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:	Drombanna
Name of provider:	The Rehab Group
Address of centre:	Limerick
Type of inspection:	Announced
Date of inspection:	16 April 2026
Centre ID:	OSV-0002652
Fieldwork ID:	MON-0041515

About the designated centre

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

Drombanna consists of a detached two-storey house located in a small housing development, in a rural area, but within a short driving distance of a city. It also consists of an apartment located within a residential apartment complex, in the same city. The centre provides full-time residential support for a maximum of five adult residents. The two-storey house can support four residents and one resident lives in the apartment with staff support. The centre can provide services for residents with intellectual disabilities and autism. All residents have their own bedrooms, while other facilities in both the apartment and the house include bathrooms, sitting rooms/lounges, kitchens and staff rooms. Residents are supported by a team comprised of the person in charge, team leader and care workers by day and night.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	4

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
Thursday 16 April 2026	09:30hrs to 17:40hrs	Elaine McKeown	Lead
Thursday 16 April 2026	09:40hrs to 17:40hrs	Kerrie OHalloran	Support

What residents told us and what inspectors observed

This was an announced inspection to monitor the provider's compliance with the regulations and to inform the decision in relation to the renewing of the registration of the designated centre. The centre was previously inspected in January 2025 as part of the current registration cycle. The findings of that inspection had required actions to be taken by the provider. It was evidenced during this most recent inspection, that some of the actions had been addressed relating to premises and residents being supported to access their finances.

There was evidence that residents were participating in more frequent and varied activities since the previous Health Information and Quality Authority (HIQA) inspection in January 2025. This included attending sensory swimming, gardening, visiting tourists attractions and participating in community events.

However, areas such as governance and management, staffing resources, personal plans and risk management were found to require improvements. The Chief Inspector of Social Services had received unsolicited information regarding this designated centre prior to the inspection taking place. As a result of the findings of this inspection there were significant concerns regarding the operations of the designated centre. These will be discussed in the relevant sections of this report.

During the inspection, the inspectors had sought clarity on the provider's requirements in-line with their medication management policy regarding the assessments of staff following training in safe administration of medications. This clarity was not available on the day of the inspection or on the following day when the feedback meeting was held. This resulted in the registered provider being issued with an urgent action under Regulation 16: Training and development. An urgent action is issued by the Chief Inspector of Social Services when a risk is identified which requires the registered provider to take action to mitigate the risk it poses to residents living in the designated centre. It was evident from the response submitted by the registered provider after the inspection had taken place that actions had been taken to address the risk.

The inspectors met with the four residents currently living in the designated centre at different times during the inspection. One resident was met by one of the inspectors in the afternoon in their apartment after they had returned from their day service. The staff member outlined how they had enjoyed horse riding earlier in the day and spoke about the support being provided to the resident which included going for walks around preferred locations in the city and engaging in community groups such as the tidy towns. This was also evident in a collage of pictures shown to the inspector by the resident. While in the apartment, the resident requested the inspector to interact with them by using gestures and this was facilitated and the resident was observed to smile.

At the start of the inspection, the three residents living in the large house were ready to attend their day service when the first inspector arrived. Residential and day service staff were present, residents were observed to be supported in-line with their preferences. One resident was observed to be smiling and responding to the staff member when discussing their food choice for breakfast. Another resident was resting on the couch and the third was sitting in their preferred seat ready to leave. Staff introduced the residents to the inspector and all acknowledged the inspector in their own way.

In the afternoon the three residents returned to the house and were being supported by two staff. An inspector observed that all of the residents appeared to engage in their preferred routines. This included having refreshments and watching television. One resident was supported to go with a staff member to collect medications from the pharmacy. Staff spoke of the positive outcomes for this resident with the use of coloured sand timers. These timers indicated different time periods such as five minutes which helped the resident to understand when their next activity would be commencing. Two care staff spoken to expressed this was helping to reduce anxieties being experienced by the resident.

Staff spoken to during the inspection outlined some positive outcomes for the residents, which included one resident engaging in training for a planned community walk and another enjoying gardening activities. However, challenges were also experienced at times when supporting the three residents in the house. This included times when two staff were supporting the three residents. One resident had a known medical condition which required staff to provide ongoing support in particular in the community. Another resident required staff supervision as they were known to leave an area such as their day service and the designated centre. Before the feedback was given the morning after the inspection, the inspectors were informed this resident had left the designated centre without staff supporting them. The team leader and person in charge were informed by the staff on duty and the resident was located within 15 minutes and returned to the designated centre.

In addition, while an inspector was speaking with the staff supporting the resident living in the apartment, the resident was observed by the staff member to pass the sitting room window. The staff member immediately followed the resident and encouraged them to return to their home. This resident has a dedicated staff supporting them by day and a sleep-over staff at night. The inspectors were informed the resident requires a staff member familiar to them to provide support at all times. If there were changes to be made to the planned rota a staff from the main house familiar to the resident was assigned to provide support and relief staff worked in the main house.

There had been some general maintenance completed since the previous inspection, which included new flooring installed on the stairs and first floor landing area. Plans to upgrade both bathrooms were still in progress. However, the inspectors observed a chair positioned in front of the sitting room door which impeded it from working as intended in the event of the fire alarm being activated. When this was brought to the attention of the person in charge and team leader the action was described as being part of one resident's regular routine and helped to reduce heightened

anxieties that could be experienced by the resident. However, when the resident left the designated centre to attend their day service the chair remained in position. This will be further discussed under Regulation 26: Risk management procedures.

One inspector spoke on the phone with a relative of one of the residents living in the house. They spoke of the positive outcomes for their relative in the last 12 to 18 months. The resident was being supported to engage in new activities such as attend sporting fixtures and cooking courses which would not have been possible previously. They informed the inspector they were assured the staff team were monitoring known health issues which had previously been associated with causing the resident discomfort/pain and result in the resident expressing themselves through increased anxiety and associated behaviours. Since January 2026 the staff team were also engaging in some social activities with the resident on alternate weeks which previously had been part of a regular routine with the relatives. This was described as working well in supporting the resident to continue to attend these social events but also getting used to other people going with them. The relative outlined their initial concerns regarding a planned holiday for the resident in 2025. However, the relative spoke of the positive experience for the resident, the photographs and experiences had a big impact on the resident who frequently talked about these events while at home.

As this inspection was announced, residents were given the opportunity to complete residents surveys. Three of these surveys were forwarded to the inspectors after the inspection. Staff had provided assistance to two of the residents to complete the surveys and a relative completed the third survey on behalf of the resident. Most of the responses were positive in nature regarding their home and being supported to manage their finances. However, one resident responded that what they chose to do everyday could be better. Two residents gave the same response regarding the food. Other responses included staff members knowing what they did not like could be better and the ability to meet visitors in private. There were some additional comments added to one of the surveys which included, " there are enough people living here" " I like having my own space".

In summary, there was evidence that residents were being supported to engage in an increased variety of activities in recent months. The inspectors were informed residents were experiencing more positive outcomes, there were less incidents of behaviours that challenge occurring and a reduction in the requirement for medications as needed (PRN) to be given to residents since the previous inspection. However, some staff had worked excessive hours in recent months. Two residents had not been able to attend for a dental check up since 2022, and one resident was waiting for a review by an occupational therapist since 2023. The current systems in place to monitor the governance and oversight also required further review to ensure they were consistently effective and demonstrated consultation/input from the residents.

The next two sections of this report will 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 provided.

Capacity and capability

Overall, this inspection found significant concerns relating to the care and support being provided to the residents. Some of the issues raised in the unsolicited information provided to the Chief Inspector in advance of the inspection were evident during the inspection.

The provider had completed an annual report for 2025. There were some actions identified which included a review of the staffing resources with the objective of increased sustainability to ensure residents were being supported appropriately. This was as a result of unforeseen leave at short notice while the day service was closed when the report was being complied in Quarter 4 2025. However, it was not evident at the time of this inspection that the provider had ensured adequate staffing resources were in place and staff were being provided with the required training to effectively support the residents assessed needs.

The provider had also completed two un-announced internal audits as required by the regulations. These had taken place in August 2025 and February 2026. Only the team leader and person in charge were consulted during both of these audits.The views of the residents were not part of either of these reports. For example the audit in Febraury 2026 took place while residents attended their day service.

On review of the annual report and the two six monthly provider audits, the inspectors were not assured that the systems in place were effective in identifying issues pertaining to the designated centre. For example, neither the August 2025 internal audit or the annual report identified that the Chief Inspector of Social Services had not been notified as required by the regulations of restrictive practices that were in place in the designated centre during Quarter 2 2025. The audit completed in February 2026 had not identified the same issue had occurred again in Quarter 4 2025. While the findings of both of these audits stated that the required notifications had been submitted within the required time frame, this was not correct. The required notifications for Quarter 4 2025 were submitted on 15 April 2026 when it was brought to the attention of the person in charge by one of the inspectors the day prior to the inspection.

The inspectors wish to acknowledge that while there were three staff vacancies reported at the time of the inspection, one of these occurred due to sudden and unexpected events which had occurred in the weeks prior to this inspection and had impacted both the residents and core staff team.

Registration Regulation 5: Application for registration or renewal of registration

The application for the renewal of registration of this centre was received and contained all of the information as required by the regulations, including the statement of purpose and proof of insurance. This was reviewed prior to the inspection. The inspectors provided details during the inspection and feedback meeting of two updated documents that had been requested from the provider prior to the inspection taking place.

Judgment: Compliant

Regulation 15: Staffing

Following a review of actual and planned rotas from 1 February 2026, the inspectors were not assured there were adequate staffing resources in place in the designated centre to meet the assessed needs of the residents. There were a total of three vacancies of care workers at the time of this inspection. One role had been recruited for and that person was completing their pre-employment induction at the time of the inspection. It was noted that staff members were working excessive amount of hours. For example, one staff member had worked 180 hours between the 9 March - 29 March 2026, this was over a three week period. Other staff had also worked in excess of their contracted hours during the same period of review.

There were 12 staff working in the designated centre at the time of this inspection. This included the person in charge, team leader and 10 care workers. In addition, there were four regular relief staff who were familiar with the residents, some of whom worked with the residents in their day service. The inspectors were informed the use of agency staff was infrequent and only occurred at times of an emergency.

On the day of the inspection, a staff member was supporting two of the residents in the designated centre in the evening. One resident had a known medical condition and required staff supervision/support. This resident could not be left in the designated centre on their own. The second resident had a history of leaving locations such as the designated centre and their day service without staff support. Two such incidents had occurred when the resident was being supported over Christmas period in 2025. The inspectors were informed these took place when no other resident was present in the designated centre and the staff member had to follow the resident. However, before the feedback meeting on the morning after the inspection the same resident left the designated centre without staff support. There were two staff on duty supporting three residents. On this occassion the team leader was contacted and they were able to locate the resident in the community within 15 minutes. The inspectors were not assured effective protocols were in place or adequate staff resources to meet the assessed needs of the residents for whom they were providing support.

Judgment: Not compliant

Regulation 16: Training and staff development

The person in charge had not ensured that assessment requirements for the staff team in relation to the safe administration of medications had been completed in-line with the provider's policy in medication administration. An urgent action was issued to the provider during the feedback meeting. The provider responded with details of actions that had been taken to address the issue.

Other gaps in staff training both within the core staff team and relief staff were identified during the inspection which included crisis prevention and intervention CPI. This training was documented as being required to be completed by staff as a control measure to support residents when they were experiencing difficult situations resulting in possible aggression being displayed towards peers or others. One relief staff member was required to complete this training. The same staff member did not have documented evidence of the completion of on-line training such as safeguarding. Members of the core team and relief staff were also required to complete other training deemed necessary to support the residents which included first aid and food safety.

Not all staff had been supported to have supervisions as required by the provider each quarter during 2025. For example, the team leader had one supervision documented for December 2025 when they had commenced in the role in January 2025.

Judgment: Not compliant

Regulation 22: Insurance

The registered provider had ensured that the designated centre was adequately insured and this information was submitted as part of the application to renew the registration. During the feedback meeting the inspectors advised an updated certificate would be required to be submitted by the provider after the 30 June 2026 once the current certificate had expired.

Judgment: Compliant

Regulation 23: Governance and management

The registered provider had not ensured the designated centre was adequately resourced to provide effective delivery of care and support in accordance with the statement of purpose. For example, not all residents had an annual needs assessment completed.

At the time of this inspection the management systems in place did not demonstrate they were effective to ensure that the service provided was safe, appropriate to residents needs, consistent and effectively monitored.

The August 2025 and February 2026 internal audits had not identified that written reports of quarterly notifications for Q2 & Q4 2025 in the designated centre had been provided to the Chief Inspector of Social Services.

The registered provider had not ensured effective arrangements were in place in the designated centre to support and develop all members of the work force to exercise their personal and professional responsibility for the quality and safety of services that they are delivering.

Judgment: Not compliant

Regulation 3: Statement of purpose

The registered provider had ensured the statement of purpose was subject to regular review. The document contained all the information required under Schedule 1 of the Regulations. Some minor changes were discussed during the inspection with the person in charge which required the provider to submitted a revised version of the document.

Judgment: Compliant

Regulation 31: Notification of incidents

The person in charge had not ensured that a written report in relation to restrictive practices was provided to the Chief Inspector of Social Services at the end of Quarter 2 or Quarter 4 2025.

Judgment: Not compliant

Regulation 34: Complaints procedure

The provider had ensured a policy was in place for the management of complaints.

- Details of who the complaint officer was were observed to be available within the designated centre in both locations. Easy-to-read information was available for residents to access.
- No complaints had been made during 2026, one complaint was made by a relative in April 2025. This was resolved to the satisfaction of the complainant who also spoke to one of the inspectors on the phone during the inspection about the issue which they said did not require to be escalated and was dealt with at local level.

Judgment: Compliant

Quality and safety

The inspectors were not assured residents were consistently being supported to receive care in-line with their assessed needs. One resident left the designated centre on the morning after the inspection without staff supporting them. The resident's assessed needs required staff support at all times in the community to ensure their safety.

During the inspection not all fire doors were free from obstruction to enable them to work as intended. A resident had a routine which included the positioning of a chair at the sitting room door. The inspectors were informed this assisted the resident to self-regulate and reduce their anxieties. However, the chair remained in place even when the resident was no longer in the designated centre and after it was brought to the attention of local management by the inspectors.

Not all residents had been supported to attend allied health care professionals and had extended periods of time since they were last reviewed by a dentist. The last time two of the residents attended a dentist was in 2022. One resident was being supported by relatives to attend a dentist privately and this was reported to be working well for the resident. Another resident was awaiting a referral for assessment by an occupational therapist since 2023.

The inspectors reviewed sections of personal plans for three of the residents. Two of the residents had not had an annual assessment completed in the previous 12 months. In addition, there was inconsistent information for staff regarding two residents daily routines. In the staff meeting notes from 18 February 2026 it was documented that a resident was not to receive fluids after 19:00 hours. This was not documented in the resident's support plan and the inspectors were informed by local management during the inspection this was not implemented. However, inspectors were not assured that all staff were informed of this. Another resident required support around accessing coffee. There was a support plan in place, however, the

inspectors were informed by staff that this was difficult to implement and not all staff adhered to the plan when the resident made requests to have coffee.

There was one vacancy at the time of this inspection in the house. One resident had chosen to avail of service elsewhere during a holiday break with relatives in August/September 2024. However, some of their personal possessions were still in the bedroom and sitting room of the space used by that resident.

Regulation 12: Personal possessions

The person in charge outlined the supports in place for each of the current residents to have access to their personal property and possessions. Residents were being supported to manage their finances. Details were provided of ongoing challenges that had been encountered to support one resident to open their own bank account. This had been recently resolved and was confirmed by the resident's relative that the resident's money was expected to be paid directly into the bank account as all documentation had been completed.

The resident who lived in the apartment had a tenancy agreement in place which outlined what they were required to pay each week and what was not provided such as food and personal toiletries. The inspectors were informed staff supporting this resident did not use these items purchased by the resident.

However, some personal possessions belonging to a former resident who had moved out of the designated centre in August /September 2024 still remained in the house. The person in charge outlined there had been a change to the original plan to return the personal possessions. There were a number of boxes still present in the vacant bedroom and sitting room where the resident used to reside. This was an extended period of time for the former resident to not have had their possessions returned to them.

Judgment: Substantially compliant

Regulation 17: Premises

Overall, the designated centre was found to be clean, ventilated and some upgrade works had been completed since the previous HIQA inspection in January 2025. These included a change to the floor covering upstairs. There was an additional sitting room upstairs which one resident used frequently. There was also a garden room at the rear of the main house which provided another space for residents to use if they chose to do so.

- Each resident had been supported to decorate their bedrooms in-line with their preferences. There were personal possessions, photographs and other decor to create a homely atmosphere.
- The upgrade works in both bathrooms in the main house had not yet progressed and the inspectors were advised this was still in review by the provider to ensure the future assessed needs of the residents would be adequately met with the upgrade. This had been identified as an action by the provider during internal audits in 2024 and was reported to be required to be completed during 2026 as documented in the annual report of 2025. Both bathrooms were observed to be clean and functional at the time of the inspection.
- The apartment was decorated to suit the preferences of the resident living there.

Judgment: Compliant

Regulation 20: Information for residents

The registered provider had ensured residents were provided with a guide outlining the services and facilities provided in the designated centre in an appropriate easy to understand format. The version submitted with the application to renew the registration was reviewed with the person in charge during the inspection as not all sections clearly reflected which area of the designated centre it related to. This included the apartment and main house. Further review was required to the document to ensure residents in both locations and an updated version was requested to be submitted during the feedback meeting.

Judgment: Compliant

Regulation 26: Risk management procedures

The registered provider had not ensured that there were effective systems in place in the designated centre for the assessment, management and ongoing review of risk.

The inspectors were informed there were no escalated risks in the designated centre at the time of this inspection.

On review of the centre's risk register and individual risk assessments for residents, not all control measures were found to be in place, this included gaps in staff training such as safe administration of medication, CPI and first aid.

The risk relating to a missing service user required further review following the event during this inspection. In addition, the controls documented as being in place were not reflective of which location in the designated centre they referred to. For example, at the time of the inspection keypads were not in place in the house but were documented as a control measure. There were no details of how staff were to support other vulnerable residents in the event of one resident leaving without staff support. None of the current residents were risk assessed to remain without staff support at any time and their assessed needs required ongoing support from staff both by day and night. It was documented in the staff meeting notes of January 2026 that staff had requested the requirement of one to one supports be provided for this resident due to the risk of them leaving without staff support.

The fire alarm in the designated centre could not work as intended with the sitting room door obstructed by a chair as part of a known routine which one resident engaged in. This was not reflected in the relevant risk assessment and directly impacted the effectiveness of the fire alarm. No other controls were documented to address this issue and the chair remained in position even when the resident was not present in the designated centre.

Judgment: Not compliant

Regulation 28: Fire precautions

The provider had protocols in place to monitor fire safety management systems which included a requirement for daily, weekly, monthly, quarterly and annual checks being completed.

- All residents had a personal emergency evacuation plans (PEEPs) in place. These were subject to regular review and were reflective of the supports and prompts that may be required for each individual. For example, the duties of the waking staff and the sleep over staff during a night time evacuation clearly outlined which resident was supported by the respective staff member. Information regarding emergency medication was also documented for the resident who required such supports.
- Fire drills had taken place frequently in the house from the records reviewed, this included a minimal staffing fire drill in December 2025. Actions and recommendations had been implemented which included creating a senario and documenting which exit was used during the drill.
- Fire doors checked during the inspection were observed to be working. However, a chair was placed by a resident in front of the sitting room door which impeded it from working as intended in the event the fire alarm was activated. The inspectors were informed this was part of a routine which one of the residents engaged in and assisted with reducing anxious behaviours. The inspectors observed the chair to remain in place throughout the inspection even when the resident was not present. This was discussed during the feedback meeting. The fire assessment risk had not identified this

vulnerability with the fire alarm functioning as intended. This will be actioned under Regulation 26: Risk management procedures

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The inspectors reviewed sections of three of the personal plans for the residents in the designated centre.

The person in charge had not ensured all residents had annual assessments completed within the previous 12 months. Of the personal plans reviewed one resident had their previous assessment completed in January 2025, the other resident had their last assessment completed in February 2025.

One resident had an identified medical requirement to be supported with monitoring their daily fluid intake. Consistent information was not in place to support the resident. There were two different volumes documented in the resident's personal plan. Variations were evident in the information provided for staff in the daily records and in the restrictive practice to support the resident in the event they consummed in excess of a stated amount of fluid.

While goals had been identified for residents not all had been attained or progress documented. This included a goal for a planned over night break for one resident. The person in charge outlined there was planned training for the staff team the week after this inspection regarding developing meaningful goals with the residents.

The inspectors were also informed residents were waiting prolonged periods of time for referrals to allied health care professionals such as an occupational therapist and two residents had not accessed a dentist since 2022. The inspectors acknowledge the person in charge provided information of barriers that had been encountered.

Judgment: Not compliant

Regulation 8: Protection

All core staff had completed up-to-date training in safeguarding of vulnerable adults. One new relief staff did not have details of completing this training on the day of the inspection.

- There were no open safeguarding plans in the designated centre at the time of this inspection. The person in charge outlined a safeguarding concern that had been opened on behalf of a resident regarding access to their finances. This matter had been addressed and the resident had their own bank account

in place and all the required documentation regarding the payment of the resident's monthly disability payment directly into that account had been completed.
- The inspectors were informed there were no concerns at the time of this inspection for any of the current residents to have access to their own finances and all could engage in activities of their choice without constraints of not been able to access their finances.
- Safeguarding was included regularly in staff and residents meetings to enable ongoing discussions and ensure awareness of possible indicators of abuse.
- Residents independence while maintaining their privacy and dignity during intimate care was promoted in personal intimate care plans.

Judgment: Compliant

Regulation 9: Residents' rights

The inspectors found that residents were being supported to engage in an increased variety of activities since the previous inspection. These included gardening activities for one resident. On the day of the inspection there were a variety of flowers growing in the garden of the house which the resident and their key worker had been responsible for.

Residents were been offered the opportunity to attend sensory swimming if they chose to do so since January 2026. One resident was being supported on alternate weeks to attend swimming during the week with staff members rather than their relative as part of progressing towards decreased dependence on their relative to attend that activity at all times.

One resident had been supported to go on a short break during 2025. This was to a location of their choosing and they had enjoyed the experience.

Residents were supported to attend activities that would not have previously been considered a possibility for them, these included attending sporting events such rugby matches.

However, residents were not always able to have freedom of choice in their daily lives due to the current staffing arrangements. The inspectors were informed one resident who would previously have gone for regular walks in the evening could not do so if only one staff was present supporting two residents as the other resident did not mobilise at the same pace.

Staff reported challenges experienced in supporting residents to engage in individual activities when minimal staff resources were on duty. In the event a resident in the house had expressed they wished to complete a community activity, staff on duty contacted the staff and resident in the apartment to see if an activity could be

arranged which suited both parties. This will be actioned under Regulation 15: Staffing

Not all residents had been supported in-line with their human rights to attend allied health care professionals such as a dentist. This will be actioned under Regulation 5: Individualised assessment and personal plan.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 5: Application for registration or renewal of registration	Compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 12: Personal possessions	Substantially compliant
Regulation 17: Premises	Compliant
Regulation 20: Information for residents	Compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Drombanna OSV-0002652

Inspection ID: MON-0041515

Date of inspection: 16/04/2026

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 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • Since the inspection, one 30-hour post has been recruited, Garda Vetting is awaited, once this is received, this staff member will be added to the rota. Two 30-hour posts have also been recruited into; these applicants are in pre-employment checks. • One permanent staff member has increased their hours from 15 to 25 hours per week. This was implemented on 20/04/2026. • One relief staff member has taken up a permanent 30-hour contract and will commence in this role on 18/05/2026. • One additional relief staff member has been recruited; Garda vetting is awaited for this person. • A 30- hour specific -purpose contract to cover sick leave and annual leave has been advertised, and interviews are scheduled to take place on 14/05/2026. • A full review of the seven-day roster was completed, and consistent staffing ratios of 1:1 have been implemented. Additional staffing is being utilised across the weekend roster, and a reduction in the number of residents in the service will impact this level of staffing. This was implemented from 23/04/2026.	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • All staff have now completed medication administration assessments. This was completed by 19/04/2026 as per the urgent action response submitted to HIQA following this inspection. The training records have been updated to reflect this.	

• Team Leader Q1 2026 supervision was completed on 21/04/2026 and second supervision will be completed before 30/06/2026.

• All other staff supervisions are up to date, with the exception of one staff member who will be vacating their post on 25/05/2026.

• The supervision schedule has been updated to reflect dates of PIC supervision.

• At the time of inspection, two staff were awaiting CPI training. One will complete this training on 14/05/2027. The other relief staff member will not be on shift again until they have completed this training.

• In the future, no new staff member commences on the rota until key mandatory training courses are completed.

• One relief staff member who required safeguarding training at the time of inspection completed the training on 20/04/2026.

• One staff member will complete food safety training on 18/05/2026.

• The PIC will ensure that there is a first-aid trained member of staff on every shift. The three staff members who are not currently first-aid trained will receive training by 31/07/2026.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:

• The Monthly Audit template has been amended to ensure Quarterly notifications are checked by the PIC to ensure all events are reported to HIQA as required. This was completed on 17/04/2026.

• The Provider has placed this service in its escalation process. A Governance Group has been established; the first meeting took place on 05/05/2026.

• Actions from this compliance plan will be uploaded onto the Provider's action database, and progress will be monitored by the Governance Group in place for the service until all actions are closed.

• The Provider has communicated with staff who complete Internal Six-Monthly visits to remind them of the requirement to review all relevant information, including notifications to HIQA, while completing visits. This was completed on 12/05/2026.

• The Provider's Board have been provided with a copy of this Inspection report and will receive quarterly updates on the progress of the compliance plan actions until all actions are closed.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:

• Retrospective quarterly notifications in respect of the use of restrictive practices were submitted to HIQA on 15/04/2026 and 24/04/2026.

• Going forward, the PIC will ensure all Notifications are submitted as required.

Regulation 12: Personal possessions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 12: Personal possessions:

• Remaining items owned by the resident who has been discharged from the service have been sent on to them. All of their personal possessions have now been removed from the service. This was completed on 24/04/2026.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:

• Two separate risk logs have now been created to distinguish between the two locations of the designated centre. This ensures that only relevant control measures for each location are listed. This was completed on 17/04/2026.

• Workplace risk assessments have been reviewed and changed to reflect the separation of the risk log. This was completed on 17/04/2026.

• Missing service user risk assessment has been reviewed and an additional control measure of a sounding bell on the front door has been implemented. This was completed on 22/04/2026.

• The chair referred to above has been removed from the service. This was completed on 22/04/2026.

• The missing service user risk assessment has been updated to reflect that a minimum of 1:1 staffing is consistently provided. Two more additional control measures have also been introduced; a sounding bell and a locked door, both have been reviewed by the Restrictive Practice Committee.

• The missing service user procedure has been reviewed; it outlines the procedure to be followed in the event of a service user going missing. This was completed on 23/04/2026.

• The Business continuity plan will be reviewed to ensure that contingency arrangements have been clearly outlined to manage situations of unplanned staff absence. This will be

completed by 20/05/2026.	
Regulation 5: Individual assessment and personal plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:

• Annual assessments have now been completed for all residents. This was completed by 15/05/2026.

• Fluid restriction volumes have been updated on the Restrictive practice approval form to reflect the most recent change. Fluid restriction volumes are now consistent on all documents. This was completed on 22/04/2026.

• Action plan training was completed at the April team meeting. Keyworkers will complete a full review of all action plans. Action plans that have not started will be removed until they are ready to be implemented. This will be completed by 27/05/2026.

• The PIC has followed up on previous referrals for OT. This was completed on 30/04/2026. Appointment dates are awaited.

• The need for dental care identified for three residents has been escalated to the PPIM, HSE and families. If no public access to dental care can be secured, private options will be explored. This will be completed by 31/07/2026.

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 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.	Substantially Compliant	Yellow	24/04/2026
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Not Compliant	Orange	30/06/2026
Regulation 16(1)(a)	The person in charge shall	Not Compliant	Red	31/07/2026

	ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.			
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	30/06/2026
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.	Not Compliant	Orange	23/04/2026
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	12/05/2026
Regulation 23(3)(a)	The registered provider shall ensure that effective arrangements are in place to support, develop and performance	Not Compliant	Orange	31/07/2026

	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.			
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Not Compliant	Orange	20/05/2026
Regulation 31(3)(a)	The person in charge shall ensure that a written report is provided to the chief inspector at the end of each quarter of each calendar year in relation to and of the following incidents occurring in the designated centre: any occasion on which a restrictive procedure including physical, chemical or environmental restraint was used.	Not Compliant	Orange	24/04/2026
Regulation 05(1)(b)	The person in charge shall ensure that a	Not Compliant	Orange	15/05/2026

	comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out subsequently as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.			
Regulation 05(2)	The registered provider shall ensure, insofar as is reasonably practicable, that arrangements are in place to meet the needs of each resident, as assessed in accordance with paragraph (1).	Substantially Compliant	Yellow	31/07/2026