



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

## Issued by the Chief Inspector

|                            |                     |
|----------------------------|---------------------|
| Name of designated centre: | Teach Cairdeas      |
| Name of provider:          | St Hilda's Services |
| Address of centre:         | Westmeath           |
| Type of inspection:        | Announced           |
| Date of inspection:        | 07 October 2025     |
| Centre ID:                 | OSV-0001831         |
| Fieldwork ID:              | MON-0039948         |

## About the designated centre

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

Teach Cairdeas designated centre run by St. Hilda's provides services to five adults whose primary diagnosis is an intellectual disability who have a level of independence such that waking night cover is not required. The service can accommodate those with a range of medical and physical issues. Teach Cairdeas is a seven day service. Residents generally attend day services during the day and in cases of short term illness arrangements are made for residents to return home. The service has fixed and planned dates for closures throughout the year in line with the operations of the day service. There is one sleepover staff at night and a second staff for hours each day. Teach Cairdeas consists of five double bedrooms and one single bedroom with a combined kitchen and dining area with a separate sitting room and it is located in large town with easy access to all amenities. Residents avail of organised transport for day services and local bus services and taxis outside of these times.

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

|  |   |
|--|---|
| Number of residents on the date of inspection: | 5 |
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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 7 October 2025   | 11:00hrs to 17:45hrs | Eoin O'Byrne | Lead |
| Wednesday 8 October 2025 | 08:45hrs to 12:00hrs | Eoin O'Byrne | Lead |

## What residents told us and what inspectors observed

This announced inspection was carried out as part of a group inspection of 6 designated centres operated by this provider. Each centre was inspected independently and findings will be reported under each centre however, complaints, staff training, policies and procedures and staff recruitment were reviewed centrally in the providers main offices.

While in the main good practice was observed and residents enjoyed a good quality of life some improvements were required particularly in relation to governance and oversight, care planning and the quality of audits carried out by the provider.

18 regulations were reviewed during the inspection: 5 regulations were identified as requiring improvement:

4 regulations were found to be non-compliant:

- Regulation 23: Governance and Management
- Regulation 34: Complaints Procedure
- Regulation 6: Healthcare
- Regulation 17: Premises

1 regulation was found to be substantially compliant:

- Regulation 9: Residents' Rights

The inspector found the residents home to be clean, well presented and homely. Each resident had their own room which was decorated to their taste. There was adequate space in the house for residents to relax in and they appeared happy in their surroundings. The previous two inspections of this centre had identified issues relating to the upkeep and appearance of the residents home. This inspection again found that the provider had failed to ensure that all aspects of the premises including the garden had been kept in a good state of repair and was suitable for the residents. The issues will be discussed under Regulation 17: premises.

Despite areas of non-compliance, inspectors observed examples of good practice. Residents were actively involved in their local community, including employment and social groups, and were supported to live as self-determined a life as possible. Inspectors met with all five residents, who chose to meet as a group. The residents appeared comfortable, engaged in conversation, and expressed satisfaction with their home and daily routines. They discussed their day service programmes, drama classes, and community events. Residents had also completed pre-inspection questionnaires, expressing positive views about their home and relationships with housemates.

Staff and the person in charge described the use of visual aids to support communication and planning. Notice boards in the dining area displayed routines, staff picture rotas, and activity options. One resident had a personalised visual schedule. Visual aids were also used during weekly meetings to support choice and reduce anxiety. The inspector observed residents referencing the visual boards when discussing activities, and staff confirmed their use in supporting residents with planning and decision-making.

The inspection identified significant areas requiring improvement, particularly in governance, healthcare, and premises suitability. While residents were observed to be leading active and engaged lives, the lack of sustained implementation of care plans and oversight mechanisms raises concerns regarding the consistency and quality of care.

## Capacity and capability

As part of the inspection, the inspector reviewed the provider's governance and management arrangements and identified areas requiring improvement. As outlined in the opening section of this report, four non-compliances were found. A common theme across these findings was inadequate oversight, including insufficient responsiveness to the changing needs of residents and a lack of timely action by the provider when issues were raised by the person in charge. Additionally, the provider did not adhere to its own policies and procedures when responding to a complaint made by a resident.

The impact of these findings is discussed under the relevant report headings and provide evidence that the providers systems for monitoring the quality and safety of the service being delivered to residents required significant review.

In contrast to these concerns, the inspector also observed examples of good practice. Staffing arrangements were found to be appropriate, and systems were in place to ensure staff received relevant and ongoing training. Staff were seen to engage with residents in a respectful and rights-promoting manner. Furthermore, residents reported feeling happy in their home during conversations with the inspector.

In summary, while the inspection identified areas requiring improvement in governance and oversight, it also highlighted positive practices that contribute to the overall wellbeing of residents. There is a clear need for the provider to review their arrangements and ensure that all aspects of the service are appropriately monitored.

## Regulation 15: Staffing

The inspector reviewed the staffing arrangements and found them to be appropriate. This included an examination of the current week's roster and rosters from 1 to 31 August 2025. The review confirmed that:

- safe staffing levels were consistently maintained
- the skill mix of staff was appropriate to meet the needs of current residents
- residents received continuity of care, supported by a consistent team
- both planned and actual rosters were available for review.

Staffing levels enabled residents to engage in a variety of community activities and ensured support was available in their home when needed. The roster was adapted to suit residents' needs. As all residents attended day services, staff shifts began at 15:30 Monday to Friday, aligning with residents' return home. One staff member completed a sleepover each night and supported residents with their morning routines before they left for activities. On weekends, staff shifts started earlier to accommodate residents being present in the house.

Discussions and observations confirmed that staff had established positive relationships with residents. Staff demonstrated strong knowledge of how to respond to and report safeguarding concerns and a clear understanding of how residents' rights were promoted and respected.

The inspection also reviewed documentation for three staff members to ensure compliance with Schedule 2 of the regulations. The appraisal confirmed that the person in charge had ensured all required information was available for review including garda vetting as required by the regulations.

Judgment: Compliant

## Regulation 16: Training and staff development

As noted in the opening section of the report, staff training was reviewed at the provider's central office. The appraisal confirmed that the staff team had received a comprehensive suite of training designed to equip them with the skills and knowledge necessary to support the residents effectively.

The inspector also reviewed staff supervision practices to ensure they were in line with the provider's policies and procedures. Supervision was being provided by the person in charge. A review of two staff members' supervision records showed that staff were actively engaging in the process, raising queries and receiving appropriate support and guidance.

Judgment: Compliant

## Regulation 22: Insurance

As part of the inspection preparation, the inspector reviewed documentation submitted by the provider. This included evidence that the provider had a suitable contract of insurance in place.

Judgment: Compliant

## Regulation 23: Governance and management

The inspector sought to review the existing governance and management arrangements in place within the designated centre. The appraisal of these arrangements identified that current operational practices were not ensuring effective monitoring of the service being provided to residents. Furthermore, issues raised by the person in charge were not being adequately responded to by the provider's senior management team.

A substantial volume of documentation was reviewed, including audits completed by the person in charge (quarterly service reviews, quarterly medication audits, health and safety incident reports, and infection prevention and control audits), an annual review completed by the provider, and six-monthly unannounced audits conducted by the provider.

The review of these audits identified that the current auditing and monitoring practices had failed to detect several issues subsequently identified by the inspector. These included:

- deficiencies in the care and support of residents in relation to their health needs
- a failure to respond to concerns regarding the suitability of the premises
- poor monitoring and follow-up of PRN (as required) medication usage for one resident
- a lack of appropriate guidance for staff regarding the rationale and conditions under which PRN medication should be administered.

While the person in charge had completed audits as part of the governance framework, the inspection findings highlighted that these systems were not sufficiently robust to identify key risks or areas requiring improvement. In some cases, concerns raised by the person in charge had not been adequately addressed by the provider's senior management team. These overarching failures in governance and oversight will be further detailed under the relevant regulatory headings.

An additional factor contributing to the oversight issues was identified during the review of the current person in charge arrangements. The person in charge holds

responsibility for this designated centre and one other, located in close proximity. During the month of September, the person in charge completed eight overnight shifts and was allocated a total of 64 protected hours to fulfil all duties associated with the dual PIC role. The inspection findings indicate that the limited protected time available to the PIC has impacted their ability to provide effective oversight of all aspects of care and support provided to residents. As a result, the existing governance and management arrangements were found to be ineffective.

Judgment: Not compliant

### Regulation 3: Statement of purpose

The registered provider prepared a statement of purpose containing the information set out in Schedule 1 of the regulations. The statement was updated when required, and a copy was available for review.

The inspector reviewed the statement of purpose as part of the preparation for the inspection. On the inspection day, the inspector was assured that it accurately reflected the service provided to the residents.

Judgment: Compliant

### Regulation 31: Notification of incidents

As part of the inspector's preparation for the inspection, they reviewed the notifications submitted by the provider. The inspection also involved studying adverse incidents that had occurred. This review showed that, per the regulations, the person in charge had submitted the necessary notifications for review by the Chief Inspector.

Judgment: Compliant

### Regulation 34: Complaints procedure

Inspectors reviewed whether any complaints had been raised within the designated centre during the current year. It was found that two complaints had been raised by a resident in recent months, both relating to the vehicle used for resident transport. While the initial complaint was managed appropriately, the provider's handling of the most recent complaint was not in line with their own policies and procedures.

The first complaint, raised in April, concerned the size of the car, with the resident reporting that they felt squashed when travelling with other residents. The person in charge escalated the matter to senior management and the transport manager, and requested an alternative vehicle. As an interim measure, it was agreed that only three residents would travel in the car at any one time. The resident was satisfied with this outcome.

However, following no change in the transport arrangements, the resident raised the same complaint again on 25 September 2025. The person in charge again referred the matter to senior management and the transport manager, and was again directed to limit the number of passengers to three. When this was communicated to the resident, they expressed dissatisfaction with the outcome.

Of concern, the provider's senior management made a decision to close the complaint, advising the person in charge to reopen it at a later date. A review of the provider's complaints management policy states that "if the complainant is still unsatisfied, they are entitled to request an external review to be carried out." This option was not offered to the resident, and the provider's response did not demonstrate that the resident's views were appropriately considered or responded to in accordance with policy.

Judgment: Not compliant

#### Regulation 4: Written policies and procedures

As discussed in the opening section of this report, the provider's policies and procedures were reviewed as part of the inspection process. It was found that the provider had established the required policies and procedures and was reviewing and updating them within the prescribed timeframes, in line with regulatory requirements.

Judgment: Compliant

#### Quality and safety

The inspection identified failings in the care and support provided to some residents, particularly in relation to the provider's response to health needs. These concerns will be discussed in detail under Regulation 6, but they reflect a lack of appropriate oversight by the provider and a limited response from the staff team to the changing needs of a resident.

Further issues were identified in relation to the residents' home environment. While many of these related to the garden area, other concerns were noted. For example,

the person in charge had raised concerns about the structural integrity of a flat roof in December 2023. At the time of the inspection, the provider had not arranged for the roof to be appropriately assessed. Additionally, the inspector identified a privacy issue concerning a resident's ground floor bedroom, which was visible to passers-by. This had not been previously identified and required attention.

Despite these concerns, the inspector also found that residents were receiving a good standard of service in many areas. Residents reported that they were able to engage in activities they enjoyed and were active members of their community. They expressed satisfaction with their living arrangements during conversations with the inspector.

The inspection also included a review of several other areas, including personal possessions, fire precautions, medication management, risk management, general welfare and development, and positive behaviour support systems. These areas were found to be compliant with the relevant regulations.

## Regulation 10: Communication

Through a review of documentation and discussions with residents and staff, the inspector found that effective arrangements were in place to support residents in communicating their needs and preferences. All residents communicated verbally, although clarity varied among individuals.

The inspector observed that the dining area featured a wide range of visual information, including:

- pictures illustrating daily routines
- photos of staff members to indicate who was on duty.

Staff also reported using visual aids during resident meetings to assist residents in choosing activities and meals.

For one resident, the inspector noted that their positive behaviour support plan included a detailed account of their communication strengths and needs. This plan clearly described how the resident communicates and provided practical guidance for staff on how to interact with and present information to them effectively.

Judgment: Compliant

## Regulation 12: Personal possessions

The inspector found that, where required, residents were provided with appropriate supports to manage their financial affairs. It was reported that some residents

managed their own finances with support from family members, others required minimal assistance from staff, and one resident required full support from staff to manage their financial matters.

For residents receiving support, the inspector found that systems were in place to safeguard against financial abuse. The person in charge was reviewing residents' bank statements on a monthly basis to ensure oversight. The inspector reviewed the financial records of two residents and found that monthly opening and closing balance checks were being completed. Staff members were conducting daily checks on residents' spending, and receipts were collated where possible. However, it was noted that some residents did not always collect receipts when making purchases. As mentioned, bank statements were being reviewed to ensure appropriate financial oversight.

In summary, there was evidence that where residents requested or required support with their finances, the provider had implemented systems that promoted safeguarded residents from potential financial abuse.

Judgment: Compliant

### Regulation 13: General welfare and development

As discussed in earlier sections of the report, residents were observed to be living active and engaged lives. They informed the inspector that they regularly participated in their preferred activities. Some residents met with friends on a routine basis, and all were supported to maintain meaningful connections with their families.

The inspector reviewed two residents' person-centred plans and found that, with support from staff, the residents had identified a substantial number of social goals. There was evidence that several of these goals had been achieved, while others were actively in progress.

The inspector was also shown an initiative developed by the provider in which residents' social activities were documented and presented in a format resembling social media platforms. This included photographs of residents participating in a wide range of activities, highlighting the provider's commitment to promoting engagement, personal choice, and social inclusion.

Judgment: Compliant

### Regulation 17: Premises

This was the third consecutive inspection that raised concerns regarding the premises of the designated centre. Although the inspector noted that actions from the previous inspection had been addressed, further issues were identified during the course of this visit.

The person in charge accompanied the inspector on a tour of the premises, including the garden. It was observed that debris had been left in a corner of the residents' garden, and building supplies had been abandoned in another area. The person in charge was unable to confirm how long the supplies had been present. The garden itself was not well maintained, with uneven surfaces and a generally cold appearance. A large container was positioned at the rear of the garden, further detracting from its visual appeal. The person in charge was unaware of the contents of the container or the duration of its placement in the garden. Although a fence had been erected in front of the container in recent years, its presence continued to negatively impact the overall appearance of the outdoor space.

During a review of maintenance records, the inspector found that in December 2023, the person in charge had raised concerns regarding the flat roof over the office and utility room. A request had been made for a structural assessment due to observed damage. However, the provider failed to arrange for this assessment, indicating an ineffective response to concerns raised by the person in charge.

In summary, while previous actions had been addressed, the inspection highlighted ongoing issues with the upkeep and management of the premises.

Judgment: Not compliant

### Regulation 20: Information for residents

During the review of documentation, the inspector found that the provider had developed a residents' guide. The guide was reviewed and found to contain the required information as set out in the regulations. It accurately reflected the nature of the service being provided to residents.

Judgment: Compliant

### Regulation 26: Risk management procedures

The inspector found that suitable systems were in place to identify and respond to risk. However, some concerns relating to the provider's response to issues with the premises were noted and are addressed under Regulations 23 and 17.

The inspector reviewed information for two residents and found that individual risk assessments had been developed. These assessments were clearly linked to the

residents' care and support plans and provided practical guidance on how to maintain their safety.

The inspector also reviewed the service's risk register, which captured both environmental and social risks. The control measures identified in response to these risks were found to be appropriate and proportionate.

In addition, the inspector requested to review adverse incidents that had occurred in the service during 2025. It was noted that only two incidents had been recorded since January, which is considered significantly low.

Overall, the inspector found that the provider had established effective systems to assess, monitor, and manage risk within the service. Risk assessments were person-centred and linked to care planning, and the service maintained a comprehensive risk register. The low number of adverse incidents further supports the conclusion that risks are being appropriately managed.

Judgment: Compliant

### Regulation 28: Fire precautions

The inspector reviewed information regarding fire safety management and found that the provider had ensured suitable systems were in place. Personal Emergency Evacuation Plans (PEEPs) had been developed for residents, and the inspector reviewed two of these plans. Each provided clear guidance on how to support the resident in evacuating safely in the event of an emergency.

The inspector examined records of fire evacuation drills completed during the year. A total of nine drills had been conducted, eight simulating daytime scenarios and one simulating a night time scenario. However, the inspector noted that the night time drill did not accurately reflect actual night staffing levels, as three staff members were involved in the exercise. This was raised as a concern during the inspection.

Following the inspection, the person in charge submitted evidence that a further night time drill had been completed involving all five residents and one staff member, accurately reflecting the staffing levels typically present during night hours.

During the inspection, the person in charge activated the fire alarm to demonstrate its functionality. All fire doors closed as expected, confirming that fire containment measures were operational and appropriate. The inspector also found that fire detection and firefighting equipment had been serviced at appropriate intervals.

Judgment: Compliant

## Regulation 29: Medicines and pharmaceutical services

The inspector reviewed the medication management systems in place and found that overall practices were appropriate. Specific concerns were noted regarding PRN medication usage and staff guidance, which have been addressed under Regulation 6.

Key findings include:

- medication storage arrangements were appropriate
- prescribed and PRN medications were readily available to residents
- no gaps were found in a sample of medication administration records reviewed
- a system for regular stock checks was in place, with quarterly reviews conducted by the person in charge
- there was a system for returning out-of-date or unused medication, with recent returns documented.

In summary the inspector found that the person in charge has ensured suitable practices for ordering, storing, administering, and disposing of medications.

Judgment: Compliant

## Regulation 6: Health care

The inspector conducted a review of the information for two residents, specifically assessing how their health needs were evaluated and addressed.

The review indicated that one resident was not receiving appropriate healthcare. During discussions with the person in charge, it was revealed that the resident received a diagnosis on September 23, 2025. The inspector requested to examine a care plan or documentation that would provide guidance for staff on how to support this resident adequately. However, it was reported that such guidance documents had not been established.

The person in charge stated that they had reached out to the resident's GP to request a dietitian review, but no further steps had been initiated. This lack of action highlights a failure to respond to the changing needs of the resident adequately.

Furthermore, it indicates that there were no arrangements in place to ensure that the staff team received proper guidance to address and meet the residents' needs effectively.

Discussions with the person in charge and the review of further information revealed that the resident had been diagnosed with a condition causing pain in 2023. The

person in charge indicated that the resident had been brought to the GP multiple times concerning this condition, yet there was no structured support plan in place.

The inspector, when reviewing the same resident's medication records, noted that PRN pain relief was administered on a regular basis. The inspector found that PRN pain relief had been administered 15 times for the two above issues between April and September. A concern was that insufficient steps were taken to investigate the resident's need for pain relief and to explore alternative interventions. The inspector found that PRN usage was being tracked as part of a quarterly medication review, but the lack of follow-up demonstrated failings in the care and support provided to the resident.

Of further concern was that the provider had failed to ensure that there were appropriate PRN medication protocols or guidance information for staff members to follow. Upon reviewing the existing information, it was noted that there were no formal guidelines for staff on the administration of PRN medication, resulting in inadequate support for the resident's healthcare needs.

In conclusion, the lack of a structured care plan, inadequate follow-up on healthcare needs, and the absence of appropriate medication protocols highlighted deficiencies in the support provided to the resident.

Judgment: Not compliant

## Regulation 7: Positive behavioural support

The inspector sought to ensure that, if required residents could access appropriate positive behaviour supports. It was found that this was the case.

The inspector reviewed a resident's behaviour support plan and found that it gave the reader a detailed account of the resident's needs, how they communicated, how to support them to have positive outcomes, how to react during challenging incidents and how to support the resident following incidents.

The inspector found that the plan was well-written and provided the reader with clear guidance on how to best support the resident. The person in charge informed the inspector that incidents were now rare and this was confirmed when reviewing adverse incidents which had occurred this year as none were related to behaviours of concern.

This demonstrated that the staff members were supporting the resident to have positive outcomes.

Judgment: Compliant

## Regulation 9: Residents' rights

On arrival to the resident's home the inspector observed that they could see into a resident's bedroom located on the ground floor. The inspector raised this issue with the person in charge who acknowledged that this had not been raised as a concern in the past. The fact that passers-by could see into the resident's bedroom did not ensure that the resident's privacy and dignity was respected. The provider had failed to identify this as an issue and it was an area that needed to be addressed.

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                |
|--|-------------------------|
| <b>Capacity and capability</b>                       |                         |
| Regulation 15: Staffing                              | Compliant               |
| Regulation 16: Training and staff development        | Compliant               |
| Regulation 22: Insurance                             | Compliant               |
| Regulation 23: Governance and management             | Not compliant           |
| Regulation 3: Statement of purpose                   | Compliant               |
| Regulation 31: Notification of incidents             | Compliant               |
| Regulation 34: Complaints procedure                  | Not compliant           |
| Regulation 4: Written policies and procedures        | Compliant               |
| <b>Quality and safety</b>                            |                         |
| Regulation 10: Communication                         | Compliant               |
| Regulation 12: Personal possessions                  | Compliant               |
| Regulation 13: General welfare and development       | Compliant               |
| Regulation 17: Premises                              | Not compliant           |
| Regulation 20: Information for residents             | Compliant               |
| Regulation 26: Risk management procedures            | Compliant               |
| Regulation 28: Fire precautions                      | Compliant               |
| Regulation 29: Medicines and pharmaceutical services | Compliant               |
| Regulation 6: Health care                            | Not compliant           |
| Regulation 7: Positive behavioural support           | Compliant               |
| Regulation 9: Residents' rights                      | Substantially compliant |

# Compliance Plan for Teach Cairdeas OSV-0001831

Inspection ID: MON-0039948

Date of inspection: 08/10/2025

## Introduction and instruction

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

This document is divided into two sections:

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

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

A finding of:

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

# Section 1

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

## Compliance plan provider’s response:

| Regulation Heading  | Judgment      |
|---|---------------|
| Regulation 23: Governance and management  | Not Compliant |
| <p>Outline how you are going to come into compliance with Regulation 23: Governance and management:</p> <p>The Audit practice and procedure has been revised and implemented on the 3rd November 2025. The service provider will implement a tracker to ensure oversight of all actions going forward. This tracker will be an agenda item on senior management team meetings and monitored by the Compliance manager.</p> <p>The Clinical Team has scheduled Risk and Care planning Training for all staff across the service which is practice based to improve the quality of care planning and understanding of same in the service to begin 7th Jan 2026.</p> <p>The service provider will create an auditing document / tool for reviewing risk and care planning in order to identify actions and monitor outcomes. This will commence after Q1 2026 to allow time for practice training to be implemented.</p> <p>The Provider will meet with the PIC to review rostering and work practice to see how protected hours are working or not and implement actions accordingly to ensure the role can be done ( 26th November 2025).</p> <p>The guidance on PRN has been revisited at a Clinical Meeting on the 5th November 2025, actions include meeting with residential team re PRN guidance and a review of cases by CNM2 to ensure compliance.</p> <p>The premises will be reviewed and actioned on the service provider maintenance schedule and form part of discussions with HSE /IMR meetings ( 13th Nov 2025) re capital.</p> |               |

|   |               |
|---|---------------|
|   |               |
| Regulation 34: Complaints procedure   | Not Compliant |
| <p>Outline how you are going to come into compliance with Regulation 34: Complaints procedure:</p> <p>The Service provider will meet with team (December team meeting on 16th) to discuss the Complaints policy and and the current complaints and how they are actioned. The process for booking additional vehicles at locations has been shared with the team to address pressure points ( ie Tuesday evenings) .</p>  |               |
| Regulation 17: Premises   | Not Compliant |
| <p>Outline how you are going to come into compliance with Regulation 17: Premises:</p> <p>The AHB (the provider) Maintenance Plans and Records schedule ( 28/5/25) shows the completed planned and responsive works at the location and the Longterm/ Capital works has identified this location for proposal and costings for Q4 and discussions with HSE. The matter was discussed at Meeting with HSE on 13/11/2025 and the provider has submitted a claim for minor capital (13/11/25). The QS costings for the works will be submitted by Provider by 12/12/2025. The Provider will continue engagement with HSE on the matter with the a view to completed the works in 2026.</p>   |               |
| Regulation 6: Health care   | Not Compliant |
| <p>Outline how you are going to come into compliance with Regulation 6: Health care:</p> <p>A referral from GP has been requested to pain management clinic for 1 service (9th October 2025). The CNM2 will review the clinical needs and monitor actions by 5th December 2025.</p> <p>The Clinical Team has scheduled Risk and Care planning Training for all staff which is practice based to improve the quality of care planning and understanding of same in the service to begin 7th Jan 2026.</p> <p>The service provider will create an auditing document / tool for reviewing risk and care planning in order to identify actions and monitor outcomes. This will commence after Q1 2026 to all time for practice training to be implemented.</p> <p>The guidance on PRN has been revisited at a Clinical Meeting on the 5th November 2025, actions include meeting with residential teams re PRN guidance and a review of cases by CNM2 to ensure compliance.</p> |               |

|  |                         |
|--|-------------------------|
|  |                         |
| Regulation 9: Residents' rights  | Substantially Compliant |
| Outline how you are going to come into compliance with Regulation 9: Residents' rights:<br>The lower window is currently being addressed to deal with dignity issues. There is a temporary fitting in place to address. Permanent works will be completed by 20th November 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 17(1)(b) | The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.   | Not Compliant | Orange      | 30/06/2026               |
| Regulation 23(1)(c) | The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored. | Not Compliant | Orange      | 07/01/2026               |
| Regulation 34(2)(d) | The registered provider shall ensure that the complainant is informed promptly of the outcome of his or her  | Not Compliant | Orange      | 16/12/2025               |

|                  |   |                         |        |            |
|------------------|---|-------------------------|--------|------------|
|                  | complaint and details of the appeals process.   |                         |        |            |
| Regulation 06(1) | The registered provider shall provide appropriate health care for each resident, having regard to that resident's personal plan.  | Not Compliant           | Orange | 07/01/2026 |
| Regulation 09(3) | The registered provider shall ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information. | Substantially Compliant | Yellow | 20/11/2025 |