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:	Cabra Road Group-Community Residential Service
Name of provider:	Avista CLG
Address of centre:	Dublin 7
Type of inspection:	Announced
Date of inspection:	25 August 2026
Centre ID:	OSV-0003059
Fieldwork ID:	MON-0042799

About the designated centre

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

Cabra Road Group - Community Residential Service is a community based residential service in Co. Dublin providing care and support for up to nine residents, over 18, with an intellectual disability. The designated centre is comprised of two properties located in close proximity to each other. The designated centre is managed by a full time person in charge. Residents are supported on a 24 hour basis by a staff team consisting of staff nurses, social care workers, and healthcare staff.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	8

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Tuesday 25 August 2026	09:00hrs to 17:15hrs	Kieran McCullagh	Lead

What residents told us and what inspectors observed

This was an announced inspection, completed to monitor the registered provider's compliance with the regulations and to inform the decision in relation to renewing the registration of the designated centre. Overall, this inspection found that there were serious risks to the safety of the residents and management systems in place failed to ensure the safety and wellbeing of residents living here. For this reason, on the day of the inspection, the inspector took the action of issuing the registered provider with an immediate and urgent action in relation to Regulation 28: Fire precautions.

Following the inspection, the registered provider submitted an urgent compliance plan in relation to risks identified by the inspector. The registered provider set out actions they had taken and intended to take in order to bring the designated centre back into full compliance. The urgent compliance plan response was reviewed by the inspector, which gave assurances that the registered provider would take necessary actions to mitigate against risks identified. This is discussed further under Regulation 28: Fire precautions, in the main body of this report.

The inspection was carried out over a single day and was facilitated by the person in charge. During the inspection, the inspector also met six staff members on duty. To assess the quality of life for residents the inspector relied on a combination of observations, discussions with residents, a review of relevant documentation, and conversations with key staff members.

The designated centre was comprised of two properties in close proximity to each other, located in Dublin. The designated centre was located within walking distance of shops, restaurants, and public transport links. The designated centre was registered to accommodate nine adults. At the time of this of this inspection there were eight residents living in the designated centre, with five residents living in one property and three living in the second. Over the course of the day, the inspector had the opportunity to meet and talk to five residents. In addition, the inspector met with the person in charge and person participating in management.

According to the designated centre's statement of purpose, its aim was to "provide a community based and person-centred setting wherein residents are cared for, supported and valued in an environment that actively supports and promotes their health, development, and well-being".

Care and support to residents was provided by a team of nursing staff, social care workers and healthcare assistants. At the time of this inspection the designated centre was operating with a 0.5 whole time equivalent healthcare assistant post. Although the person in charge was endeavouring to back fill vacant shifts, it was

found that there was an over reliance on relief and agency and relief staff to cover vacant shifts, which was having a negative impact on residents.

The first premises visited by the inspector was home to five residents. It was a large wheelchair accessible bungalow, with six bedrooms, one of which was a staff sleepover room / office space. It had two large accessible bathrooms, a kitchen, a dining / living room, and a sitting room. The inspector completed a walk through of the premises in the company of the person in charge. The inspector identified a number of maintenance issues that required the registered provider's attention. Specifically, visible damage to walls throughout the premises was observed, and further damage and scuff marks to doors and architraves was also noted. Stained ceilings and areas of mould as a result of previous leaks was noted by the inspector, and chipped grout, damaged bathroom cabinets, and patches of rust were visible. Some of these issues had been previously identified during the designated centre's previous inspection, which was completed in February 2026. It also was noted by the inspector that enhancements were required regarding the storage of residents' wheelchairs and hoists, and communal areas within the designated centre would benefit from repainting, thereby enhancing the cozy atmosphere and improving the overall aesthetics.

To the rear of the premises there was a shed, which was used as a laundry room, and housed the washing machine and tumble dryer. The inspector identified a number of potential fire safety risks specifically related to the shed. For instance, it was not fitted with a self-closing fire door, and automatic fire detection was not provided in this room. Furthermore, the inspector observed that a number of combustible items were being stored within the space, which further increased the risk to residents and staff members. The inspector issued an immediate action to the registered provider to ensure specific risks around fire were appropriately mitigated.

The second premises visited by the inspector was home to three residents. It was a semi-detached house, with five bedrooms, one of which was a staff sleepover room. It had a kitchen, a living / dining room, two bathrooms, and a storage room. Like the first property visited, there was a shed to the rear of the premises that was primarily used as a laundry room. The inspector also noted a number of potential fire safety risks specifically related to the shed, including no self-closing fire door, and automatic fire detection was not provided in this room. The inspector also identified further maintenance issues that required attention and repair. This is discussed further under Regulation 17: Premises.

The inspector had the opportunity to meet and talk to five residents over the course of this inspection. In the first premises the inspector met and spoke with three residents. One resident had recently moved into the designated centre. They were still settling into their new home, but told the inspector they felt happy and safe. They were supported to keep in contact with their previous housemates, and were being supported by a familiar staff member to meet some friends for lunch. The resident told the inspector they preferred their new bedroom as it was more spacious. They did not have any complaints on the day of this inspection.

Two other residents the inspector met with also had plans for community based activities. One resident had an appointment to get their nails done and were supported by staff to attend that appointment. They briefly engaged with the inspector and spoke about a recent trip they had taken to Cork to meet up and spend time with some family friends. The other resident was relaxing at the dining table and appeared content and comfortable in the presence of the inspector. They smiled and spoke about their plans for the day. The inspector noted that interactions between the resident and staff were familiar, and it was clear that they had a good rapport.

In the second premises the inspector spent time talking to two residents. One resident showed the inspector their bedroom. They told the inspector they really liked their bedroom and they had chosen the colour to paint the walls. They had spent the day in their day service programme and asked to speak with the person in charge about their day. The inspector noted that staff supporting the resident, including the person in charge, were very attentive to their needs and gave them the time and space to speak about their day. The other resident briefly engaged with the inspector. They were observed to be relaxing in the living room, watching television and doing a jigsaw. The inspector noted that staff supported and interacted with the resident in a kind and caring manner, responding to questions, and providing care when required.

The inspector spent time speaking with the person in charge. They informed the inspector that the highest rated risk in the designated centre pertained to the timely evacuation of residents during an emergency. Concerns were raised regarding the lack of service specific emergency mat training for evacuation purposes for all staff members and the high frequency use of relief and agency staff. Staff members spoken with also raised concerns regarding the over reliance on relief and agency staff. Specific concerns raised included lack of formal positive behaviour support plans for staff to follow, and residents unfamiliarity with relief and agency staff and engaging in behaviours that challenge especially during times of personal and intimate care.

In summary, the registered provider had failed to ensure their management systems were providing a service that was safe, appropriate to residents' needs, consistent, and effectively monitored at all times. Strategies to support residents were not effective and there remained an ongoing risk to residents wellbeing and safety.

In response to the high levels of non-compliance found on this inspection, the Office of the Chief Inspector of Social Services invited the registered provider to attend an escalation meeting requiring the registered provider to bring the designated centre back into full compliance with the regulations outlined in this report.

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

Capacity and capability

This section of the report presents the inspection findings regarding the leadership and management of the service, and evaluates how effectively it ensured the provision of a high-quality and safe service. Overall, it was determined that the registered provider had failed to ensure that management systems in place in the designated centre were effective in providing a service that was safe, appropriate to residents' needs, consistent, and effectively monitored at all times.

The registered provider had not ensured that the designated centre was adequately resourced to ensure the effective delivery of care and support. The registered provider failed to put in place appropriate contingency arrangements to respond to residents' assessed needs, including behavioural support needs. The heavy reliance on relief and agency staff meant there was limited continuity of staffing which supported the building of relationships between staff and the residents who relied on staff support.

The registered provider and the person in charge did not have effective systems in place to assure them that all staff employed to work in the designated centre had the required mandatory or service specific training in order to fully support residents living in this designated centre. Gaps in staff training further highlighted the inadequate oversight and review of staff training.

Improvements were necessary to ensure that appropriate oversight systems were in place in order to maintain an accurate and up-to-date resident directory for all residents living in the designated centre.

The registered provider had not ensured appropriate oversight and monitoring of the designated centre. The inspector noted that staff team meetings were not occurring on a regular basis, and critical actions as a result of internal audits had not been initiated or completed. This led to a number of non compliance judgements and resulted in urgent actions been issued to the registered provider following inspection. Overall, the registered provider's governance and management of the designated centre had failed to account for both known and potential risks, and they did not ensure that the designated centre was appropriately resourced and monitored to provide consistent, effective care and support for residents at all times.

The following section of this report will focus on how the management systems in place are contributing to the overall quality and safety of the service provided within this designated centre.

Regulation 15: Staffing

Overall, improvements were required to the oversight of staff rosters, and staffing arrangements to ensure continuity of care for all residents residing in the designated

centre. In addition, further improvements were required to ensure the person in charge had obtained in respect of all staff the information and documentation as specified in Schedule 2.

At the time of this inspection the designated centre was operating with a 0.5 whole time equivalent (WTE) vacant healthcare assistant position. Although the registered provider and person in charge was endeavouring to back fill vacant shifts, it was found that there was an over reliance on agency and relief staff. t Following a review of staff rosters it was unclear as to the reason the person in charge was using agency and relief staff to cover shifts as there appeared to be no staff on annual leave or sick leave at specific times when agency use was high. Therefore, a full review of the designated centre's staffing WTE was necessary to ensure staffing levels were in place to meet residents' assessed needs.

Following a review of the planned and actual rosters maintained in the designated centre for the months of June and July 2026 it was found that:

- 11 different agency staff members covered a total of 26 shifts over a two week period in June 2026
- Eight different relief staff members covered 22 shifts over the same two week period
- Ten different agency staff members covered a total of 13 shifts over a two week period in July 2026
- 11 different relief staff members covered 33 shifts over the same two week period.

The registered provider and person in charge had not ensured that suitable contingency arrangements were in place to ensure continuity of care for residents. This was of concern given the complex needs of the residents, and required comprehensive review by the registered provider.

Improvements were required to the recording of agency and relief staff used to back fill vacant shifts. For example, there were numerous occasions in which the full name of the relief and agency staff or the agency used was not recorded. This required enhancement to ensure the registered provider and person in charge had easy access to accurate and up-to-date staff rosters.

The inspector reviewed three staff records, and found that improvements were required. Specifically, the inspector noted that that one staff member's Garda vetting had expired, details and documentary evidence of qualifications were missing, and one staff member did not have a full employment history on file. This required further review and consideration by the person in charge.

Judgment: Not compliant

Regulation 16: Training and staff development

Staff were required to complete training as part of their professional development and to support them in the delivery of appropriate care and support to residents. A review of the most recent training records made available to the inspector evidenced gaps in relation to both mandatory and service specific training for staff.

Specifically, the inspector noted the following training deficits:

- Staff had not completed service specific emergency mat training to safely evacuate residents
- Staff had not completed service specific Emotionally Unstable Personality Disorder (EUPD) training
- Three staff had not completed basic life skills training
- One staff had not completed safeguarding vulnerable adults training
- One staff had not completed fire safety training
- Three staff had not completed managing behaviour that challenges training.

In addition, a number of regular relief staff did not have up-to-date training in fire safety, food safety, Children First, safeguarding of vulnerable adults, manual handling, and safe administration of medication.

The deficits in staff training posed a risk to the quality and safety of the care and support provided to residents and their wellbeing, and required considerable review by the registered provider and person in charge.

Staff supervision was not reviewed as part of this inspection.

Judgment: Not compliant

Regulation 19: Directory of residents

Improvements were required to ensure the registered provider and person in charge had appropriate oversight systems in place in order to maintain an accurate and up-to-date resident directory for all residents living in the designated centre.

The inspector reviewed the directory of residents, and found that information as set out under Schedule 3 had not been recorded or maintained for two residents living in the designated centre. This required review and improvement to ensure ongoing accuracy. Specifically, the address of one resident's next of kin was missing and the name, address and telephone number for another resident's General Practitioner (GP) was not documented on the designated centre's directory of residents.

The inspector confirmed that all information pertaining to the other five residents met the required standards as set out in Schedule 3. For instance, the name, address, date of birth, sex, and marital status of each resident, the name, address and telephone number of each resident's next of kin or representative, and the

name, address and telephone number of these residents' GP was documented in line with regulatory requirements.

Judgment: Substantially compliant

Regulation 23: Governance and management

Improvements were required to ensure the registered provider and person in charge had suitable oversight of the designated centre, and that effective governance arrangements were in place to ensure the service was safely and effectively managed. The registered provider had not ensured the designated centre was resourced or monitored in a way that ensured effective delivery of care and support to residents at all times.

This inspection highlighted that the governance and management practices had not effectively addressed previously identified concerns. Specifically, the registered provider and person in charge had failed to complete actions set out in their compliance plan response following a previous inspection completed in February 2026. That inspection identified a number of areas of concern pertaining to staffing and governance and management. The registered provider had provided written assurances to the Chief Inspector that all actions would be complete by the end of June 2026. However, this inspection found that actions had not been completed, and in some circumstances initiated in order to bring the designated centre back into full compliance with the regulations. Furthermore, additional concerns regarding staff training and development, fire precautions, and positive behavioural support were identified.

The inspector found that the registered provider's auditing systems were not operating effectively, and registered provider led six monthly unannounced visits were not taking place in line with regulatory requirements. For instance, one unannounced visit took place in August 2026, while the previous report on file took place across three days in June and July 2025. This was outside of the specified timeframe, as outlined under the regulations. Moreover, the purpose and rationale for staggering dates across two months was unclear, and required review by the registered provider.

Following review of reports maintained, the inspector found that improvements were required regarding the accuracy of recorded and reported information. Specifically, the most recent registered provider led six monthly unannounced report failed to identify concerns regarding staffing and the over reliance on the use of agency and relief staff, gaps in staff training, residents' assessed positive behavioural support needs and lack of formal positive behaviour support plans, and significant fire safety risks.

Improvements were also required to weekly and monthly local auditing systems. Local audits were completed as part of governance arrangements, and covered

critical areas such as premises, fire, residents' finances, and infection prevention and control (IPC). A review of audits completed by the inspector evidenced that local auditing systems in place were not identifying risks regarding IPC, fire safety, or the storage of residents' medicines. This required a comprehensive review.

The person in charge informed the inspector that monthly staff team meetings were intended to occur on a monthly basis. Upon request, the inspector reviewed the minutes of staff team meetings held at the designated centre across 2026. The inspector noted that three staff team meetings had took place so far in 2026, with meeting minutes missing for the months of February, March, June, and July 2026. This did not provide sufficient assurance to the inspector that all staff were being adequately updated and informed about the evolving needs of residents within the service, and this posed a risk to the staff members providing person-centred, safe, and effective support.

Judgment: Not compliant

Quality and safety

The registered provider did not demonstrate the capacity or capability to operate the service in compliance with the regulations and in a manner which ensured safe and quality care to all residents. Overall, strategies in place to support residents' assessed positive behavioural support needs were not effective, and there remained an ongoing risk to residents' safety due to risks related to fire safety.

During this inspection, a number of maintenance issues were identified that warranted thorough review and prompt attention from the registered provider. Some of these issues, had been previously identified in an inspection completed in February 2026. The inspector observed noticeable wear and tear and some areas of damage throughout both premises that comprised the designated centre, including damage to walls, doors and architraves, stained ceilings and areas of mould as a result of previous leaks, and areas of rust. Addressing these maintenance deficits was required to ensure residents were provided with a safe, comfortable, and welcoming environment.

There were a number of fire safety risks identified on this inspection. Of particular concern were issues and risks pertaining to the absence of appropriate fire containment within two sheds being used as a laundry room. These deficiencies demonstrated that the registered provider had failed to ensure that adequate fire safety measures were in place to protect residents, staff, and visitors from the risk of fire. The absence of appropriate detection, containment, and fire prevention measures increased the potential for a fire within either shed to go undetected and to spread, thereby comprising the safety of all residents living in the designated centre.

The person in charge ensured that there were appropriate and suitable practices relating to medicine management within the designated centre. This included the administration of residents' medicines and medicine audits. However, improvements were necessary to ensure all staff, including relief staff used to backfill vacant shift, had up-to-date safe administration of medication training. Furthermore, improvements were also required to the safe storage of all medicines within the designated centre.

Residents were seen to be supported to access relevant healthcare appointments, and to live busy and active lives in line with their assessed needs and preferences. It was found that residents had assessments of need on file. Care intervention plans were derived from these assessments of need. Care intervention plans were comprehensive, and were written in person-centred language. Residents' needs were assessed on an ongoing basis, and there were measures in place to ensure that their needs were identified and adequately met. However, improvements were required to ensure all residents had up-to-date assessments of need on file.

The registered provider had failed to ensure that residents with identified positive behavioural support needs had access to appropriate and structured supports. As a result, some residents were exhibiting behaviours, including instances of self-injury, and staff were left without the vital guidance or tailored support strategies required to effectively intervene and promote safer, positive outcomes within the designated centre. In addition, improvements were required to ensure all restrictive practices in use were notified to the Chief Inspector, appropriately risk assessed and reviewed by the registered provider's restrictive practice committee.

Regulation 17: Premises

Improvements were required by the registered provider to ensure that both premises that comprised the designated centre were kept in a good state of repair, and met the requirements as outlined under Schedule 6. This had been found on the previous inspection, which was completed in February 2026.

During this inspection, the inspector identified a number of maintenance issues that detracted from the welcoming atmosphere of the designated centre.

Specifically, the following was observed:

- Damage to walls in both premises that required repair
- Damage to bathroom cabinets, doors, and architraves
- Stained ceilings from previous leaks and areas of mould
- Damage to hallway doors
- Damage to staircase and banister
- Broken bathroom tiles and chipped grouting
- Damage to bathroom floor
- Detached plastic edge trim moulding which required repair in one bathroom

- Rust around bathroom grab rails which required replacement.

Furthermore, storage practices in both premises warranted considerable improvement. For example, in one location, the inspector noted that residents' wheelchairs and hoists were kept in communal hallways, which impeded residents' free movement around their home. In another, a storage room needed cleaning and reorganisation, while a shed to the rear of one premises was overcrowded with archived items and seasonal decorations.

Judgment: Not compliant

Regulation 28: Fire precautions

There were a number of fire safety risks identified on this inspection which posed a risk to the safety of the residents. Due to these risks, an immediate and an urgent action was issued to the registered provider, which required them to submit an urgent compliance plan response detailing the actions they would take to address these risks in a timely manner and bring the designated centre back into full compliance under this regulation.

The registered provider had not implemented appropriate arrangements to prevent, detect, and contain fire within the two sheds located to the rear of each home that comprised the designated centre. The sheds were primarily used as utility areas and housed the designated centre's washing machines and tumble dryers, which presented an increased potential fire risk due to the nature of the equipment and its associated electrical use. The inspector observed that neither shed was provided with appropriate fire detection and alarm systems or smoke detection. In addition, there were no fire resistant doors in place to provide appropriate fire containment and limit the potential spread of fire. The inspector also observed a number of combustible items being stored within one of the sheds, further increasing the risk of fire to develop and spread.

As a result of the above, the inspector issued the registered provider with immediate actions to ensure that the risks around fire safety were suitably mitigated. The provider ensured that all potential ignition sources and combustible items were required to be removed prior to the inspector leaving, and battery operated fire and smoke detection systems were to be installed in both sheds.

As previously reported under Regulation 16: Training and staff development, the staff team had not completed required emergency mat training. This was concerning, as three residents required the use of an emergency mat in order to be safely evacuated in the event of an emergency. This requirement was also specified in residents' personal emergency evacuation plans (PEEPs) and reinforced as an additional control measure in their individual fire risk assessments. Without the required training, staff were unable to evacuate all residents safely, increasing the overall risk in the event of a fire.

Following the inspection the registered provider submitted an urgent compliance plan, which outlined the actions they would take. The inspector reviewed the response and was assured that the registered provider would put in place necessary actions to bring the designated centre into compliance. For example, the registered provider outlined the following in their compliance plan response:

- Immediate action has been taken to address the identified deficiency in fire detection systems in the shed to the rear of the designated centre. The required smoke detection device has been installed and verified as operational. This is a temporary measure as an immediate action.
- The registered provider has committed to updating the current fire system in the designated to include coverage in the external laundry areas.
- Staff training in the use of equipment required for the safe evacuation of the residents (Emergency Mat Training) within the designated centre has been scheduled on 2 and 4 September 2026.
- Mandatory fire safety training has been scheduled for the staff member identified as requiring this training.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

The registered provider had procedures in place for the safe administration of medicines. However, improvements were required to ensure all staff had appropriate training. Further improvements were necessary in the management procedures for the storage of residents' medicines including PRN medicines.

There were practices and arrangements in place for the management of residents' medicines, including for the ordering and administration of medicines. The practices were underpinned by the registered provider's established medication management policy.

Residents were in receipt of a comprehensive individualised service from their pharmacist, who facilitated the safe and timely supply of medicines, as well as information and pharmaceutical care to ensure the best possible outcome for each resident living in the designated centre.

The inspector found evidence to support that each resident's medicines were administered and monitored in line with best practice as individually and clinically indicated. For instance, the inspector reviewed the practices and arrangements for three residents and spent time talking through residents' medicines with a staff nurse and a social care worker on duty. Following conversations, it was evident to the inspector that staff were very knowledgeable of the professional guidelines and professional code of practice that governed medicines management, and continually adhered to these requirements.

Staff were required to complete training before they administered medicines, and a review of staff training records evidenced not all staff members were in receipt of this. For example, as previously reported under Regulation 16: Staff training and development, a number of relief staff did not have up-to-date safe administration of medicine training.

Further improvements were also required to the safe storage of all medicines within the designated centre. For instance, the inspector noted that a resident's medicine, which required refrigeration, was stored in the communal kitchen fridge in one house. This approach failed to align with the registered provider's established medication management policy in relation to safe storage of medication and posed a potential safety risk, and required improved and more secure storage arrangements. In addition, the inspector noted that one resident's PRN was not properly labelled, which posed a potential risk of misadministration. This required review and consideration by the person in charge.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

The person in charge had ensured assessments of residents' needs were completed and informed the development of personal plans. However, improvements were required to ensure that all residents had up-to-date assessments of need on file.

Assessments of need informed comprehensive care plans which were written in a person-centred manner and detailed residents' preferences and needs with regard to their care and support. For example, the inspector observed plans on file for residents relating to the following:

- Communication
- Feeding, eating, drinking, and swallowing (FEDS)
- Mobility
- General healthcare.

However, one resident's assessment of need, which was last reviewed in August 2026, required further review. Specifically, sections pertaining to behaviours that challenge were marked as requiring support. However, following review and discussions with staff and the person in charge, the resident did not present with an assessed need under positive behavioural support. The oversight arrangements for reviewing residents' assessments of need required strengthening to ensure that accurate and up-to-date information regarding each residents' needs was maintained on file.

Residents were supported to plan meaningful personal goals in line with their personal will and preference. Examples of goals included joining a local flower arranging class and visiting family. Residents were supported to break their goals

into achievable steps, and documentation was available to demonstrate their progress, and their goal attainment.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

The inspector reviewed the arrangements in place to support residents' positive behaviour support needs and found that the registered provider had failed to provide all residents with timely and effective positive behavioural support in line with their assessed needs. In addition, the inspection highlighted gaps in the oversight of restrictive practices, which required comprehensive review by the registered provider and person in charge.

On the day of inspection, it was found that two residents with assessed positive behavioural support needs did not have formal positive behaviour support plans on file. Both residents presented with behaviours that challenge including self-injurious behaviours, verbal aggression, low mood, and anxiety disorder. Staff reported that one resident frequently engaged in behaviours that challenge during personal and intimate care routines. This was of particular concern given the over reliance on unfamiliar relief and agency staff.

On the day of this inspection the staff team had not received service specific training in the management of EUPD and three staff had not completed managing behaviour that challenges training. As a result, staff did not have the necessary knowledge, skills, and competencies to effectively implement positive behavioural supports or respond appropriately to behaviours that challenge. Furthermore, the lack of formal positive behaviour support plans meant that the staff team did not have crucial information on antecedents, proactive and reactive strategies, and detailed background on the behaviours.

During this inspection the inspector identified two restrictive practices in use which had not been identified by the registered provider, risk assessed, approved by the registered provider's restrictive practice committee, or notified to the Chief Inspector. For example, two residents required staff presence and supervision whenever they were together, thereby limiting their freedom of movement within their own home. In addition, residents' finances were stored in a locked safe thereby restricting their access to their own finances.

This absence of timely documentation impeded the management's ability to track patterns and implement proactive reduction strategies, further highlighting the need for strengthened governance and transparency in the use of restrictive practices.

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	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 19: Directory of residents	Substantially compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 7: Positive behavioural support	Not compliant

Compliance Plan for Cabra Road Group-Community Residential Service OSV-0003059

Inspection ID: MON-0042799

Date of inspection: 25/Aug/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:

Regulation 15(1)

The registered provider is committed to ensuring that the centre is adequately resourced to meet the assessed needs of the individuals supported, in accordance with the centre's Statement of Purpose.

The Person in Charge (PIC) and Provider Representative/Person Participating in Management (PPIM) will review the staffing complement within the centre to ensure that the Whole-Time Equivalent (WTE) staffing level is appropriate and reflective of the assessed needs of the individuals residing in the centre and that the updated information will be included in the Statement of Purpose which was submitted on 30/08/2026

Due for Completion 30/09/2026

Regulation 15(3)

The registered provider is committed to recruiting staff to fill the vacancies identified in the centre. As of 14/09/2026 one new 0.5 WTE HCA has commenced in the centre.

The Registered provider will identify a cohort of relief/agency staff to cover vacant shifts while recruitment is under way to ensure continuity of care during this period.

Due for Completion 31/01/2027

Regulation 15(4)

A robust system will be implemented to monitor and review the use of agency staff within the centre, with increased oversight of the allocation and deployment of agency staff to ensure that staffing arrangements are appropriate to the needs of individuals

supported. A system will be introduced to regularly review and audit staff rosters, ensuring that all required staffing information is accurately, clearly and consistently documented.
Completed 11/09/2026

Regulation 15(5)

A comprehensive review of all Schedule 2 staff information and supporting documentation will be completed to ensure full compliance with the relevant regulatory requirements.

Due for completion 30/11/2026

Regulation 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
Regulation 16(1)(a)

The PIC will review the Training Needs Analysis monthly through PPIM meetings to monitor training compliance, identify gaps, and ensure staff complete required mandatory and specialist training in line with residents' assessed needs. Training compliance will be reviewed through governance meetings and six-monthly provider audits, with any outstanding training actions tracked until completion and full compliance is achieved.

The required training identified is to be completed as follows

Fire Safety Training due for completion by 06/10/2026.
Safeguarding Training due by 11/11/2026.
ALBAC training for all house staff and regular relief staff to be completed by 22/09/2026.
EUPD training follow-up ongoing with Mental Health team 30/11/2026.
Managing Signs of distress training attended by 2 staff on 17/09, 5 staff in centre to complete refresher training in MSOD by 12/10/2026.

Due for Completion 31/12/2026

Regulation 19: Directory of residents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 19: Directory of residents:
Regulation 19(3)
A comprehensive review of the Directory of Residents will be completed by the PIC to ensure that it contains all information required under Schedule 3 of the relevant regulations.
The PIC will ensure that the required information is accurately recorded for each individual residing in the centre and that any identified gaps or omissions are addressed in a timely manner. The Directory will be maintained and updated on an ongoing basis to ensure that the information remains accurate and current.
This was completed on 04/09/2026

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
Regulation 23(1)(a)

The registered provider will ensure that the Statement of Purpose accurately reflects the assessed needs of the residents living in the centre and clearly outlines the service provided. The Statement of Purpose will be reviewed and updated as required to ensure that the staffing complement, skill mix, and support arrangements detailed within it are reflective of the current needs of residents and the operational requirements of the centre. Ongoing oversight and review will be undertaken to maintain compliance and ensure that practice remains consistent with the Statement of Purpose.

Due for completion 31/01/2027

Regulation 23(1)(c)

The registered provider has reviewed the governance and management systems in place. Additional weekly local governance meetings have commenced since the inspection to provide enhanced governance and oversight of the centre.
PPIM and PIC will meet weekly to review compliance plans arising from internal audits and recent inspections to ensure follow up on all actions is completed within timeframes.
The provider will meet with the PPIM and PIC monthly to provide oversight and ensure operational governance of all action plans. In addition, the Provider nominee/ senior

manager will visit the designated centre weekly to enhance oversight and governance arrangements.
The provider will meet with the Assistant CEO (ACEO) monthly to ensure oversight of the implementation of the compliance plan; progress will be reported to the CEO and Executive team.
Due for completion 31/10/2026
Regulation 23(2)(a)
The provider has committed to undertake a nominee provider visit on an enhanced schedule as part of the compliance plan. All recent provider visits and associated documentation will be maintained on file within the centre to ensure that there is a clear and accessible record of provider oversight and governance activity.
Due for completion 31/10/2026

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
Regulation 17(1)(b)
The provider has sourced external contractors to complete the remedial works necessary within both centres to achieve compliance.
Painting has been completed throughout the centre and immediate actions identified on date of inspection has been completed.
The PIC will complete the weekly walk around and all maintenance issues are discussed and logged at PPM/PIC meeting.
The provider has identified work within one location in the centre which will support accessibility and fire evacuation.
Due for completion: 31/01/2027

Regulation 17(7)
The registered provider has committed to adding additional storage in the centre.
Archiving of documents which were stored in the centre has been completed and alternative storage solutions have been found for items stored inappropriately.
Due for completion: 31/01/2027

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:

Regulation 28(1)
Immediate action was taken to address the identified deficiency in the fire detection system within the shed located to the rear of the designated centre. A smoke detection device has been installed and verified as fully operational. The provider has committed to extending the existing fire detection system to include coverage of the external laundry area. In addition, all items that had been inappropriately stored in this area have been removed.
A review of the fire safety arrangements within the designated centre was completed by the Director of Property and Estates on 27 August 2026. The review confirmed that all required emergency lighting is installed and maintained in accordance with Section 3.3.13 (Emergency Lighting) of the Code of Practice for Fire Safety in New and Existing Community Dwelling Houses 2017.
Completed 25/08/2026
Regulation 28(2)(c)
As the designated centre is a small, single-storey house with straightforward and clearly identifiable escape routes, exit signage is not required. Exit signage is only necessary where escape routes are not readily apparent and where a risk assessment identifies a need for signposting. In such circumstances, signage must be provided in accordance with S.I. No. 299/2007 - Safety, Health and Welfare at Work (General Application) Regulations 2007.
Completed 25/08/2026
Regulation 28(3)(a)
The designated centre has a fully operational fire detection system that is tested, serviced, and maintained in line with the provider's Fire Safety Policy. Appropriate firefighting equipment is in place throughout the centre and is maintained and serviced in accordance with policy requirements.
The centre has been constructed in compliance with the Code of Practice for Fire Safety in New and Existing Community Dwelling Houses 2017, including the installation of all required internal fire doors.
The provider has robust auditing arrangements in place to monitor and assess the effectiveness of fire safety measures on an ongoing basis. Additional governance of the auditing arrangements has commenced.
Monthly fire drills are conducted during both day and night shifts. These drills demonstrate that residents and staff are familiar with the fire evacuation procedures and designated escape routes.
Completed 25/08/2026
Regulation 28(4)(a)
Training in the use of the ALBAC evacuation equipment has been scheduled for staff on 2 and 4 September 2026. Mandatory fire safety training has also been arranged for the staff member identified as requiring refresher training. All staff, including relief and agency staff, receive a comprehensive induction that includes fire safety procedures specific to the designated centre.
An audit of all residents' Personal Emergency Evacuation Plans (PEEPs) was completed on 26 August 2026. This audit identified areas for improvement and ensured all relevant information was accurately recorded, including residents' mobility requirements and issues identified at fire drills. All actions arising from the audit were completed, and PEEPs were updated on 27 August 2026. These plans will be reviewed again following completion of the scheduled ALBAC training to ensure they remain accurate and reflective of residents' needs.

Due for completion: 22/09/2026

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
Regulation 29(3)

The provider has committed to ensuring medication fridge is available to the center to ensure all medications are stored appropriately and in accordance with relevant requirements.
Completed 07/09/2026

Regulation 29(4)(a)

The centre has access to 24 hour Nursing staff who oversee the dispensing and administration of medications, as well as the associated medication management systems and processes. This ensures that medication is administered by appropriately trained personnel and that the necessary controls and oversight remain in place at all times. The PIC will ensure that resources are allocated to support residents in administration of their medication in the centre.

Completed 07/09/2026

Regulation 5: Individual assessment and personal plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
Regulation 05(1)(b)
The provider has committed to conducting a comprehensive audit of all residents' care plans to ensure they are current, person-centred, accurately reflect each resident's assessed needs, and contain clear guidance for staff. Any gaps or inconsistencies identified through the audit will be addressed promptly, with care plans reviewed and updated as required to ensure compliance and effective delivery of care.

Due for completion 31/10/2026

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
Regulation 07(1)

The PIC will make referrals to the CNS in Positive Behaviour Support, where required, to ensure that residents receive appropriate specialist assessment and support.
The PIC will ensure that comprehensive Positive Behaviour Support Plans are developed and implemented for residents who require them, providing clear guidance to staff on proactive and responsive strategies for supporting individuals who present with behaviours of concern.

Due for completion 31/10/2026

Regulation 07(2)

MSOD training remains ongoing. Two staff members attended training on 17/09/2026, and a further five staff members are scheduled to attend refresher training to ensure staff have the knowledge and skills required to support residents who present with behaviours of concern.

EUPD training follow-up will continue in collaboration with the Mental Health Team to enhance staff understanding of Emotionally Unstable Personality Disorder and to support the effective assessment, identification and management of behaviours of concern.

Due for Completion 30/11/2026

Regulation 07(4)

The use, identification and review of restrictive practices will be a standing agenda item at staff meetings to promote oversight, discussion and least restrictive practice principles. The Person in Charge (PIC) will ensure that all restrictive practices are recorded in the restrictive practice log, monitored regularly, and notified to the Chief Inspector through the quarterly notification process in line with regulatory requirements.

Due for Completion 30/11/2026

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 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/Sep/2026
Regulation 15(3)	The registered provider shall ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.	Not Compliant	Orange	31/Jan/2027
Regulation 15(4)	The person in charge shall ensure that there is a planned and actual staff rota,	Not Compliant	Orange	11/Sep/2026

	showing staff on duty during the day and night and that it is properly maintained.			
Regulation 15(5)	The person in charge shall ensure that he or she has obtained in respect of all staff the information and documents specified in Schedule 2.	Not Compliant	Orange	30/Nov/2026
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Not Compliant	Orange	31/Dec/2026
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Not Compliant	Orange	31/Jan/2027
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Not Compliant	Orange	31/Jan/2027
Regulation 19(3)	The directory shall include the information specified in paragraph (3) of Schedule 3.	Substantially Compliant	Yellow	4/Sep/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	31/Jan/2027
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	31/Oct/2026
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding	Not Compliant	Orange	31/Oct/2026

	the standard of care and support.			
Regulation 28(1)	The registered provider shall ensure that effective fire safety management systems are in place.	Not Compliant	Red	28/Aug/2026
Regulation 28(2)(c)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Red	28/Aug/2026
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Red	28/Aug/2026
Regulation 28(4)(a)	The registered provider shall make arrangements for staff to receive suitable training in fire prevention, emergency procedures, building layout and escape routes, location of fire alarm call points and first aid fire fighting equipment, fire control techniques and arrangements for the evacuation of residents.	Not Compliant	Red	28/Aug/2026
Regulation 29(3)	The person in charge shall ensure that, where a pharmacist provides a record of a medication-	Substantially Compliant	Yellow	7/Sep/2026

	related intervention in respect of a resident, such record is kept in a safe and accessible place in the designated centre.			
Regulation 29(4)(a)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that any medicine that is kept in the designated centre is stored securely.	Substantially Compliant	Yellow	7/Sep/2026
Regulation 05(1)(b)	The person in charge shall ensure that a 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.	Substantially Compliant	Yellow	31/Oct/2026
Regulation 07(1)	The person in charge shall ensure that staff have up to date	Not Compliant	Orange	31/Oct/2026

	knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.			
Regulation 07(2)	The person in charge shall ensure that staff receive training in the management of behaviour that is challenging including de-escalation and intervention techniques.	Not Compliant	Orange	30/Nov/2026
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.	Not Compliant	Orange	30/Nov/2026