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:	The Bridge
Name of provider:	St John of God Community Services CLG
Address of centre:	Louth
Type of inspection:	Unannounced
Date of inspection:	12 May 2026
Centre ID:	OSV-0005789
Fieldwork ID:	MON-0045292

About the designated centre

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

The Bridge is a designated centre operated by St John of God Community Services CLG. The Bridge is a community residential house situated in a town in Co. Louth. The centre is home to four adult residents. The house is a large bungalow with four bedrooms, one of which has an en-suite bathroom. There is also a large bathroom, kitchen/dining area, a utility room and two sitting rooms. At the back of the property is a large garden with seating areas for residents to enjoy. The property has been adapted to meet the needs of residents with mobility issues. The residents are supported by a team of staff 24 hours a day. The team consists of social care workers, nurses and health care assistants. There are three staff on duty all day and two waking night staff. The person in charge is responsible for three other centres under this provider. To ensure oversight of the centre, they are supported by a clinic nurse manager who is supernumerary. A shift leader is also assigned to oversee the care and support provided each day. The residents do not attend a formal day service and are supported by staff to access meaningful activities during the day. A bus is provided in the centre to facilitate this and other appointments.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	4

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Tuesday 12 May 2026	09:00hrs to 16:30hrs	Kieran McCullagh	Lead

What residents told us and what inspectors observed

The purpose of this unannounced inspection was to monitor the care and welfare, and support arrangements for residents living in the centre and assess compliance with the regulations. This inspection determined that although residents were provided with quality care and support, improvements were identified under a number of regulations inspected. Specifically, enhancements were necessary regarding residents' assessed communication needs and supports. In addition, further improvements were required pertaining to staff training and development, written policies and procedures, individualised assessment and personal plans, and positive behavioural supports.

The inspection was conducted over a single day by one inspector. The person in charge facilitated the inspection and promptly provided all requested documentation as part of the inspection. The designated centre is registered to accommodate four residents. The inspector had the opportunity to meet and speak with all residents living in the designated centre.

This designated centre was a community residential service located in a town in County Louth. It provided full-time residential services to adults with disabilities who require support with a range of mobility, healthcare, and emotional support needs. The premises was a large, fully accessible bungalow comprising four resident bedrooms, one of which had en suite facilities, a large kitchen / dining room, two sitting rooms, a large accessible bathroom, and a utility room. To the rear of the premises was a large garage used for storage purposes, and a well-maintained garden area with a patio and accessible seating for residents to use at their leisure.

Care and support to residents was provided by a team of nursing staff, healthcare assistants, and a social care worker. Staffing levels included three staff members on duty during the day, and two staff members provided waking night time supports. The designated centre was managed by a full time person in charge and house manager who also had responsibilities for three other designated centres operated by the registered provider. Over the course of this inspection, the inspector had the opportunity to meet and talk to three staff members on duty, the person in charge, and the house manager.

The inspector completed a walk through of the designated centre in the presence of the person in charge. The inspector noted that the designated centre was clean, and homely. Residents' personal photographs, artwork, and possessions were displayed throughout the home, and residents had access to equipment that was well-maintained and in good working order. Residents had their own bedrooms, which allowed for personal space and privacy, while communal areas were found to be thoughtfully arranged to encourage social interaction and relaxation. The overall

interior decor and furnishings were tasteful and well maintained, contributing to a warm and inviting environment.

The inspector observed good fire safety systems. For instance, there was fire detection and fire-fighting equipment in the designated centre, and individualised personal emergency evacuation plans were available to guide staff on the supports required by residents. There was a small amount of restrictive practices used in the designated centre. The inspector found that they were applied in line with the registered provider's established policy and residents' consent.

The inspector was unable to meet or speak with the relatives of any residents during the inspection. However, a review of the registered provider's annual review of the quality and safety of care revealed that relatives were satisfied with the care and support provided to the residents.

All residents living in the designated centre presented with an assessed communication need. The inspector noted that there was no accessible or easy-to-read information on display throughout the designated centre regarding the complaints process, safeguarding, menu plan for the week, daily or weekly activities, or the staff team on duty. Interactions between residents and the staff team providing care and support was observed to be respectful, warm, and attentive. It was apparent to the inspector that staff knew the residents well, and were aware of each of the residents likes and dislikes.

Residents living in the designated centre led meaningful lives, were well known to the local community, and they all participated in a wide range of social and recreational activities. For instance, some residents attended concerts, cinema outings, community events, and shopping. In addition, opportunities for relaxation and well-being were provided through holistic therapy activities including massage, gong therapy, and reflexology. On the day of this inspection, the inspector noted that all residents participated in a gymboree play and music class facilitated by an external professional.

Over the past year residents had engaged in a number of different activities and celebrations. For instance, some residents had gone on holidays, attended a family wedding, attended horse therapy, enjoyed local bingo events, and met up with old friends. Residents the inspector met with expressed their interests in music, animals, nature, and sport. The inspector noted that the staff team supporting residents were very attentive to their needs, and provided care and support in line with with their assessments of need and individual personal plans.

Staff spoke with the inspector regarding the residents' assessed needs, and described training that they had received to be able to support such needs, including safeguarding, safe administration of medication and managing behaviour that is challenging. The staff members on duty were knowledgeable of residents' needs and the supports in place to meet those needs. Staff were aware of each resident's likes and dislikes and told the inspector they really enjoyed working in the designated centre and were happy with levels of support they received from management.

In summary, residents indicated to the inspector they were happy living in the designated centre. Staff described meaningful opportunities for residents to engage in activities they enjoyed, and the inspector observed residents taking part in activities they enjoyed at home and to leave the centre to engage in activities in the community. Residents were supported to stay in touch with the important people in their lives.

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

Capacity and capability

This section of the report sets out the findings of the inspection in relation to the leadership and management of the service, and how effective it was in ensuring that a good quality and safe service was being provided. Overall, the inspector found that the centre was well governed and that there were systems in place to ensure that residents were safe and received a high quality service in the centre. However, improvements were required to Regulation 16: Training and staff development, and Regulation 4: Written policies and procedures.

There was a clearly defined management structure in place, and staff were aware of their roles and responsibilities in relation to the day-to-day running of the designated centre. There was a regular core staff team in place, and they were knowledgeable of the assessed and changing needs of the residents. In addition, they had built a professional and strong rapport with them. The staffing levels in place in the designated centre were suitable to meet the assessed needs and number of residents living there.

The education and training provided to staff enabled them to provide care that reflected up-to-date, evidence-based practice. However, improvements were required to ensure that all staff were in receipt of formal supervision in line with the registered provider's established supervision policy.

The registered provider ensured that the directory of residents was readily available in the designated centre, in full compliance with regulatory requirements. It contained accurate and up-to-date information for each resident.

The registered provider had implemented management systems to monitor the quality and safety of service provided to residents and the governance and management systems in place were found to operate to a good standard in this designated centre. The registered provider had completed an annual report of the quality and safety of care and support in the designated centre for 2025, which included consultation with all residents and their families and representatives. It was

evidenced that there was regular oversight and monitoring of the care and support provided in the designated centre, and there was regular management presence within the designated centre.

The person in charge was aware of their regulatory responsibility to ensure all notifications were submitted to the Chief Inspector of Social Services, in line with the regulations.

There were relevant policies and procedures in place in the designated centre. However, improvements were required to ensure that all policies and procedures required by the regulations were reviewed and updated where necessary every three years.

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

Regulation 15: Staffing

On the day of this inspection, the registered provider ensured there was sufficient staffing levels with the appropriate skills, qualifications, and experience to meet the assessed needs of the residents at all times, in accordance with the statement of purpose, and the size and layout of the designated centre.

The staff team was comprised of the person in charge, house manager, nurses, one social care worker, and healthcare assistants. The person in charge was supported in their role by a house manager, and both had responsibilities for three other designated centres operated by the registered provider. The inspector spoke to the person in charge, house manager, and to three staff members on duty, and found that they were knowledgeable about the support needs of residents, and about their responsibilities in the care and support of residents.

The inspector examined the planned and actual staff rosters for March. April, and May 2026. It was found that regular staff were employed, and the rosters accurately represented the staffing arrangements, including the full names of staff on duty during both day and night shifts. The inspector noted that the staff team were appropriately qualified, and dedicated to delivering care that upheld residents' rights and ensured their safety.

The registered provider and management team was actively working to maintain continuity of care for residents by utilising the core staff team, and a small panel of regular relief staff to back fill any vacant shifts. This approach ensured that, despite any staffing vacancies, and both planned and unplanned absences, residents continued to receive care from skilled staff who were familiar with their individual needs and preferences.

Judgment: Compliant

Regulation 16: Training and staff development

Improvements were required to ensure that all staff received formal supervision, as per the registered provider's established supervision policy.

Staff were required to complete training as part of their professional development and to support them in the delivery of appropriate care and support to residents. A review of the most recent training records made available to the inspector evidenced that all staff had completed a variety of training courses, ensuring they had the necessary knowledge and skills to support residents effectively. This included mandatory training in areas such as fire safety, managing behaviour that challenges, and safeguarding vulnerable adults.

In addition and to enhance quality of care provided to residents, further training was completed, covering essential areas such as manual handling, people moving and handling, Children First, safe management of people with dysphagia, safe administration of medication, infection prevention control, and epilepsy and Buccal Midazolam.

The inspector completed a review of four staff members' supervision records. It was found that not all staff were in receipt of formal supervision as outlined in the registered provider's established supervision policy. Specifically, all staff were required to have formal biannual supervision by either the person in charge or the house manager. Additionally, staff nurses were required to have one professional development plan (PDP) meeting, and one supervision meeting each year. Upon reviewing the arrangements for staff nurses, it was evident that supervision meetings had not taken place in 2025. This required consideration and review by the person in charge.

Judgment: Substantially compliant

Regulation 19: Directory of residents

The registered provider and person in charge ensured that a directory of residents was available in the designated centre which met the requirements of the regulations. The directory of residents was made available for the inspector to complete a thorough review.

The inspector reviewed this, and found that it included accurate and up-to-date information in respect of each resident living in the designated centre. For example, information pertaining to the name, address and telephone number of each resident's general practitioner (GP), the date in which the resident first moved into

the designated centre, and the name, address, and telephone number of each resident's next of kin was all recorded.

Judgment: Compliant

Regulation 23: Governance and management

The registered provider had systems in place to ensure the delivery of a safe, high-quality service to residents, fully aligned with national standards and guidance. Clear lines of accountability were established at individual, team, and organisational levels, ensuring that all staff were aware of their roles, responsibilities, and the appropriate reporting procedures.

To ensure residents received effective, person-centred care, and enjoyed a high quality of life, the registered provider maintained appropriate resources. This included staffing levels aligned with residents' assessed and changing needs, and active multidisciplinary team participation in care planning.

The designated centre operated with a well-defined management structure, ensuring staff clarity regarding roles and responsibilities. The service was effectively managed by a capable person in charge, who with the support of their house manager, possessed a thorough understanding of all residents' and service needs, and had established structures in place to fulfill regulatory obligations. Furthermore, all residents benefited from a knowledgeable and supportive staff team.

Effective management systems ensured the designated centre's service delivery was safe, consistent, and effectively monitored. A comprehensive suite of audits, covering infection prevention control, fire safety, residents' medicines, residents' individual personal plans (IPPs). residents' finances, and maintenance, was conducted by the local management team. A review of these audits confirmed the audits thoroughness and their role in identifying opportunities for continuous service improvement.

An annual review of the quality and safety of care had been completed for 2025. The inspector completed a review of this and found that all key stakeholders, including residents,and their family members were all consulted in the annual review. In addition, the inspector reviewed the action plan created following the registered provider led most recent six-monthly unannounced visit, which was carried out in March 2026. The action plan documented a total of 10 actions and the inspector noted that the majority of actions were completed, effectively contributing to service enhancement.

Judgment: Compliant

Regulation 31: Notification of incidents

The person in charge was aware of their regulatory responsibility to ensure notifications were submitted to the Chief Inspector, in line with the regulations.

Prior to and during the course of this inspection, the inspector completed a review of notifications submitted to the Chief Inspector, and found that the person in charge ensured that all relevant adverse incidents were notified in the recommended formats, and within the specified time frames.

In addition, the inspector observed that learning from the evaluation of incidents was communicated promptly to appropriate people and was used to improve quality and inform practice within the designated centre.

Judgment: Compliant

Regulation 4: Written policies and procedures

Improvements were required to ensure that all policies and procedures required by the regulations were reviewed and updated where necessary every three years.

Policies and procedures are essential to guide staff to consistently provide safe and effective person-centred care. The inspector found that the registered provider had prepared written policies and procedures on the matters set out in Schedule 5 and these were available in electronic format for staff to refer to.

However, a number of policies had not been reviewed as per regulatory requirements. Specifically, the following policies required review:

- Provision of personal intimate care
- Provision of behavioural support
- Visitors
- Monitoring and documentation of nutritional intake
- Provision of information to residents
- Medication management
- The handling and investigation of complaints.

Judgment: Substantially compliant

Quality and safety

This section of the report provides an evaluation of the quality of services delivered and the effectiveness of measures implemented to ensure the safety of residents. Overall, a good quality of service was provided to all residents. However, improvements were necessary regarding Regulation 10: Communication. Further improvements were also required pertaining to Regulation 5: Individualised assessment and personal plan, and Regulation 7: Positive behavioural support.

This inspection found that improvements were required to ensure the staff team completed total communication training in order to appropriately and effectively communicate with all residents in line with their assessed communication needs and preferences. Enhancements were also required regarding information provided to residents. Specifically, critical information regarding residents' rights, and their care arrangements was not aligned to residents' assessed communication needs.

The inspector found the atmosphere in the designated centre to be warm and relaxed, and residents appeared to be very happy living in their home. A walk around of the designated centre confirmed that the design and layout of the premises ensured that each resident could enjoy living in an accessible, comfortable, and homely environment. The registered provider ensured that the premises, both internally and externally was of sound construction and kept in good condition. There was adequate private and communal spaces, and residents had their own bedrooms, which were decorated in line with their personal tastes and preferences.

Arrangements were in place to ensure residents received adequate, nutritious, and wholesome meals tailored to their dietary requirements and personal preferences. Residents were encouraged to eat a varied diet, and were supported by a coordinated multidisciplinary team, including medical professionals and speech and language therapists. During the inspection, staff were observed following the guidance and expert recommendations provided by these specialist services.

The registered provider had mitigated against the risk of fire by implementing suitable fire prevention and oversight measures. There was documentary evidence of servicing of equipment in line with the requirements of the regulations. Residents' personal emergency evacuation plans were reviewed regularly to ensure their specific support needs were met. The inspector noted that evacuation routes were unobstructed, and assembly points were clearly marked in order to guide all occupants to safety during an emergency.

Residents were in receipt of appropriate care and support that was individualised and focused on their needs. Residents were seen to be supported to access relevant healthcare appointments, and to live busy and active lives in line with their assessed needs and preferences. It was found that residents had comprehensive assessments of need on file. Care and support plans were derived from these assessments of need. The inspector noted that care and support plans were comprehensive, and were written in person-centred language. However, improvements were required to ensure all residents had up-date care and support plans on file. Additionally, improvements were also required to ensure effective goal tracking systems were implemented for all residents.

Where required, positive behaviour support plans were developed for residents, and staff were required to complete training to support them in helping residents to manage their behaviours of concern. However, improvements were necessary to ensure all residents had an up-to-date positive behaviour support plan on file that reflected their current assessed needs. There were some restrictive practices in the designated centre. The rationale for the restrictions was clear, and the registered provider had prepared a written policy to govern their use. The person in charge ensured that the service continually promoted residents' rights to independence and a restraint-free environment. For example, restrictive practices in use were clearly documented, and were subject to review.

Regulation 10: Communication

All residents living in this designated centre presented with assessed communication needs. However, this inspection found that staff had not received comprehensive training in total communication approaches, and the information provided to residents was not consistently delivered in accessible formats. As a result, significant improvements were required to ensure all residents could both access information and express themselves in line with their current assessed communication needs.

The inspector completed a thorough review of the staff training records maintained by the person in charge for the designated centre. However, the inspector noted that there was no documented evidence indicating that the staff team had completed any training on total communication methods. This gap in training meant that staff did not have the essential skills needed to communicate effectively with residents. As a result, residents' communication needs were not being fully met.

The inspector observed that information provided to residents was not presented in an easy-to-read or accessible format. For example, critical documents such as residents' contracts of care, weekly resident meetings, feedback questionnaires, details about staff on duty (both day and night), weekly meal plans, safeguarding information, advocacy resources, complaints procedures, and activity schedules were not formatted in a way that matched residents' assessed communication needs. This failure to provide accessible information put residents as risk of not fully understanding their rights and care arrangements.

This required considerable review by the person in charge and registered provider.

Judgment: Not compliant

Regulation 17: Premises

The inspector found the atmosphere in the designated centre to be warm and calm, and residents appeared to be very happy living in their home, and with the support they received.

The registered provider ensured that the designated centre was designed and arranged to align with the service's aims and objectives, as well as the number and needs of residents. The centre was clean and appropriately decorated. The living environment was stimulating and provided suitable areas for rest and recreation.

Residents had their own bedrooms, each considerately decorated to reflect their individual style and preferences. For example, bedrooms were personalised with family photographs, artworks, soft furnishings and possessions, all in line with each residents' interests. This not only promoted their independence and dignity, but also celebrated their uniqueness and personal taste. Additionally, each bedroom was equipped with ample and secure storage for personal belongings.

The equipment used by residents was both easily accessible and stored securely. Records reviewed by the inspector evidenced that the equipment was regularly serviced, with items such as overhead hoists and tracking systems undergoing annual servicing.

Residents had access to facilities which were maintained in good working order. There was adequate private and communal space for them, and the designated centre was found to be clean, comfortable, homely, and overall in good structural and decorative condition.

Judgment: Compliant

Regulation 18: Food and nutrition

Residents with assessed needs in the area of feeding, eating, drinking and swallowing (FEDS), had up-to-date FEDS care plans on file. The inspector reviewed four FEDS care plans, and found that there was comprehensive guidance regarding each residents' meal-time requirements including food consistency, equipment and environment, and the residents' likes and dislikes.

Staff spoken with were very knowledgeable regarding FEDS care plans, and were observed to adhere to the directions from specialist services such as speech and language therapy. For example, staff were observed to adhere to therapeutic and modified consistency dietary requirements as set out in FEDS care plans when preparing residents' breakfast meals. All residents were provided with wholesome and nutritious food, which was in line with their assessed dietary needs.

The inspector observed a good selection and variety of food and drinks, including fresh and perishable food items, in the kitchen for residents to choose from, and all

food items were hygienically stored and labelled correctly. The kitchen was also clean, well-maintained, and well-equipped with cooking appliances and equipment.

Judgment: Compliant

Regulation 28: Fire precautions

The registered provider had taken appropriate steps to mitigate the risk of fire by implementing effective fire prevention and oversight measures. During this inspection, the inspector observed that the designated centre was equipped with fire and smoke detection systems, emergency lighting, and fire fighting equipment.

A review of maintenance records confirmed that these systems and equipment were subject to regular checks by staff, and inspections and servicing by a specialist fire safety company.

The inspector noted that the fire panel was addressable and easily accessible in the entrance hallway of the designated centre. Additionally, information pertaining to fire zones was readily available and accessible to the staff team in the event of an emergency. It was observed that all fire doors, including bedroom doors, closed properly when the fire alarm was activated. Furthermore, all fire exits were equipped with thumb lock mechanisms, which ensured prompt evacuation in the event of an emergency.

The registered provider and person in charge had implemented comprehensive measures to ensure that each resident was aware of fire safety procedures. For instance, the inspector reviewed the personal emergency evacuation plans of all residents living in the designated centre. Each plan outlined the specific support required to assist residents during an evacuation, both during the day and at night.

The inspector examined the fire safety records, including fire drill documentation, and confirmed that regular fire drills were conducted in accordance with the registered provider's established policy. The registered provider demonstrated that they were capable of safely evacuating all residents under both day and night-time conditions.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

Improvements were required to ensure all residents had up-date care and support plans on file. Additionally, improvements were also required to ensure effective goal tracking systems were implemented for all residents.

The inspector reviewed four residents' assessments of need, and found that they were were recently reviewed and contained up-to-date information. Assessments of need informed comprehensive care and support plans which detailed residents' preferences and needs with regard to their care and support. For example, the inspector observed care and support plans on file for residents relating to the following:

- General healthcare
- Positive behavioural support
- Personal and intimate care
- FEDS.

Following a review of a sample of residents' general healthcare plans, the inspector noted that a number of healthcare plans required updating and review. Specifically, two residents' epilepsy management plans required review to ensure the most accurate and up-to-date information was available to staff in order to provide appropriate care and support.

All residents were actively engaged in the person-centred planning process, and the inspector saw evidence that residents had an annual review of their individual personal plan (IPP) on file. However, following review, the inspector noted that some residents had not set goals for 2026. Furthermore, some residents had not participated in monthly keyworking meetings. For example, the inspector observed that the last recorded keyworking meeting for one resident was dated February 2026.

Additionally, there was insufficient evidence on file that staff had been consistently documenting and monitoring residents' progress on goals set. This gap in documentation hindered the inspector's ability to assess whether goals had been achieved or what progress had been made. Consequently, it was recommended that improvements be made in documentation practices to ensure that goals were clearly tracked.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

Improvements were necessary to ensure all residents with an assessed positive behavioural support need, had up-to-date positive behaviour support plans on file.

Two of the four residents living in this designated centre had an assessed positive behavioural support need. The inspector reviewed both positive behaviour support plans on file. Both positive behaviour support plans reviewed by the inspector were detailed, comprehensive, and developed by an appropriately qualified person. In addition, each plan included antecedent events, proactive and preventive strategies in order to reduce the risk of behaviours that challenge from occurring.

However, the inspector noted following a review of documented nursing notes dated January 2026, and a discussion with the person in charge that a number of changes pertaining to one resident's presentation, mood, medicines, and family circumstances had taken place in the last number of months. Specifically, concerns were raised regarding the resident's loss of energy, mental health, and changes in appetite. However, on the day of this inspection a full review of the resident's positive behaviour support plan had not taken place to reflect this. This required consideration and review by the person in charge.

There were five restrictive practices used within the designated centre. The inspector completed a thorough review of these, and found they were the least restrictive possible and used for the least duration possible. The inspector confirmed that these had been appropriately risk assessed, in accordance with the registered provider's established policy, and were subject to regular review.

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 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 19: Directory of residents	Compliant
Regulation 23: Governance and management	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 10: Communication	Not compliant
Regulation 17: Premises	Compliant
Regulation 18: Food and nutrition	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 7: Positive behavioural support	Substantially compliant

Compliance Plan for The Bridge OSV-0005789

Inspection ID: MON-0045292

Date of inspection: 12/05/2026

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • Schedule of staff Supervision in place to ensure all staff receive biannual supervisions (to be completed by 31.07.2026)	
Regulation 4: Written policies and procedures	Substantially Compliant
Outline how you are going to come into compliance with Regulation 4: Written policies and procedures: • Provision of personal intimate care - Orders Policy dated April 23 - Policy circulated for feedback prior to review • Provision of behavioural support- Orders Policy dated April 23 - Policy circulated for feedback prior to review • Visitors - Orders Policy dated Nov 22 - Updated version at approval stage • Monitoring and documentation of nutritional intake - Orders Policy dated April 23 - Updated version near completion (awaiting dietician review) Local policy dated May 23, awaiting orders policy to review local one. • Provision of information to residents - Local policy dated Nov 22 - will be reviewed by May 29th. • Medication management - Orders Policy reviewed and awaiting approval, Local policies under review and awaiting circulation of Orders policy. • The handling and investigation of complaints - Orders Policy dated Nov 22 - near approval stage.	

Regulation 10: Communication	Not Compliant

Outline how you are going to come into compliance with Regulation 10: Communication:

• Staff will complete "communicating with People who have an intellectual disability on HSELand and submit certs (To be completed by 31.08.2026)

• SLT will provide additional inclusive communication training for staff (To be completed by 31.08.2026)

• Easy read and accessible documentation will be developed in line with the Residents assessed communication needs(To be completed by 31.08.2026)

Regulation 5: Individual assessment and personal plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:

• Residents Epilepsy management plans and Healthcare plans will be reviewed and updated to reflect current care and support needs (Completed on 31.05.2026)

• Residents will be assisted to set SMART social goals and all tracking progress will be completed for each stage of each goal set. Completed on 31.05.2026)

• Residents will be supported to participate in regular keyworker meetings and all discussions will be documented accordingly (Completed 31.05.2026)

Regulation 7: Positive behavioural support	Substantially Compliant

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

• CNS in Behavior will review the recent changes in the particular residents circumstances and all relevant strategies and information will be inputted and reflected throughout the body of his BSP. (To be completed by 30.06.2026)

• CNS in Behavior will review the recent changes in the particular residents circumstances and all relevant strategies and information will be inputted and reflected throughout the body of his BSP. (To be completed by 30.06.2026)

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 10(1)	The registered provider shall ensure that each resident is assisted and supported at all times to communicate in accordance with the residents' needs and wishes.	Not Compliant	Orange	31/08/2026
Regulation 10(2)	The person in charge shall ensure that staff are aware of any particular or individual communication supports required by each resident as outlined in his or her personal plan.	Not Compliant	Orange	31/08/2026
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	31/07/2026
Regulation 04(3)	The registered provider shall review the policies and procedures referred to in	Substantially Compliant	Yellow	31/12/2026

	paragraph (1) as often as the chief inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.			
Regulation 05(5)	The person in charge shall make the personal plan available, in an accessible format, to the resident and, where appropriate, his or her representative.	Substantially Compliant	Yellow	30/06/2026
Regulation 05(6)(b)	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 conducted in a manner that ensures the maximum participation of each resident, and where appropriate his or her representative, in accordance with the resident's wishes, age and the nature of his or her disability.	Substantially Compliant	Yellow	30/06/2026
Regulation 05(6)(d)	The person in charge shall ensure that the	Substantially Compliant	Yellow	30/06/2026

	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 take into account changes in circumstances and new developments.			
Regulation 05(8)	The person in charge shall ensure that the personal plan is amended in accordance with any changes recommended following a review carried out pursuant to paragraph (6).	Substantially Compliant	Yellow	30/06/2026
Regulation 07(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.	Substantially Compliant	Yellow	30/06/2026