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:	Ardeen Cheshire Home
Name of provider:	The Cheshire Foundation in Ireland
Address of centre:	Wicklow
Type of inspection:	Unannounced
Date of inspection:	03 March 2026
Centre ID:	OSV-0003456
Fieldwork ID:	MON-0049403

About the designated centre

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

The designated centre comprises of fifteen self-contained bungalows, each have a sitting room, kitchen, bathroom and bedroom. Two of the bungalows have two bedrooms. There is a three bedroom bungalow which has three large en-suite bedrooms and provides respite service. There is accommodation for a maximum of 22 residents, and the provider describes the service as being offered to people who have a physical disability or neurological condition, and sometimes secondary disabilities which could include a learning disability, mental health difficulties or medical complications like diabetes. Ardeen Cheshire staff aim to support people in different areas of their lives including assistance with personal care and grooming, health support, social supports and liaising with relevant health professionals. Support offered may also include assistance with activities such as home maintenance, preparation and eating of meals, assisting with cleaning duties and grocery shopping, and the paying of bills. The centre employs one full-time person in charge, a CMN2, staff nurses, social care workers, care support staff, catering, housekeeping/cleaning, drivers, laundry and maintenance staff including a community employment (CE) supervisor and CE participants.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	14

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 3 March 2026	12:00hrs to 20:30hrs	Caroline Meehan	Lead
Wednesday 4 March 2026	12:30hrs to 19:15hrs	Caroline Meehan	Lead
Tuesday 3 March 2026	12:00hrs to 20:30hrs	Kieran McCullagh	Support
Wednesday 4 March 2026	12:30hrs to 19:15hrs	Kieran McCullagh	Support

What residents told us and what inspectors observed

This risk inspection was carried out in response to solicited information received by the Office of the Chief Inspector of Social Services (Chief Inspector). The provider had notified the Chief inspector of 19 incidents where residents required hospital transfer or admission since the last inspection in February 2025. This inspection was to ascertain the provider's compliance regarding the safety and wellbeing of residents living in this centre.

Significant concerns were identified on the first day of inspection regarding the governance and management of this centre and the safety of residents. Immediate actions were issued on the first day relating to the person in charge and to fire safety, with a further immediate action issued on the second day of inspection, also related to fire safety. Inspectors also observed poor infection prevention and control (IPC) practices, and this was of particular concern given the known healthcare risks for residents in the centre. These matters will be further discussed later in this report under the relevant regulations.

The centre comprised of a three-bedded bungalow (from which respite services were provided), 15 single-storey apartments: two could accommodate two residents and the remaining could accommodate one resident each. There were also two single-occupancy cottages. At the time of the inspection there were 12 residents living in the centre and two residents availing of a respite service for a one week stay.

The inspectors had the opportunity to meet 11 of the 12 residents living in the centre, and the two residents availing of respite services. Overall residents did appear happy in the centre, and said they liked living there. One resident said they would not change anything about the service, and they liked the independence they had living in the centre. Another resident said they had friends in the centre but they would like to live with a younger group of people. The inspectors spoke to the two residents staying in the centre for the week, and both residents said they enjoyed staying in the centre.

Some residents attended day services, one resident had a job locally, and one resident worked in a charity shop. The centre employed an activities staff, and two centre-based activities were organised daily. These included for example, art, bingo, music sessions, table quizzes and board games. The inspectors spoke with one of the residents who with the help of a staff member communicated their interest in art, and in gardening. The resident showed the inspectors a raised garden they maintained as well as paintings they had completed, and they also showed the inspectors a range of photos and pictures of their interests on display in their apartment.

Residents were being supported to communicate in the way they preferred and the inspectors observed that staff knew residents preferences in this regard. For example, a staff member was observed to communicate by spelling out words on a resident's hand, to gain consent for inspectors to meet them. Similarly, staff were observed to interpret and respond to gestures and vocalisations residents used to communicate requests, and engage in conversations.

From speaking with the staff team it was evident they knew the residents well, and residents were observed to appear comfortable in the presence of staff. Staff were observed to be kind and respectful in all their interactions with residents. One resident told the inspectors that they felt safe in the centre, got on well with the other people living there, and that staff helped them when they needed it. This resident showed the inspector the call bell system in place, and said that staff would always come and help them. The resident also told the inspector they ate most of their meals in the main house, and the inspectors saw midday and evening meals were provided to residents. The resident said the food provided was good, and that they went shopping for their breakfast and for snack items, which they keep in their apartment.

The next two sections of the report outline the governance and management arrangements and how these have impacted on the quality and safety of care and support residents received in the centre.

Capacity and capability

The management systems in this centre were not ensuring the service provided to residents was safe and effective and high levels of non-compliance were identified on this inspection.

There was no person in charge on the day of inspection, and a number of concerns regarding the safety and welfare of residents were found. Due to the serious concerns identified on the first day of inspection, the inspectors issued immediate actions, requiring the provider to give assurances on the measures they were taking to ensure a person in charge was employed in the centre and to ensure immediate risks regarding fire safety were mitigated. While actions were taken regarding the person in charge, the actions in response to fire safety the service manager stated were complete, were observed not to be wholly complete, and a further immediate action regarding fire safety was issued. The inspectors confirmed by the end of the first day of inspection that the measures outlined by the provider in response to the fire safety immediate action were complete.

While the provider had systems in place to monitor the service these were not ensuring the service was safe, effective and was monitored effectively This included issues identified on this inspection related to risk management, the response to serious incidents, fire safety and infection prevention and control. As a result,

systems to identify risks and concerns, and to take effective actions were not in place.

Regulation 14: Persons in charge

The provider had notified the Chief Inspector in October 2025 of a change in person in charge in the centre. At the time of this notification some prescribed information was outstanding, and remained outstanding up to the day of inspection.

On arrival to the centre, the person who had been nominated by the provider, informed the inspectors they were no longer the person in charge. This meant there was no identified person in charge in the centre to provide oversight of the day to day operation of the centre and to carry out their regulatory responsibilities in line with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013. This role is pivotal to the oversight of the quality and safety of the service delivered to residents and given the findings on the inspection it was evident that this was not taking place.

An immediate action was issued to the provider on the first day of the inspection requiring the provider to give assurances that a person in charge would be in place in the centre, and these assurances were provided in writing by the end of the day. The provider informed the inspectors in writing that the regional manager would be the person in charge and a notification would be submitted to the Chief Inspector.

Judgment: Not compliant

Regulation 15: Staffing

There were sufficient staff employed in the centre at the time of inspection. The centre employed senior care workers and care workers who provided direct care and support to residents on a day-to-day basis.

In the respite unit there were two staff on duty during the day and one staff in a waking capacity at night time.

In the 10 apartments and one cottage there were between seven and nine staff on duty up to 14.00hours; approximately six to seven staff on duty until 20.30 hours; and four staff on duty until 11pm. Two staff worked a waking shift overnight. Nurses were employed in the centre and one nurse worked 12 hours during the day, seven days a week. Nursing staff included two clinical nurse manager 1's and a staff nurse, and there was one clinical nurse manager 2 vacancy due to planned leave.

The inspectors reviewed a sample of rosters for two months and overall consistent staff had been provided. There were some relief staff employed in the centre and

they provided cover for planned or unplanned leave. There were no agency staff in use in the centre, and continuity of care and support was being provided to residents. While the roster did require some minor improvement to ensure all managers on duty were recorded on the roster, overall rosters were being effectively maintained.

Staff files were not reviewed as part of this inspection.

Judgment: Compliant

Regulation 23: Governance and management

The governance and management arrangements in this centre were not ensuring the service provided was safe and effective, and as a result residents were being put at a risk of harm. There was ineffective monitoring of the services provided, and audits and reviews were not identifying the issues raised on this inspection.

A numbers of risks identified on this inspection meant that residents were at risk of harm, in particular related to fire safety, risks and protection against infection (IPC). The provider had a number of processes in place for reviewing the service and these included IPC audits, fire safety audits, six monthly unannounced visits by the provider, meetings between the person in charge and regional manager, quarterly incident review, site visits by the clinical partner, and an annual review of the quality and safety of care and support provided to residents.

The inspector reviewed records of these meetings, audits and reviews; however, the IPC and fire safety issues found on this inspection had not been identified on any of these reviews as concerns. For example, a clinical site visit included reviewing IPC, red risks, notifications, and incidents and the inspectors reviewed records for five visits in 2025. However, no red risks were noted, IPC actions did not identity concerns with PPE and medical equipment storage, and there was no evidential review of procedures to ensure they were in keeping with best practice related to IPC. Similarly an IPC audit conducted in December 2025 did not identify issues noted on this inspection. As a result there were no plans in place to address these concerns, and to mitigate risks to residents.

The management reporting structure was not clear. Staff told the inspectors they reported to the senior care worker or sometimes the nurse on duty, and a handover was completed between staff on duty morning and evening with the nurse on duty also in attendance. The nurses and senior care workers reported to the person in charge who reported to the regional manager. The regional manager confirmed they meet the person in charge once a month and minutes of these meetings were maintained and a sample of three meetings in 2025 were reviewed by the inspectors. However, fire safety and IPC were evidently not reviewed at these meetings. The regional manager confirmed they attended the centre once a month and complete a walkaround but they did not complete a review or audit during this

walkaround, and stated they had no concerns regarding IPC, and there was always room for improvement.

Overall while the provider had put systems in place for review of the services provided to residents, these were ineffective in identifying risks, and developing and completing improvement actions to ensure the safety and wellbeing of residents living in this centre.

Judgment: Not compliant

Quality and safety

The quality and safety of care and support in this centre required significant improvement and the arrangements in place for risk management, infection prevention and control, and for fire safety were not ensuring that residents' safety and wellbeing was maintained.

While there was good practice overall found in the provision of healthcare, the standard of IPC practices, the management of risk and incidents and fire safety were putting residents at risk of harm. Significant improvement was required in fire safety and two immediate actions were issued on the days of inspection, requiring the provider to give written assurances on the actions they were taking to ensure the immediate safety of residents. These assurances were provided by the end of the first day of inspection.

The known risks of acquiring a healthcare associated infection were further compounded for residents by poor IPC practices including improper storage and cleaning of medical devices, personal equipment, and of PPE. These risks were not being identified by the provider, as well as risks arising from serious incidents in the centre, and ineffective monitoring of control measures, and risk management plans.

Regulation 26: Risk management procedures

The risk management processes in the centre required significant improvement to ensure control measures were being implemented and incidents were being effectively reviewed to reduce the risk of harm to residents.

While there was risk and incident management systems in place, these were not being reviewed within the timelines set by the provider, and to inform a change of practice where required. The inspectors reviewed the risk management policy, the adverse event policy, and the serious incident management policy. The adverse event policy stated all serious incidents require implementation of the serious

incident management policy. The serious incident management policy defined a serious incident as an unexpected occurrence involving death, and a catastrophic event as an unexpected death or suicide of a service use or staff and a known healthcare associated infection which may result in death, and included the death of any service use following transfer to hospital from the centre. The policy outlined the need for immediate investigation and response to events including unexpected deaths, an outbreak of an notifiable disease, and the unexpected absence of a resident. The Chief Inspector had been notified of a number of serious incidents since the last inspection.

The inspectors found that the policy was not consistently implemented for 4 of 5 serious incidents in the centre, and no serious incident reviews had occurred following these incidents. The inspector spoke to the regional manager and to a nurse, and while one confirmed these had not taken place, another presumed they had been done but was not aware of the outcome of these reviews. Similarly, there was no evidence of review of a significant incident and actions taken to prevent reoccurrence in line with the policy on adverse events. Subsequently a serious incident occurred involving a resident three days later.

The inspectors acknowledged end of life notifications were submitted to a review team, and end of life meetings had occurred for a sample of cases reviewed by inspectors. However, a review of practices or procedures where required, were not discussed or recommended at these reviews. This meant that opportunities to improve or address risks in the centre were not being highlighted or responded to in line with the centre policy.

The serious incident policy outlined a preliminary report was required to be submitted to the Chief Executive Officer within 20 days of a serious incident; however, the regional manager provided a document which outlined a preliminary report was completed 77 days after a recent serious incident. The final report of the incident remained outstanding on the day of inspection, and was outside of the timeframe outlined in the policy of 60 days.

The inspectors acknowledged plans for some initial gathering of information leading up to and surrounding this serious incident had commenced on the following day, and this was documented in the meeting between the regional manager and the service manager.

The inspectors reviewed the risk management policy; however, practices for review of risks in the centre did not consistency align with the centre policy. For example, the risk register dated October 2025 identified one red risk relating to falls however, this had not evidently been reviewed monthly in line with the centre policy. A number of residents' risk assessments had not been reviewed at the interval stated in the risk management policy. These included for example, healthcare risks, fire evacuation risks, mobility risks and use of a call bell. This meant that the level of risk and the control measures in place were not being reviewed to ensure they were effective, with additional control measures agreed and implemented where required.

The inspectors observed the control measures related to smoking were not being implemented for a resident. This was discussed with the service manager who was unaware of the ongoing presenting risk of an outbreak of fire.

Judgment: Not compliant

Regulation 27: Protection against infection

The arrangements in the centre for infection prevention and control (IPC) were unsafe and were putting residents at risk of healthcare acquired infections.

The inspectors observed the storage of personal protective equipment (PPE) on corridors external to apartments was not hygienically maintained, and these IPC stations were inappropriately placed. For example, there were two IPC stations hung on walls above planting areas. These units were observed to be visibly dirty, and chipped paint on units meant these were not conducive to effective cleaning. Aprons stored above one of these units were observed to have a collection of dust on them. The inspectors discussed this with the co-ordinator, who confirmed these PPE stations were used by staff to restock PPE every evening in apartments. This was also confirmed by staff on duty on the day of inspection. The location of a handwashing sink above one of these planting areas was also inappropriate, and was not in keeping with the requirement for suitable hand hygiene arrangements.

The inspectors visited a number of apartments and met with residents in their homes. However, the layout and maintenance of some apartments meant that there was ongoing risks to residents. For example, in one unit there was no door between the bedroom and the ensuite bathroom. A half-length shower curtain was hung to visibly divide the bedroom and the ensuite bathroom. The inspectors observed that a nebuliser mask and C-Pap mask were left exposed in this bedroom and while they appeared clean, the exposure to the bathroom area, meant that there was a risk of contamination of these masks. In addition, scheduled deep cleaning was carried out in this apartment every week, with the masks left exposed.

The inspectors spoke to a clinical nurse manager 1 (CNM1) about the arrangements to clean medical equipment, and they confirmed masks were washed and left out to dry, however, were not covered or protected once dry. The CNM1 also outlined that nebuliser tubing was washed and hung in bathrooms to dry out. This meant there was a risks of cross-contamination of medical equipment used by the resident. Given the poor IPC practices and the known risks for some residents, residents were being exposed to ongoing risk of healthcare acquired infections.

Assistive equipment was provided to support residents with their personal care needs; however, some equipment was not being stored in hygienic conditions. For example, in a number of apartments the inspectors observed commode pan inserts were being stored on bathroom floors, along with incontinence wear. This meant that there was a risk of cross-contamination of equipment, and exposing residents

to infectious agents. Similarly a flat head mop was observed to be placed beside a commode pan insert on the bathroom floor.

Hand hygiene arrangements required improvement, and disposable hand towels were not consistently stored in dispensers. For example, the inspectors observed paper hand towels stored on windowsills.

Food safety practices required improvement. While there were arrangements for food to be labelled once opened, this was not being implemented in practice, and open food packages in one unit were observed not to be labelled. In addition, the storage of enemas beside food in a fridge was not appropriate.

The maintenance arrangements to ensure effective IPC measures required improvement. For example, the floor covering in one unit was damaged in some areas, and was covered with tape; in another unit there was damage to the tiles on a handwashing area, and in another unit mould was observed on the grout of tiles in the shower. The inspectors observed a mouse trap on a window sill in one resident's bedroom, and a rat trap was located at the fire assembly point outside two units.

Given the health needs of resident's, and the known vulnerability of some residents to infection, the IPC arrangements observed on the days of inspection were putting residents at ongoing risk of exposure to infection, and as result a risk to their health and wellbeing.

Judgment: Not compliant

Regulation 28: Fire precautions

The arrangements in the centre for containment of fire, evacuations, and for reducing fire risks were not safe and were putting residents at risk of harm

The inspectors were shown around the premises by a co-ordinator and observed a number of issues with fire safety. There were unsafe arrangements for containment of fire. In one unit, the self-closing devices on two doors were broken and these doors were wedged open. This meant that in the event of a fire these doors would not automatically close, and the arrangements to contain fire within this building could not be implemented.

There were unsafe arrangements for the evacuation of residents from the centre to a place of safety. On the first day of inspection the inspectors observed the fire assembly point outside a unit was blocked by a build-up of maintenance waste. The inspectors asked a staff about the alternative arrangement for an assembly point for a resident and staff indicated the resident would be evacuated to another assembly point. However, on observation, there was no signage at this assembly point, and the inspectors were told the sign had been removed and not rehung after a wall was painted. A fire escape route in one unit was observed to be blocked by a mattress,

in another room of this unit by a sofa, and in another unit by a coffee table. This meant that in the event of a fire, the evacuation routes were not clear.

An immediate action was issued to the provider on the first day of inspection, requiring the provider to give written assurances on the actions they were taking to ensure residents safety in the event of a fire, specifically the containment measures and safe evacuation to an assembly point. The inspectors were provided with written assurances, and on review of these, an action related to wedging fire doors open was not complete, and doors remained wedged open.

Later inspectors also observed that a wooden shed was housing a washing machine and condenser dryer approximately 1 metre from the external walls / roof of the unit. The shed was observed to have exposed insulation material on one wall. The inspector also spoke to a staff member in this unit, and they stated they had never taken part in a fire drill in which they had evacuated resident, and had only participated in simulated drills with staff. This staff member had been working in the centre for one year approximately. In addition, one resident had been living in the centre since May 2025, and the staff member stated the resident had also never participated in a fire drill.

Further assurances were therefore requested to be provided in the immediate action relating to the use of this room as a laundry, and for staff and a resident to participate in a fire drill, and these were completed by the end of the first day of inspection.

The centre was made up of four areas. One three-bedded respite unit, two adjoining cottages, and two areas each of which contained seven single-storey apartment buildings. Each single-storey apartment was connected at roof level in each of the two areas. On review of fire drills it was evident that only one apartment was ever evacuated during fire drills, and the rationale for this was outlined as containment measures were in place to roof level. However, this was discussed with the regional manager on the first day of inspection, and confirmation of containment measures to roof level was requested by inspectors. By the second day of inspection, the regional manager gave the inspectors a written document which stated that containment to roof level could not be confirmed. Therefore, the arrangement to evacuate only one unit, in the absence of confirmation of containment to roof level was not safe or appropriate.

The inspectors reviewed records of fire drills, and staff confirmed these take place every Friday morning or early afternoon. As mentioned, only one unit is evacuated during fire drills. Therefore all conditions under which residents may need to be evacuated had not be practiced or planned for.

Judgment: Not compliant

Regulation 6: Health care

Residents' healthcare needs were being provided for; however, improvement was required to ensure some residents were provided a specific vaccination.

Residents had been offered the opportunity to avail of the annual flu vaccine and a booster Covid-19 vaccine and records were available in online records or medical notes. However, evidence was not available on the day to confirm residents in an at risk group had received or were offered pneumococcal vaccine in line with the recommended vaccination schedule. This was reviewed with the clinical nurse manager on the second day of inspection who stated they would make arrangements to confirm the vaccination status of these residents.

The inspector met two staff members, two clinical nurse managers and a coordinator, and they were knowledgeable on the healthcare needs of residents, and on how to identify and respond to incidents where a resident may present with a range of infections, or with a decline in their physical presentation. Residents' healthcare needs were being monitored in line with healthcare plans, for example, consistent blood glucose monitoring was observed to be recorded for a resident, and recommended interventions provided in line with the guidelines on hypoglycaemia. The nurse on duty checked in with residents twice a day.

Residents healthcare needs had been assessed and residents attended a local general practitioner (GP). Residents could also access the services of allied health care professionals for example, an occupational therapist, a physiotherapist and a speech and language therapist

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Not compliant
Regulation 15: Staffing	Compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 26: Risk management procedures	Not compliant
Regulation 27: Protection against infection	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 6: Health care	Substantially compliant

Compliance Plan for Ardeen Cheshire Home OSV-0003456

Inspection ID: MON-0049403

Date of inspection: 04/03/2026

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 14: Persons in charge	Not Compliant
Outline how you are going to come into compliance with Regulation 14: Persons in charge: • A current, experienced Cheshire Ireland Person in Charge has been made PIC of the Ardeen service until the current service manager attains the relevant management qualification.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • The service structure has been reviewed and an experienced person in charge has been appointed to ensure that all regulatory requirements are completed, maintained, and monitored on an ongoing basis. The Service Manager reports to the Person in Charge, while the rest of the team continues to report into the Service Manager. The Person in Charge and the Service Manager report to the Regional Manager (PPIM). PIC and PPIM will both be overseeing all actions as part of this Compliance Plan with the PIC retaining responsibility for the actions. • The Regional Manager (PPIM) will visit the service fortnightly to ensure oversight of the service with an additional focus on IPC and Fire Safety. Notes of these visits will be shared with the Head of Operations and Business Development, Head of (Clinical Services) Quality and Compliance and CEO. • The Regional Manager (PPIM) will provide updates on the actions required from the service to the QSRM sub-group at their scheduled monthly meetings. Following these meetings, the CEO will send a written update to the Chairman of the Board of Trustees and the Board HIQA Registered Provider Representative as to progress of actions. • The service's structure chart has been reviewed and same is being communicated to all staff. • Meetings were held with all staff and management in the service to reiterate the	

responsibility and accountability of staff at all levels of the service in relation to Infection Prevention and Control, Fire, and Risk.
• Management processes in the service have been reviewed to clarify and strengthen systems in place to ensure the service is safe, effective and monitored effectively.
• The service will maintain a maintenance works list on which areas of the service, identified through local, Provider, and external audits, as requiring refurb or replacement are entered for action and monitoring to completion. This also in turn informs applications to HSE/Council/Other for funding to address fire prevention; IPC, building deterioration, grounds maintenance etc
• The Service Manager has commenced and is ensuring regular walk throughs of the service are completed to ensure oversight of fire prevention; IPC; building maintenance, deterioration, grounds maintenance etc
• On at least a monthly basis any actions identified for completion will be reviewed and monitored via supervision meetings between the Service Manager and the Maintenance Lead and Head of Support Services
• The Head of Support Services and Maintenance Lead will meet weekly to review and discuss works required.
• All actions identified, including any outstanding actions and areas of non-compliance, will be escalated by the Regional Manager (PPIM), as deemed necessary, to ensure appropriate governance, follow-up, and assurance.

• The Ardeen HIQA inspection of 3rd and 4th March 2026 was included as a specific item on the agenda for the Cheshire Ireland Quality Safety and Risk Management Sub-Committee (QSRM) meeting of 9th March 2026 and was included as a specific item on the agenda for the Cheshire Ireland Board of Trustees Meeting of 25th March 2026.
• At each meeting the details of the inspection findings and the required actions and oversight were discussed. The Committee and the Board required assurance from the CEO that all necessary steps are being taken to return the Ardeen service to compliance.
• The Regional Clinical Partner (reporting directly to the Head of (Clinical Services) Quality and Compliance) will be on site weekly (these visits will include a monthly site visit) to provide additional clinical support and oversight, with a particular focus on Infection Prevention and Control.
• The Head of Operations and Business Development will co-ordinate the service action plan and report to the QSRM Board Sub-Committee.
• The National Risk Manager will co-ordinate the actions required to remedy the Risk Management and Fire Safety concerns within the Inspection report and return the service to compliance with regulation, and report to the QSRM Board Sub-Committee.
• Findings and actions identified as required from Provider Audits will be reviewed and monitored by the Head of Quality & Compliance and the Head of Operations & Business Development.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
• A review of the Adverse Event Policy and the Serious Incident Policy was already underway to support the organisation to align with the HSE Incident Management Policy and the HSE Open Disclosure Policy. This will result in both policies being replaced by a

single Cheshire Ireland Incident Management and Open Disclosure Policy.
• The National Risk Manager conducted a safety and risk audit of Ardeen on 31/03/2026 and any actions identified are now addressed or added to the maintenance log for action.

• Individualized risk assessments are in place for each person supported and are reviewed at a frequency indicated by the risk rating, sooner if required.
• Review of incidents in the service are conducted by the local management team, Regional Clinical/Quality Partners/other relevant function which identifies if escalation or addition of a new risk assessment is required.
• Incident data is collated on a quarterly basis and is reviewed by the Regional Support Team for analysis and trending.
• All line managers are responsible for updating risk assessments for their area, as per the service's risk register.
• The Service Manager will audit the service risk register monthly and ensure that service staff are kept informed of any changes in risk management, eg risks, controls etc.
• National Clinical Risk Register is available to all staff via the intranet and is managed by the Head of (Clinical Services) Quality and Compliance.
• The Regional Clinical Partner will meet with all nurses/line management to strengthen service wide understanding of risk management processes in service and nationally.
• Findings and actions identified as required from Provider Audits will be reviewed and monitored by the Head of Quality & Compliance and the Head of Operations & Business Development.

• The Provider maintains a Regional After-hours Emergency On-call Service operated by designated employees to provide assistance or advice in the event of an emergency situation or crisis. A designated person acts as the person responsible for dealing with all serious situations or occurrences that happen unexpectantly within the services in the particular region.
• On 9/1/2026 the Regional Manager (PPIM) submitted applications to the HSE for Minor Capital and AMRIC seeking funding to ensure IPC, Fire Safety, Building Deterioration; Grounds Maintenance etc. Items on the applications include: Fire doors, windows, main house and respite flooring, domestic kitchen for respite house, replacement dining tables and chairs etc – decision on application is pending.
• On 16/1/2026 an application was submitted to the County Council's Historic Structure's Funds for funding to replace windows.
• The Service Manager has sourced a handyman who commenced work in the service on 23/03/2026 in order to enhance the service's capability to address works required.

Regulation 27: Protection against infection	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
The majority of issues highlighted in relation to IPC have been addressed following the inspection (including acquisition of medication fridge etc.). Additional solutions, requiring external support, (including flooring/tile repair and the insertion of a new door etc.), are being sourced as a matter of urgency.
• A weekly IPC checklist will be completed by the shift lead and signed off by the Regional Clinical Partner at the monthly site visit. All outstanding actions will be

discussed with service manager and local management team.
• IPC Local Operating Procedure and cleaning checklists are being reviewed by the Service Management Team and the Regional Clinical Partner. Once finalized same will be disseminated and discussed with all staff.
• CNM I to complete HSE IPC link practitioner program (Sept 2026).
• The Regional Clinical Partner (reporting directly to the Head of (Clinical Services) Quality and Compliance) will be on site weekly (these visits will include a monthly site visit) to provide additional clinical support and oversight, with a particular focus on Infection Prevention and Control.
• The IPC audit will be repeated by an IPC link practitioner external to the service with repeated auditing until the service is achieving necessary standards.
• The Head of (Clinical Services) Quality and Compliance will undertake a full IPC audit within 3 months of the HIQA Inspection (3rd and 4th March 2026) to ensure that actions have been implemented and learnings from said inspection have resulted in improved standards throughout the service.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• The majority of issues highlighted during inspection in relation to fire have been addressed and additional solutions requiring external support are being sourced as a matter of urgency. A clarified and strengthened management system is now in place to ensure the service is safe and effectively monitored.
• An external assessment of Compartmentalisation standards within the services (Bungalows 1-15) apartments was undertaken by FCC Fire Cert Ltd on 24th March 2026. While awaiting this assessment, contingency measures were put in place. Following the inspection, fire drills of the respite house and group evacuation of the terraced bungalows were conducted. Staff participation in fire drills is being recorded to ensure all are familiar with evacuation procedures across varied scenarios.
• The report from this assessment details that the buildings are substantially compliant with a number of Medium Priority Actions, to be completed within twelve months and Low Priority Actions to be completed within eighteen months. The additional evacuation measures implemented in March 2026 will remain in place until the necessary works are completed.

• The National Risk Manager conducted a safety and risk audit of Ardeen on 31/03/2026 and any actions identified are now completed or added to the maintenance log for action.
• The Service Coordinator is meeting with resident/s who smoke to engage with them regarding risk reduction control measures and risk assessments will be amended to reflect same.
• Daily visual fire checks are carried out by the fire wardens for the main house, respite, apartments and cottage. Service Manager/PIC audits these checks weekly.
• Fire drills are being conducted.
• Staff participation in fire drills is being recorded to ensure all are familiar with evacuation procedures across varied scenarios.
• The Service Manager will ensure that people residing in Ardeen Cheshire or availing of respite in the service are supported in their awareness and understanding of fire safety and evacuation measures

• Fire safety procedures are currently being discussed with each individual service user. These discussions will be clearly documented in the individual's file and will be followed up on a regular basis, with frequency and approach informed by the individual's identified needs. • An external Fire Safety Officer is being invited to attend a residents' meeting for a fire safety information session.

Regulation 6: Health care	Substantially Compliant
Outline how you are going to come into compliance with Regulation 6: Health care: • Liaison has taken place with the GP's office regarding the status of pneumococcal vaccinations and persons' records have been updated to reflect same. • Appointments are pending for vaccinations for those individuals that wish to have them – vaccines available on 19/4/2026 • Going forward the nursing team will ensure that discussions regarding this vaccine take place when Covid and Flu vaccine discussions/offerings are being made.	

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 14(2)	The post of person in charge shall be full-time and shall require the qualifications, skills and experience necessary to manage the designated centre, having regard to the size of the designated centre, the statement of purpose, and the number and needs of the residents.	Not Compliant	Red	03/03/2026
Regulation 23(1)(b)	The registered provider shall ensure that there is a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.	Not Compliant	Orange	30/04/2026

Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	30/04/2026
Regulation 26(1)(d)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: arrangements for the identification, recording and investigation of, and learning from, serious incidents or adverse events involving residents.	Not Compliant	Orange	31/05/2026
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Not Compliant	Orange	30/04/2026
Regulation 27	The registered provider shall ensure that residents who may	Not Compliant	Orange	30/04/2026

	be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.			
Regulation 28(1)	The registered provider shall ensure that effective fire safety management systems are in place.	Not Compliant	Orange	30/04/2026
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Red	03/03/2026
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.	Not Compliant	Red	03/03/2026
Regulation 28(4)(b)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, in	Not Compliant	Orange	30/04/2026

	so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.			
Regulation 06(1)	The registered provider shall provide appropriate health care for each resident, having regard to that resident's personal plan.	Substantially Compliant	Yellow	30/04/2026