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:	Lios na Greine
Name of provider:	Health Service Executive
Address of centre:	Louth
Type of inspection:	Announced
Date of inspection:	06 August 2025
Centre ID:	OSV-0002566
Fieldwork ID:	MON-0039108

About the designated centre

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

The designated centre provides 24-hour nurse-led residential care and currently accommodates five adults, with intellectual disabilities. The building is a large detached bungalow on a private site. There is a lobby area and a spacious hallway on entering the house. There are five bedrooms, one of which has an en-suite bathroom. One resident has the exclusive use of a bathroom next to their bedroom, with three other residents sharing a communal bathroom. There are two sitting rooms, one which includes a dining area. There is a kitchen and utility room and an office next door to it. There is a large room for activities and just off this area is a storage room and a staff toilet. There is a large fenced garden out the back of the house with summer furniture and an unused garden shed. The centre is located near a large town, and there are transport facilities for residents to access amenities in the town.

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
Wednesday 6 August 2025	09:00hrs to 17:15hrs	Eoin O'Byrne	Lead

What residents told us and what inspectors observed

This was an announced inspection carried out to monitor compliance with regulations and standards and to help with the decision regarding the ongoing registration of the centre.

The findings from the inspection presented a mixed picture, highlighting both positive aspects and areas that require improvement. Thirteen regulations were reviewed, and nine were found to be compliant. However, three regulations, including safeguarding, governance and management and personal possessions were found to be non-compliant. Additionally, the regulation focused on residents' communication was found to be substantially compliant with the regulations.

It was found that staff practices regarding residents' finances were not appropriate. Of concern was that the provider had identified such issues in the past and had implemented actions to improve this; however, the necessary improvements were not achieved. The practices in place failed to adequately support residents with their finances and protect them from potential financial abuse. These issues will be discussed in more detail later in the report.

The residents' home was found to be a busy environment, with five residents and five staff members who provided daily support.

During the inspection, the inspector was introduced to all five residents. Residents were observed spending time in the garden, while others watched TV and engaged in activities with staff. Some residents also participated in meal preparation with minimal support and supervision from staff members.

The residents mainly communicated through non-verbal forms of communication. Observations on the day of inspection identified that the residents appeared at ease in their home and their interactions with those supporting them.

Notwithstanding, the review of systems in place to help residents with their communication needs identified that improvements were required. For example, a visual aid book had been introduced to support a resident in expressing their wishes. The inspector found that the book was not brought with the resident when they went on an outing, nor was it offered to the resident when they appeared upset. This showed that, staff were not always following guidance on how to best support the residents with their preferred style of communication.

The review of daily notes for some residents and person-centred plans for others indicated that residents were being supported to engage in a range of activities and were encouraged to lead active lifestyles outside their home. Some residents had been on short holiday breaks, while others participated in activities such as horse riding or enjoyed walks in the countryside. During the morning portion of the

inspection, residents went on walks and participated in other activities with staff members, and appeared happy on their return home.

The inspector noted that the home was clean and well-maintained, benefiting from recent renovations that significantly improved its overall appearance

In summary, the inspection process revealed mixed findings. While positive aspects were noted, such as a well-maintained environment and participation in various activities, significant concerns were raised regarding monitoring, oversight, and staff practices, particularly relating to financial management and supporting residents' communication needs.

The next two sections of the report outline 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 residents lives.

Capacity and capability

The inspector reviewed the governance and management arrangements of the provider and concluded that they had not ensured effective monitoring of the service and care provided to residents. Additionally, the provider had not ensured that residents were safe and protected from all forms of abuse. The inspection process revealed inappropriate staff practices in areas such as managing residents' finances and supporting their communication needs.

Of particular concern was the fact that the provider's reporting and auditing systems had previously identified failures in the staff team's management of residents' finances; however, necessary improvements had not been made. This raised concerns about the provider's ability to effectively manage the performance of all staff members.

On a more positive note, the inspector found that the provider maintained safe staffing levels each day, and ensured continuity of care for residents. The review of information also showed that staff members had received sufficient training. Additionally, there were arrangements in place to ensure that required notifications were being submitted to the Office of the Chief Inspector as per the regulations.

In summary, the inspection process highlighted the need for improvements to ensure that governance and management arrangements were effective, and that staff members adhered to the provider's policies and procedures to guarantee that residents received the best possible service.

Regulation 15: Staffing

The inspector verified that the provider had sufficiently staffed the service to meet the residents' needs. The staff team consisted of the person in charge, staff nurses, social care workers and healthcare assistants. Each day, five staff members were scheduled, with two staff members on duty at night. This is a nurse-led service, meaning that there is at least one nurse on duty on a 24/7 basis.

The inspector reviewed the current roster and rosters from March and January of 2025. The review of the rosters showed that the provider was ensuring that the required safe staffing levels were being maintained. There was also evidence of additional staff being rostered to support social events if needed.

Residents were receiving continuity of care, with a settled staff team in place. There were some staff shortages, but consistent agency staff were completing shifts when and if required.

The inspector completed a review of three staff members' information and found that the person in charge had ensured that they had gathered the required information under Schedule 2 of the regulations for each staff member, including evidence of qualifications, experience and Garda vetting.

This inspection did identify however that at times, some staff were not adhering to policy and procedures that guide practice in the service. This issue is discussed in detail and actioned under Regulation 8: Protection, Regulation 10: Communication and Regulation 23: Governance and Management.

Judgment: Compliant

Regulation 16: Training and staff development

The inspector requested confirmation that the staff team had access to and had completed the necessary training. Upon reviewing the training records, they found that training needs were regularly assessed and that staff attended training as required.

Staff members had completed training in various areas, including:

- fire safety
- safeguarding vulnerable adults
- managing challenging behaviour
- dysphagia
- infection prevention and control (IPC)
- a human rights-based approach
- basic life support
- medication management
- Children first
- manual handling

- autism awareness.

The inspector found that the training needs of the residents were being closely monitored by the person in charge. Previous audits had identified that some staff members had outstanding training, but this had been addressed prior to this inspection. Letters on file also confirmed that agency staff members had up-to-date training.

The person in charge was providing formal supervision to the staff team. The inspector reviewed the information for two staff members and found that the supervision was focused on improving the service provided to the residents. The person in charge explained that due to annual leave, some supervision sessions were outstanding, but there was a plan in place to complete these promptly.

In conclusion, the review of the training records demonstrated that the staff team was receiving adequate training to support the residents effectively.

Judgment: Compliant

Regulation 23: Governance and management

The inspector's analysis of the provider's governance and management arrangements concluded that they had not ensured that the residents were being protected from all forms of abuse. Additionally, this inspection found that at times, staff members were not adhering to policies and procedures that guide practice or that residents were receiving the best possible service.

The provider had completed audits and reports to monitor the service being provided to the residents. Following these audits, areas that required improvement were identified. For example, there were several instances where issues were raised regarding staff members not following policies and procedures regarding the management of residents' finances. However, the inspection process found that despite audits identifying areas for improvement, there was a lack of effective follow-through on these findings.

For example, two significant financial incidents have occurred in recent months where money has been found to be missing from residents' wallets, which were stored in the service. Staff members did not follow best practice when the money was found to be missing, and on one occasion, there was a lengthy delay in the incident being reported. These concerns will be discussed in more detail under Regulation 8: Safeguarding.

On the 1 August 2025, a communication was issued to the staff team by the provider's director of nursing. The communication identified that initial investigations had revealed that the staff team had repeatedly failed to follow the provider's policies and procedures regarding the management of residents' finances. This was of concern to the inspector as policies establish practices and standards to be

adhered to, help reduce risk, and help ensure that staff are consistent in how they provide support to the residents.

Of further concern was that this communication stated that the staff team had not followed additional safeguarding measures that were introduced in the centre on the 26 July 2025. This further demonstrated that there were ongoing issues regarding staff members adhering to and implementing actions resulting from the auditing process. Again, this was of concern to the inspector as these actions were to be implemented to protect the residents from further potential abuse. In turn, this issue had the potential to negatively impact the safety of service provided to the residents.

As stated above, audits and reports were being completed, identifying areas that required improvement. However, the systems in place to ensure that these actions were being fully addressed was not effective and required review.

Staff members continued to fail to demonstrate best practices concerning residents' finances. The inspector also identified instances where staff did not follow communication support plans and noted delays in updating residents' care and support plans. This raised concerns about the provider's ability to manage the entire staff team effectively. It is essential that proper procedures are followed to ensure residents are adequately protected and supported.

In conclusion, the ongoing failures in governance and staff adherence to policies significantly undermine the safety and well-being of residents.

Judgment: Not compliant

Regulation 31: Notification of incidents

As part of the inspector's preparation for the inspection, they reviewed the notifications submitted by the provider to the Office of the Chief Inspector.

The inspection process also involved studying the provider's restrictive practices and adverse incidents.

This review of information showed that, as per the regulations, the person in charge had submitted the necessary notifications for review.

Judgment: Compliant

Quality and safety

The inspection findings indicated that improvements were necessary to ensure residents received the best possible service. As already mentioned above the inspector found that residents' finances were not being properly managed, and on two occasions, sums of money were found to be missing from their accounts. Staff members had not followed the provider's policies and procedures regarding financial management and had not demonstrated good practices in this area.

Furthermore, improvements were needed to better support residents in communicating their needs and wishes. These issues will be discussed in more detail in the relevant sections later in this report.

As noted in the opening section of the report, the inspection process also identified some good practices within the service. For example, the inspector assessed several key areas, including individual assessments and personal plans, risk management, positive behavior support systems, general welfare and development, and fire precautions. The review found these areas to be compliant with regulations.

In conclusion, the inspection found both areas of concern and examples of good practice within the service. However, the areas of concern had a significantly greater impact than the positive findings.

Regulation 10: Communication

The residents in the service primarily communicated through non-verbal methods. The inspector reviewed the measures in place to support the communication of two residents. Staff members had developed communication passports for these individuals. The inspector found that the passports contained information on how the residents expressed themselves through non-verbal communication, how they conveyed their emotions, and, in one case, a list of sign language the resident understood. Additionally, there was a poster in the sitting room displaying the signs used by the residents to encourage the use of sign language. The inspector observed that this resident was comfortable interacting with staff and participating in activities.

While the communication passports captured how the residents expressed themselves, the inspector identified the need for improvements in the guidance provided to staff on how to effectively communicate with the residents. The inspector discussed this with the person in charge, who explained that in 2023, a Speech and Language Therapist (SLT) conducted communication assessments for the residents. However, the assessment findings were not stored alongside the communication passports. Upon reviewing the findings, the inspector noted that they provided a clear picture of the residents' communication skills, identified areas in which they needed support, and outlined specific steps staff members should take for effective communication.

The person in charge informed the inspector that recommendations from the SLT reports were trialed in 2023, but staff members reported that the residents chose

not to engage at that time. However, these recommendations were recently reintroduced, and it has been reported that the residents have begun to engage with them. For example a staff member showed the inspector visual schedules being developed for one of the two residents to help them process information and understand their routines.

For the other resident, a picture book was reintroduced to assist them in expressing their wishes, such as requesting a hot drink. However, a concern arose when the inspector found that the picture book was not taken along with the resident during an outing with staff but was left in a drawer in the sitting room. The inspector raised this issue with the person in charge, who acknowledged that the book should have accompanied the resident.

During the morning of the inspection, the same resident appeared distressed. Although staff members attempted to provide verbal reassurance, the inspector noted that the resident was not offered their visual support book to help express their needs. Later, it was discovered that the resident was upset because they had to wait for a vehicle to return before participating in an activity. The inspector found this concerning, as a visual means of communication could have supported the resident in expressing themselves, helped them better understand the situation, reduced their frustration, and alleviated their distress.

In conclusion, while efforts have been made to improve communication support for the residents through the implementation of communication passports and the incorporation of recommendations from the SLT, there are still areas requiring improvement. The recent reintroduction of supportive materials, such as the picture book, has led to positive engagement from the residents. However, the oversight of not bringing this communication tool on outings highlights the need for better adherence to individualised communication plans. Staff should ensure that all necessary communication supports accompany residents during activities, as this can help them better express their wishes and preferences.

Judgment: Substantially compliant

Regulation 12: Personal possessions

The residents living in the service required support to manage their finances. As discussed in earlier sections of the report there had been incidents where residents' finances were found to be missing and numerous examples of staff members not following the provider's policies and procedures.

Each resident stored a sum of money in a locked safe in the kitchen area of their home. The sum of money was to be checked each day by two staff members but audits and investigations identified that staff were not doing this on a consistent basis, often only one staff member reviewed the finances and in some cases the checks were not completed.

The provider and those supporting the residents had therefore failed to appropriately support the residents in managing their finances. This matter is further discussed under Regulation 8: Protection.

Judgment: Not compliant

Regulation 13: General welfare and development

The inspector reviewed four of the residents' information regarding their general welfare and development.

The inspector reviewed two residents' daily notes for the previous two week period and reviewed recent service user monthly reports for the two other residents.

The inspector found that residents had been supported to identify social goals. There was evidence of the residents being supported to achieve or work towards these, for example one resident had recently gone on holiday to Scotland and another had just returned from an overnight city break in Ireland.

The review of information and observations on the day identified that the residents were active outside of their home on a daily basis. Some of the residents enjoyed going for walks in the countryside by their home, others went further afield to go on walks with staff members. Residents were going out for food, some enjoyed going for a drink, horse riding and one resident was attending a gym.

While residents did not inform the inspector that they were happy with the service they were receiving, the review of information showed that the residents were being supported to have active lifestyles and appeared to be enjoying the activities they were engaging in.

Judgment: Compliant

Regulation 17: Premises

This service was previously inspected in May 2024, that inspection identified significant concerns with the premises. In the months following the inspection the residents were supported to move out of their home to allow for the construction work to begin.

The work completed to the residents home addressed the concerns raised in the 2024 inspection and also enhanced the appearance externally and internally. The premises was found to be clean, well presented and to suit the needs of the residents.

Judgment: Compliant

Regulation 26: Risk management procedures

The inspector evaluated the provider's processes for identifying and managing risks. As part of this review, the inspector examined records of adverse incidents that occurred between May and July. Although incidents happened regularly, staff members managed them effectively, ensuring the safety of the residents. Risk assessments were created for each resident.

The evaluation of two of these assessments indicated that they were directly linked to the residents' individual needs and support plans. These risk assessments were concise, well-written, and provided all necessary information to ensure the safety of the residents. The inspector noted that the risk control measures implemented were appropriate for the identified levels of risk.

Adverse incidents were discussed during team meetings, and the inspector observed a strong emphasis on understanding and reducing the occurrence of these incidents.

In conclusion, the inspector's review highlighted effective risk management practices.

Judgment: Compliant

Regulation 28: Fire precautions

The provider and person in charge had ensured there were effective fire safety management systems.

The review of fire evacuation drills demonstrated that the residents and staff team could evacuate under both day and night time scenarios. There had been issues where a resident had refused to evacuate during a night time event. This resulted in changes being made to the resident's Personal Emergency Evacuation Plan (PEEP), and further drills were completed that demonstrated that the resident would evacuate but also that there was a plan in place to evacuate the resident if they chose to refuse in the future.

The inspector reviewed two other residents ' PEEPs and found that they listed how to evacuate residents in the event of an emergency safely; one of the PEEPs required some updates, and this was completed promptly by the person in charge.

The review of information found that the fire detection and fire fighting equipment had been serviced on a regular basis. Emergency lighting and fire containment measures were also in place. Checks were conducted to identify any areas of

concern, and there was evidence of the provider responding to any issues promptly relating to fire management.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

During the review of information, the inspector found that audits and reports had identified that residents' plans and person-centred plans required attention. For example, the memo sent to staff members on the 1 August 2025 by the director of nursing referenced how there had been delays in these plans being updated.

The inspector reviewed the information of two residents and found that aspects of the plans had been updated in recent days. It was found that assessments of residents' needs had been completed and that care and support documents had been developed that accurately reflected the residents' strengths and areas requiring support.

Therefore, at the time of the inspection, there was accurate information for staff members to follow when supporting the residents.

Judgment: Compliant

Regulation 7: Positive behavioural support

Following assessments, the provider identified that the residents living in the service require positive behaviour support. The inspector found that the presentation and incidents involving the residents were under close review, an external behaviour specialist had reviewed some of the residents, and others had been reviewed using the provider's arrangements.

The inspector reviewed the information of two of the residents. One resident had a responsive behaviour support plan, and the other had a positive behaviour support plan developed by an external behavioural specialist.

The inspector reviewed two of the residents plans and found that for both residents the information was well written, focusing on understanding the residents' behaviours. The plans provided insights into the reasons behind these behaviours and outlined practical strategies for preventing or responding to incidents when they occurred.

Judgment: Compliant

Regulation 8: Protection

It is the provider's responsibility to ensure that all residents are safeguarded from all forms of abuse. Recently, financial abuse was identified when money was discovered missing from the wallets of two residents, which were stored in a locked safe within the house.

Specifically, €20 was missing from one resident's wallet, and €50 was missing from another. Concerns arose regarding the staff members' response when the missing funds were reported. Instead of immediately notifying management, staff members used petty cash from another fund to reimburse one resident, while another staff member reimbursed the other resident using their personal funds.

Moreover, staff members did not document the missing funds or the steps they took to reimburse the residents. As a result, when management conducted audits of the residents' finances, the amounts stored in the safe and the spending records appeared to match, preventing any identification of the issue.

Another concern was the delay in reporting the incident involving the missing €50. Staff discovered the missing money on 7 June 2025, but management was not informed until 25 July 2025. The second incident of missing funds was identified on the 16 July 2025, and this was reported to on-call management on the same day. However, during the initial review of financial records, it was found that staff had not completed the financial checks for the previous four days, indicating that they were not adhering to the provider's policies and procedures.

Additionally, prior to these incidents, the provider had recognised failures in staff compliance with policies regarding the management of residents' finances. There were multiple instances where only one staff member signed the financial checks, although two signatures were required as per the providers own processes. There were also occasions, as mentioned earlier, when the financial checks had not been completed.

At the time of the inspection, the provider had initiated an investigation into both incidents and had reported the matters to the Gardaí.

In conclusion, the failure by staff to adhere to financial management policies have raised concerns regarding the safeguarding of residents' finances. The instances of missing funds, the lack of proper documentation, and delays in reporting indicate a failure to follow established protocols designed to protect residents from financial abuse.

Additionally, the provider needed to review their safeguarding systems and processes in place as they were ineffective in ensuring that residents were protected from financial abuse and to ensure that all staff were adhering to safeguarding policy and legislation.

Judgment: Not 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	Not compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 10: Communication	Substantially compliant
Regulation 12: Personal possessions	Not compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Not compliant

Compliance Plan for Lios na Greine OSV-0002566

Inspection ID: MON-0039108

Date of inspection: 06/08/2025

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The person in charge has a quality assurance tracker in place to monitor all actions identified from internal and external audits & inspections. Areas for improvements have a specific timeframe for completion included.

Training by the risk advisor on incident reporting and completing the incident form is being organised for all staff in the designated centre to include the responsibility and obligation of reporting at the point of occurrence in line with the HSE Incident Management Framework.

Staff adherence to all policies in the designated centre is being monitored by the PIC in the first instance and further supported by routine visits by the ADON and DON.

Staff supervision and performance development meetings are being completed with all staff and a specific focus of these individual meetings will include safeguarding, reporting obligations and adherence to the policies of the service.

Daily checks on the records of residents monies by staff will be completed the PIC and the shift leader and spot checks will be undertaken to ensure balances of money tally with the records and monthly audits are completed.

Any discrepancies will be rectified immediately in being identified. Receipts will be checked to ensure evidence is available for all transactions.

The CNM2 is carrying out performance development reviews with the staff team within the designated centre.

Where there are failings to adhere to the services policies and procedures disciplinary

actions will be taken as necessary through the HSE procedure. Specific timelines will be followed as outlined in the HSE HR procedures.

If required these will form part of stage 1 of the disciplinary procedure by the PIC in the event of failure to adhered to financial procedures. The Human Resource team is advising the CNM2/PIC with this process.

In the immediate aftermath of the inspection all staff were directed to ensure individualised communication aid accompany residents to support them in expressing themselves on outings. This is now monitored by the shift leader.

Regulation 10: Communication	Substantially Compliant

Outline how you are going to come into compliance with Regulation 10: Communication: In the immediate aftermath of the inspection all staff were directed to ensure individualised communication aid accompany residents to support them in expressing themselves. The resident's communication passport was updated immediately after the inspection.

Additional communication tools such as visual schedule boards, PEC's folders, Communication App on resident's personal mobile, objects of reference are being introduced to support residents as part of their communication supports.

Where required, skills teaching programmes will be developed with residents who require additional supports to use the communication tools.

Staff members who are trained in Lámh communication will work closely with resident and staff team to develop this tool further within the Designated Centre and share their expertise and learning with fellow colleagues.

The policy on communication will be discussed with staff at the team meeting to ensure that communication booklet goes with resident on all outings so that residents are facilitated to express their needs through their assessed communication tool in use.

On a daily basis, each resident is allocated a support staff who is responsible for ensuring the resident needs are met in reaction to their communication needs. This will be monitored by the shift leader.

Regulation 12: Personal possessions	Not Compliant

Outline how you are going to come into compliance with Regulation 12: Personal possessions: Internal financial protocol in line with financial policy was put in place to ensure strict guidelines for staff to follow when supporting residents with their money. The person in charge and shift leader are monitoring the compliance with financial policy on a daily basis to ensure two staff members check and sign to verify all records are accurate and in line with the procedures of the policy. Should any discrepancies be identified it will be reported and managed with immediate effect. An incident report and Safeguarding report will be completed and investigated. An incident review meeting was held on 14/08/2025 with relevant members of the senior management team including HR & risk management departments. Recommendations arising from this are being implemented by the Person in Charge. A preliminary screening has being completed to notify the Safeguarding team which concluded the need for a formal safeguarding plan for two residents. The Open Disclosure process was implemented to inform both residents' representatives. The risk register has been reviewed to ensure controls are adequate to protect all residents and mitigate the risk of financial abuse. Additional face to face safeguarding training is being sourced for staff in relation to recognising all types of abuse and reporting safeguarding incidents in timely manner. An internal financial review of the financial, systems within the designated Centre is to be carried out by members of the finance department. The CNM2 is carrying out performance reviews with the staff team within the designated centre. If required these will form part of the informal counselling stage of the disciplinary procedure. The service Human Resource team is advising the CNM2/PIC with this process where necessary.	
Regulation 8: Protection	Not Compliant
Outline how you are going to come into compliance with Regulation 8: Protection: The provider has reviewed their safeguarding systems and processes in place to ensure they are sufficient in ensuring residents are protected from financial abuse and to ensure that all staff were adhering to safeguarding policy and financial procedures. Internal financial protocol in line with financial policy was put in place to ensure strict	

guidelines for staff to follow when supporting residents with their money to ensure two staff members check and sign to verify all records are accurate and in line with the procedures of the policy.

The person in charge and shift leader are monitoring the compliance with financial policy on a daily basis.

An incident review meeting was held on 14/08/2025 with relevant members of the senior management team including HR & risk management departments. Recommendations arising from this are being implemented by the Person in Charge.
Training by the risk advisor on incident reporting and completing the Incident Form is being organised for all staff in the Centre to include the responsibility and obligation of reporting at the point of occurrence in line with the HSE Incident Management Framework.

A preliminary screening has being completed to notify the Safeguarding team which concluded the need for a formal safeguarding plan for two residents.

Additional face to face safeguarding training is being sourced for staff in relation to recognising all types of abuse and reporting safeguarding incidents in timely manner

An internal financial review of all financial systems within the designated Centre is to be carried out by members of the finance department.

The CNM2 is carrying out performance reviews with the staff team within the designated centre. If required these will form part of the informal counselling stage of the disciplinary procedure. The service Human Resource team is advising the CNM2/PIC with this process where necessary.

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 10(1)	The registered provider shall ensure that each resident is assisted and supported at all times to communicate in accordance with the residents' needs and wishes.	Substantially Compliant	Yellow	30/11/2025
Regulation 12(1)	The person in charge shall ensure that, as far as reasonably practicable, each resident has access to and retains control of personal property and possessions and, where necessary, support is provided to manage their financial affairs.	Not Compliant	Orange	30/11/2025
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre	Not Compliant	Orange	30/11/2025

	to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.			
Regulation 23(3)(a)	The registered provider shall ensure that effective arrangements are in place to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.	Not Compliant	Orange	30/11/2025
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	30/11/2025