Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	Sylvan Services
Name of provider:	Ability West
Address of centre:	Galway
Type of inspection:	Unannounced
Date of inspection:	19 August 2025
Centre ID:	OSV-0001485
Fieldwork ID:	MON-0047940

About the designated centre

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

Sylvan Services is a designated centre providing respite and residential care for up to nine male and female adults, who are over the age of 18 years, and who have a disability. Residents have various degrees of support needs, ranging from minimum to high, which may include co-morbidity. Sylvan Services comprises of two houses which are located a short distance from each other in residential settings on the outskirts of a city. The houses are centrally located and close to amenities such as shops, restaurants, public transport, pharmacists and churches, which are comfortably furnished, and provide residents with outdoor garden areas. Staff are on duty both day and night in each house, to support these residents.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	7

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 19 August 2025	10:00hrs to 14:00hrs	Anne Marie Byrne	Lead

What residents told us and what inspectors observed

This was an unannounced risk inspection that was carried out following receipt of unsolicited information by the Chief Inspector of Social Services. This information related to the safety of residents, supervision arrangements in this centre, and the management and response to incidents in the centre. This was a focused inspection which looked at the specific regulations associated with the unsolicited information received. Overall, this inspection did find that incidents pertaining to these concerns had occurred in this centre; however, the provider had responded to these and had implemented a number of measures to maintain oversight of re-occurrence. Although fire precautions were not intended to be incorporated as part of this inspection, due to concerns found by the inspector over the course of this inspection, this regulation was also reviewed, resulting in an immediate action being given to the provider in relation to fire containment arrangements. This, along with the other findings of this inspection will be discussed in further detail later on in the report.

The inspection was facilitated by the person in charge and a team leader. The inspector had the opportunity to briefly meet one of the residents who was being supported to have their day service in the comfort of their home, and with two staff also present at the centre. Due to the assessed communication needs of this resident, they didn't engage directly with the inspector, but did greet them. They were in the process of finishing their morning exercises when the inspector arrived, and later headed out with their supporting staff. This designated centre comprised of two houses, and were both visited by the inspector. As the unsolicited information received pertained to the care and support in one of these houses, most of this inspection was carried out at that house.

Here, two residents resided and had lived together for a number of years, and got on very well together. They were both quite socially active, and liked to get out and about regularly, and often headed out together. They liked to go for walks, to head out to nearby coastal attractions, and liked to do a small bit of shopping from time to time. One of them attended day services out in the community, while the other had a wrap around service. Although these residents did require staff support to maintain their active lifestyles, most of their care and support needs were in relation to behavioural support and the management of identified risks, as they both presented with a significant risk of absconsion and both had specific risks associated with their dietary care needs. This required them each to have one-to-one staff support during day-time hours, with a waking staff member on duty each night. This was a bungalow house that comprised of resident bedrooms, en-suites, a shared bathroom, and a sensory room. The layout of this house allowed them to have their own kitchen, dining and living space; however, as they got on well together, the inspector was informed that they generally liked to spend time together in these areas. The second house was a two-storey dwelling that at the time of this inspection, was providing full-time residential care to four residents, with one respite bed also in use most nights. Similar to the other house, residents had their own

bedroom, shared bathrooms, and communal use of the general living areas. At the time of this inspection, there were upgrade works underway so as to provide these residents with a new dining area. Much of this house had been newly decorated since the last inspection, with the previous dining area now turned into a second sitting room for residents to use. The residents in this house were also very socially active, with sufficient transport and staffing arrangements in place to support them to do so.

As mentioned, the lines of enquiry for this inspection were primarily focused in one house, which included a review of the incidents that had occurred, the assessed dietary needs of both residents in that house, the staffing and supervision arrangements in place for both of these residents, along with the process for responding to unexplained bruising. Overall, this inspection found that the provider had been made aware all incidents that had occurred in this centre, had quickly responded to these, and had taken appropriate action through their own risk management system so as to monitor for re-occurrence. There was some improvement found to some aspects of the provider's risk assessment process; however, it is important to note that this did not have any negative impact on the quality and safety of care received by these residents.

The findings of this inspection will be discussed in the next two sections of this report.

Capacity and capability

There was a defined management structure in place in each house, which included two team leaders and a full compliment of staff. Team leaders regularly met with the person in charge to discuss any concerns relating to the care and support of residents. The person in charge also maintained regular contact with their line manager in overseeing all other operational matters. Regular team meetings were also occurring to discuss residents' care and support arrangements, and these were routinely attended by the person in charge. Although there were good local governance and management arrangements found to be in place, this inspection did identify where the provider had not adequately responded to the outcome of a fire assessment that was conducted in this centre in May 2025, so as to ensure interim measures were clearly identified, to mitigate against the risk to fire containment that this fire assessment clearly indicated.

Staffing levels in this centre were subject to on-going review, ensuring an adequate number of staff were at all times on duty to meet residents' assessed needs. Two of the residents who lived in this centre required one-to-one staff support during waking hours, and this was consistently provided.

The monitoring of the quality and safety of care in this centre was greatly enhanced by the capacity of the person in charge to be able attend the centre regularly each week. This provided them with the opportunity to meet with staff, their team

leaders, with the residents, and to be able to directly oversee the delivery of care. The person in charge maintained very frequent oversight and monitoring of all incidents that had occurred in this centre, to ensure a safe and good quality of service was delivered to these residents.

Regulation 14: Persons in charge

The person in charge held a full-time role and was present in the centre multiples times a week. They were very familiar with the needs of the residents, and with the operational needs of the service delivered to them. They were supported by two team leaders and their staff team in the running of this centre, and were also supported by their line manager in the managerial aspects of the service. They did have responsibility for two other designated centres operated by this provider; however, the current governance and management arrangements provided them with the capacity to ensure this service was effectively managed.

Judgment: Compliant

Regulation 15: Staffing

At the time of this inspection, the provider was operating with a full compliment of staff in both houses. Where additional staffing resources were required from time to time, the provider had arrangements in place for this. Some residents were assessed as requiring a specific level of staff support during the day, and the provider had ensured this was consistently available to them. A planned and actual staff roster was in place for each house, clearly indicating the full name of each staff member, and their start and finish times worked.

Judgment: Compliant

Regulation 23: Governance and management

The provider had suitable persons appointed to manage and oversee the running of this service, and also ensured that resources were made available to both houses to ensure residents' assessed needs were met. Although this inspection did identify many good practices, some areas in relation to the overall risk management of fire containment issues required review.

Through the completion of their own assessment of fire safety arrangements, the provider identified that a number of fire containment measures required upgrade works. Although the provider had plans for these to be addressed, they hadn't put

robust interim measures in place, to mitigate against and monitor for this risk to fire containment, until such a time as repair and upgrade works were completed in this centre.

Judgment: Substantially compliant

Quality and safety

There were good practices found with regards to the system for the assessment and personal planning of residents' needs, and also in relation to safeguarding arrangements. However, this inspection did find that significant improvement was required in relation to the response a risk that was known to the provider in relation to fire containment, with more minor improvements also required to the overall assessment of identified risks.

Regular fire drills were routinely conducted in both houses, and staff were consistently able to support all residents to evacuate in a timely manner. However, following a fire assessment that was conducted in May 2025 which identified a number of fire containment issues with multiple fire doors, an immediate action was required to be issued to the provider to review interim fire containment measures for both houses, until such a time as this fire containment issue was resolved.

Of the incidents which had occurred in this centre, local management were very aware of these and had implemented a number of response and monitoring measures. Where incidents relating to residents' safety, unexplained bruising, and non-adherence to resident supervision arrangements had happened, these were appropriately responded to by the provider and had not re-occurred for a number of months. There was good internal communication maintained in both houses about all incidents, which were discussed with staff at team meetings and daily handover, with the occurrence of some incidents resulting in local protocols being developed so as to further guide all staff on specific control measures that required to be consistently adhered to.

Regulation 26: Risk management procedures

There were specific risks associated with some of the residents that resided in this centre. Although these were well-known among staff and local management, some improvement was required in relation to the assessment of these risks, with similar findings found with regards to the assessment of some organisational risks.

For two residents, their assessed dietary needs presented a significant risk, should they have access to, and injest certain foods. An incident had occurred in relation to this a few months prior to this inspection, which was responded with additional

measures, was well communicated between all staff members, with no further reported incident of this re-occurring. However, the risk assessments associated with these specific dietary risks required additional review to ensure better clarification on the measures that were required to be implemented by staff daily to manage this risk.

In response to the specific incidents that had occurred in this centre in the months prior to this inspection, the person in charge routinely monitored risks pertaining to resident supervision arrangements, safeguarding, occurrence of unexplained bruising, and specific identified risks associated with residents care and support arrangements. Again, this level of monitoring had resulted in no similar incidents relating to these aspects of care re-occurring for a number of months. However, the risk assessments relating to these areas within the risk register required review to reflect the particular measures and monitoring arrangements that were routinely carried out in this centre in response to these risks. Furthermore, in response to the outcome of the fire safety assessment that was completed in May 2025, the fire safety assessment within this register had not been reviewed to incorporate any additional control measures to maintain this service safe, while upgrade works were awaiting completion. The risk-rating of this fire safety risk assessment had also not been reviewed to reflect the increased risk the outcome of this assessment posed to fire safety in this centre.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Not all aspects of this regulation were looked at as part of this inspection.

In May 2025, a fire assessment of both houses within this centre was completed. Each assessment identified a number of repair works required to multiple fire doors. Some doors were identified not to be closing properly, others had gaps in fire seals, and some required repair works to hinges. At the time of this inspection, the repair and upgrade works required to these fire doors had not commenced, and there was no commencement date yet identified. Since the issue with these fire doors was brought to the attention of the provider, they had not locally reviewed or defined what additional fire safety precautions needed to be taken on an interim basis, to mitigate against this fire containment risk that these fire doors now posed. An immediate action was given to the provider on the day of this inspection to address this, to include, clarification and definement of the additional measures that were to be carried out in both houses and assurances around the monitoring processes that would be implemented to oversee this. This was completed by close of this inspection.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

The provider had a system in place for the re-assessment of residents' needs on a regular basis, also ensuring their personal plans were updated, as and when required. The inspector reviewed the assessed needs of two particular residents over the course of this inspection, both whom had assessed dietary needs, and associated risks should they have access to certain foods. This was well-documented and well known, with their personal plans clearly outlining how these dietary needs were being met in the centre. Similarly, these two residents also had specific needs in relation to their personal safety, which required specific daily interventions to ensure they were maintained safe at all times. Again, this was clearly documented within their personal plans, and subject to on-going re-assessment.

Judgment: Compliant

Regulation 8: Protection

There were procedures in place to support staff in the identification, reporting, response and monitoring of any concerns relating to the safety and welfare of residents in this centre. Where incidents of unexplained bruising occurred in this centre, the provider had a system in place to ensure these were reviewed in line with their safeguarding procedures, and referred to the designated officer for review. They had also ensured that any safeguarding incident was notified to the Chief Inspector within the required timeframe. There was one safeguarding plan in place at the time of this inspection, which was maintained under regular review.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 23: Governance and management	Substantially compliant
Quality and safety	
Regulation 26: Risk management procedures	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Sylvan Services OSV-0001485

Inspection ID: MON-0047940

Date of inspection: 19/08/2025

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 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
Fire Containment Protocol Introduced:
A comprehensive interim Fire Containment Protocol was developed immediately following the inspection.
This protocol outlines interim fire safety measures, including:
Fire door management; All internal doors to be closed at all times unless in active use. Staff to ensure to close all fire doors to slow the spread of fire. Closing doors is a containment measure, providing critical time for evacuation.
FLEX to be submitted if any additional decline of the fire doors ,status update on a commencement date for repair of fire doors to be submitted via FLEX weekly.
All electrical appliance not in use, must be unplugged
No phone, tablets, laptops or any devices is permitted when retiring to bed, all charges to be unplugged at night.
Dryer not to be used, during lone working hours (night duty)
Extension leads not to be overloaded and all plugs and appliances are in good condition.
All staff to ensure fire risk register is completed and any issues identified, require a FLEX (major) and escalated to ancillary services and senior management.
All staff have received and signed this protocol.
Fire safety risk rating has been escalated to 'High - Orange' to reflect its critical nature.
Staff Training and Communication:
All updated protocols and risk assessments were reviewed during staff meetings and distributed to all team members for signing and acknowledgement (meeting held 26/08/2025).
Completed; 26th August 2025.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
Actions Taken:
Review and Update of Risk Assessments:
All individual risk assessments relating to residents' care, including dietary needs, safeguarding concerns, and supervision arrangements, have been reviewed and updated.
Specific attention was given to the dietary risks for two residents with food allergies. A new protocol was developed, implemented and signed by all staff.
The protocol clearly outlines prevention strategies, emergency responses and daily responsibilities of staff to mitigate this risk.
Increased Monitoring and Communication:
All identified incidents (e.g. bruising, non-adherence to supervision) were investigated, protocols introduced and no reoccurrence has been noted since.
Risk assessments have been updated to reflect real-time monitoring practices already in place.
Staff are briefed regularly through daily handovers and team meetings.
Risk Register Updated:
The centre risk register has been reviewed and updated to accurately reflect all current risks, with detailed control measures documented.
Fire safety risk rating has been escalated to 'High - Orange' to reflect its critical nature.
Staff Training and Communication:
All updated protocols and risk assessments were reviewed during staff meetings and distributed to all team members for signing and acknowledgement (meeting held 26/08/2025).
Completed; 26th August 2025.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Actions Taken: Fire Containment Protocol Introduced:
A comprehensive interim Fire Containment Protocol was developed immediately following the inspection.
This protocol outlines interim fire safety measures, including:
Fire door management; All internal doors to be closed at all times unless in active use. Staff to ensure to close all fire doors to slow the spread of fire. Closing doors is a containment measure, providing critical time for evacuation.
FLEX to be submitted if any additional decline of the fire doors and a status update to be submitted via FLEX weekly.
All electrical appliance not in use, must be unplugged

No phone, tablets, laptops or any devices is permitted when retiring to bed, all charges to be unplugged at night.
Dryer not to be used, during lone working hours (night duty)
Extension leads not to be overloaded and all plugs and appliances are in good condition.
All staff to ensure fire risk register is completed and any issues identified, require a FLEX (major) and escalated to ancillary services and senior management.
All staff have received and signed this protocol.
Fire Risk Assessment Updated:
The fire risk assessment has been updated to reflect the findings of the May 2025 fire door inspection.
Risk level escalated in the register to "High - Orange" due to fire door defects.
Engagement with Ancillary Services:
Email sent to ancillary services requesting urgent confirmation of commencement date for fire door upgrade works.
Specific priority was requested for the kitchen x2 doors and office door due to their essential role in fire containment.
Follow-up initiated to ensure tracking of progress and contractor scheduling.
CEEP Updated:
The Centre Emergency Evacuation Plan (CEEP) was reviewed and revised to ensure that current fire containment concerns are accounted for.
Evacuation plans revised based on current risks and staff roles clearly defined.
Fire Drills Conducted:
Three fire drills were conducted since the HIQA inspection in both houses.
All drills were in line with the updated containment protocol and drill outcomes were documented and reviewed.
Improvements from drills were discussed in team meetings and reflected in updated procedures.
Resident Involvement:
Fire containment protocols and evacuation information were discussed at weekly service user house meetings.
Residents were supported in understanding their role in fire drills and safety awareness.

Completed ;20th August 2025.
Proposed Date for repair of fire doors 20th October 2025

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Substantially Compliant	Yellow	26/08/2025
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Substantially Compliant	Yellow	20/08/2025
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for	Not Compliant	Red	20/10/2025

	detecting, containing and extinguishing fires.			