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

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| Name of designated centre: | Kingfisher 1 |
| Name of provider: | Brothers of Charity Services Ireland CLG |
| Address of centre: | Limerick |
| Type of inspection: | Unannounced |
| Date of inspection: | 26 June 2025 |
| Centre ID: | OSV-0004836 |
| Fieldwork ID: | MON-0047544 |

## About the designated centre

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

Kingfisher 1 provides a full-time residential service for up to seven adult residents with an intellectual disability. The designated centre aims to provide residents with a safe and homely environment, which promotes independence and quality care, based on the individual needs and requirements of each person. The designated centre comprises of three community houses. Two houses are located in new developments and one is located in mature residential area. All are located within easy access to local services and amenities. All of the houses are two storey buildings, providing residents with their own bedroom, one with lift access to the first floor. One house has a self contained apartment next to the main house. Each house has access to garden areas with parking also available to the front of the properties. The residents are supported in their homes through a social model of care, with staff available during the day, in line with the assessed needs of the residents. There is a sleepover staff in each house by night.

**The following information outlines some additional data on this centre.**

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| 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 |
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| Thursday 26 June 2025 | 18:00hrs to 22:00hrs | Deirdre Duggan | Lead |
| Friday 27 June 2025 | 12:50hrs to 20:30hrs | Deirdre Duggan | Lead |

## What residents told us and what inspectors observed

From what the inspector observed and from speaking with residents and staff, residents living in this centre were being offered a good quality service tailored to their individual needs and preferences. Efforts were ongoing to provide a service that was safe and effective for residents. However, this inspection found that some improvements were required in relation to governance and management, healthcare and residents' access to finances and advocacy services. Continued non compliance was also noted in relation to premises and fire precautions and the provider had submitted a timebound plan to the Chief Inspector of Social Services that would address these issues.

The centre is comprised of three premises. A new premises had been added to the footprint of the centre, and an older premises removed also by applications to vary submitted by the provider. Two of the premises are located in urban housing developments and the third is a detached residence with an adjoining apartment on it's own grounds. All of the buildings are located in the suburbs of a large city. Residents have access to local amenities such as shopping centres, supermarkets, cinemas, and recreational facilities.

This centre is registered to provide supports to seven adults. This had reduced from nine following applications to vary from the provider since the previous inspection. At the time of this inspection, six residents were living in the centre and there was one vacancy. One resident had unfortunately passed away in the previous year. Two residents had moved into a new premises that had been adapted to suit their assessed needs and another resident had transferred internally to another unit of the designated centre. The inspector had an opportunity to visit two locations and meet with five residents and a number of staff members. This was an unannounced risk inspection completed over two days. Insofar as possible, this inspection focused on meeting residents and staff and observing residents in their homes.

The inspector spent two evenings in one house, where residents attended day services until late afternoon, and spent an afternoon in a second house where residents received day services in their home. One resident, who lived alone, chose not to meet with the inspector and this wish was respected. All of the residents met with communicated verbally. Some residents chose not to interact at length with the inspector and did not respond to all of the inspectors questions and their wishes were respected. Some residents showed the inspector their bedrooms and apartment and one resident demonstrated to the inspector how the lift worked in their new home. A resident pointed out to the inspector a new bus the service had received.

On the evening of the first day of the inspection, two residents attended the providers' monthly social night and were observed getting ready for and returning from this event and showed the inspector the raffle prizes that they had won and all residents enjoyed a cup of tea before retiring to bed at times of their own choosing.

One resident was supported by staff to charge a new pair of headphones. The third resident living in this house declined to attend the social and was supported to remain at home. The inspector spent a significant portion of time with this resident in the sitting room and heard and observed staff regularly interacting with and checking in with this resident. All staff spoken to reiterated to the inspector the importance of sitting with and spending time on a one-to-one basis with residents where possible. On the second evening, residents were observed relaxing in their home and attending to routine chores and activities.

In the second premises, the inspector observed both residents being offered a home cooked lunch before going out for a drive in the early afternoon. One resident was observed leaving the centre with a family member later in the day for the weekend and was seen to be excited about this. In both premises, the inspector saw that residents were being supported in relaxed and calm environments by staff that presented as committed to their roles.

Residents told the inspector that they felt safe in their home and told the inspector that they liked the staff that worked with them. Three residents had moved homes since the previous inspection and told the inspector about this. These residents presented as content with their new living arrangements are were very proud of their new bedrooms and how these were decorated and personalised.

In total, the inspector met nine staff members, including staff providing day service supports in one house. Some of these interactions were brief but the inspector had an opportunity to interview six of these individuals over the two days. The person in charge was on leave at the time of this inspection but did also make themselves available to meet with the inspector. A family member was also met with briefly when they were collecting a resident for a home visit.

Positive, respectful interactions were observed between residents and the staff supporting them on both days of the inspection and residents appeared comfortable in the presence of the staff present on both days.

It was seen that there were no fire doors present in the first premises visited. The provider had plans for this premises to be replaced and this will be discussed further in the report. A vacant room upstairs had been converted into a sitting room used by a resident. The second premises had been added to the footprint of the centre since the previous inspection and was seen to be modern and adapted to meet the needs of the two residents living there. This was a three storey house located in a housing estate. The ground floor contained communal areas including kitchen and laundry facilities. Each resident had a separate area that they liked to use to relax, with comfortable seating and a TV in each area. Resident bedrooms were located on the middle floor and a lift had been installed to allow residents convenient access to this level. The top floor of this building was used by staff and not accessed by residents. The third premises is a recently constructed two storey dwelling that was seen to have suitable fire safety measures in place and suited to the needs of the single resident living there during the previous inspection.

For the most part, the two premises visited during this centre were seen to be clean and well maintained. All residents had their own bedrooms, personalised according to their individual tastes. There were adequate toilet, shower and laundry facilities to meet residents' needs. Communal areas were very homely and there were numerous pictures of residents on display and televisions were located in all communal areas. Some issues were noted in the first premises visited, which the provider intended to replace in 2026. There were no fire doors and some fixtures and fittings in an apartment area, such as in the bathroom, were noted to be rusted and stained. There were also a number of large potholes in the backyard area of the premises which a resident showed to the inspector. The inspector was told that the resident had made a complaint to the provider about these and that some remedial work had been carried out but that this area was awaiting further works to be completed.

Overall, this inspection found that there was evidence of ongoing efforts to ensure compliance with the regulations in this centre and to provide residents with safe and person centred services that met their assessed needs. The next two sections of the report present the findings of this inspection in relation to the governance and management arrangements in place in the centre, and how these arrangements impacted on the quality and safety of the service being delivered.

## Capacity and capability

While local management systems in place in this centre were ensuring that overall the services being provided were of good quality and appropriate to residents' needs, the arrangements in place were not fully effective to ensure full oversight could be provided at all times. There was also ongoing non compliance related to fire precautions and premises in one unit of the centre.

This inspection found that the provider was ensuring that this designated centre was overall adequately resourced to provide for the effective delivery of care and support in accordance with the statement of purpose. For example, staffing levels were good and residents living in the centre had access to transport and ongoing work was progressing to provide all residents with modern homes that met their assessed needs.

There were previously identified issues under Regulation 28: Fire precautions and Regulation 17: Premises in this centre and a restrictive condition had been attached to the registration of this centre. This unannounced risk inspection was carried to assess compliance with the regulations following a number of adverse incidents reported from the centre, and also ongoing progress with the providers plan to bring the centre into compliance with previously identified issues. At the time of this inspection it was seen that the provider was continuing to make some progress with the actions required to bring this centre in to compliance with these regulations. A second premises had been replaced with a fire compliant premises and residents

had transferred into this premises since the previous inspection. There were plans for residents of one remaining not compliant premises to transfer to new premises in 2026 that would be compliant with fire regulations. The provider had submitted an updated timebound plan in relation to this earlier in March 2025 and made an application to extend the date applied to a restrictive condition. This had been accepted and at the time of this inspection work was ongoing to bring an identified premises up to the required standard as per this plan.

The person in charge had recently been appointed to the role, having occupied a team leader role in the centre prior to this. This individual reported to an area manager and this individual was also a named person participating in the management of this centre (PPIM). The person in charge was also supported in their role by social care workers and care staff that worked in the centre. Staffing levels in the centre were seen to be adequate to meet the assessed needs of residents and the provider had put in place additional unfunded wake night staff in one area of the centre to support the changing needs of the residents in the centre.

Although not requested to attend the centre for the inspection, the inspector met with the incoming person in charge for a period on both days of the inspection. The inspector also spoke with residents and staff working in the centre. The person in charge was on leave at the time of the inspection but made themselves available to the inspector if required. The PPIM was also on leave but spoke with the inspector over the telephone also. Both these individuals were seen to be committed in their roles and the inspector saw that the both of these individuals were very aware of their regulatory responsibilities and were very committed to enhancing and improving the services offered to residents.

The inspector was satisfied that the management team had overall good oversight of any issues in the centre and maintained a strong presence in the centre. It was evident that residents and staff were very familiar with the management team and felt well supported by them. Staff members spoken to in the centre reported that the person in charge was very supportive to the staff team and that they would be comfortable to raise any concerns to any of the management team. An on call management rota was in place to provide staff with additional support if required out of hours. However, some issues with the governance arrangements in place were identified. For example, staff teams worked across a specific shift pattern in the centre, meaning there were generally two separate staff teams in place. The person in charge worked on one shift rota and this meant that there were difficulties in maintaining oversight of the staff team working on the opposite shift pattern. The person in charge told the inspector about the challenges that this presented and the efforts that they made to try to maintain oversight of the staff team on the opposite shift but these were not fully effective in ensuring that the person in charge could maintain full oversight in this area. For example, one staff member had not received formal supervision in line with the providers policies due to the person in charge being unable to meet them at at suitable time.

An annual review had been completed in respect of the centre for the previous year and the inspector reviewed this document. This included consultation with residents and their family members. Unannounced six-monthly visits were being conducted by

a representative of the provider and a report on the most recent of these carried out in February 2025 was reviewed. An action plan in respect of identified actions was also reviewed and this showed action was being taken in relation to issues identified. There was evidence that learning from incidents was considered. For example, following medication errors, staff had attended refresher training to support safe administration of medication and if required performance improvement plans were initiated to support staff in specific areas. Also, following some falls, a resident was referred to physiotherapy and the orthotics clinic.

Overall, this inspection found that there was evidence of good efforts to bring the centre into compliance with the regulations in this centre but that ongoing non compliance in relation to Regulation 28 meant that all residents were not yet being provided with fully safe services. The next section of the report will reflect how the management systems in place were contributing to the quality and safety of the service being provided in this designated centre.

## Regulation 14: Persons in charge

At the time of this inspection the registered provider had appointed a suitable person in charge. The registered provider had submitted appropriate documentation to show that this person possessed the required qualifications, experience and skills for the role. This was reviewed by the inspector and this individual and was seen on the day of the inspection to maintain good oversight of the centre. The person in charge was full time in their role as is required by the regulations.

Judgment: Compliant

## Regulation 15: Staffing

The registered provider was ensuring that the number of staff was appropriate to the number and assessed needs of residents, the statement of purpose and the size and layout of the designated centre. The provider had taken into account residents' changing needs and provided additional staffing where required, including waking night staff in one area of the centre. Some of the staffing in place was unfunded but the provider had committed to ensuring this remained in place for the safety and well-being of residents.

A planned and actual staff rota was maintained in the centre and a sample of this rota was reviewed by the inspector. The centre was staffed by a core team of suitably skilled staff and rosters showed efforts being made to provide a consistent staff team to provide continuity of care for residents. Residents were supported by a team consisting of social care workers and support workers. Three residents were supported by two staff by day and a sleepover staff by night in one location. In the

second location, two residents were supported by two staff by day and a waking staff member by night. In the third location one resident was supported by one staff member by day and a sleepover staff member by night. A sample of the roster over a six week period was reviewed by the inspector. This showed that staffing levels were appropriate to the number and assessed needs of the residents living in the centre.

Judgment: Compliant

## Regulation 16: Training and staff development

Training records viewed showed that staff working in this centre had access to appropriate training, including refresher training and there was evidence of oversight of the training needs of staff.

The inspector reviewed a training matrix for 16 staff that were also named on the centre roster. This matrix showed that staff were provided with training appropriate to their roles and that the person in charge was maintaining good oversight of the training needs of staff. Mandatory training provided included training in the areas of fire safety, manual handling and safeguarding and overall, staff had received appropriate training in all of these areas. Four staff were overdue refresher training in managing actual and potential aggression and one new staff member had not yet completed this training. All of this training had been scheduled for the weeks following the inspection. Agency staff were not regularly rostered to work in this centre.

The person in charge confirmed that they took part in one-to-one meetings with their own line manager on a regular basis and these were also documented. There was a schedule in place that showed that staff were offered formal supervision and staff met with reported that they had the opportunity to partake in formal supervision on a regular basis. However, one staff member had not received formal supervision since early 2024. This has been addressed under Regulation 23: Governance and Management.

Staff spoken with who had commenced working in the centre in recent times reported that they were provided with a good induction that included shadow shifts, information about residents and safeguarding plans, and appropriate training. Rosters viewed showed shadow shifts were planned for new staff.

Judgment: Compliant

## Regulation 23: Governance and management

There was ongoing non compliance in relation to Regulation 28 in this centre. However there had been progress with the plans in place to bring the centre into compliance with this regulation. Two out of three premises now had appropriate fire precautions in place. The provider was actively working to bring the centre into compliance with the regulations and actions were underway for the required works and premises upgrades and changes to be completed so that residents could transition from the remaining non compliant premises.

There was a governance structure in place that set out the lines of accountability within the service. While management systems were in place to ensure that the service provided was appropriate to residents' needs and consistent, the systems in place did not always mean that the service provided could be effectively monitored. As discussed in the capacity and capability section of the report the shift patterns in place meant that the person in charge faced challenges in maintaining full oversight of all staff in the centre. For example, although almost all staff had received recent formal supervision in the centre, one relief staff member had not received formal supervision since February 2024, despite efforts on the part of the person in charge to complete this.

Documentation reviewed by the inspector during the inspection such as provider audits, team meeting minutes, the annual review, and the provider's report of the most recent six monthly unannounced inspection, showed that the provider was maintaining overall oversight of the service provided in this centre. However, some gaps in oversight were noted during a period when the individual then occupying the role of team leader was absent and these had not been identified until their return. For example, team meeting records viewed in one location showed that no formal staff meetings had taken place between December 2024 and June 2025.

Prior to the person in charge being appointed to the role, they had occupied a team leader role with administration and oversight duties for this centre and generally this individual had supported the previous person in charge, an area manager with significant remit in their role, in maintaining day-to-day oversight of the centre. During a period when this individual was absent another team leader had been appointed to cover this role. However, some oversight issues were identified during this period, indicating that the arrangements in place were not fully effective and were not robust in ensuring continuity of oversight in the event of an absence. It is acknowledged that some of the issues identified had since been addressed.

Since then, this individual had been appointed person in charge with remit over this centre only and the inspector was told that there were plans for this centre to have a dedicated person in charge going forward. The person in charge was due to depart the role in the period following the inspection and the inspector was told about the handover arrangements that were planned to ensure continuity of oversight.

Judgment: Not compliant

## Regulation 31: Notification of incidents

Incidents reported in the centre over a five month period were reviewed. The person in charge had notified the chief inspector in writing, as appropriate, of any incidents that had occurred in the designated centre.

Judgment: Compliant

## Quality and safety

From what the inspector observed and heard while in the centre, residents in this centre were being well cared for and were living good lives in this centre. The inspector met with a committed staff team that was in place during the inspection and saw that this was providing for consistency of care and support and a good quality service was being offered. The provider had made some progress with their plans to replace two of the premises that made up this centre and three of the six residents were now living in a new premises that provided a very good standard of accommodation to them. Outstanding issues in relation to the fire precautions in place remained for one unit of the centre and the provider had plans in place to address these. Some issues were noted in relation to the ongoing monitoring of one residents' weight and nutritional intake and also in relation to resident's rights.

Residents took part in regular house meetings that included information about various topics including rights, health and safety and regulation. One resident told the inspector their understanding of regulation and it was evident that this had been discussed at these meetings. A sample of residents individual files including healthcare support plans and personal care plans were viewed. Plans were seen to be overall up-to-date and provide good guidance for staff to ensure that residents were appropriately supported. Residents were observed to be active in their community and had suitable transport available to them to attend day services, leisure activities and healthcare appointments. There was evidence of consultation with residents and their representatives on issues relevant to the centre.

A number of staff related and peer-to-peer safeguarding concerns had been reported from this centre since the previous inspection. In general, these related to two of the units in the centre and indicated that at times the safeguarding measures in place had not been effective to fully protect all residents from abuse and a reluctance to report safeguarding concerns among some staff. However, the provider had made clear efforts to respond to, investigate and take action in response to concerns raised and this meant that residents were being protected from a re-occurrence of incidents reported. The findings of this inspection indicated that ongoing work was being carried out within the centre to embed a culture that

promoted safeguarding of residents and encouraged open reporting from staff and residents of any safeguarding concerns.

## Regulation 10: Communication

The registered provider was ensuring that residents were assisted and supported to communicate in accordance with their needs and wishes. Staff were observed to be very familiar with and respectful of residents' communication methods and styles. The inspector reviewed the communication guidance in residents' personal plans and saw that relevant guidance was available to staff in relation to supporting residents to communicate.

Communication preferences were documented in the sample of resident files reviewed. Rosters reviewed showed that familiar staff were allocated to the centre on an ongoing basis and that in the event that relief or agency staff were required, efforts would be made to arrange that they would be on duty with a familiar staff member that knew residents' communication styles and preferences.

Residents had access to media such as television, magazines and radio and residents could communicate with family members and supporters by telephone if desired. Some residents were observed to have their own mobile phones and landline and mobile phones were observed in the houses also.

Good practice was observed in relation to supporting residents in this area. For example, the inspector observed ample easy-to-read documentation was available to residents and was used to communicate on specific issues with residents. Social stories were in use in the centre also for some residents. One resident had an accessible TV schedule to guide them about when their favourite television programmes were scheduled. A visual meal planner was used also in conjunction with residents meetings for menu planning.

Each resident had their own schedule which was on display in a living room, as per the residents' own wishes. These were seen to be accessible to residents. Pictorial menus were also viewed on display and a menu planning sheet signed by residents was seen in the kitchen that documented residents' choices around their meals for the week ahead. Easy-to-read information was on display in the centre that provided residents with information about issues such as complaints, advocacy, finance, regulation, governance arrangements and safeguarding.

Judgment: Compliant

## Regulation 12: Personal possessions

Residents were seen to have sufficient storage space for their belongings. Some issues related to this found in the previous inspection had been addressed by a change in premises. Residents retained control over their own possessions. There was access to laundry facilities in all areas of the centre.

The inspector saw evidence that the provider was making efforts to ensure that each resident has access to and retains control of person property and possessions and support is provided to residents, where necessary, to manage their financial affairs. The inspector was also told that a recent financial audit had been completed of residents' finances by an external auditor in one location. A review of two residents' finances indicated that there were systems in place to protect and safeguard residents' monies. The inspector saw evidence that the provider had refused to pay money belonging to a resident into an account held in a financial institution that was not in the name of the resident to which the money belonged.

While some improvements had been made since the previous inspection, some residents continued to not have full access to their own money at all times. This meant that residents could not always decide how to spend their own money or had to wait a period of time for access to funds or approval for larger purchases. For example, the provider was supporting one resident who was awaiting full access to their funds but was delayed due to banking issues they had encountered.

One resident did not have access to their own money and there was evidence that the provider was making efforts to support the resident in this area and to put in place more robust arrangements to fully ensure this residents' monies were appropriately safeguarded and that the resident was not restricted in their activities or choices by the arrangements in place, but this had not been fully addressed at the time of this inspection. This is covered under Regulation 9: Residents rights.

Judgment: Substantially compliant

## Regulation 13: General welfare and development

The registered provider was providing each resident with appropriate care and support in accordance with evidence-based practice. Residents in this centre had access to opportunities and facilities for occupation and recreation and were supported to maintain and develop relationships with important people in their lives.

The inspector saw that residents were very content and well cared for in their home and were comfortable in the presence of the staff team that supported them. The inspector was told about how residents maintained contact with family and friends and one resident was observed to go on a family visit on the day of the inspection. Residents were seen to lead active lives in their communities and to take part in activities of their choice including social events, shopping, meals out, sports and visiting friends and significant people in their lives.

Documentation in place about residents was seen to provide good guidance to staff about the supports residents required to meet their healthcare, social and personal needs as outlined in other sections of this report. Residents were also provided with supports to manage their behaviour and behaviour support plans were seen to be in place for residents that required these. Staff were observed to be very responsive to residents and were observed to support residents in line with these plans.

Three residents had transitioned into new homes since the previous inspection. There were strong indications that these transitions had been positive for residents. Resident groupings provided for improved compatibility and reduced impact of peer-to-peer safeguarding incidents. The inspector viewed a report from a mental health professional that indicated that one resident had experienced improvements in their presentation following the transition to their new home. Two residents were now facilitated to remain in their home by day if they chose to and day service staff supported these residents in their home on a one-to-one basis. The provider had also submitted a business case to the funder for these residents to be provided with a 24-hour model of support that would promote continuity of care for residents.

Judgment: Compliant

## Regulation 17: Premises

The inspector viewed two of the three premises of this designated centre and saw that they were overall clean, adequately maintained and decorated in line with residents individual preferences. There was adequate cooking and bathroom facilities and good outdoor space was available to residents. Some premises changes had occurred since the previous inspection, as outlined in the report above. The new premises added to the centre was seen to provide for a very high standard of accommodation for the two residents living there. There were plans to further change the premises that made up the centre and new accommodation was planned for the remaining cohort of residents living in one premises that was not in compliance with fire regulations. The inspector was told that these plans had been considered to ensure that the new premises would meet the assessed needs of residents. For example, one resident would be supported to continue living in their own apartment that was linked to the main premises. Some issues were identified in relation to the original premises that residents remained living in at the time of the inspection:

-large pot holes in a concreted back yard area presented a hazard to residents playing basketball and accessing the garden area and polytunnel.

-some fittings and fixtures in the apartment bathroom were seen to be rusted and stained.

-watermarks from a leak were evident on the ceiling of a downstairs bedroom.

Judgment: Substantially compliant

## Regulation 26: Risk management procedures

Overall, risk was seen to be well managed in this centre. A system was in operation for the recording and review of incidents occurring in the centre. For example, residents had specific seating arrangements on the centre transport to support their needs and manage risks and one-to-one staffing was provided to residents if required. Waking night staff were introduced in one area of the centre in response to an incident and the escalation of this risk to the provider.

Individualised risk assessments were viewed in residents' files and a local risk log was in also in place and reviewed by an inspector in one unit. Risk assessments were seen to be subject to regular review. However, some out-of-date information was reviewed in one residents' individual risk log, despite it having been updated recently following a medical procedure. Personal emergency evacuation plans were viewed.

From a sample of risk assessments reviewed, the measures outlined to mitigate against risk in the centre had been put in place. For example, one resident presented with a very specific risk that could impact on themselves or others. To reduce the risk to other residents, this resident was supported to live in their own single occupancy apartment and was provided with one-to-one staffing by day. There was clear measures outlined in the documentation in the centre to protect both the resident themselves and other residents and guidance was available to staff to effectively support them to manage this risk. Following an incident, it had been identified that these measures had not always been followed by staff. Action had been taken to address this and the measures outlined were observed to be in place on the day of the inspection.

Judgment: Compliant

## Regulation 28: Fire precautions

The registered provider had not ensured that effective fire safety management systems were in place in all parts of this centre at the time of this inspection.

- Appropriate containment measures were not in place in one premises. There were no fire doors in place in that premises at the time of this inspection.
- Also, a review of fire drill records showed that no evacuation drill that simulated a night time/reduced staffing scenario had been completed in one house in 2024 or 2025.

It is acknowledged that since the previous inspection a second premises had been replaced and this was seen to have appropriate fire safety management systems in place, including fire doors, an fire detection and alarm system and fire-fighting equipment. The outstanding premises that required fire works as mentioned above was due to be replaced in 2026 as per the providers' plan.

Judgment: Not compliant

## Regulation 5: Individual assessment and personal plan

The person in charge had ensured that an annual assessment of need had been completed for residents and overall the registered provider had arrangements in place to meet the assessed needs of the residents living in this centre. For example, the inspector saw evidence of multidisciplinary team reviews completed in a number of residents files and these were attended by a large number of health and social care professionals. Overall, support plans in place for residents were comprehensive and the findings of this inspection indicated that staff were familiar with and followed the guidance contained in these. However, some recommendations for one resident had not been fully implemented at the time of this inspection.

The inspector reviewed four residents' files and personal plans during this inspection. Plans in place had been carried forward throughout transitions into new homes for three residents and these indicated that significant work had been completed prior to residents moving into their new homes, including assessments of their living environment pre and post the move into their homes by appropriate allied health professionals. Appropriate staffing was in place to meet the assessed needs of the residents living in the centre and prior to moving house, the provider had ensured that necessary adaptations were carried out to meet residents' assessed needs. For example, a lift had been installed into one premises to support residents with mobility issues and individualised staff supports were available to residents if these were required.

The person in charge had ensured that personal plans were in place for residents that reflected their assessed needs, outlined the supports required to maximise residents' personal development in accordance with their wishes, age and nature of their disability. A sample of four personal plans were reviewed by the inspector. The inspector saw that goal planning was documented in the centre and that residents were being afforded opportunities to set and achieve goals. Personal plans were subject of a review, carried out annually or as changing circumstances required. One residents' plan was seen to be due for review and staff showed the inspector that preparations had begun for this.

Support plans were in place that provided good guidance to staff about the supports residents required to meet their healthcare, social and personal needs and that identified supports required to safeguard residents. The information reviewed in incident reports indicated that staff were following the positive behaviour support

guidelines in place. Plans in place for residents contained relevant guidance for staff about the assessed needs of residents and the indications from this inspection were that these were being updated as required to reflect any change in circumstances. This meant that the care and support offered to residents was evidence based and person centred.

Judgment: Compliant

## Regulation 6: Health care

Overall, the resident files reviewed showed that the registered provider was providing appropriate health care for each resident, having regard to that resident's personal plan. There was evidence that residents had accessed numerous multidisciplinary supports as required, including general practitioner, allied health and mental health supports. Where residents had visited hospital, they were supported by staff. Residents had access to a Clinical Nurse specialist in Age Related care if required within the providers own resources. However, some of the guidance from a healthcare professional had not been fully implemented for one resident.

- weekly weight checks were recommended but the records viewed indicated that these were not being completed or attempted on a weekly basis.
- Food and fluid intake records kept did not always clearly indicate that recommendations were being fully followed and inconsistent recording of food and fluids consumed by the resident meant that it would be difficult to monitor their intake effectively.

Judgment: Substantially compliant

## Regulation 8: Protection

Arrangements were also in place to safeguard residents from abuse. These included safeguarding training for all staff, a safeguarding policy and personal and intimate care plans to guide staff. A designated safeguarding officer was in place if required. The inspector had an opportunity to speak with a number of staff across different staff teams during this two day inspection. The staff spoken to in the centre had a very good awareness of the safeguarding procedures that were in place in the centre and were able to tell the inspector what they would do if they had a concern.

Safeguarding measures in place in the centre included the provision one-to-one staffing for residents that required this support at specific times. Staff rotas reviewed, observations on the day of this inspection, and discussions with staff

indicated that this was usually in place. One resident lived in a single occupancy apartment in line with their assessed needs.

One safeguarding incident that had been reported from this centre was attributed to staff not fully following the guidelines in place for the supervision of residents. The actions reported by the provider included ensuring that all staff were fully aware of the safeguarding plans in place and supervision requirements for residents and this was a key focus of this inspection. During the time spent in the centre, the inspector saw that staff were vigilant in relation to the supervision of residents in the centre and that staff were aware of the importance of this. This was carried out in a manner that was respectful to residents' rights and there were clear protocols viewed to be in place in respect of these arrangements.

A formal safeguarding plan reviewed included actions related to providing a resident with information and education for self-care and protection. Regular house meetings were documented as taking place with residents and the minutes of these included details of discussion around safeguarding matters and rights and the person in charge had linked with the day service in relation to providing ongoing education to the resident. Residents spoken with told the inspector that they felt safe in their homes. Staff were aware of and spoke confidently about safeguarding plans and protocols that were in place in the centre. While there was some evidence that team meetings had not been held regularly with the full staff team for a period of time, the inspector was told that staff were communicated with regularly by the person in charge through other methods and it was evident that the staff team had a strong awareness of recent safeguarding issues in the centre and the plans in place to manage these. One staff member spoke to the inspector about a recent safeguarding that they had identified and the procedures they followed to report this and told the inspector that the provider and management team had responded immediately.

The provider had in place a 'National Policy for the Safeguarding of Vulnerable Adults at Risk of Abuse' and this was in date and viewed in the centre. Details of the providers' designated officer were on display in both areas of the centre visited. Safeguarding standards were available to staff in the centre. Resident and centre specific safeguarding information available to staff was reviewed and this was seen to be comprehensive and provide clear guidance to staff about important issues, including forensic risks and recommendations from appropriate allied health professionals. A safeguarding checklist for new staff was viewed also. Intimate care plans were viewed to be in place in residents' files. An intimate care plan reviewed by the inspector documented important details such as the very specific individual preferences and how staff could support the resident in this area.

The inspector requested information relating to the garda vetting of staff and assurances were provided by the provider that all staff working in the centre had received appropriate garda vetting disclosures.

Judgment: Compliant

## Regulation 9: Residents' rights

Residents were consulted with appropriately in this centre through a variety of means and communication methods. Staff were observed to speak to and interact respectfully with residents on the day of the inspection.

Overall, residents were supported to exercise choice and control over their daily lives and participate in meaningful activities. Residents were offered choices in relation to their food and mealtimes. The inspector heard a staff member speak with a resident about supporting them to clean their room. This was declined and this wish was respected with the staff member heard to offer this again later.

A human rights charter was viewed on display in the hallway of one part of the centre and the inspector also saw a travel agreement in place that had been signed by all of the residents living in one house. There was evidence that a resident had the input of a social worker to support them with dealing with issues in relation to medical care. Residents were also informed about how to make complaints in the centre through weekly house meetings. There was evidence that staff had supported some residents to make complaints if they wished to do so. Nine complaints had been received from residents in one unit since February 2024, with evidence that these were responded to.

While residents were provided with information in relation to advocacy services and had accessed advocacy services in the past, this had not been considered at the time of the inspection for one individual in respect of supporting them to retain control over their own finances. Records reviewed showed that this resident did spend small amounts of pocket money provided by their family regularly but that they did not have full access to their own monies or full autonomy to spend their own monies as they chose. While this resident was seen to be very well presented and reported to have access to anything that they needed on the day of this inspection, there were indications from staff and management that the arrangements in place could restrict the residents choice on occasion, such as when out in the community or having equal opportunities to participate in regular activities associated with community living such as purchasing clothes, meals, snacks and personal items. It was unclear if full efforts had been made to ensure that the arrangements in place for this resident had been fully discussed with, and consented to, by the resident.

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 | Compliant |
| Regulation 15: Staffing | Compliant |
| Regulation 16: Training and staff development | Compliant |
| Regulation 23: Governance and management | Not compliant |
| Regulation 31: Notification of incidents | Compliant |
| **Quality and safety** | |
| Regulation 10: Communication | Compliant |
| Regulation 12: Personal possessions | Substantially compliant |
| Regulation 13: General welfare and development | Compliant |
| Regulation 17: Premises | Substantially compliant |
| Regulation 26: Risk management procedures | Compliant |
| Regulation 28: Fire precautions | Not compliant |
| Regulation 5: Individual assessment and personal plan | Compliant |
| Regulation 6: Health care | Substantially compliant |
| Regulation 8: Protection | Compliant |
| Regulation 9: Residents' rights | Substantially compliant |

# Compliance Plan for Kingfisher 1 OSV-0004836

## Inspection ID: MON-0047544

## Date of inspection: 27/06/2025

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

This document is divided into two sections:

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

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

A finding of:

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

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

## Section 1

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

**Compliance plan provider's response:**

| **Regulation Heading** | **Judgment** |
|---|---|
| Regulation 23: Governance and management | Not Compliant |

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

• The services recognize that the PIC role was vacant for a number of weeks as the PIC was on leave. The PIC subsequently transferred to another role within the organization and was replaced by a Team Leader. This Team Leader will meet the criteria to become the PIC on 22/10/2025.

• Area Manager post currently being filled as candidate has been offered the position and is going through the recruitment process. An acting Area Manager is in place in the interim.

• Relief staff member without supervision since February 2024, was supported to have supervision on 22.7.25. Staff meeting took place in June for staff. Team leader that started in August held team meeting on 28.8.25. Team leader has set out dates for staff meeting for rest of the year across the Centre staff which has been circulated to the Centre.

• New Person in charge has replaced the Person in charge who has departed, team administrator has also begun in the role since start of August (team administrator is eligible in October for Person in charge role).

• Approval of funding for the upgrade of the house, purchased to replace the non fire compliant house in the Designated Centre, was received from the local council following approval by Department of Environment on 28th August 2025. This allows for tender process to proceed.

• Tender for house upgrade will now go live on 18th September 2025. Once tender report is agreed with Council we expect contractor to be on site by 5th January 2026.

• This house will be fully fire compliant and will meet the needs of current residents

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| Regulation 12: Personal possessions | Substantially Compliant |

Outline how you are going to come into compliance with Regulation 12: Personal possessions:
• The system in place for resident to access their monies.
• Plan in place that staff/team leader regularly monitor person supported ledger account, once reached a set amount in the account, team leader/staff request money from family member deposits money in to the account set up in agreement with finance department.
• A referral to the national advocacy service has been sent on behalf of a resident in relation to not maintaining full control over their own finances on 24.8.25.
• Currently given changes to bank accounts available to support individuals with their money it is not possible to open a "person in care" account for people supported who opt for this option.

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| Regulation 17: Premises | Substantially Compliant |

Outline how you are going to come into compliance with Regulation 17: Premises:
• As of 23/8/25 - Potholes have been covered by maintenance.

• Leak was identified and fixed. Team leader resubmitted on 23.8.25 maintenance request for rusted fitting/fixtures and watermarks in downstairs bedroom.

• Approval of funding for the upgrade of the house, purchased to replace the non fire compliant house in the Designated Centre, was received from the local council following approval by Department of Environment on 28th August 2025. This allows for tender process to proceed.

• Tender for house upgrade will now go live on 18th September 2025. Once tender report is agreed with Council we expect contractor to be on site by 5th January 2026.

• This house will be fully fire compliant and will meet the needs of current residents.

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| Regulation 28: Fire precautions | Not Compliant |

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| Outline how you are going to come into compliance with Regulation 28: Fire precautions:<br>• All houses if not done so already have been instructed to carry out a night time fire drill asap as directed by team leader as of 23.8.25. One Centre carried out night time fire drill on 24.8.25<br><br>• Approval of funding for the upgrade of the house, purchased to replace the non fire compliant house in the Designated Centre, was received from the local council following approval by Department of Environment on 28th August 2025. This allows for tender process to proceed.<br><br>• Tender for house upgrade will now go live on 18th September 2025. Once tender report is agreed with Council we expect contractor to be on site by 5th January 2026.<br><br>• This new house will be fully fire compliant and will meet the needs of current residents. | |
| Regulation 6: Health care | Substantially Compliant |
| Outline how you are going to come into compliance with Regulation 6: Health care:<br>• Correspondence was sent out on 23.8.25 in relation weight chart to each of the staff teams working in houses of the Designated Centre.<br><br>• This was also discussed at the staff meeting on 28.8.25 along with any food/fluid charts | |
| Regulation 9: Residents' rights | Substantially Compliant |
| Outline how you are going to come into compliance with Regulation 9: Residents' rights:<br>• A referral to the national advocacy service has been sent on behalf of a resident in relation to not maintaining full control over their own finances on 31/03/2026. It is expected that the Advocate will be in place as soon as one is appointed. | |

## Section 2:

## Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

| Regulation | Regulatory requirement | Judgment | Risk rating | Date to be complied with |
|---|---|---|---|---|
| Regulation 12(1) | The person in charge shall ensure that, as far as reasonably practicable, each resident has access to and retains control of personal property and possessions and, where necessary, support is provided to manage their financial affairs. | Substantially Compliant | Yellow | 30/09/2026 |
| Regulation 17(1)(b) | The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally. | Substantially Compliant | Yellow | 30/09/2026 |
| Regulation 23(1)(c) | The registered provider shall ensure that management systems are in place in the | Not Compliant | Orange | 30/09/2026 |

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| | designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored. | | | |
| Regulation 28(1) | The registered provider shall ensure that effective fire safety management systems are in place. | Not Compliant | Orange | 30/09/2026 |
| Regulation 28(3)(a) | The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires. | Not Compliant | Orange | 30/09/2026 |
| 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 so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire. | Substantially Compliant | Yellow | 30/09/2025 |
| 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 | 30/09/2025 |
| Regulation 09(2)(d) | The registered provider shall | Substantially Compliant | Yellow | 31/03/2026 |

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| | ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability has access to advocacy services and information about his or her rights. | | | |