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:	No 11 Ard Na Greine
Name of provider:	Peter Bradley Foundation CLG
Address of centre:	Cork
Type of inspection:	Unannounced
Date of inspection:	20 May 2025
Centre ID:	OSV-0001522
Fieldwork ID:	MON-0046778

About the designated centre

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

No 11 Ard Na Greine consists of a detached dormer bungalow located in a small town. This designated centre provides a residential neuro-rehabilitation service for five residents with an acquired brain injury. Both male and females over the age of 18 can avail of the centre. Each resident has their own bedroom and other rooms in the centre include bathrooms, kitchen/dining areas, sitting or living rooms and staff rooms. Residents are supported by the person in charge, team leaders and rehabilitation assistants.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	5

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Tuesday 20 May 2025	09:05hrs to 16:15hrs	Robert Hennessy	Lead

What residents told us and what inspectors observed

Five residents resided in the designated centre on the day of inspection. The centre was registered for five residents and was at capacity on the day. The centre was on the outskirts of a small town. From what the inspector observed and from speaking to staff and management, the residents were receiving good care and support in this centre. All five residents were met during the inspection and three of the residents spoke with the inspector in detail.

When the inspector arrived at the centre the residents were undertaking their morning routines. The inspector met with the person in charge in an outdoor area that residents could use for various activities. Residents were undertaking their activities with support from residents in an unhurried and respectful manner.

After the initially speaking with the person in charge a walk around of the designated centre was conducted. There had been recent improvements in the premises with a outdoor pod for activities for residents. One resident's bedroom had been renovated and extended and this worked well for them as they required more space. There was new flooring throughout the designated centre. Information on safeguarding and advocacy was on display for residents throughout the centre. The residents' bedrooms were personalised with items that were important to the residents, such as CDs, DVDs and puzzle books. Two fire doors in the centre were seen not to be operating correctly this is discussed under Regulation 17.

Staff members were seen to be supporting residents with their activities such as going swimming with them and other staff in the centre were seen playing cards with another resident when they returned to the centre following their activities. Staff members that spoke with the inspector were knowledgeable in how to support the residents and appeared to know them well. Staff were seen and heard to be friendly and respectful towards the residents at all times during the day.

The inspector spoke to three residents for a time. One residents spoke of the diary they kept and how they were able to keep track of what they had done throughout the day. Staff reported that this was helpful when discussing activities that they had completed with the resident. One residents spoke of how busy there were and how they were part of two choir groups. One of these choir groups was performing in a large shopping later in the week and the resident was really looking forward to this. All residents spoken with said they were looked after well by staff and were very happy living in the designated centre.

The next two sections of the report present the findings of this inspection in relation to the governance and management arrangements in place in the centre, and how these arrangements impacted on the quality and safety of the service being delivered.

Capacity and capability

Management systems in place in this centre were ensuring that overall the services being provided were safe and appropriate to residents' needs. This inspection found that the management and staff team in place in the centre were familiar with the residents living in the centre and were committed to providing an effective service that met their assessed needs. There was a clear management structure present and overall there was evidence that the management of this centre were maintaining oversight and that these individuals maintained a strong presence in the centre. However, an unannounced provider visit required by the regulations had not taken place in the previous six months.

The person in charge had ensured that the staff team had received appropriate training to meet the needs of the residents. There was evidence of the training programme being monitored to ensure that the staff team remained up to date with training. There was a supervision schedule in place for staff. The staff team had access to the regulatory and legal information that they may require for their roles through an online platform.

Staffing levels were maintained in the centre to ensure the residents could be supported to undertake the activities they wanted. Residents said they received good support from the staff. The staff team were knowledgeable of the residents' needs when they spoke with the inspector.

Regulation 15: Staffing

Staffing levels were maintained at appropriate level to the number and the assessed needs of the residents and the layout of the centre. The staffing levels also corresponded to the staffing levels described in the statement of purpose. A planned and actual staffing rota was available on the day of the inspection. Staff spoken with on the day were very familiar with the residents' needs and spoke about them in a respectful manner. Residents were seen to be comfortable with staff for example staff were playing a game of cards with a resident in the dining area. The staffing levels on the day of the inspection allowed residents to undertake their activities that they had planned that day.

Judgment: Compliant

Regulation 16: Training and staff development

Training was being undertaken by staff in the centre that was required for the residents' needs. The inspector viewed the training matrix for the designated centre which tracked the training undertaken by the staff. It was evident from this training matrix that the person in charge had maintained oversight of the training needs of the staff.

A schedule for staff supervision was maintained and this was provided to the inspector. The schedule showed that supervision had begun for the year and that there was a schedule to complete regular staff supervision sessions throughout the year.

Staff were asked how they might access relevant legislative and guidance documents, they explained they could do so online and had access to this at work.

Judgment: Compliant

Regulation 23: Governance and management

The most recent annual review had been completed in May 2024. This was a thorough review of the quality of service provided to the residents. This report was made available to the inspector. The review contained surveys completed by the residents which were very positive.

The designated centre had staff meetings once a month which discussed the safeguarding of the residents. These meetings also discussed restrictive practices in the centre.

Resident's meetings were also taking place once a month in the designated centre where again safeguarding was discussed as a topic.

This regulation requires that the registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least every six months. The latest unannounced visit had been completed in July 2024 which was 10 months prior to the inspection. The person in charge informed the inspector that the next unannounced visit was expected to take place soon after the inspection.

Judgment: Substantially compliant

Quality and safety

There were no safeguarding concerns in the centre on the day of the inspection. Staff were aware of how to deal safeguarding issues in the centre. It was evident

that previous safeguarding concerns in the centre had been taken into account when creating the positive behaviour support plans for the residents.

The person in charge had ensured there were relevant assessments undertaken and personal plans in place for the residents. These were reviewed in a timely manner. These plans contained information on residents' needs in relation to healthcare and also on how they communicate and how they liked to be communicated with.

Residents' rights were respected and upheld in the centre and the centre was resident led in the way it was run. Residents had goals for the year created and these goals were realistic and reviewed. Risk was well managed in the centre and measures were in place for safeguarding of residents. Residents had positive behaviour support plans in place when they required support in this area.

In relation to the premises two fire doors required repair, the person in charge was aware of this and a fire safety person visited the centre on the day of the inspection to assess the repairs needed.

Regulation 10: Communication

Residents' personal plans contained information on how the residents communicated. These plans also contained information on how residents liked to be communicated with.

Residents had access and were using smart devices on the day of the inspection such as tablet devices, speakers and televisions. One resident had an assistive device for speech. The resident did not currently use this device but was available to them if they needed it. Staff working with the residents knew how the residents communicated and gave them time to let them communicate and comprehend what was being said. This was done in a respectful manner.

Residents were given information on safeguarding with this information being discussed at residents' meetings and also information was available in easy to read format throughout the centre.

Judgment: Compliant

Regulation 17: Premises

The registered provider had ensured that the premises was centrally located to ensure that residents had access to local amenities and services. There was adequate communal and private space for residents. One resident had their bedroom adapted and there was extra space for this resident to mobilise while in there. Improvements had been made throughout the centre with flooring being

replaced and a new outdoor pod provided the residents with more communal space to undertake activities.

Two fire doors in the centre were not operating correctly on the day and required attention. The fire safety person was seen in the centre assessing what was needed to complete these repairs.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

The risk register and individual residents' risks had been reviewed in the previous 12 months.

There was suitable risk management policy put in place by the registered provider which contained identified and contained the control measures for specified risks required under the regulation.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

Assessments and personal plans were viewed for three of the residents. Review of the personal plans had taken place in the last 12 months. There was evidence in the personal plans of multidisciplinary team involvement in supporting the residents throughout the year.

Residents healthcare needs were well supported and one residents who was undergoing changing healthcare conditions was being provided with suitable supports in this area.

Residents were undertaking activities on the day of inspection and were leaving the centre at different stages throughout the day. Staff spoke about booking a holiday for one of the residents for later in the summer and staff discussed the planning involved in the holiday. Residents had a mix of goals that involved both enjoyable activities and also ways of increasing the residents' independence. It was evident that these goals for the residents were being monitored and the achievements being documented.

Judgment: Compliant

Regulation 7: Positive behavioural support

There were no restrictive practices used in the centre on the day of the inspection. Staff were provided with training in the area of de-escalation and intervention when residents required this.

Positive behaviour support plans had been created for residents that required them. Three of these plans were viewed and they contained extensive information about how the resident may escalate and how strategies may be implemented to ensure residents engaged in positive behaviour.

Judgment: Compliant

Regulation 8: Protection

There were no safeguarding issues in the centre on the day of the inspection. All staff had received training in the area of safeguarding. The staff spoken with during the inspection were aware of abuses that may occur and how this should be dealt with. The organisations policy in relation to safeguarding was provided in an easy to read format.

Residents had intimate care plans to identify the supports the residents required in this area.

Staff members were seen to speak with residents in a kind and respectful manner. Staff were seen to be respectful of the residents' privacy and sought permission from residents when providing support to them.

Judgment: Compliant

Regulation 9: Residents' rights

Residents had a choice of activities available to them. There was adequate space in the centre for the residents to undertake their activities in private if they wished.

Residents had a meeting in the centre on a monthly basis. Residents discussed safeguarding and other topics during these meetings. Consent was evident in personal plans for the residents' intimate care. Residents had completed surveys which were incorporated into the service's annual review.

Residents were enabled to contribute to the management of their own finances. One resident had their family involved in managing their finances, but consent for this

was clear on the part of the resident. Staff reported that this never caused concern for the resident and they had enough money for their activities.
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 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Substantially compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for No 11 Ard Na Greine OSV-0001522

Inspection ID: MON-0046778

Date of inspection: 20/05/2025

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The provider is committed to ensuring the designated centre achieves full compliance with Regulation 23: Governance and Management.

The providers Quality and Safety Department has scheduled and will ensure completion of the required six-monthly unannounced visit by 30/06/2025. A follow up unannounced provider visit will be completed no less than 6 months later by 30/12/2025. The provider has introduced increased monitoring of compliance with Reg 23, led by the Quality Department, to ensure that unannounced visits occur within the required timeframe. Unannounced provider visits will be followed up with a comprehensive report including recommendations for service improvement. PIC will assign responsibility and timelines for all recommendations within 10 working days of receipt of the report. Progress will be monitored by PIC monthly with updates documented in the centres Quality improvement plan (QIP). All reports are available to residents, their families and the Chief Inspector as requested.

PIC is completing an annual review of Quality and Safety of care and support from 2024 with an action plan for 2025. Anonymous USPEQ surveys were completed by an external agency in March 2025. Results will inform the annual review and quality improvement priorities and will be shared with residents, families and staff once published. The Annual review will be available to residents, families and the Chief inspector from 01/07/2025. Key findings and a summary of the review will be included for discussion in the July residents and staff meetings.

PIC will continue to monitor staffing levels to ensure effective delivery of care and support in line with the designated centres Statement of Purpose (SOP). The SOP includes clearly defined management structures and a visual of the provider's organisational structure. The SOP is reviewed regularly and updated as required.

Staff Support & Supervision and Performance management schedules are in place. These meetings as well as Monthly Team Meetings, daily handover, employee engagement days and inclusion on provider committees provide opportunities for staff to raise any concerns in relation to the quality and safety of the care provided to residents. The provider actively encourages reporting of any concerns in line with its policies and procedures.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
The provider is committed to achieving compliance with Regulation 17: premises, ensuring that the design, layout and condition of the building continue to meet the needs of residents.
The premises underwent significant renovations in 2023, which greatly enhanced accessibility and improved communal spaces for residents. In June 2024, final bathroom upgrades were completed to further support accessibility and promote independence.
A regular maintenance schedule as well as Health & Safety, Fire safety & cleaning audits are in place for internal and external areas to ensure these are safe and well maintained. Any required actions identified through these processes are addressed promptly.

Assistive technology is provided for residents in line with individual needs, as identified through the quarterly individual rehabilitation plan review process, with input from the multidisciplinary clinical team. Support is available from the providers Create Team who assist residents to access and use digital assistive technology to support independence, communication, leisure and other suitable goals.

During a routine monthly fire drill, two fire doors were noted as not operating correctly. A fire safety technician was contacted and completed a site visit on 20.05.25. The technician recommended replacing the closing mechanisms. There has been a delay in sourcing the required parts and repairs are scheduled to be completed prior to 30.06.2025. Interim measures have been implemented to reduce any risk to staff and residents, and the issue has been recorded on the local risk register. Fire doors are manually checked and closed in all areas as part of nightly fire safety checklist.

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 17(4)	The registered provider shall ensure that such equipment and facilities as may be required for use by residents and staff shall be provided and maintained in good working order. Equipment and facilities shall be serviced and maintained regularly, and any repairs or replacements shall be carried out as quickly as possible so as to minimise disruption and inconvenience to residents.	Substantially Compliant	Yellow	30/06/2025
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least	Substantially Compliant	Yellow	18/07/2025

	once every six months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.			
Regulation 23(2)(b)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall maintain a copy of the report made under subparagraph (a) and make it available on request to residents and their representatives and the chief inspector.	Substantially Compliant	Yellow	18/07/2025