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:	Hortlands
Name of provider:	Gheel Autism Services CLG
Address of centre:	Dublin 16
Type of inspection:	Announced
Date of inspection:	24 February 2025
Centre ID:	OSV-0003507
Fieldwork ID:	MON-0037640

About the designated centre

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

Hortlands designated centre is comprised of three buildings in two different suburbs of Dublin. Hortlands House and apartment are located in South Dublin and have capacity for 5 residents between the house and adjacent apartment. The second property is located in North Dublin and has capacity for two residents. Hortlands accommodates both male and female residents over the age of 18. The two houses and the apartment offer residents their own private bedrooms and shared communal facilities such as kitchens, bathrooms, living rooms and laundry facilities. The designated centre is staffed by a team of social care workers and healthcare assistants. These staff are directly overseen by a location manager and a person in charge. Residents have access to nursing supports as required. The designated centre has a low arousal philosophy, which is used to support adults with a diagnosis of autism. Residents are supported by a team of social care workers and care workers.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	6

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
Monday 24 February 2025	10:00hrs to 17:30hrs	Jennifer Deasy	Lead
Tuesday 25 February 2025	11:00hrs to 15:30hrs	Jennifer Deasy	Lead

What residents told us and what inspectors observed

This inspection was an announced inspection was carried out to inform decision making in response to the provider's application to renew the centre's registration. The inspector visited all of the properties that comprised the centre and had an opportunity to meet each of the residents over the course of the two day inspection. The inspector used conversations with residents and staff, observations of care and support and a review of documentation to inform judgments in respect of the quality and safety of care. Overall, the inspector found that residents in this centre were in receipt of person-centred care from a familiar staff team and that residents had freedom and choice in their everyday lives.

The designated centre is comprised of three buildings located in two separate suburbs of Dublin. Hortlands House is located in a suburb of South Dublin and is home to four residents. Beside Hortlands House is Hortlands apartment which is home to one resident. A third property, Phoenix House, is located in North Dublin and has capacity to accommodate two residents, one resident was living in the house at the time of inspection.

A walk around of all three buildings was completed. The inspector saw that they were all clean and generally well-maintained. Some minor painting upgrade was required, for example, to the handrail on the stairs in Hortlands House. Residents each had their own private bedroom and shared communal facilities such as bathrooms, kitchens, sitting rooms and laundry facilities. The houses all had large, well-maintained back gardens and residents in Hortlands House had access to a wooden cabin for quieter activities.

The inspector attended Hortlands House and apartment on the first day of inspection, and Phoenix House on the second day. They met the residents in Hortlands House on arrival. One of the residents told the inspector about their planned trip to visit family in another county over the weekend. They told the inspector that a staff member would drive them to see their family in the centre's vehicle and would collect them afterwards. Another resident greeted the inspector and the inspector saw that they were wearing headphones and were listening to music. The staff team told the inspector that they had worked with this resident to enhance their autonomy in respect of accessing and controlling their preferred music. This had a positive impact on the resident's well-being and staff reported that there had been a reduction in self-injurious behaviour as a result. Staff told the inspector that they had completed training in human rights.

Staff in this house also spoke of how they had supported a resident through a recent significant health event. They described how they had explained to the resident about required assessments and interventions in a format and manner which best suited the resident, for example, through role play. This had resulted in decreased anxiety and increased compliance in health care appointments.

Two residents in this house showed the inspector their bedrooms. One resident showed the inspector a religious items that was important to them and were carefully displayed in their bedroom. Another resident showed the inspector their wardrobes and were happy with the storage facilities for their possessions. Residents' bedrooms were personalised and were decorated in line with their preferences. The inspector observed residents coming and going from this house throughout the day. Residents appeared to be relaxed and comfortable in their home. The inspector also heard friendly and kind interactions between staff and residents. Staff were responsive to residents' communication.

In the apartment, the inspector met a resident who had recently moved in. They told the inspector that they had lived in the apartment previously and had then moved to another, supported-living house in the community. They had returned to the apartment as the house which they were living in was sold by the landlord. The resident expressed that while they were happy living in the apartment, they would have loved to have stayed living in their former house. This resident told the inspector that they enjoyed working part-time in the community and maintained their autonomy in respect of many aspects of their life. The resident showed the inspector around their apartment. The inspector saw that it was very clean, well-maintained and that there was plenty of storage space for the resident's important possessions.

The inspector attended Phoenix House on the second day of inspection and met with the resident who lived there. This resident showed the inspector their bedroom. They appeared comfortable in their house and were seen to be familiar with their staff team. One of the staff members showed the inspector around the rest of the house. The inspector saw that this property was also well-maintained although there was some minor works required to bathrooms and flooring. The inspector spoke with a staff member regarding the resident's needs. The staff member described how they provided choice to the resident and supported the resident to have control over their everyday life.

Overall, the inspector found that residents in this centre were supported by a familiar staff team who worked to enhance residents' autonomy and who treated residents with respect. There were improvements required to staff training and to the review and implementation of care plans. This will be discussed in the next two sections of the report. The next two sections of the report detail the oversight arrangements and how effective these were in ensuring the quality and safety of care.

Capacity and capability

This section of the report sets out the governance and management arrangements and describes how effective these were in ensuring oversight of the care provided in the centre. The inspection found that there were stable and consistent management

systems and that the centre was resourced effectively to ensure the delivery of person-centred care. Improvements were required to ensure that registration applications were submitted in a timely and accurate manner, to the completion of mandatory staff training and to ensure that the required policies were implemented in order to guide staff in the delivery of care. While there were some gaps identified in the governance and management systems, these were not resulting a medium or high risk to residents.

There were clearly defined management structures. The centre was staffed by a consistent team of social care workers and healthcare assistants who reported to a location manager. The location manager was supernumerary and had defined responsibilities to oversee the day-to-day running of the centre. The location manager reported to the person in charge. There was a schedule of meetings at all levels of the management chain to ensure that risks could be escalated to the provider level.

There were also effective arrangements in place to performance manage all staff; however, a number of key staff were found to require mandatory training in important areas such as safeguarding vulnerable adults. While the provider had identified this on a recent audit, the training had not yet been fully completed by the time of inspection. Improvements were required to ensure that staff completed required training in a timely manner.

A number of gaps were identified at the provider level in respect of the maintenance and updating of required documents such as the Schedule 5 policies, the directory of residents and the centre's floor plans.These areas required review and enhancement by the provider.

Registration Regulation 5: Application for registration or renewal of registration

The registered provider was invited to submit an application to renew the centre's certificate of registration and was required to submit this application along with prescribed information by a specific date. The application was received late but within a two week time frame and so Section 48 protection was afforded. However, the application form when initially received was incomplete and did not meet the minimum criteria required. A revised application was required to be submitted and was subsequently accepted.

The prescribed information which was submitted also required review. It was found that the floor plans were not an accurate representation of the designated centre and the provider was required to submit revised floor plans in order to progress the application to renew.

Judgment: Not compliant

Regulation 15: Staffing

The designated centre was staffed by a team of social care workers and health care assistants. Planned and actual rosters were maintained for the centre. The inspector reviewed the roster for February 2025 and saw that staffing levels were maintained in line with the statement of purpose. Vacancies and gaps in the roster were filled by regular relief staff. This was ensuring continuity of care for residents. The inspector saw that there were sufficient staff on duty to meet the number and needs of the residents, and to provide care in a person-centred manner which supported residents to have autonomy in their daily lives.

The inspector saw that residents were familiar with the staff on duty and that staff and resident interactions were friendly and relaxed.

Schedule 2 files for staff were not reviewed as part of this inspection.

Judgment: Compliant

Regulation 16: Training and staff development

The inspector reviewed the training records for the staff team in the designated centre. It was seen that there were a number of gaps in compliance with completion of mandatory training.

For example, two staff required training in safeguarding vulnerable adults, four staff required training in safe administration of medication (SAMS) and six staff required fire safety training.

This had been identified on the provider's most recent six-monthly audit of the centre in December 2024 however, the required training had not yet been completed by staff at the time of the inspection.

Judgment: Not compliant

Regulation 19: Directory of residents

A directory of residents was maintained in the centre and was reviewed by the inspector. The directory of residents was generally up to date however some of the required information, such as admissions information, was absent.

Judgment: Substantially compliant

Regulation 22: Insurance

The provider submitted copies of their insurance policies with their application to renew the centre's certificate of registration. This showed that the provider had effected insurance against injury to the residents.

Judgment: Compliant

Regulation 23: Governance and management

There were clearly defined management systems in the designated centre. The staff team reported to a location manager, who in turn reported to a person in charge. The person in charge had oversight of another designated centre and had additional duties. Changes had been made to the provider's oversight arrangements to support the person in charge in their role. For example, the location manager was previously rostered on as part of the centre's whole time equivalent staffing; however, they were now supernumerary and had time to complete management duties and to liaise with the person in charge.

Staff in this centre were supported and performance managed through regular staff meetings and individual supervision and appraisal sessions. The inspector reviewed the minutes of the last two monthly staff meetings and saw that they discussed topics relevant to staff members' roles and responsibilities such as residents' needs, training needs, safeguarding and infection prevention and control.

The inspector also reviewed the supervision records for three staff members including a location manager. The records demonstrated that staff members were performance managed and had an opportunity to raise concerns to management and to identify their own professional development needs.

Regular meetings were held at all levels of the management change in order to discuss and escalate any risks in areas such as staffing, safeguarding or facilities. Monthly staff meetings were held in the designated centre along with monthly location manager meetings with the person in charge. Regional meetings had also been introduced and afforded the person in charge an opportunity to liaise with the provider's multi-disciplinary team, human resources team and senior managers.

While the management systems were clearly defined, it was identified that there were some gaps in these systems which required review. For example, it was found that a number of quarterly notifications in respect of minor injuries to residents had not been submitted. This required review to ensure that the management systems were effective in ensuring compliance with the regulations.

There were also gaps identified on this inspection in respect of the required

Schedule 5 policies. For example, the provider's policy on the management of residents' finances and possessions was out of date and required review. Centre based operating procedures for management of residents' finances and possessions meant residents were being suitably supported. However, the provider is required to ensure that all Schedule 5 policies are reviewed every 3 years and that they are available to staff to guide their everyday practice.

Therefore, while local procedures in place were supporting residents they were not underpinned by an overall up-to-date organisational policy and procedure in relation to residents finances and possessions.

A gap was also identified in the provider's emergency planning policy as it did not provide guidance on appropriate evacuation time frames. This is discussed further under Regulation 28.

The provider had completed an annual review of the quality and safety of care for 2023 and a draft copy of the report for 2024 was made available for the inspector to review. The inspector saw that these reviews consulted with residents' representatives regarding their views on the quality of the service; however residents' views were not included in these reports. It was therefore not clear how residents' views were being used to guide the future development of the service.

Six monthly unannounced visits were completed by the provider's quality team. The two most recent audits for Hortlands House and the most recent audit for Phoenix House were reviewed by the inspector. The inspector saw that these comprehensively identified areas for improvement and that SMART action plans were implemented in order to address any risks identified.

Judgment: Substantially compliant

Quality and safety

This section of the report describes the quality of the service and how safe it was for the residents who lived there. Overall, the inspector found that residents were in receipt of a very good quality and safe service although some improvements were required to the review and implementation of residents' care plans. A review was also required of the fire evacuation arrangements for one of the premises.

The inspector reviewed three of the individual assessments and care plans for residents who lived in the centre. The inspector saw that each resident had an up-to-date assessment which was used to inform care plans. Annual reviews of the assessment and care plans were completed by the staff team and it was not evidenced that the annual review was informed by relevant multidisciplinary team professionals as required. There were also some gaps in some care plans, for example an absence of detail regarding residents' preferences in respect of their care and improvements were required to another care plan to ensure it was

implemented accurately.

Many residents in this designated centre required support with communication and management of finances. The inspector spoke with staff about the supports that they offered and reviewed the associated care plans. The inspector saw that support was offered to residents in a manner that enhanced their autonomy and that was in line with their communication needs. A number of residents also required support with medication management. The inspector reviewed the procedures in place for medicines with a staff member and saw that these were administered in a safe manner and in line with the provider's policy.

Residents were living in suitable accommodation to meet their needs. Residents had access to private and communal facilities which were clean and homely. There were suitable fire management systems in place although assurances were required that there was a protected corridor which afforded residents up to 30minutes to evacuate in one of the properties. The provider had sought a report in this respect and was awaiting a copy of this.

Regulation 10: Communication

The inspector saw, and was told, that a number of residents in this centre had assessed communication needs. The inspector was told of how staff had recently worked with one resident in particular to support their understanding of a medical condition and the associated medical assessments and interventions required. Staff had communicated this information to the resident in a format and at a time that suited the resident. This had resulted in the resident consenting to and complying with the medical team who were supporting them and had a positive impact on their physical health.

The inspector was also shown how the staff team had introduced technology to allow the resident to independently access their music. Staff had taught the resident to use this technology in a way that supported the resident's communication skills. The result of this was a reduction in incidents of self-injurious behaviour for that resident.

Residents in this designated centre had access to communication technology such as phones, radios and televisions.

Judgment: Compliant

Regulation 12: Personal possessions

The inspector saw that residents had sufficient space to store their possessions in a manner in line with their preferences. One resident showed the inspector how their

collection of money boxes, which were very important to them, were displayed neatly throughout their private spaces. Another resident showed the inspector their wardrobes and expressed that they were happy with these. Residents' possessions were clearly respected and protected. Records of residents' possessions were also maintained in the centre.

There were systems in place to ensure local oversight of resident's finances. Staff members showed the inspector the procedure for supporting residents with their finances. Each resident had their own bank account and their allowances and wages from paid employment were paid directly into this. An assessment of residents' capacity in respect of finances was maintained on residents' files and detailed the supports that some residents required to manage their finances; however, as discussed under regulation 23 there was an absence of an up-to-date provider level policy for the management of residents' finances. This required review by the provider.

Staff spoken with were familiar with the local operating arrangements for the management of residents' finances. Records of residents' finances were maintained and regular checks were completed to ensure oversight of these.

Judgment: Compliant

Regulation 17: Premises

The inspector reviewed all three buildings which comprised the designated centre on the day of inspection. The buildings were all very clean and generally well-maintained. Some painting was required in Hortlands House and Phoenix House; however, this had been self-identified by the provider through their audits and a plan was in place to complete these works.

Residents in all buildings had their own individual bedrooms. Some of the residents showed the inspector their bedrooms and spoke about, or showed her, their important possessions, family photographs, and clothes. Religion was very important to one resident and they showed the inspector religious items which were displayed in their bedroom. Residents appeared proud of and happy with their bedrooms. Each of the buildings also provided a communal kitchen, accessible bathrooms, living room and laundry facilities for residents. Residents had access to well-maintained gardens. The residents in Hortlands House also had access to a wooden cabin in the garden which they used for art and for other activities.

The designated centre was designed and laid out in a suitable manner to meet the needs and number of residents. The inspector saw residents coming and going throughout the centre and into the garden and community over the course of the inspection.

Judgment: Compliant

Regulation 20: Information for residents

The registered provider submitted a copy of the residents' guide with their application to renew the centre's certificate of registration. This was reviewed by the inspector and was found to contain all of the information as required by the regulations. For example, the residents' guide provided information to residents on the complaints procedure and the services and facilities provided in the designated centre.

Judgment: Compliant

Regulation 28: Fire precautions

Overall, there were adequate fire management systems in the designated centre. There were facilities in place for the detection, containment and extinguishing of fire. Doors throughout the centre were fire doors and were fitted with self-closing mechanisms, fire extinguishers were in place and were serviced regularly, along with a fire panel.

Monthly fire drills were held and these included an annual night time (deep sleep) fire drill. The inspector reviewed these records and saw that residents evacuated in a timely manner by day; however, the most recent night time fire drill in Hortlands House was reported as taking "longer than usual" at 4 minutes and 30 seconds for the full evacuation. The inspector asked if the provider's associated policy defined a suitable time frame for evacuation or guided staff on the procedure to be followed in the event of a fire drill taking longer than usual. The inspector was told that this information was not contained in the policy. This required review by the provider.

Additionally, on completing a walkaround of Hortlands House, it was not evident that there was a protected corridor for residents to evacuate. The inspector was told that the provider had sought a fire audit review by the landlord for the property and was awaiting this report.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

The inspector reviewed the medication management arrangements in Phoenix House. The inspector saw that medications were stored securely and hygienically.

The provider had recently effected a medication policy and was in the process of communicating this policy to staff at the time of inspection. The policy was reviewed by the inspector and it was seen that there was a clear procedure for the administration of medications set out.

A staff member demonstrated the medication administration procedure to the inspector. The inspector saw that this was in line with the provider's policy. Regular audits and checks of medications were completed. Staff were informed of the reporting procedure in the event of a medicines error.

An assessment of capacity to self-administer medicines was available on residents' files. Where residents required support with the administration of medications, this was provided by staff. A number of staff required training in safe administration of medications however this has been detailed under Regulation 16.

One resident was independent in receiving and administering their own medication and this was respected by staff.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The inspector reviewed the individual assessments of three of the residents who lived in the centre. The inspector saw that each of these residents had a comprehensive assessment which detailed their needs. Individual assessments were updated annually by staff members; however, it was not evidenced that the annual review of residents' assessments and care plans were informed by the required multidisciplinary professionals. For example, two residents were detailed as having assessed communication needs and another resident was assessed as having sensory needs but there were no updates from multidisciplinary professionals such as speech and language therapists or occupational therapists in respect of these needs.

The residents' assessments were used to inform care plans which detailed how staff should provide care to best meet residents' assessed needs. For example, up-to-date care plans in areas such as eczema and post-surgery wound management were maintained. However, there was an absence of care plans to inform some of the practices in the centre. For example, one resident was described as requiring support with weight management and the inspector saw that the resident's weight was recorded monthly however there was no weight management plan in place, or evidence of support from an associated health care professional such as a dietitian. One intimate care plan was seen to require further detail in respect of the residents' preferences. For example, the care plan detailed that the resident required full support with all personal care including nail care and hair washing but did not detail how best to support the resident with these tasks in line with their personal preferences.

The inspector also saw that one care plan, although reviewed by the relevant multidisciplinary professional, was not wholly implemented by the staff team. One resident received medicines to assist with low sodium levels. The inspector asked to see the associated health care plan and saw that it was detailed that the resident should have no more than 1000mls of fluid in a 24 hour period; however, the local recording systems did not monitor this accurately. For example, records indicated the resident had consumed liquids such as water and soft drinks during the day but not did record the actual amount consumed to ensure the correct volume was being adhered to each day.

Judgment: Not compliant

Regulation 8: Protection

The provider had effected a safeguarding policy which had been recently reviewed and updated. Staff spoken with were informed of their safeguarding roles and responsibilities. The inspector saw that there was accessible information throughout the premises of the designated centre which guided staff in identifying and escalating safeguarding risks to the provider level.

There had been a number of peer to peer related incidents of abuse reported to the Chief Inspector in recent months. The inspector reviewed the safeguarding records maintained in respect of three of these incidents which occurred in December 2024. The inspector saw that each incident was notified to the safeguarding and protection team and that an interim safeguarding plan had been implemented. Safeguarding plans detailed specific actions to ensure that residents were protected from abuse including, for example, completing a staff roster review and arranging a multidisciplinary review of residents' assessed needs. Staff spoken with were familiar with these safeguarding plans and of their responsibilities in keeping residents safe.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 5: Application for registration or renewal of registration	Not compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Not compliant
Regulation 19: Directory of residents	Substantially compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Substantially compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 12: Personal possessions	Compliant
Regulation 17: Premises	Compliant
Regulation 20: Information for residents	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 8: Protection	Compliant

Compliance Plan for Hortlands OSV-0003507

Inspection ID: MON-0037640

Date of inspection: 25/02/2025

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**
Registration Regulation 5: Application for registration or renewal of registration	Not Compliant
Outline how you are going to come into compliance with Registration Regulation 5: Application for registration or renewal of registration: Application for registration or renewal of registration: In line with Regulation 5 (registration/re registration of services Gheel have implemented the following Actions. Gheel have implemented a structured process which ensures effective and comprehensive oversight of the completion and submission of the Application to re register designated centers. Implemented on Monday the 10/03/2025. As soon as a notification is received from Hiqa Gheel will instigate an immediate planning meeting with the relevant parties to priorities the key task within the specified timeframe. Review of progress will be monitored by the PIC role and all required documentation will be submitted in line with Regulation 5 .	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: Staff Training, Gheel have a comprehensive internal staff training calendar which is accessible to all staff through our GRASP on line system. A full suite of mandatory training modules are available on HSE Land website. Staff training is a key agenda item at team meetings. To ensure that Gheel address the gaps in staff training highlighted at the time of our Inspection the following actions have been agreed. To ensure full compliance all staff will complete their internal mandatory training we have	

implemented focused topics for training each month which will be subsequently discussed at the next team meeting to enhance informed practice.
To ensure full compliance all staff will complete their mandatory HSE Land training modules by the 30/04/2025. Internal mandatory training will be completed by the 31/05/2025.

Regulation 19: Directory of residents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 19: Directory of residents:
Directory of residents: The Directory of residents has been reviewed and any identified gaps related to the admission of residents to Gheel Services has been updated. 1/03/2025

Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
Policies. Gheel are fully committed to ensuring that all policies are in date and inform staff practice. Gheel is about to commence a thorough review and update of all schedule 5 policies to be completed by the 30/06/2025.

Notifications – Gheel have revisited the communication structure in place to facilitate a weekly review of all incidents logged on our internal Q Pulse System. This specific oversight will clearly identify any additional non-urgent (3 day notifications) and ensure that relevant incidents are included in the Quarterly Returns if required. Implemented on the 28/02/2025.

Annual review of Quality and Safety care for residents- The Audit process is being amended to ensure that the audit report reflects consultation with residents as a key component of the report. 30/06/2025.

Fire Evacuation – Please see measures outlined in Regulation 28 Fire Precautions.
Protected Fire Corridor – Please see measures/actions outlined in Regulation 28 Fire Precautions.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Gheel prioritize the safety and wellbeing of residents at all times, The PIC , Social Care Manager and Gheel Quality Officer facilitated a meeting on the 07/03/2025 with the Leasehold Landlord. Master Fire completed a quarterly review on the standard of fire protection within the building on the 05/03/2025
Alongside this Gheel have made contact on the 07/03/2025 with the HSE Fire Prevention Officer to obtain assurance that the property is aligned with Community Dwellings fire safety standards, at the time of compiling this Compliance Plan we are awaiting confirmation. A protected corridor has been highlighted as necessary with a suggestion that this could be established within the property by utilizing the crossover stairway. This will need to be assessed and approved by the HSE Fire Prevention Officer. At the time of compiling this Compliance Plan we are awaiting confirmation of an assessment date.
Staff Training - All staff have completed their mandatory Fire Training 21/03/2025.

Evacuation - The associated Fire Policy is scheduled to be reviewed which will include the specified timeframe for night time evacuation fire drills – to be completed by the 30/06/2025.

Regulation 5: Individual assessment and personal plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
All Personal Care Plans are in place, all outstanding assessments will be updated . The updates will specifically demonstrate the engagement and input provided by the following – SLT/OT/Dietician /Geriatrician and fully reflective of our multidisciplinary team and Autism Practice team approach. All plans will be updated by the 30/03/2025.

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
Registration Regulation 5(2)	A person seeking to renew the registration of a designated centre shall make an application for the renewal of registration to the chief inspector in the form determined by the chief inspector and shall include the information set out in Schedule 2.	Not Compliant	Orange	10/03/2025
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	31/05/2025
Regulation 19(3)	The directory shall include the information specified in paragraph (3) of	Substantially Compliant	Yellow	12/03/2025

	Schedule 3.			
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.	Substantially Compliant	Yellow	30/06/2025
Regulation 23(1)(e)	The registered provider shall ensure that the review referred to in subparagraph (d) shall provide for consultation with residents and their representatives.	Substantially Compliant	Yellow	31/05/2025
Regulation 28(2)(b)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Substantially Compliant	Yellow	30/06/2025
Regulation 28(4)(a)	The registered provider shall make arrangements for staff to receive suitable training in fire prevention, emergency procedures, building layout and escape routes, location of fire alarm call points and first aid fire fighting	Substantially Compliant	Yellow	30/06/2025

	equipment, fire control techniques and arrangements for the evacuation of residents.			
Regulation 05(4)(b)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which outlines the supports required to maximise the resident's personal development in accordance with his or her wishes.	Substantially Compliant	Yellow	21/03/2025
Regulation 05(6)(a)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall be multidisciplinary.	Substantially Compliant	Yellow	09/04/2024
Regulation 05(6)(c)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall assess the effectiveness of	Substantially Compliant	Yellow	12/03/2025

	the plan.			