were issues in these centre that impacted on the quality and safety of care being provided. The provider was failing to monitor the safety and quality of their own centres.

In one designated centre, inspectors read provider-led audits, including health and safety audits, annual reviews, and six-monthly unannounced visit reports which all identified that a resident had mobility issues and that there were significant access issues in the premises. The resident was also sustaining regular bruising from banging their limbs because there was not enough space for them to manoeuvre in the premises. This matter had also been found during inspections of the centre in 2021 and 2023. An occupational therapy assessment in 2020 made recommendations to address the accessibility issues. On an inspection in 2024, the inspectors found that the recommendations had not been implemented and the resident could still not freely access areas of their home.

In another centre, inspectors found that a request to the provider's maintenance team to fit handrails to support residents at risk of falling had been made in 2021. Health and safety reports and the provider's own audits of the centre had also highlighted this requirement. During 2024, the provider submitted notifications to the Chief Inspector that residents were experiencing falls in the centre. However, despite this, at the time of the inspection the provider had still not installed the handrails.

Inspectors also found that the provider failed to implement the improvement actions which they committed to following inspections.

In one centre, an external fire safety assessment had made recommendations in 2021 that were risk-rated as 'high' by the provider's own fire safety expert. In

December 2023, the Chief Inspector required the provider to attend a warning meeting as the majority of the recommendations had not been implemented. A subsequent inspection in May 2024 found the same findings.

In another centre that experienced high levels of escalation and enforcement activities during 2022 to 2024, inspectors found that the provider had failed to implement actions which they had committed to for the safety and wellbeing of residents. For example, the provider set out the actions that they commited to implementing that related to the premises, positive behaviour support, infection prevention and control and fire precautions. On a follow-up inspection, inspectors found that the provider had not implemented these actions. Furthermore, inspectors found that where some improvement actions had been completed, they had not been sustained. For example, during an inspection in 2024 of the centre, inspectors observed a recurrence of poor practices relating to the management of soiled laundry and hand hygiene which had been improved following a previous inspection.

Inspectors identified another example of poor oversight by the provider in another centre. In 2023, the provider wrote a letter to residents in a centre to inform them that the lease for the centre would expire in August 2025 and that residents would no longer be able live in their home after that date. Inspectors were informed by staff that the centre was owned by Sunbeam House Foundation. During the 2024 inspection, the first thing that residents said to inspectors on their arrival was that they were really worried and upset about having to move from their homes. Inspectors spoke with management and staff who confirmed that residents had been sent letters informing them that they would have to move out in 2025. They said that there had been no further communication from the provider on this matter but that staff had been told to reassure residents.

Inspectors found that there was the lack of communication, support and response from the provider to residents about this significant life event. This lack of communication was having a considerable negative impact on residents' wellbeing and mental health due to worry about their future. Inspectors spoke with residents and staff during the course of the inspection and they told inspectors that residents and their families had been told to fill out local authority housing application forms and send them to their county council. Some staff spoken with on the day said they had helped residents to fill out the forms as the residents were unable to do so independently.

Inspectors found that residents had not been consulted about this measure and that there had been no planning or input from the multidisciplinary team to inform any actions that the provider might undertake or to asses the impact that such a significant action would have on the residents.

Regulation	Judgment
Regulation 23: Governance and management	Not compliant

Residents' experiences and views

Inspectors endeavour to meet with residents on every inspection. Spending time with residents, hearing about what it is like to live in their home or to use respite services, and observing their day-to-day life is fundamental to every inspection and is crucial in helping inspectors form judgments on compliance.

During the 34 inspections between 04 January 2024 and 14 August 2024, inspectors met and spoke with approximately 100 residents. Some residents communicated verbally and were able to clearly express their views. Other residents communicated differently, and where required, staff helped them to engage with inspectors. Some residents did not communicate their views, but did engage with inspectors through non-verbal means such as eye contact and gestures. If a resident chose not to meet with inspectors, their decision was always respected. However, most residents welcomed inspectors, and were keen to share their views and experiences.

Many residents gave positive feedback and told inspectors that they were happy, felt safe, and liked the staff working in their homes. However, while most residents were complimentary of staff, other residents told inspectors that they were not happy with staff because the staff kept changing and they had people working with them that they did not know.

Many residents told inspectors that they made choices and decided how they lived their lives. Some residents were affected by restrictive practices and were able to tell inspectors that they consented to their use. However, other residents said they were not happy with restrictive arrangements and inspectors found that the use of restrictions was ambiguous with poor adherence to the provider's policy, as discussed earlier in this report.

Some residents said that they got on well with their housemates, and described each other as "good friends". However, others expressed concerns and upset about their living arrangements due to incompatibility issues.

Most residents liked to show inspectors around their homes, and in particular their bedrooms. In some centres, residents were being encouraged to use the facilities in their home. For example, inspectors saw some residents preparing meals and doing household chores. Some residents also had pets that were very important to them. These types of premises were designed and laid out in a manner that promoted residents' independence and dignity, and recognised their individuality and preferences.

Some premises were poorly maintained, others presented as institutional in layout and design and in some instances residents' homes did not ensure accessibility

arrangements for all residents living there. For example, one resident told inspectors that the bathroom facilities were not suitable and they said that because of this, they could not look after their own personal care independently and had to have staff with them which impinged on their privacy and dignity.

In many instances, inspectors observed that issues with the premises were long-standing despite local management escalating the issues to the provider. These issues impacted on residents' lived experience and in some cases posed a risk to their safety. Overall, the provider had failed to maintain these centres to an appropriate standard and had not responded to risks in a timely manner. This demonstrated poor regard for residents' rights to privacy, dignity, safety and independence.

Not all residents felt safe or happy living in their homes and told inspectors about how different factors such as the behaviours of other residents were negatively impacting on their life. As discussed previously under Regulation 8: Protection, some residents were not being adequately safeguarded from the risk of abuse.

Some residents told inspectors that they were upset and wanted to move out of their homes or live on their own due to the ongoing aggressive behaviours of other residents. They said they had told staff that they were unhappy, but that staff had not listened to them. Others told inspectors that they did not feel safe in their homes and while they had made complaints about their concerns, their concerns had not been resolved. One resident explained that they had engaged in self-injurious behaviour due to being upset and stressed about their living circumstances. They also said that they had been promised a separate apartment in the past but it never materialised.

Residents told inspectors about the measures they took to minimise the impact from other residents' behaviours. For example, some residents said that they had to go into their bedrooms and lock the doors when there was shouting, put on music and wear earplugs to block out noise, and lock their bedroom doors to prevent other residents from taking their personal items.

In addition to meeting with residents, inspectors spoke with their representatives such as families and advocates when the opportunity arose during an inspection. Their opinions were mixed. In respite centres, most families were happy with the services provided, had no complaints, and complimented the care and support from staff.

In one full-time residential centre, families expressed their concern about the staffing arrangements, residents' safety and wellbeing due to safeguarding risks, and the

management of behavioural incidents. They had raised their concerns with the provider, but were not satisfied with the outcome.

An independent advocate told inspectors that they were concerned about the quality of care and support provided to residents, and the ongoing psychological abuse that residents endured within the centre.

Conclusion

This report consolidates the findings and Chief Inspector's judgments on five regulations from 34 inspections carried out in centres operated by Sunbeam House Services CLG from 4 January to 14 August 2024.

In July 2024, the Chief Inspector commenced a regulatory escalation programme in response to a concerning level of regulatory non-compliance, which was impacting on the safety and quality of life of residents, frequent enforcement activities by HIQA being carried out in response to poor inspection findings and concerns raised about the provider's ability to ensure the safety of all residents in their centres.

Speaking with residents and hearing about their lives was a crucial aspect of this programme. Some residents said that they were happy with the services they received. However, inspectors found from speaking with residents, their observations and through the review of documentation, that some residents were living in centres where they experienced aggression from peers, restrictions on their rights, and an overall poor service that was adversely impacting on their quality of life and one that was not meeting their individual needs.

The provider had not put effective governance and management systems in place to deliver safe, effective and appropriate services in all their designated centres.

The provider's communication with residents, particularly in response to their concerns, was also not adequate and failed to provide assurances to the residents and or their loved ones.

The provider's own auditing systems were weak, and where the regulator had identified issues, the provider did not take appropriate action.

In response to this report, the provider submitted to the Chief Inspector a compliance improvement plan on how they intend to strengthen their oversight of centres, and how they intend assuring themselves that these actions are effective in driving improvements in the lived experience of residents. The Chief Inspector will monitor the implementation of the plan through a schedule of meetings with the provider. Inspections will also be undertaken to verify whether the actions of the provider are being implemented and are effective to ensure that residents are safe and in receipt of care and support that is appropriate to their needs. The Chief Inspector will continue to monitor for compliance and take responsive regulatory action as required.

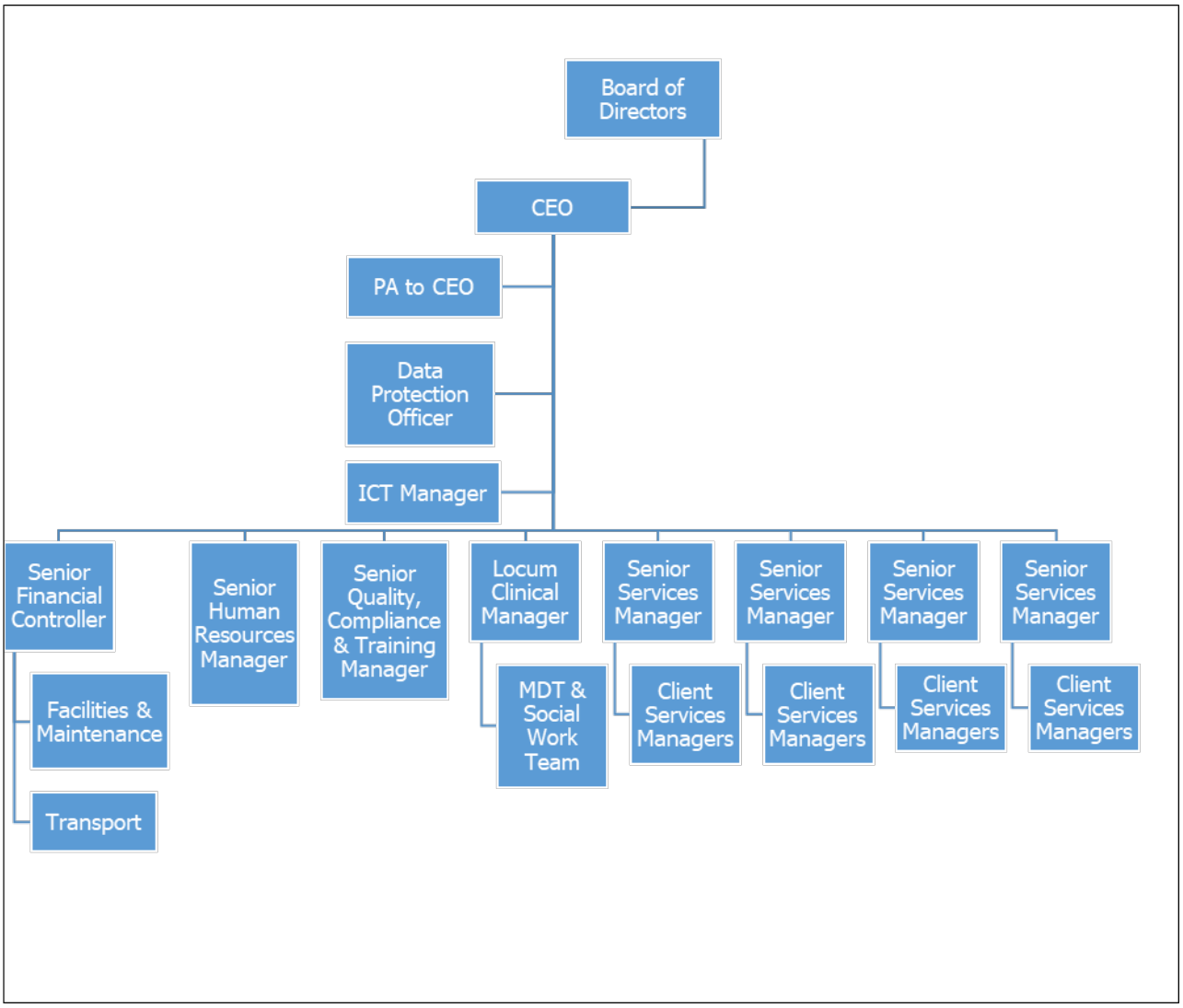
The Chief Inspector will continue to use its regulatory powers and processes proportionately and fairly to ensure that residents are safeguarded and have a good quality of life.

Appendix 1 – Regulations inspected under this programme

The inspections that were carried out under this programme assessed compliance with the Health Act 2007 (as amended) and the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013. The table below shows the aggregated compliance rating:

Regulation	Judgment
Capacity and capability	
Regulation 23: Governance and Management	**Not Compliant**
Regulation 15: Staffing	**Not Compliant**
Quality and safety	
Regulation 5: Individualised assessment and personal plan	**Not Compliant**
Regulation 7: Positive behavioural support	**Not Compliant**
Regulation 8: Protection	**Not Compliant**

Appendix 2. Sunbeam House Services CLG organisational structure 2024



Sunbeam House Service CLG's response and compliance plan

This section outlines Sunbeam House Service CLG's response to the report and the actions it has taken and intends to take.

Compliance plan in response to the 'Overview report of governance and safeguarding in designated centres operated by Sunbeam House Service CLG' - 2024

Regulation 23: Governance and Management	**Judgment: Not Compliant**

Board Development

Increasing Capability

- A Board led Nominations Committee (NC) has completed a skills assessment (October/November 2024) for current Board Members.
- The Board have engaged an external party to complete a Board effectiveness and skills audit. The oversight of the process is managed by the NC with anticipated completion by March. On completion of the analyses, the Board will compile an action plan in relation to Board composition, roles and responsibilities, culture, governance and finances.

Board Recruitment

- The NC, in conjunction with CEO have developed the Induction Program for new Board Members and have completed an update of the NC Terms of Reference.(September 2024), for review by the Board at the end of Q1.
- The NC have engaged with an external company for the recruitment of new Board members with additional skillsets to enhance the knowledge and capability of the Board.
- The NC have conducted a number of interviews with interested persons. Currently, there are 5 new Board members within the onboarding process and it is anticipated they will commence their position on the Board by April 2025
- Induction and training will be arranged to coincide with these new Directors joining.

Quality Assurance

- A series of annual/quarterly position reports has been implemented in 2024, with the accumulation of the Annual Report Q1 2025, as follows:
  - Safeguarding Position Report
  - Health & Safety Position Report
  - Quality and Compliance Position Report (complaints, compliments, open disclosure etc)
  - Operations Position Report
  - HR Position Report

- Data Protection Position Report
- ICT Position Report
- Annual Consultation Exercise (ACE)

The related action plans will be reflected in the Business Plan objectives for 2025.

- A QA themed Board meeting is scheduled in Feb 2025 to review the annual reports related action plans reviewed and monitored, quarterly thereafter.
- Each report, annual and quarterly, will include an executive summary and action plan and will be reviewed by the Board. The data and its analyses will be interrogated by the Board and the actions/recommendations presented by the Executive in relation to the reports will be agreed and monitored thereafter for completion as a standard agenda item where deficits/delay/ challenges will be addressed.
- The provider will develop and implement an overarching Service Improvement Plan 2025 9 December 2024) and its monitoring for progress and effectiveness in response to the escalation program. The plan is reviewed monthly by SenLT, Quarterly by the Quality and Risk Committee (Board Chair) with a subsequent update to the Board from the Chair.
- The SenLT are invited to participate in Board meetings on an agreed schedule throughout 2025 where they can directly respond to Board questions relating to performance data and related action status/ recommendations.
- In addition to the Minutes of Board meetings, a Board Meeting Action Item Tracker has been established. The tracker will display the agreed SMART actions from the Board meeting and will be updated by the relevant parties, including the Executive with progress/challenges reviewed at each Board meeting. The Board action tracker will facilitate the monitoring of the action status and any potential impediments that require further attention.

<u>Strategic Planning</u>

- The Board has assigned two members to join the executive to provide oversight to the final steps in the strategic plan 2025-2030.January 2025.
- A corporate planning event in support of the strategic Plan 2025-2030 is scheduled for March 2025, where all stakeholders are invited to the transformation and planning event. The event will incorporate a review of the Annual Reports and compliance status and the related action plans
- The organisational governance and management plan 2024 is updated by the Senior Leadership Team with review at scheduled meetings by Board of Directors, of 37 action 26 were completed in December 2024.
- The Business Plan 2025, consisting of SMART objectives, was approved by the Board on 19th December 2024, the Plan encompasses the remaining

outstanding actions from the Governance and Management Plan 2024 and its progress will be monitored quarterly by the SenLT and Board.

Senior Leadership Team

- Update from the previous Board meeting is a formalised standing agenda item by CEO for SenLT meeting, where decisions/ actions and related objectives will be agreed. (December 2024).
- A schedule of meetings to review key performance indicators and related actions is implemented for 2025 where the data and analysis is reviewed by the Senior Leadership Team (SenLT), the Quality and Risk Management Committee (QRMC – a Board led committee) and the Board.
- An SMART action tracker for SenLT is established where identified actions are monitored at monthly meetings and adapted/completed as required.
- A new post of Operations Director (OD) has been established from September 2024, responsible for the leadership, management and development of services ensuring the highest possible quality of service delivery. (See attached Org Chart Page 32).
- The SenLT will complete Individual Department objectives, reflecting quality initiatives and Business Plan 2025 which will be reviewed at SenLT meeting February 2025 and at individual 1:1 business meetings with CEO, to monitor progress and address potential challenges.

PPIM

- The OD has scheduled 1:1 business meetings with the SOMs/OMs/PPIMs where progress and shared problem solving is included in discussions. Updates from SenLT meetings are shared.
- Objectives for 2025, in line with the Business Plan 2025, have been agreed and are reviewed at the scheduled meetings.
- In September 2024, as part of the Provider's Governance & Management plan 2024 quantum of work for Senior Service Managers / PPIMS has been reassigned from 4 to 6 newly assigned posts responsibility for PPIMs new operational roles have been established to alleviate quantum of responsibilities, thereby enhancing the capacity for oversight and monitoring of services.
- The PPIM will carry out the induction for the PIC, the Operations Director will carry out inductions for PPIMs, and the assigned document is saved on the HR file. Effectiveness is monitored by two formal reviews at 3 months and 5 months. Thereafter, the Supervision and Performance Appraisal process will be followed by Line Manager and recorded on the HR file.
- PPIMS will attend a three-day training on the role of PPIM in March 2025. This training programme will be delivered by an external company.

Effectiveness will be monitored by Supervision and Performance Appraisal process.
- A resilience program for PPIMs is currently being sourced, pending feedback from current program as referred to under PIC initiatives below.

PIC

- The CEO delivered governance workshops to PICs/Deputy Managers to further enhance best practice and these workshops will continue to be scheduled throughout 2025. A total of 37 attended and a further 31 to attend. Workshops will be held in May 2025.
- The PPIM will manage and support the induction for the PIC, the Operations Director will carry out inductions for PPIMs, and the assigned document is saved on the HR file. Effectiveness is monitored by two formal reviews at 3 months and 5 months. Thereafter, the Supervision and Performance Appraisal process is followed by Line Manager and recorded on the HR file.
- Enhancement of PPIM Governance and Management oversight of designated centres each quarter will include; unannounced site visit, 1:1 business/support meeting, governance assurance meetings. Records of the business/support meeting and governance assurance meetings, are stored on the providers CID. Unannounced site visits do not require a report, however, should concerns arise, appropriate action will be taken. Visits are recorded in the Visitors Sign In book.
- The development and implementation of QA Framework inclusive of interactive toolkit, scheduled for completion 2nd quarter, 2025. This is currently being developed in line with HIQA National Standards under 8 themes. Its purpose is to link the individual regulation with each standard and identify documentation required as a guidance and support to PIC This is being done in conjunction with the SenLT.
- PIC are currently undertaking a Resilience Program (commenced June 2025).
- A manager's Handbook is currently under design as an HR led initiative and scheduled for completion in Q2.

Interdepartmental Quality Improvement Initiatives.

- The provider will develop and implement an overarching Service Improvement Plan (SIP) 2025 and its monitoring for progress and effectiveness in response to the escalation program. 31.12.24

- Ongoing scheduled planning meetings for 2025 with the funders in identifying our financial capacity to provide safe and effective support and future planning to meet the changing needs of residents.
- The Provider has established a Housing Committee that is working collaboratively with relevant stakeholder to strengthen access to appropriate housing.
- PBS Framework Development as incorporated within MDT key responsibilities. (See regulation 7 regulation 8 for details)
- Maintenance and Facilities Department has been restructured to include additional resource and oversight to include additional maintenance staff see department structure chart. Appendix 4.
- The provider has appointed a specific role of Senior Social Work Safeguarding Liaison Officer in September 2024, to enhance governance and oversight of safeguarding protection.
- The Provider has conducted an annual consultation exercise (ACE) in November 2024. A report and related action plans will be disseminated in February 2025. ACE is an Annual Consultation Exercise conducted with residents to elicit their views on the quality of service delivery by the Provider. The findings are shared throughout the organisation and where required, an action plan will be taken to address any gaps locally.
- A review of the provider audit system and process was completed in June 2024.

A review in capability and skill was included and a restructuring of the department addressed identified deficits. An oversight structure is established, supported by the enhanced access through the implementation of an IT audit management system that is accessible, providing effective and efficient oversight, 31.01.25.

- An increase from annual to biannual medication audits at provider level will be conducted in 2025 in all designated centres in addition to current local medication audits and checks. An external allied healthcare professional will conduct one of these audits for all designated centres. The findings, action plans and timelines will be processed through an online auditing application.
- Implementation of a Regulatory Themed Self Audit schedule within designated centres to commence 2nd quarter 2025 in addition to current provider audits. These audits will be carried out by the PIC/DSM. The findings, action plans and timelines will be processed through an online auditing application.

- Additional resource to support an enhanced focus on recruitment is in place. Additional 1 WTE resource has been assigned to the Recruitment Officer which has improved the speed of the recruitment process.
- Recruitment and retention plan is in place and will continue as a priority for the providers Business Plan for 2025.
- In 2024, members of the Human Rights Committee provided learning sessions in 2 designated centres and one Area/Cluster. In 2025, an eLearning Restricted Practices module will be delivered to all staff working in designated centres. This training will commence in Q2.
- SHS Restrictive Practice Policy has been reviewed and implemented, September 2024. The Restrictive Practice Policy was reviewed by MDT Lead and QCT Manager. The Provider is assured of its implementation through the Human Rights Committee and governance and assurance processes with PPIM and PIC.

Regulation 15: Staffing	**Judgment: Not Compliant**

The following additional actions were undertaken during 2024 to address staffing challenges:

Retention of staff

In support of PIC development, a resilience programme involving close support and systems reviews commenced in 2024 to run in two phases from 2024 to 2026. Each programme runs for 12 months. The programme is based on Emotional Intelligence (EI) assessment, personal development (self awareness, self regulation) in EI and applicability to workplace challenges (establishing healthy boundaries), the subphases include individual coaching, group coaching support and building of internal ongoing support network across participants. In phase 1, 13 PICs of designated centres are currently participating and in Phase 2, the remaining 15 PICs will participate in the programme. This programme is run by an external provider, and is individually tailored to each PIC. The purpose is to enhance the resilience resources of the PICs, provide a resilience framework of reference and to support their focus on the resilience of their teams. Phase 1 commenced in June 2024 and runs for 12 months. Phase 2 will be completed by June 2026.

Restructure of Team Roles

A general operational management restructure and additional resourcing of management has been undertaken. HR Team also restructured to support service specific this recruitment and retention.

Key initiatives delivered in Recruitment during 2024

Sourcing and Marketing

- SHS is across 9 key social media and recruiting channels; Branding work was undertaken for adverts and public documentation Third Level Education Placements: 19 third level student course placements were undertaken in 2024. There was 11.57% vacancy rate across all disciplines at the end of Dec 2024.
- The Provider recruitment function identified and commenced implementing a number of strategy initiatives beginning in Q3 2024 and running to end 2025:
    - Resourcing the recruitment administration process to enhance processing throughput, Aug 2024
    - Creation of the Organisation Capability role in HR Team to enhance gap analysis/prioritisation/competency mix assessments and planning. This is monitored by the Senior Leadership Team, Oct 2024
    - Joint branding initiative with a sector representative group and the Funder. The purpose of this is to attract a wider candidate pool and guide candidates to the Provider recruitment web page, Q2 2025
    - Securing higher visibility and duration of visibility in online recruitment platform presence, Q1 2025
    - Internal information IT system enhancements development to enhance workforce planning/Work Roster Management/ Agency Staff Monitoring/Applicant Tracking and qualification of application/CV processing/distribution, Q4 2025
    - Participating additional recruitment fairs Q1 2025

- An interdepartmental working group on staffing was established to review challenges to recruitment in designated centres where there are high levels of agency staff, commenced 8th July 2024. A Staff Establishment and a Cost Containment group was established and is chaired by the CEO and will continue to meet quarterly.
- Open roles have been advertised on social media platforms and have been emailed internally to all staff.
- Centres which had specific term purpose open vacancies are using regular agency staff, this has provided consistency to the residents. All agency staff receive induction, including specific location training. The PIC of each designated centre is responsible for ensuring the centre has an induction folder and the agency staff has reviewed this folder.

- In unusual / emergency circumstances where agency is unknown to the residents all efforts are made to introduce agency staff to residences by familiar staff.
- Centres have induction folders in place that Agency staff will review the needs of the residents, agency staff are also set up on the providers database so they will record reports and incidents for residents to ensure accurate information is passed on. The PIC of each designated centre is responsible for ensuring the centre has an induction folder and the agency staff has reviewed this folder.
- The provider is committed in providing the residents with consistency and continuity in staffing, where centres have open roles, where feasible regular agency staff are allocated to these roles.
- All mandatory training is scheduled for new employees prior to commencing employment. Training compliance is monitored by the PIC throughout the year. Additional training sessions will be added to meet the learning and development needs of staff as required in 2025. PPIM as part of their governance assurance meetings discuss staff training records each quarter with the PIC. QCT department carry out quarterly and annual reports on training compliance, and this information is shared with the PPIMs and improvements are made where required.

Regulation 5: Individual assessment and personal plan	**Judgment: Not Compliant**

- A keyworker training programme will be developed and rolled out by the end of the second quarter 2025 for all key worker staff in designated centres. This will be delivered internally by the Quality co-ordinator.
- Special interest group with task of standardisation of all documents for Q2 2025. A Senior Operations Manager has been assigned to lead this group. The overall objective of the SIG is to ensure that all client-related documentation is centralised and standardised across the organisation. This will enhance the efficiency and effectiveness and consistency of documentation and reduce the risk of using unapproved materials. Achieving this goal will involve completing the prescribed documentation templates, as outlined by the Quality Assurance Framework, and removing any non-essential documentation from circulation. The timeframe for completion of this project may vary due to the volume of documentation, however an initial estimate referenced in the Providers business plan is the 31st June 2025. Should the timeframe require an extension this will be reflected in an updated TOR / the Providers business plan on or before 31st June 2025.
- The development and implementation of QA Framework inclusive of interactive toolkit, scheduled for completion 2nd quarter, 2025.
- Audits of resident's documentation completed by PIC bi-annually (or more frequently if required). Audits of the Resident's personal profile documentation

will be completed by the Key Worker and PIC using the personal profile checklist.
- A PIC handover document has been developed to enhance continuity of service provision. This will be implemented by the PPIM should a PIC resign from their post and reviewed prior to their end date.
- The compatibility assessment tool has been further developed by the MDT in conjunction with Operations in March 2024. This will be used for new vacancies within the designated centre.
- All transition plans are now centralised through the internal referrals committee in November 2024.
- A Clinical Case Review (CCR) process has been developed and implemented with scheduled meetings as required with all relevant stakeholders. Work flowchart has been amended to include the PIC.

Regulation 7: Positive behaviour support	**Judgment: Not Compliant**

- The Provider commissioned the development of a person-centred positive behaviour training programme to enhance our existing positive behaviour support programme.
- SHS will commence a Restrictive Practice awareness campaign in conjunction with the Human Rights Committee throughout 2025.
- The practice of night checks is under continuous review and risk assessment where the least restrictive support will be applied in consultation with the resident, and the Human Rights Committee. In line with best practice underpinned by a Human Rights based approach using the FREDA principles.
- To date 127 staff members have completed the Positive Behaviour Support (PBS) framework training. 20 staff have received Autism specific training. 425 staff to include PICs, DSM and Frontline staff, will complete PBS Training by end of 2025. 32 training sessions will be facilitated by Behaviour Support Practitioner from January-December 2025
- There are 32 sessions of the new PBS framework training planned for 2025 this is available to the Workforce. Each session will accommodate up to 15 participants.
- The PBS Dept will continue to support and offer PBS specialised training across all designated centres as needed.
- An additional Positive Behaviour Specialist is joining the PBS Dept in February 2025.
- There is a robust plan in place to identify and prioritise PBS needs. A live traffic light system is being implemented in locations by 28th Feb 2025. This

will include all PBS plans that are in each specific location and their review dates. The tracker will be the responsibility of PICS/Identified PBS Team member it is live and will be monitored by the said locations. The provider is currently reviewing the referral process on The Central Information Database (CID) including clarifying the referral responsibilities of each PBS team member. This updated process will be in place by the 31/03/2025

- The Provider has commenced a process of sourcing a forensic specialist to review residents support plans who require specialist support in this area. In the interim the Provider has engaged external consultation as required. The Provider has engaged with an external Psychologists Service to further review and assess associated risks identified by the Provider. Assessments will be completed by the external psychologist with each identified resident. These assessments will be informed by observations, review of files and liaising with the PIC and staff teams.
- MDT Lead is supporting and communicating with the external psychologist for all assessments and has devised a Term of Engagement form to be completed.

Regulation 8: Protection	**Judgment: Not Compliant**

- New robust Safeguarding systems have been implemented by the National Safeguarding Team namely "Safeguarding Portal" this works in conjunction with The Providers internal system. The Providers Senior Social Work Safeguarding Liaison Officer has requested National Safeguarding team to support the Providers inhouse training with PICs/PPIMs. This training will support the completion of submitting a Safeguarding concern to the National Safeguarding Portal and is due to commence on 27th January 2025. The Providers Senior Social Work Safeguarding Liaison Officer has communicated with all Designated Officers/PICs to assure that all DOs/PICs have registered on the National Safeguarding Portal. The Provider has also contacted the National Safeguarding office requesting a list of all registered Providers DOs on their portal.
- The Provider has reviewed and updated the Safeguarding Policy (October 2024) with additional appendices, of robust processes and systems put in place to support all Safeguarding within all the Providers Departments.
- A Senior Social Work Safeguarding Officer has been recruited by the Provider to oversee all Safeguarding and implemented robust plans on 09/12/2024. The Providers Senior Social Work Safeguarding Liaison Officer is implementing training in order to streamline the Safeguarding plans' process with all DOs. The Safeguarding workflows are monitored and overseen by the use of a live tracker.
  The Provider is currently reviewing technical changes to our CID platform which will provide more oversight of Safeguarding plans and ensure actions have been

completed and closed, within appropriate timelines. The implementation of these plans are due by end February 2025.

- The Safeguarding Officer continues to complete in-house Safeguarding training with all PIC/Deputy Manager to date 4 sessions have taken place with capacity for 12. To date 30 participants have attended this training. Additional dates will be provided for March 2025 for the remaining 15 PICs/DSMs to undertake this training.
- The Provider has implemented Safeguarding reporting structures. The Provider's Safeguarding Officer provides reports to the Provider's Board of Directors/Senior Management Team on a monthly, quarterly and annually basis. Included in these reports are the related data and analysis relating to Safeguarding. The Quality and Risk Monitoring Committee is chaired by a Board member. The Safeguarding report is discussed, and an analysis of the findings and action plan is presented, reviewed and discussed by the committee. The Chair then provides an update to the Board, agreement on the proposed actions will be minuted and the Senior Leadership Team will be notified of any changes or queries.
- The Provider has commissioned an Annual Safeguarding Position Report for 2023 which will be continued annually going forward to provide continual analysis, inform learning and to devise an action plan for the organisation to continue to strive to improve Safeguarding within the organisation. This report is compiled by the MDT Lead and Senior Social Work Safeguarding Liaison Officer. The report contains a summary of actions implemented throughout the year, which is monitored by the Senior Leadership Team.
- The Provider has recently employed a second Social Worker within the Social Work Department. The Provider backfilled an open vacancy in the Social Work department which now provides sufficient social work support.
- The Provider's MDT Lead and Social Work Department have met and will continue to meet with the Safeguarding Principal Social Worker from the National Safeguarding Team and their team, to review SHS Safeguarding statistics and advocate for change on supports relating to Safeguarding within SHS. These meetings take place quarterly, next due to take place 23rd Jan 2025. Our most recent meeting took place on the 23rd September 2024 and feedback provided by the National Safeguarding Team was as follows:
    - The Provider has developed a Friendships, Relationship and Sexuality Educational programme this has been delivered to PICs/Deputy Managers. The programme is called "Time To Talk". The training schedule for all staff is established for 2025. Residents will be offered Time To Talk Training commencing end of Feb 2025.
- RUA (Relationship Understanding Awareness Programme) will commence February 2025 and will provide peer to peer educational programmes across

the Provider's services. Residents will be offered Time To Talk Training commencing end of Feb 2025. Two staff qualified in RUA training will deliver this programme 2 days per month. Topics of discussion will include Identity /Consent/Friendships/Relationships and Sexuality.

- The Provider has formal liaison with the National Safeguarding Team Social Work team who have acknowledged and confirmed on 27/09/2024 that the Providers increase in submissions of Preliminary Screening Forms (PSF1) is positive and evidences a growing culture of adult safeguarding within the organisation. The National Safeguarding Team confirmed on 03/12/2024 all the Providers PSF's submissions are consistent and matching of their records.

Section 2:

Regulations to be complied with

The registered provider has failed to comply with the following regulation(s).

Regulation	Judgment	Date to be complied with
Regulation 23	Not compliant	31 December 2025
Regulation 15	Not compliant	31 December 2025
Regulation 5	Not compliant	31 December 2025
Regulation 7	Not compliant	31 December 2025
Regulation 8	Not compliant	31 December 2025

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