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:	Hawthorns
Name of provider:	Health Service Executive
Address of centre:	Co. Dublin
Type of inspection:	Unannounced
Date of inspection:	12 August 2025
Centre ID:	OSV-0003359
Fieldwork ID:	MON-0046385

About the designated centre

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

Hawthorns provides residential care for up to 16 adults, both male and female, with an intellectual disability. The centre consists of five detached bungalows and a self-contained apartment on a campus setting with green areas to the back and front. Each bungalow has an open plan living room with a defined dining area. Each home has a kitchen, a utility room and laundry facilities. Each resident has their own bedroom and access to a number of bathrooms. The centre is in a suburban area of Dublin close to a local village with easy access to shops and other local facilities. The centre is close to public transport links including a bus and train service which enables residents to access local amenities and neighbouring areas. Residents are supported by a staffing team 24 hours a day seven days a week and the team comprises of a person in charge, clinical nurse managers, staff nurses and care staff.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	16

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 12 August 2025	10:30hrs to 19:30hrs	Karen Leen	Lead
Tuesday 12 August 2025	10:30hrs to 19:30hrs	Brendan Kelly	Support

What residents told us and what inspectors observed

This unannounced risk-based inspection was completed following receipt of both solicited and unsolicited information of concern from this designated centre. The solicited information related to notifications of five separate allegations of abuse between December 2024 to April 2025, two pieces of unsolicited information were received by the Chief Inspector of Social Services via the concerns process relating to safeguarding, governance and management, and the quality of care and support for residents. The provider was issued with two provider assurance reports (PARs) in December 2024 and January 2025 following receipt of the unsolicited information, with the provider's assurance responses used as some of the lines of enquiry for this inspection.

Overall, the inspection found high levels of non-compliance with the regulations reviewed and found that the provider had not implemented a number of actions identified in their provider assurance report responses submitted to the Chief inspector in December 2024 and January 2025. Inspectors found that there were insufficient resources available to residents in the centre and that resources available were not being utilised in a manner that supported the safeguarding of residents or promoted residents to access meaningful activities. Furthermore, inspectors found that incompatibility of some residents posed a serious ongoing risk to their wellbeing and safety.

The Hawthorns comprises five houses and one single occupancy apartment based on a campus on the south side of Dublin. The centre was home to 16 residents, both male and female with intellectual disabilities. During this inspection, inspectors used observations, conversations with residents and staff, and a review of documentation to form judgments on the quality and safety of care and support provided to residents in the centre. The provider had implemented a number of documentation systems in place in order to capture the daily lived experience of the resident, for example, each resident had a daily report, house specific daily report which captured all residents in each house and a further global report. However, inspectors found that reports reviewed differed and did not always capture significant events such as safeguarding or peer-to-peer incidents which had occurred in the centre. Inspectors found that this inconsistency resulted in incidents not being effectively identified, recorded and as a result were not being reviewed and escalated through the appropriate channels in order to support residents.

The inspection was carried out by two inspectors over one day. Inspectors met with 11 residents, 12 staff members, the person in charge, clinical nurse manager 1 (CNM1) and administration staff. The inspectors also met with the assistant director of nursing (ADON) and the director of nursing (DON), both of whom held broader governance responsibilities across the provider’s service.

On arrival to the designated centre, the inspectors were met by one resident and support staff. The resident told inspectors that they were very happy to meet with

them. The inspectors asked the resident if they could come into their home and speak about what it was like to live there. The resident showed one inspector around their home, while the other inspector met with another resident. One resident brought one inspector into their bedroom and proudly showed the inspector photographs of family members, their work gear and personal items they had collected. The resident was more than happy to show the inspector around the remainder of their home and gave the inspector a run down of function of each room in the house. They also said they were very happy with the staff team working in the house. The resident then left the inspector to speak with staff while they went to the sitting room where the second inspector was speaking with another resident. The resident in the sitting room immediately responded with a marked change in presentation following a negative interaction with their peer that took place in front of an inspector, the resident presented as speaking in a much lower tone of voice and appeared anxious. The inspectors identified this interaction as a possible safeguarding concern in relation to the peer-to-peer interaction which led to the negative change in the presentation of one resident. The inspectors brought their concern to the attention of the person in charge and the assistant director of nursing, in order to escalate this allegation so that the appropriate review procedures could be initiated by the provider. Despite inspectors raising this concern, following the inspection, the provider failed to submit the relevant notification to the office of the Chief Inspector in line with the requirements of the Regulation.

During the course of the inspection, inspectors observed one resident request to go out on the bus with staff. This request could not be facilitated by the staff team due to lack of bus drivers available. Staff informed the inspectors that on the day of the inspection there was one driver on duty to cover the six houses that make up the centre. The staff had put together a plan to ensure that all residents who requested a bus trip could be facilitated, however, this plan would continue into the afternoon and evening. Inspectors observed staff supporting the resident as they were demonstrating distress that they could not go for a drive on the bus with staff at the time they had requested. Inspectors observed additional staff from other houses in the centre assisting the resident who was waiting beside the bus requesting to leave the campus.

Inspectors observed one resident attending an outdoor activity supported by day service staff in the garden of the centre. The inspectors observed the resident to be fully engaged with the activity and observed the support staff to be interacting with the resident in a kind and caring manner. Inspectors spoke to another resident who informed them that they were heading out shopping with a support staff for the afternoon and following their shopping trip they had a plan to go for dinner.

Inspectors reviewed a sample of residents supports plan to gain a greater understanding of their goals, interests and activities that they like to participate in both in the centre and within the wider community. Inspectors found that for residents who required additional supports such as one-to-one staffing support opportunities to participate in community activities were impacted by staff vacancies and the reliance on agency staff who may not be familiar to the assessed needs of residents. Inspectors reviewed samples of activities available to residents in the

centre which included watching tv, listening to music, household chores, family visits, soft ball play, Siel Blue (in house day service provision) and music and art therapy.

In summary, the inspectors found that the lived experience of residents in the centre was directly impacted in areas such as access to community activities and social well being due to the insufficient resources such as the providers reliance on agency staff to fill staffing vacancies leading to inconsistent continuity of care and transport difficulties including staff that cannot drive the centres vehicles. Furthermore, inspectors found that a recent admission to the centre had led to compatibility concerns and was resulting in a number of peer-to-peer safeguarding concerns.

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

This inspection was completed as a risk-based response following the receipt of solicited and unsolicited information of concern by the Chief Inspector of Social Services. Inspectors were not assured on the day of the inspection that appropriate governance systems were in place to ensure that the service provided was consistent and responsive to residents' needs. The inspectors identified concerns in relation to the reporting and screening of potential peer-to-peer safeguarding concerns. Furthermore, gaps were identified in the providers governance and oversight systems in relation to staff training and supervision and residents general welfare and development.

The staffing structure comprises of staff nurses and healthcare assistants, at the time of the inspection there was 11 whole time equivalence vacancies in the centre. A review of the rosters demonstrated a reliance on a high number of different agency staff in order to cover staff vacancies, annual leave and sick leave. The reliance on agency and relief staff did not ensure continuity of care for the residents. On the day of inspection, there was one permanent staff member on duty across each of the houses in the centre, the inspectors found that there was eight agency staff working including one agency staff who had not previously worked in the centre and was being inducted to the centre by another agency staff. The inspectors acknowledged that the agency staff completing the induction had completed a number of shifts across the centre in the previous months.

During the course of the inspection, the inspectors reviewed the centre's complaints log and found that although the complaints policy had been mostly adhered to by

the person in charge and the provider, two complaints made to the person in charge had not been referred for review under the providers safeguarding policy or additionally reviewed under the providers trust in care policy.

Regulation 15: Staffing

Inspectors reviewed rosters from May, June and July 2025 for all locations in the centre. The statement of purpose outlined 10 staff vacancies currently in the centre, management reported to inspectors that one position had been offered but that has now been declined leaving 11 current vacancies. The roles currently vacant included a clinical nurse management 2 (CNM2), staff nurses and health care assistants. As a result of the ongoing vacancies in the centre there was a high reliance on the use of agency. For example, inspectors reviewed rosters from May 2025 for each house in the centre and found that 351 agency shifts were used in one month across all of the houses that make up this designated centre. This did not support continuity of care for residents and did not ensure that the staff providing support were always skilled and trained to cater for individual residents' assessed needs.

Inspectors identified a number of weeks in the month of May 2025 where houses in the centre were staffed predominantly by agency staff. A further review of the individual rosters showed during the week commencing 19 May 2025, with the exception of one night duty which had one permanent staff in place, the centre was staffed wholly by agency staff. Inspectors found in the week commencing 21 July 2025 one house was staffed exclusively with agency staff, this house was home to three residents.

In addition, inspectors found that during the weeks commencing 12 May 2025, 3 June 2025 and 7 July 2025 multiple agency staff used were used to support residents from Monday to Saturday, however, no agency staff were used on Sunday in any of the houses in the centre, with full support to residents provided by permanent staff team members. On discussion with the person in charge and CNM1 inspectors were informed that safe staffing levels in the centre required a minimum of 12 staff on duty during the day and six staff on duty at night time to support residents individual care and support needs. Inspectors found that the high use of agency staff did not allow for continuity of care for residents who required one to one support for areas of care including positive behaviour supports, personal care and community activities.

The inspectors found that there was multiple changes in agency support staff utilised in the centre. A review of rosters commencing 05 May 2025, 12 May 2025 demonstrated that 31 different agency staff were used to cover staff vacancies across the designated centre. Inspectors reviewed the agency induction folders for the centre, induction sheets were found to be generic with no mention of the individual houses or the level of support required by each individual. The induction checks were found to be signed by new staff in 2022 and the same list used by staff inducted in 2025, The inspectors found that the induction list had not been reviewed

or updated to reflect changes in residents assessed needs, levels of support or admissions to the centre.

Judgment: Not compliant

Regulation 16: Training and staff development

On the day of the inspection, the inspectors reviewed the most recent training matrix as provided by the person in charge and the provider. However, the inspectors found that the matrix had gaps in relation to both mandatory and non-mandatory training for staff. Inspectors found that the matrix was difficult to review, with the training details in place for 69 staff. The training schedule included permanent staff and agency staff. The inspectors were informed that where gaps had been identified in the training matrix the schedule of completion was held in an additional file. Following the inspection, the person in charge submitted a revised training matrix, which outlined completed mandatory training and the schedule for upcoming staff training.

The provider had submitted a provider assurance report (PAR) in January 2025, that outlined specific actions around training needs for staff. One action outlined by the provider was that staff would undergo training in risk and risk assessment with the action completion date 01 May 2025. On review of the training matrix 15 of the 69 staff listed had completed the training since the submission of the PAR. A second action with a completion date of 31 March 2025 detailed that dates for a workshop on 'tools for safe practice' would be identified, on the day of inspection it was confirmed by the centre management team that this had not happened. A third action stated that food safety training would be continued in quarter one and quarter two 2025 with a completion date of 01 April 2025. A review of the training matrix showed both permanent and agency staff were still outstanding of this training.

Alongside the the training issues identified, both permanent and agency staff were found to have expired training dates in infection prevention and control and hand hygiene.

Judgment: Not compliant

Regulation 23: Governance and management

Inspectors found that while there were clear lines of authority within the designated centre, significant improvements were required in relation to the oversight and

governance systems in place. The inspectors found that there was insufficient resources available to support residents in meeting their assessed needs and achieving social goals and where resources were available to residents in the centre they were not being utilised in a manner that was person-centred.

Inspectors found that enhancements were required in relation to the documentation, record keeping and reporting of incidents which were contributing to a negative lived experience for some residents in the centre in relation to safeguarding and protection. Inspectors reviewed a number of peer-to-peer incidents which had occurred in the centre from March to June 2025 which had not been identified by the provider as part of their reviews and audits. The inspectors found that incidents occurring were not being recorded in a manner which would lead to escalation and review by an appropriately qualified person, either within the provider's governance structure or by external stakeholders.

The inspectors reviewed staff meetings held in the centre from January to June 2025. The inspectors found that the person in charge was present at each staff meeting. On review of staff meetings the inspectors found a number of items discussed which had not been escalated, with no action plans in place to minimise or reduce impact on residents. For example, staff meeting held in April 2025 discussed a closed complaint in the centre, during this overview of the complaint different forms of abuse were discussed with the staff team. However, it was not recognised that this complaint should have been screened under the providers safeguarding policy. In addition, the inspectors reviewed staff meetings in January, February and April 2025, which was a reminder to staff that external doors in the centre should not be locked from the inside. This was a practice which inspectors observed in place during the course of the inspection. Furthermore, the provider had not completed an unannounced visit to the centre in line with the regulation, with the last unannounced visit taking place in January 2025.

On review of the PAR response sent by the provider in December 2024 to the Chief Inspector, the provider had stated as part of their improvement plan that a CNM2 would be in place in the centre to work alongside the person in charge. This it was stated would ensure that they worked a number of hours during the week together and would work opposite weekends in order to provider supervision and support for staff. The provider had given an assurance that this would be in place from 10 January 2025, on the day of the inspection the CNM2 post remained vacant.

Judgment: Not compliant

Regulation 34: Complaints procedure

The complaints policy and complaints log were reviewed by inspectors, the provider's complaints policy had been reviewed in line with the provider's timelines

and the regulation and was available on the day of inspection. Complaints had been logged as outlined in the provider's policy and responses were made to complaints within the stated timelines. However, inspectors found that there were issues with the screening process, outcomes of complaints, statutory reporting obligations not followed and there was no evidence of learning from complaints.

The inspectors reviewed complaints made in the centre from January to August 2025. A review of complaints found that one complaint from January 2025 was closed by the provider despite the complainant stating in emails that they were 'not happy' with the outcome and the complaint was not closed in their view. The inspectors acknowledge that the provider had upheld the complaint, and was closed with the issue of an apology. The provider had liaised with the complainant around the appeals process and was given information in relation to external stakeholder supports. The complainant was offered the opportunity to appeal the decision, however, they had chosen not to avail of the process.

In addition two further complaints were reviewed in relation to staff conduct, one complaint was made internally in April 2025 and the second complaint made externally in June 2025. Neither incident was reported within the required three day timeframe to the Chief Inspector of Social Services as an allegation of abuse or reporting the alleged conduct of staff. Neither incident led to an initiation of the trust-in-care policy despite both incidents alleging possible abuses. In relation to one incident, inspectors reviewed the performance management meeting minutes for one staff member and it was highlighted that if a similar incident happened again it would be reported as a safeguarding concern and the trust in care process used at that stage.

The inspectors were not assured, that the screening of complaints led to an effective identification of safeguarding concerns that in turn could be reported to the authority, investigated appropriately and effective learning taken from the incidents. This will be discussed under Regulation 8: protection.

Judgment: Substantially compliant

Quality and safety

Overall, inspectors found that residents immediate needs were being met by staff in their home. However, inspectors were not assured that residents were receiving a consistently high quality of person centred care. Furthermore, inspectors found that the governance and oversight structures in place required review to ensure that incidents and safeguarding concerns were appropriately identified and reviewed by the provider.

The inspectors completed a review of a sample of residents files including day reports, communication reports, finance reports and global reports and found for a number of residents access to meaningful community activities and development of

planned goals were limited. Inspectors found that consistent support was not available due to the high reliance of agency staff and this impacted on residents' meaningful days due to the required support of staff who were familiar with their assessed needs.

The inspectors reviewed three positive behaviour support plans for residents and found that they were up-to-date and had been reviewed in the last 12 months. However, inspectors found on review of an additional support guidelines document in one home, that staff were advised to remove residents from communal areas in the home in order to reduce the impact of possible behaviours. Residents were to be offered a drive in the centres vehicle or to go their bedroom to relax. Inspectors found that residents did not have access to the centre vehicle at all times or that there was not always a staff present with the ability to drive the vehicle. Furthermore, times that residents had been requested to leave communal areas had not been reported or logged as a restrictive practice. In addition, on review of the providers training matrix a number of staff were out of date in training behaviour support. This meant that staff may not have been able to provide behaviour support interventions to residents that were in line with best practice.

Regulation 13: General welfare and development

In order to gain an insight into the range of activities available to residents, inspectors reviewed a sample of support files, person centred plans, financial records, daily reports and global daily reports for three residents in the centre. Inspectors found that for some residents' opportunities to participate in activities outside of the designated centre were limited for a number of reasons such as staffing resources or lack of drivers for transport. In addition inspectors found that a number of goals and aspirations for residents had been in place for long periods of time. For example, one resident had a goal to attend the cinema weekly with the support of staff. This planned goal had been in place since September 2022. Inspectors found that this goal had been reviewed in February 2024 with the review stating that the resident "does not get enough chance to go to the cinema and staff to support this". However, inspectors found no support plan in place in order to assist the resident with this goal. The goal remained open without review until the 21 February 2025, furthermore, inspectors could only find evidence that the resident had attended the cinema on one occasion in April 2025.

Inspectors reviewed the financial records of a resident and found that for May 2025 the resident had purchased three take away meals, a birthday present and clothes. The inspectors reviewed the resident's file and could not identify through daily reports or communication documentation if the resident has participated in the purchasing of their clothes. Further expenditure records reviewed for June 2025 identified that the resident had purchased six take away meals and had purchased items for a birthday party being held for the resident in the centre for their own birthday. These items included cutlery and finger foods.

The inspectors reviewed records of activities completed in the centre for one resident. Support staff maintained a tick chart each month which demonstrated activities that the resident availed of in the centre. For this resident, examples from the table consisted of bus drives, walks, household chores, personal space, playing with toy soldiers, softball play, playing with coins, picnic, cinema and a day service support ran by the provider in the afternoon for residents to avail of. The inspectors reviewed a period of two weeks from 31 May 2025 to the 09 June 2025 for one resident which included their daily report, communication report, and global report. This demonstrated that the resident had gone on 13 drives in the community and had played with coins on thirteen occasions. Furthermore, the inspectors reviewed the financial records of the resident for May 2025, which identified that they had the opportunity to spend on three occasions, two of these occasions were for a take away meals and the third was to purchase toiletries. The inspectors reviewed the documentation for the resident on the date in which the toiletries had been purchased and found no evidence the resident had been involved in shopping with staff to purchase such supplies or a risk assessment or support need which identified they did not like such an activity. Inspectors spoke to staff members during the course of the inspection in relation to limited access to community activities such as meals out when on a bus drive or going for a coffee in the local community. Inspectors were informed that for some residents it was due to modified diets and inability to eat certain foods. However, as previously discussed the inspectors reviewed financial receipts which identified residents purchasing fast food and take away meals to eat in their home.

Residents had access to a number of internal activities and supports in line with some of their assessed needs. For example, the provider had recruited an art therapist as an identified goal for some residents. Residents had access to a music therapist, internal day service that residents could avail of in the afternoon. This day service could be held outside during periods of warm weather or inside depending on residents wishes.

Judgment: Not compliant

Regulation 7: Positive behavioural support

The inspectors reviewed the positive behaviour support plans in place for three residents in the centre. In addition to positive behaviour support plans, support staff completed ABC (Antecedent, Behaviour, Consequence) charts which are intended to capture what occurred before, during, and after a behaviour of concern. The inspectors reviewed 11 ABC charts completed by staff during the period of March to June 2025. This review identified that responses given to one resident during periods of distress or anxiety by staff differed from the responses identified in the resident's positive behaviour support plans. For example, one resident's positive behaviour support plan stated that when a resident had entered a period where they were presenting with levels of anxiety that staff should give the resident space, observe from a distance and that support staff should reduce the conversation.

Furthermore, staff supporting should not try to communicate with the resident when they are screaming loudly as they cannot process or take what is being said due to levels of distress. However, on review of ABC charts inspectors found that during one incident the resident was told by staff "not to shout at staff or service users" another ABC chart noted that staff informed the resident that "cursing is not tolerated in this facility". Residents' positive behaviour support plans identified the requirement of familiar staff in order to reduce identified stress factors, however, one ABC chart reviewed identified that the cause of the behaviour was that "maybe the resident was not familiar with new staff".

The inspectors reviewed a protocol in place for one resident which was to be utilised if they present in a distressed manner which may present in the resident shouting and screaming at staff and residents, swearing or using inappropriate language which could be directed at staff. This guidance document advised staff to remove other residents who may be present in the environment either by asking would they like to go to their bedroom, offer a walk or a bus drive. Inspectors observed that on the occasions documented in ABC charts when residents were redirected to their bedrooms this was not documented or recorded as a restrictive practice, as not all communal areas of their home were accessible during these periods. In addition, due to lack of transport or drivers across the roster for the centre, staff could not offer residents an activity outside of the designated centre. Inspectors reviewed a number of documents reviewing incidents of concern in the centre which stated staff members "encouraged resident to stay in their room which they agreed".

Inspectors found that a number of restrictive practices were occurring in the designated centre that had not been reported to the Chief Inspector of Social Services and were not recorded in the centre. During a walk through of the designated centre, the inspectors found that a number of external doors were locked. Inspectors found that two external final-exit fire doors in one house had been locked from the inside, the locks consisted of internal thumb locks. On a review of staff meetings held on the 19 January 2025 and 02 February 2025 it was discussed that staff were required to complete restrictive practice folders in "relation to the thumb locks on doors not being able to open by service users. "Restriction has to be recorded". Inspectors found no evidence that the locked doors had been recorded in the centre and found that in the event of a fire the two final exit doors would not release.

Furthermore, inspectors found that nine staff had not completed mandatory refresher training in the providers positive behaviour support workshop. The inspectors reviewed one safeguarding plan in place for one residents which identified the need for all staff working with the individual to have training in positive behaviour support.

Judgment: Not compliant

Regulation 8: Protection

Through a review of documentation and discussions with staff, inspectors identified that improvements were needed to ensure incidents of a safeguarding nature occurring in the centre were appropriately documented and reviewed. This is to ensure all allegations of abuse involving residents are reviewed and escalated through the appropriate channels, as required by the provider's policy.

Inspectors reviewed documentation including complaints made to the provider, daily communications and residents ABC charts and identified nine separate incidents that occurred in the centre between January and June 2025. From the nine identified incidents, inspectors found that eight of these were not reported as safeguarding concerns and, as a result, had not been appropriately screened. Additionally, inspectors found that where screening had been completed for one incident it was found that 'no grounds for concerns' were identified, however, the staff documented that the resident presented as visibly upset by the peer to peer incident.

The inspectors reviewed a complaint brought to the provider in relation to an alleged staff incident. A nominated person met with the residents to discuss the concern, inspectors found that the resident identified that they had not been spoken to by staff during an interaction in an appropriate manner and that requests they had made to complete an activity had been refused. This allegation was reviewed under the providers complaints policy and was not appropriately referred through safeguarding or the providers trust in care policy.

During the review of staff training records, inspectors found that staff had completed mandatory refresher training in safeguarding adults at risk of abuse. As of the day of inspection, one staff member was overdue for this training. As previously discussed the training matrix held for the centre incorporated both permanent and agency staff. Inspectors found that the provider had an agency folder in place which gave an overview of each agency company utilised and an agreement that agency had completed mandatory training.

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 23: Governance and management	Not compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 13: General welfare and development	Not compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Not compliant

Compliance Plan for Hawthorns OSV-0003359

Inspection ID: MON-0046385

Date of inspection: 12/08/2025

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant

Outline how you are going to come into compliance with Regulation 15: Staffing:
Regulation 15: Staffing:13(1)
The registered provider shall provide each resident with appropriate care and support in accordance with evidence-based practice, having regard to the nature and extent of the resident's disability and assessed needs and his or her wishes.

1. The rolling recruitment campaigns for Clinical Nurse Managers , Staff Nurses and Care Assistants will continue.- Ongoing
2. All efforts will be made to fill vacancies so there is consistent staffing across the Designated Centre this will include the provider submitting a business case to the REO to secure the uplift in WTE ceiling for the centre in line with DCDE pay and Number Strategy(PNS).- Ongoing
3. A core group of agency staff nurses and care assistants with a suitable skill set to meet the residents needs will be identified to fill vacancies until such times as staff are recruited.-Ongoing
4. Skill mix and balance of HSE staff vs agency staff will be reviewed by the PIC to ensure there is continuity of care and appropriate levels of over a 7 day a week across 24 hrs period. Completed and Ongoing
5. The trend analysis of HSE staff Vs agency staff will continue but instead will be undertaken by the PIC so that risks regarding skill mix within the roster will be identified and addressed particularly during months when statutory leave is most in demand. Ongoing
6. An assessment of need of each resident will inform the continued staffing levels and skill mix required to support each residents.-Ongoing

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: Training and staff development:

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

1. A system will be put in place to ensure that all staff will attend statutory and mandatory training when allocated and a clear record of same is maintained. completed
2. The training matrix will be simplified so records are clear and easily legible.Ongoing
3. Incident management training is continuous has taken place with xx staff. Completed
4. Risk Management training has occurred with 2 sessions on in August & 9/9/25. Ongoing. Further training will be planned in Q4 2025 in order for all staff including regularly rostered agency staff to attend. Ongoing
5. Person Centre Planning and Goal setting training will be carried out and will be bespoke to the Designated Centre
6. Agency staff must have statutory training completed as part of the HSE Agency framework and dates undertaken will be included on the training matrix and folder. Completed

Regulation 16(1)(b) The person in charge shall ensure that staff are appropriately supervised.

1. Management Structures will be reviewed so staff are supervised. An appropriate staff/manager in charge will be identified on roster when there is planned and unplanned absences of the Person in Charge while awaiting the recruitment of a CNM2. Completed
2. Daily rounds by the Person in Charge will be documented and any actions that are required following the rounds are documented and actioned. Ongoing
3. Daily rounds by the Nurse in Charge will be documented and any actions that are required following the rounds and will be signed by the PIC Ongoing
4. Clear induction process which is bespoke to the residents house documented and signed by the relevant staff Ongoing
5. Action plans from staff meetings will be developed and reviewed at every staff meeting to ensure each action is completed Commenced and Ongoing

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 shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.

1. The statement of purpose and function will be reviewed to ensure it accurately describes the staffing levels and skill mix that is required to provide quality and safe care. This will be reviewed by the Quality Improvement Team in line with the Terms of Reference. Ongoing
2. There will be an additional resource identified to support the PIC to ensure compliance ,oversight and governance throughout the week.- Completed
3. The rolling recruitment campaigns for Clinical Nurse Managers , Staff Nurses and Care Assistants will continue. Ongoing
4. All efforts will be made to fill vacancies so there is consistent staffing across the Designated Centre this will include the provider submitting a business case to the REO to secure the uplift in WTE ceiling for the centre in line with DCDE Pay and Number Strategy (PNS). Ongoing

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.
1. The registered provider will ensure there is a weekly audit of incidents to identify and address risks and ensure that they are reported to the authority within the timelines specified. Ongoing
2. The registered provider will implement a system and process to review periodical documentation of care which will including care planning, goal setting and report writing. Ongoing
3. A template for Staff team meetings will be recorded to include SMART action plans to ensure any gaps identified will have clear actions assigned. Action logs from all staff meetings will be developed and reviewed at every staff meeting to ensure each action is completed. Commenced & Ongoing
4. Management Structures will be reviewed so staff are supervised. An approapriate staff/manager in charge will be identified on roster when there is planned and unplanned absences of the Person in Charge while awaiting the recruitment of a CNM2 Ongoing
5. Quality and Improvement Oversight Team which has been established include input from the following departments :
• Quality and Patient Safety Advisor
• HSE safeguarding
• HSE Patient Engagement Officer
• Complaints Manager
• Day Opportunities Manager
There is a clear Terms of Reference and actions identified will be SMART leading to high levels of compliance. Commenced and Ongoing
Regulation (23)(2)(a)
1.The registered provider will ensure compliance by completing the unannounced visits at 6 monthly intervals. A written report along with a SMART action plan will be developed if gaps in care delivery are identified. Completed
2. An unannounced inspection will occur immediately for the period of time not accounted for and an action plan put in place. Completed

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
The registered provider shall ensure that any measures required for improvement in response to a complaint are put in place.
Regulation 34(2)(e)

1. All complaints are reviewed within specific timelines in accordance to Your Service Your Say and local policy. Completed
2. Where a complaint is received with a safeguarding and protection aspect two processes (Complaints and Safeguarding) will commence to ensure residents safety and protection, notifications will be sent to all relevant authorities this is to commence immediately. The local policy has been amended to reflect same. Completed

Regulation 13: General welfare and development	Not Compliant

Outline how you are going to come into compliance with Regulation 13: General welfare and development:
The registered provider shall provide each resident with appropriate care and support in accordance with evidence-based practice, having regard to the nature and extent of the resident's disability and assessed needs and his or her wishes.
Regulation 13(1)
1. All residents Person Centre Plan will be reviewed to ensure meaningful activities in line with there preference are clearly outlined. Ongoing
2. Clear and SMART goals will be documented in the care plan in order to support the residents choice of activity and meaningful day. Ongoing
3. Keyworker will lead on supporting the residents choice of activity within the community and document progress accordingly. Ongoing
4. Staff will be reminded of the local policy of Social inclusion and Person Centred support plans through staff meetings. Ongoing
5. Person Centred Planning and Goal setting training will be provided on site to both both HSE and agency staff to ensure social goals are SMART , captured correctly robustly and accurate. Ongoing

Regulation 13(2)(b) The registered provider shall provide the following for residents; opportunities to participate in activities in accordance with their interests, capacities and developmental needs

6. All residents Person Centre Plan will be reviewed to ensure meaningful activities in line with there preference are clearly outlined. Ongoing
7. Clear and SMART objective goals will be documented in the care plan in order to support the residents choice of activity and meaningful day. Ongoing
8. Social Inclusion staff member and Day Opportunities along with the PIC will undertake a review of activities available within the centre and in the wider community. This will form part of the Person Centre Planning review. Ongoing

Regulation 13(2)(c) The registered provider shall provide the following for residents; supports to develop and maintain personal relationships and links with the wider community in accordance with their wishes.
1. The Social Inclusion staff and the PIC will ensure there is evidence of community based activities for all of the residents in line with their Will and Preference in the designated centre. This will be documented clearly and in an appropriate manner in the care plan Ongoing
2. Any resident who chooses not to engage in certain community activities due to the nature of their disability will have a clear rational and alternatives documented in their care plan. Ongoing
3. Audit of the activities as part of the person centred review against existing documented preferred activities this will shared in accessible from with the residents and the care plan will be updated accordingly to reflect any changes or choices. Ongoing
4. Quality improvement Team that has been established has included there will be review of meaningful activities for each resident. Ongoing

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour. Regulation (07)(1)

1. The Person in Charge has arranged for Positive Behaviours Support Training training (Studio 3)for all staff. Completed
2. The CNM positive behavior support provides onsite support and training. They are also studio 3 instructor. Completed
3. Any incident regarding behavior that is challenging is reviewed and discussed with staff that were present notes and actions are recorded in the care plan. Completed and Ongoing.
4. Where there are deficits identified in staff practices and any staff that operate outside of the care plans or positive behavior support plan are held accountable through the performance achievement and supervision processes evidence of same is documented. Ongoing

5. Any restrictions that are in place and impact other residents is recognised as such and recorded in line with Restrictive practices and are returned via notifications to HIQA . Completed and ongoing
6. Where incompatibilities of residents living together are identified this will be reviewed and a plan put in place to support the residents in the context of future alternative living arrangements. Ongoing
7. Incident management training has taken place and will be delivered on a continuous basis. with staff. Completed and ongoing
8. Risk Management training has occurred with 2 sessions on in August & 9/9/25. Completed and on going
9. Further training will be planned in Q4 2025 in order for all all staff including regularly rostered agency staff to attend. Ongoing
10. Stress management plans and behavior support plans have both pro- active and reactive strategies this will be reviewed with supporting documentation with the PBS staff and PIC. Completed
11. ABC documents will be reviewed safeguarding concerns will be identified and returned retrospectively, going forward this will be returned by the PIC. Completed

The person in charge shall ensure that staff receive training in the management of behaviour that is challenging including de-escalation and intervention techniques. Regulation (07)(02)
1. Staff are trained in Studio3 low arousal approach to behaviours that challenge an audit of the training records will be carried out. Refresher training is required every 2 years. Completed
2. Stress Management Plans and Behavior Support Plans are reviewed at least annually or sooner if needed .Ongoing
3. PIC is a trained Studio 3 Trainer and must attend CPD to practice. Completed
4. After any incident the PIC and or Positive Behaviour Support staff will review each incident report/ABC form to ensure Proactive and Reactive approaches to Positive Behavious Support. Ongoing

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection: Regulation 08(2)
The registered provider shall protect residents from all forms of abuse.
1. Any form of abuse either suspected or confirmed will be reported to the relevant authorities in the time lines outlined in the Regulations to the HSE Safeguarding Team and HIQA. Ongoing
In person bespoke training from HSE safeguarding team is planned this is to compliment the HSEland training. Ongoing
2. Any retrospective notifications will be sent immediately to HIQA and to HSE safeguarding team following reviews .Ongoing
3. Anytime residents are required to move from one area of their homes to another area

such as visitors room or bedroom this will be recognised and documented as a restriction and returned as required by the regulations. Completed

Regulation 08(3) The person in charge shall initiate and put in place an Investigation in relation to any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.

1. All incidents of suspected or confirmed abuse will be investigated in line with National policy, local policy and regulations.
2. An audit of incidents has occurred retrospective notifications has been submitted to the relevant bodies (HIQA and HSE safeguarding) Completed
3. Any incident of suspected abuse including peer to peer will be submitted Ongoing

Regulation 08(7)he person in charge shall ensure that all staff receive appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse
1. All HSE staff are up to date and have undergone HSEland training on Safeguarding Vulnerable Persons. In person training occurred in June 2025
7 staff attended and will continue this is open for both HSE staff and agency staff. Completed and going
2.Assurances from agencies will be sought again to ensure all agency staff are compliant with statutory training which includes safeguarding. Completed

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 13(1)	The registered provider shall provide each resident with appropriate care and support in accordance with evidence-based practice, having regard to the nature and extent of the resident's disability and assessed needs and his or her wishes.	Not Compliant	Orange	31/12/2025
Regulation 13(2)(b)	The registered provider shall provide the following for residents; opportunities to participate in activities in accordance with their interests, capacities and developmental needs.	Not Compliant	Orange	31/12/2025
Regulation 13(2)(c)	The registered provider shall provide the	Not Compliant	Orange	31/12/2025

	following for residents; supports to develop and maintain personal relationships and links with the wider community in accordance with their wishes.			
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	31/12/2025
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	31/12/2025
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	31/12/2025

Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	31/12/2025
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	31/12/2025
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	31/12/2025
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	Not Compliant	Orange	31/12/2025

	support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.			
Regulation 34(2)(e)	The registered provider shall ensure that any measures required for improvement in response to a complaint are put in place.	Substantially Compliant	Yellow	31/12/2025
Regulation 07(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.	Not Compliant	Orange	31/12/2025
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	31/12/2025
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures	Not Compliant	Orange	31/12/2025

	are applied in accordance with national policy and evidence based practice.			
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	31/12/2025
Regulation 08(3)	The person in charge shall initiate and put in place an Investigation in relation to any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.	Not Compliant	Orange	31/12/2025
Regulation 08(7)	The person in charge shall ensure that all staff receive appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse.	Not Compliant	Orange	31/12/2025