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:	The Comhar Centre
Name of provider:	St Joseph's Foundation
Address of centre:	Cork
Type of inspection:	Unannounced
Date of inspection:	25 February 2025
Centre ID:	OSV-0001816
Fieldwork ID:	MON-0046052

About the designated centre

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

The Comhar Centre is a detached purpose built one-storey building located in a town that provides support for a maximum of seven residents (six full-time residents and one respite resident). The centre can support residents of both genders, over the age of 18 with intellectual disabilities who may also have physical disabilities. Seven individual resident bedrooms are present in the centre along with two sitting rooms, a kitchen/dining room, bathrooms, a staff bedroom and an office. Support to residents is provided by the person in charge, social care workers and care assistants.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	6

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 25 February 2025	09:15hrs to 17:30hrs	Robert Hennessy	Lead
Tuesday 25 February 2025	09:15hrs to 17:30hrs	Lisa Redmond	Support

What residents told us and what inspectors observed

This was an unannounced inspection by two inspectors which was part of an overall focused programme of inspections for the registered provider. The last inspection of the designated centre took place in June 2023, good levels of compliance were found on that inspection. From what the inspectors observed residents were receiving good care and support in this centre.

The Comhar Centre is an eight bedroom house on the outskirts of the town. The centre is registered to support seven adult residents. There were six residents in the centre on the day of the inspector and the person in charge explained there was currently no plan for another resident to move into the centre. All six residents spoke with the inspectors. One resident had recently moved to the centre from another designated centre of the registered provider and explained to both inspectors that they were happy with the move. They told the inspectors that they liked their new home and it was easier to undertake their daily activities from this centre. The resident was seen to be comfortable in the presence of staff and other residents on the day.

One resident spoke with the inspectors about a recent shopping trip they had taken where they had brought new clothing. This resident told inspectors they liked to go shopping and showed an inspector some of their recent purchases. They also spoke about recent activities they had undertaken, such as going to the gym and attending a local coffee morning. The resident spoke about how varied their activities were from day to day. Residents were returning from activities outside the centre throughout the day.

Two residents returned from their computer course. Inspectors spoke with both residents. One of the residents spoke with an inspector in a quite area. They said to the inspector that the "house was not for them" and the house was "too noisy at night time". The resident told the inspector that they would like to live with fewer people and that this is part of their personal planning goals. Regular meetings were held with the resident about this and they told the inspector that they felt like they were being supported with this however, they did note that they were not aware of the progress of this. This resident did tell the inspector that they had two key workers and that they 'couldn't do anymore' for them.regarding the resident's transition. The resident did however explain that staff were supporting them to gain independence for example, cooking meal and attending educational classes. The inspector advised the person in charge of the resident's wish to make a complaint. This complaint was discussed with the person in charge and they explained that the registered provider was currently working on a plan for suitable alternative home.

One resident showed inspectors their bedroom. They had recently purchased a new bed and a chair where they could relax and watch their television. This resident attended a day service 4 days each week. The resident told inspectors that they had a day off from day service on the day of the inspection and that they planned to

complete some laundry. Later in the afternoon, the resident was observed going to access their local community independently.

The centre was being painted in areas during the inspection. The whole centre was being painted and one resident spoke to the inspector about the colours they had picked for their bedroom. The centre was functional and resident's bedrooms were decorated and furnished according to their wishes. The centre included accessible bathrooms for the residents. Residents had the choice whether they wanted to lock their bedrooms or not.

There was a staff meeting in progress as the inspectors arrived. The inspectors spoke to staff that had worked the previous night and all the staff that were working there during the day. Some of the staff explained that during a period where the centre was experiencing issues in safeguarding of residents they felt there was a lack of support form senior management and communication to staff working in the centre could be improved. The person involved in many of the safeguarding incidents had moved to another designated centre and staff reported that this had improved things. This had improved in the weeks leading up to the inspection as the person in charge had spent more time in the centre. The person in charge was seen having formal supervision sessions with staff members on the day of inspection.

Staff working with the residents on the day of the inspection were seen to be kind and respectful and supported them in a number of their preferred activities.

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

This centre is run by St Joseph's Foundation. Due to concerns in relation to overall compliance levels from inspections of St Joseph's Foundation's designated centres and other regulatory engagement throughout 2024, the Chief Inspector of Social Services is undertaking a targeted inspection programme in the provider's designated centres. All inspections conducted for the duration of this programme will be unannounced and will have a focus on specific regulations. These regulations are Regulation 5 Individualised assessment and personal plan, Regulation 7 Positive behavioural support, Regulation 8 Protection, Regulation 9 Residents' rights, Regulation 10 Communication, Regulation 16 Training and staff development, Regulation 23 Governance and management, Regulation 31 Notification of incidents, and Regulation 34 Complaints procedure. These regulations were reviewed on this inspection and this inspection report will outline the findings under each regulation.

Staffing rosters were examined for six weeks and found that they were suitable for the residents' need. Mandatory training was being completed and there was good

oversight of this. Staff supervisions had been planned and were being undertaken by the person in charge. There was a plan was in place to complete these over the next 12 months.

The person in charge was employed on an interim basis. They had a remit over other centres for the registered provider. This impacted on the oversight of some documentation, personal plans and the supporting of staff.

Incidents had been submitted to the office of the Chief Inspector as required by the regulations. Complaints were managed in line with the registered provider's policy.

Regulation 15: Staffing

Staffing levels were suitable for the size and layout of the centre and the skill mix was suitable to the needs of the residents. Staff rosters actual and planned were viewed for a period of six weeks. It was evident from these rosters that suitable staff levels were maintained as required. Relief staff were used in the centre when the permanent staff were unavailable. The relief staff were regularly working in the centre and knew the residents.

Staff files for four members of staff were reviewed. The registered provider had oversight of the documents as set out in Schedule 2 of the regulations. This included Garda vetting and two references from previous employers.

Inspectors met with all staff members working with the residents on the day and met with one staff member that was working nights with the resident. The staff working with the residents knew them well.

Judgment: Compliant

Regulation 16: Training and staff development

The staff training matrix for the centre was reviewed.The training matrix showed that staff were provided with training appropriate to their roles and that the person in charge was maintaining good oversight of the training needs of staff. Dates for further updates in training were provided. The training needs of staff were being appropriately considered and this meant that residents could be provided with safe and good quality care and support appropriate to their needs.

There was a plan in place for staff supervision to be completed this year for staff and supervision sessions were taking place in the centre on the day of the inspection.

Judgment: Compliant

Regulation 23: Governance and management

The management team of the centre had recently changed and there had been periods of time where local oversight had been impacted by changes in management. Staff in the centre told the inspector that more in person support was needed by the management team. The person in charge of the centre had other responsibilities with the registered provider. The person in charge was able to spend more time in the centre in the weeks after the inspection. It was identified in the registered providers six monthly audit that the person in charge was on an interim basis and a permanent person in charge was required by the centre.

Provider six monthly unannounced visits were occurring as appropriate and there was an auditing system in place. These unannounced visits are specifically required by the regulations and are intended to review the quality and safety of care and support provided to residents.

Some staff vacancies, including the person in charge role, was seen to have impacted on some aspects of the service such as oversight of some documentation, personal plans and delays in providing staff supervision.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

Inspectors reviewed the designated centre's incident log from 20 February 2025 to 06 January 2025. There was evidence of some disagreements between residents being documented in the incident log however it was evident that these were reviewed by the designated officer and where they did not meet the criteria for notification as an allegation of suspected abuse the rationale was clearly documented. There was no evidence of any incidents of suspected abuse that were not notified to the office of the chief inspector.

Judgment: Compliant

Regulation 34: Complaints procedure

An easy-to-read complaints procedure was located on the notice board in the centre. The details for the complaints officer was located there as well. There were no open complaints in the centre at the time of inspection. Previous complaints in

the centre had been recorded and managed within the centre's complaints procedure.

Judgment: Compliant

Quality and safety

While most residents appeared content in the centre, based on the inspectors observations and what was found during the inspection, further action was required to ensure residents were supported in line with their specific needs.

Residents' personal plans contained informative material in relation to communicating with the residents in a suitable manner. The personal plans had guidance on how to support residents but some of the personal plans and behaviour supports plans were inconsistent and some of the actions in these plans were not be implemented. This is discussed further under Regulation 5 and Regulation 7.

The registered provider was proactive in relation to allegations of abuse and had safeguarding plans in place for residents some of these plans including required review and updating as discussed under Regulation 8. Residents finances were not in line with residents rights that the registered provider had identified this as a restrictive practice and not in line with the registered providers resident's finance policy as outlined in Regulation 9.

Regulation 10: Communication

In the residents' personal plans viewed a communication profile document had been developed for each of the residents, which included details of how they communicate and how information should be communicated to them. Each resident had access to the Internet, television and smart devices. A number of residents told inspectors that they had mobile phones so they were able to keep in contact with family and friends.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

Inspectors reviewed the personal plans in place for plans for three residents. Residents' personal plans included information about their likes and dislikes and things they are proud that they have achieved. For one resident, this included

details of courses they had attended and skills they had developed including learning to cook independently and engaging in travel training. It also included as assessment of their personal, social and health care needs.

Residents had been supported to develop goals and these were linked to their likes and interests. One resident liked horses and in line with their goals had plans to go to the horse-racing. The resident spoke about this with inspectors and noted that they hadn't yet decided where they would go to see this. They also had plans to complete a first aid course and go for a shopping trip.

Areas which required attention in relation to residents personal plans included:

- It was not clear from the personal plans when they had been reviewed as the documentation was not properly dated, some documentation only stating the month of review and not the year. Assessments and goals in one personal plan had not be reviewed in the previous 12 months.
- One personal plan contained multiple documents in relation to reports from psychology assessments. These reports offered different guidance to staff. It was not clear which guidance that staff should be following when supporting the resident.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

A behaviour support plan had been put in place for one resident to support their anxiety and associated behaviours that were noted to impact on those they lived with. This plan was dated November 2022 and there was no evidence that this had been reviewed since this time. It was also identified that there three additional documents to support the resident with aspects of their behaviour support. These guidance documents included conflicting information on the strategies in place to support the resident. For example, one plan stated that the resident had two talk-time sessions with staff daily, while a second stated that the resident had a daily chat each morning with staff outlining the 'do's and don'ts in the centre. When this was raised with staff in the centre they noted that there were no talk time sessions completed with this resident as outlined in these documents.

A second resident's behaviour support plan had been developed in March 2024. This plan did not include details of any reactive strategies to support the resident in relation to behaviour that is challenging despite them having a PRN protocol which stated that they could have PRN medicines in response to behaviour that is challenging. It was also noted that this PRN protocol had some details of reactive strategies in place which were not outlined in the behaviour support plan.

Judgment: Not compliant

Regulation 8: Protection

The registered provider had developed a safeguarding policy which had been reviewed in October 2023. An easy-to read safeguarding policy was observed in the designated centre's hallway.

Residents were supported to develop an intimate care plan which outlined the supports they required to meet their personal hygiene needs, and where they had the skills to manage these without staff support. It was noted that the guidance in one resident's personal file regarding intimate care plan provided conflicting guidance on the levels of support the resident required in this area. This required review.

One resident spoke about their attendance at a money management course and how they had enjoyed this session.

For the most part, there was evidence of review and learning in response to allegations of suspected abuse in the centre. This included consultation with the organisation's designated officer and the development of a safeguarding plan. Inspectors were informed there were two open safeguarding plans in place in the centre and these were reviewed as part of the inspection. It was noted that one of these safeguarding plans was due to be reviewed in November 2024 however there was no evidence that this review had taken place. Inspectors requested to review documentation including the safeguarding plan in place following an additional allegation of abuse that had been reported to the chief inspector in February 2025. Staff members were unable to find this safeguarding plan and the associated documentation. As a result, inspectors were not assured that staff members had effective guidance to ensure the safeguarding of residents in response to this incident.

Judgment: Substantially compliant

Regulation 9: Residents' rights

On the day of inspection the residents were engaged in various activities throughout the day. The residents spoke with the inspectors on what activities and appointments they had during the day. For example, a resident spoke of a medical appointment they attended that day with the support of staff. The resident told inspectors that the staff member could support them to understand all the information involved, the resident said they were happy for this to happen.

Information from a resident's personal plan was stuck on the wall of the kitchen/dining room of the centre. This was removed by the person in charge when their attention was drawn to this.

A rights restriction logged identified a restriction regarding residents finances. Residents did not have direct access to their finances. Such arrangements were not consistent with the registered provider's policy on residents' finances. This policy stated that the registered provider would ''respect a resident's right to control their finances'' and was ''committed to supporting residents who use our services to use and manage their money''. However, given that the restrictions in place relating to residents' finances, improvements were required by the provider to come into compliance in relation to residents being able to exercise their legal rights around their finances.

Judgment: Substantially 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
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for The Comhar Centre OSV-0001816

Inspection ID: MON-0046052

Date of inspection: 25/02/2025

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 wishes to confirm that ongoing recruitment of staff is a priority for the organisation in particular for the roles of Persons in Charge. The Provider can confirm that currently it is on boarding a number of relief Social Care Workers. The PIC wishes to confirm that staff working in the centre have received at least 1 supervision year to date in 2025. The Provider does acknowledge the remit of the PIC in regard to other responsibilities, however notwithstanding this, the Provider wishes to assure the Chief Inspector that the PIC is on site at the centre on a regular basis to maintain its governance and oversight.	
Regulation 5: Individual assessment and personal plan	Substantially Compliant
Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan: The PIC wishes to assure the Chief Inspector that all personal plans now have the month and year on each assessment so that it is clear as to when the plans have been reviewed. The PIC can confirm that goals and assessments in regard to one of the Resident's personal plans has now being reviewed. Furthermore, regarding the personal plan that had multiple documents pertaining to psychology assessment, a scheduled date of April 25th has been assigned for this to be reviewed by Psychology in which clear guidance for staff will be outlined.	

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
The PIC acknowledges to acknowledge that one resident's Positive Behaviour Support Plan (PBSP) was out of date. The PIC can confirm that a full review of this PBSP will be carried out by Psychology with an expected completion date of April 25th 2025. In addition, a review of another Resident's PBSP will be carried out by Psychology to include reactive strategies and PRN protocol in response to behaviours that challenge.

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
The PIC wishes to confirm that all support plans have now been updated to reflect the current needs of the resident in question.
The PIC can also confirm that the safeguarding plan which was not reviewed in November 2024 has now been reviewed by Designated Officer.

Regarding an allegation of abuse which was reported to the Chief Inspector in February 2025, the Provider wishes to confirm that this incident was reviewed by the Designated Officer at the time and there is a PSF1 form on file in the centre.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
St Joseph's Foundation is actively reviewing its practices in terms of supporting residents managing and accessing their finances. This involves reviewing and updating the policies impacting our resident's, particularly our Finance and Restrictive Practices Policies, mindful of our responsibilities on implementing the assisted Decision- Making Act 2015 ad the Health act 2007.
The Foundation is also engaging with other service Providers, who have conducted reviews of their practices in order to share their learning.

The Foundation has also scheduled a meeting with the Local banks, to discuss more accessible options, which would uphold our resident right's to access their funds while ensuring safeguarding is considered.
Any new practice that is adopted will be in line with legalisation and best practice. It is envisaged that full implementation of changes to our current practice could take eight to ten months.

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)(b)	The registered provider shall ensure that there is a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.	Substantially Compliant	Yellow	31/07/2025
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Substantially Compliant	Yellow	25/04/2025
Regulation 05(6)(d)	The person in charge shall ensure that the	Substantially Compliant	Yellow	25/04/2025

	personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall take into account changes in circumstances and new developments.			
Regulation 05(8)	The person in charge shall ensure that the personal plan is amended in accordance with any changes recommended following a review carried out pursuant to paragraph (6).	Substantially Compliant	Yellow	25/04/2025
Regulation 07(3)	The registered provider shall ensure that where required, therapeutic interventions are implemented with the informed consent of each resident, or his or her representative, and are reviewed as part of the personal planning process.	Not Compliant	Orange	25/04/2025
Regulation 08(6)	The person in charge shall have safeguarding measures in place to ensure that staff providing personal intimate care to residents who	Substantially Compliant	Yellow	15/04/2025

	require such assistance do so in line with the resident's personal plan and in a manner that respects the resident's dignity and bodily integrity.			
Regulation 09(2)(c)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability can exercise his or her civil, political and legal rights.	Substantially Compliant	Yellow	31/12/2025