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:	Teach Rua
Name of provider:	The Rehab Group
Address of centre:	Clare
Type of inspection:	Unannounced
Date of inspection:	30 July 2025
Centre ID:	OSV-0007972
Fieldwork ID:	MON-0043263

About the designated centre

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

Teach Rua is a designated centre run by The Rehab Group. The centre is registered to provide accommodation for a maximum of two residents, who are over the age of 18 years and who have an intellectual disability. The centre comprises of one two-storey building on its own spacious site located a few kilometres from a busy town in Co. Clare. Residents are provided with their own bedroom, one en-suite facility, shared bathrooms, a main sitting room, kitchen and dining area and relaxation rooms. A staff office and a staff bedroom are also provided. Residents have access to a spacious rear garden where recreational equipment suited to their age and needs is provided. Staff are on duty both day and night to support the residents who live in this centre. Management and oversight of the service is delegated to the person in charge supported by a team leader.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	2

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
Wednesday 30 July 2025	10:00hrs to 18:00hrs	Mary Moore	Lead

What residents told us and what inspectors observed

This inspection was undertaken on behalf of the Chief Inspector of Social Services to monitor the provider's compliance with the regulations and the standards. This was a good service but there were matters that impacted on the appropriateness, quality and safety of the service and on the provider's level of compliance with the regulations.

For example, as found at the time of the last Health Information and Quality Authority (HIQA) inspection undertaken in January 2024, the provider was experiencing staffing challenges and did not consistently maintain the staffing levels residents needed. Improvement was needed in other areas such as how the provider used, in a timely manner, the information that it gathered about the service to assure and improve the quality and safety of the service. For example, there was an acknowledged absence of compatibility between the needs of the residents who lived together in this designated centre and many of the arrangements in place were in response to this. However, what the provider did not have was an explicit decision and plan as to whether residents continuing to live together was a sustainable and appropriate arrangement. In addition, better oversight and arrangements that ensured consistency of support for residents between the different services they attended was needed.

Two residents receive a full-time residential service in this designated centre. Both residents are of a younger age profile, have complex sensory needs and can present with behaviour of concern. The provider had reduced the capacity of the centre following the last HIQA inspection as the provider acknowledged the additional challenges that would present to compatibility if a third resident was admitted to the designated centre.

Both residents attend off-site day services Monday to Friday and the house may not be staffed when the residents are at their day services. This inspection was initially facilitated by the team leader and then by the person in charge both of whom came to the house when contacted by the inspector who had arrived unannounced. The inspector also had the opportunity to speak with the integrated services manager. The inspector met with both residents when they returned in the evening from their respective day service and with the staff team members who came on duty to support the residents. The inspector also met with the family of one resident who were visiting.

The inspector saw how the provider had used the additional space available in the house to develop rooms that residents could use individually. There was a shared communal space but both residents now had their own "chill-out" room.

Overall, the inspector found that the house was well-maintained internally and had recently been redecorated. The team leader described how different colours were used to support residents to understand and identify their own areas of the house.

However, the inspector saw a general need for external maintenance and upkeep the details of which will be discussed in the main body of this report.

As the inspector walked through the house the inspector noted that progress had been made in the reduction of restrictions. For example, residents had greater access to a range of fresh and dry food items and one resident had increased access to a good range of personal clothing in their bedroom. The team leader confirmed that the reduction plans were going well without any evidence of increased anxiety or incidents. However, while each resident had restrictions in place in response to their assessed needs and risks, there were restrictions that were needed for one resident but not the other. For example, one resident required a minimalist environment while the other did not and there was a requirement for consistent staff supervision while residents were present in the house together that was in itself restrictive. Staff had to monitor and manage matters such as noise levels as they could trigger responsive behaviour in a peer. Residents largely had different daily routines due to their differing needs and the risk that could present due to these differences.

The assessed needs of the residents included communication differences and verbal communication with the exception of specific vocabulary was not their primary means of communication. Guidance for staff on how each resident communicated was set out in the personal plan. Both residents looked well and were in great form. Residents understood what was said and responded with "hello", a big smile and gentle hand gestures when the inspector spoke with them. The residents presented as relaxed in the house and with the staff members on duty including the person in charge.

The inspector saw how one resident used gestures to communicate to staff what they wanted to watch on their television. The resident did not have access to the remote control or the television controls. The resident was patient and gestured up or down until their preferred programme was found by staff. The resident happily sat down to watch the programme and smiled broadly when the inspector acknowledged the patience the resident had demonstrated.

The other resident walked about listening to music on their phone. The resident was wearing the headphones stipulated in their personal plan as the music could act as a trigger for responsive behaviours in their peer.

The inspector noted how the residents moved about from the shared communal space to their own individualised "chill-out" rooms. One resident received his family in his room and both parties were evidently very happy to see each other. The inspector introduced themselves and established that the inspector's presence would not disturb the visit. These family members told the inspector they were happy with the service. The location of the centre was very suitable for visiting as it was near home. This was important for them as there were times when the resident liked to spend a good amount of time with them and other times when the resident preferred a brief visit. When asked if there was anything about the service that could be improved the feedback provided to the inspector was in relation to staffing. Family spoke of the turnover of staff and the importance of having regular staff who

were familiar with the resident as family noted how staff turnover and staff changes impacted on the resident.

The inspector saw that the provider had sought family feedback as part of their own annual review of the quality and safety of the service. This review was completed in May 2025. That feedback was from the family of the other resident. Overall, the feedback was positive but communication with family was highlighted as an area that could be improved. The provider had concluded that this pertained to communication with and from the day service rather than the residential service.

The matters raised by family were matters reflected in these inspection findings. For example, records seen and staff spoken with confirmed that the provider continued to experience challenges to the recruitment and retention of staff and, the agreed staffing level of three staff on duty each evening and at weekends was not consistently maintained. This meant that residents could go for a drive but could not leave the service vehicle as they each required support from two staff members so as to safely access the community. This was a repeat inspection finding. In addition, in response to recent incidents staff concerns had been raised about the adequacy and safety of the staffing levels in the house.

In relation to communication between and from services there was evidence of inconsistent support between the day and residential services and there was no formal system of daily handover between the services. The need for such as system had been discussed internally by the provider in November 2024. These matters had impacts particularly in relation to supporting residents to manage behaviour of concern.

Staff spoken with described how the residents could and did spend time together once supervised by staff but overall residents had different routines. For example, a staff member was cooking an appealing stir-fry for the residents evening meal but confirmed the residents would eat separately. A similar routine was in place for breakfast and the general morning routine of the house. There was an accepted absence of compatibility between the needs and abilities of the residents. These separate routines were in place to manage this absence of compatibility and prevent for example, peer-to-peer incidents some of which had occurred in the service.

While effective in the prevention of such incidents the matter for the provider was the sustainability of this living arrangement and whether it promoted or not the safety, quality of life and the general welfare and development of both residents. It was clearly set out in the findings of a compatibility assessment that it possibly would not. However, there was no plan in place in response to the findings of the compatibility assessment. In addition, the most recent annual review completed in March 2025 had highlighted the need for an explicit compatibility risk assessment setting out the existing controls and any additional controls that might be needed up to and including the possibility of alternative accommodation. That risk assessment was not yet complete.

In summary, the provider monitored resident health and well-being and sought to ensure that residents received a good standard or support and care. Residents had

good access to home and family and had opportunities for community engagement in their respective day service. However, the provider did not always have the required level of staffing in place, there was evidence of inconsistent support between services that impacted on residents and, the staff team was actively managing on a daily basis the absence of compatibility between the needs and the abilities of the residents. This active management managed risk but was not the same as ensuring each resident was in receipt of the service that was best suited to their particular needs and abilities.

The next two sections of this report will discuss the governance and management arrangements in place and how these impacted on the appropriateness, quality and safety of the service.

Capacity and capability

There was an established management structure in place that set out clear lines of responsibility and accountability. Residents were provided with a good service on many levels. However, the centre was not always adequately and appropriately staffed. The provider had quality assurance systems and these were consistently implemented. However, these did not always capture pertinent information and when they did, the provider was not robustly using that information to address and put service improvement plans in place.

The day-to-day management and oversight of the service was delegated to the person in charge. The person in charge had responsibility for another designated centre and described for the inspector how they maintained a presence in each centre and prioritised that presence as needed depending on the needs of each centre.

The person in charge had management support in each centre from a team leader. The team leaders had delegated duties. There were systems of governance that reflected this management structure. For example, the team leader undertook weekly audits of matters such as the completion by staff of the daily support and care notes and the management of medicines. The person in charge maintained oversight of these weekly audits and completed their own monthly audits.

The person in charge described the systems in place for the support and supervision of the staff team. This included the completion of formal staff supervisions, the convening of monthly staff meetings and ongoing oversight of staff attendance at training.

A planned and actual staff duty rota was maintained. The person in charge confirmed there were staff vacancies, an ongoing process of staff recruitment and two staff members were in pre-employment. The provider was awaiting records such as of satisfactory Garda vetting. However, when the inspector reviewed the staff duty rota it was evident that the provider tried to but did not always

consistently maintain the required staffing levels. This impacted on the quality and safety of the service.

In addition to the weekly and monthly audits mentioned above the provider had also completed the annual and at least six-monthly provider-led reviews of the quality and safety of the service. Based on the records seen these reviews were completed on schedule and quality improvement plans were progressed locally. As mentioned in the opening section of this report these reviews provided for consultation with families, residents and staff. However, while these audits reviewed the arrangements in place they did not always robustly address the reason for many of the arrangements which was the fundamental absence of compatibility between the residents.

Regulation 14: Persons in charge

The person in charge worked full-time. The person in charge had the qualifications, skills and experience needed for the role. The person in charge was relatively new to the role but had a good understanding of the role and their responsibilities. The person in charge could clearly describe and demonstrate to the inspector how they managed and maintained oversight of the designated centre.

Judgment: Compliant

Regulation 15: Staffing

The provider did not consistently ensure that the number of staff members on duty was appropriate to the assessed needs of the residents. Suitable staffing contingencies were not in place for responding to staff shortages. This impacted on the quality and safety of the service.

The person in charge confirmed that the agreed staffing level was three staff members on duty up to 20:00hrs when both residents were in the house. The inspector reviewed the planned and actual staff duty rotas from the 14th July 2025 to the 30th July 2025. The inspector also reviewed the staff sign-in sheets completed each day by staff and spoke with the person in charge, the team leader and two staff members. It was evident from what the inspector read and discussed that there were at least five occasions in this short time frame when two and not three staff members were on duty. This did not provide the two-to-one staff support residents needed to safely access the community. This access was not just needed to support social engagement for the residents but could also be needed to support residents to regulate and to manage anxiety and behaviour of concern. For example, the inspector reviewed a recent incident where staff had reported they could not

offer a resident a drive and a walk so as to help a resident to regulate as sufficient staff were not on duty.

Staff shortages were due to current staff vacancies but also in response to staff absences. The provider did utilise relief staff but these contingencies were not always responsive to the absences that arose. For example, the centre was short-staffed on the day of this inspection even though one staff member on duty was already a relief staff member. The person in charge planned to work until 19:00hrs in response to this absence so that residents could be offered a drive.

In addition, the inspector was advised that concerns had been raised by staff members' at the most recent staff meeting as to the safety of the staffing levels in the centre. These staff concerns arose following recent incidents of behaviour of concern towards staff. The minutes of the meeting were not yet available but the person in charge confirmed that the concerns had been raised.

Judgment: Not compliant

Regulation 16: Training and staff development

The inspector saw that the person in charge maintained a record of the training completed by staff members and a record of the certificates provided to staff when they completed training such as in safeguarding, fire safety and responding to behaviour that challenged including training in de-escalation and intervention techniques.

The person in charge maintained oversight of staff training requirements and there was documentary evidence that refresher training for staff such in manual handling and de-escalation and intervention techniques was booked.

Staff had completed on-line training and internal training facilitated by the positive behaviour support team in promoting a human rights based approach to care and support.

The inspector saw records of the monthly staff team meetings convened by the person in charge. There was good staff attendance at the meetings or staff who were no present subsequently read and signed the minutes of the meetings. The meetings were used to support and guide staff. For example, the person in charge told the inspector that the positive behaviour support specialist had attended the most recent staff meeting following recent incidents that had occurred and that had impacted on staff.

While the inspector did not review the actual supervisions there was a schedule in place for the completion of formal staff supervisions. These were completed quarterly and the person in charge confirmed they were all on schedule.

Judgment: Compliant

Regulation 23: Governance and management

Based on these inspection findings that provider was not effectively using the information that it gathered about the service to assure and improve as needed the appropriateness, quality and safety of the service provided to residents. The centre was not always adequately resourced.

In general, the inspector found there were good local systems of management and oversight. For example, in relation to supporting and supervising staff and ensuring residents had access to the services and health care professionals that they needed. The provider did maintain oversight of these local management systems and did gather information about the appropriateness, quality and safety of the service. For example, the annual service review referred to the risk posed by the absence of compatibility and the behavioural needs of each resident that could impact on the other in their shared living arrangement.

However, this absence of compatibility and its impacts was not a strong theme in other completed provider-led reviews seen by the inspector. There was no plan other than the arrangements put in place such as the separate routines in the house, the use of restrictions and the consistent vigilance of staff. Ultimately, the matter for the provider was, was it reasonable and appropriate to continue to respond to the absence of compatibility or was a plan to address it needed. The findings of the compatibility assessment completed on behalf of the provider indicated that a plan was needed so as to ensure and assure the lived experience of both residents.

The inspector was advised at the verbal feedback of these inspection findings that the risk posed to the lived experience of each resident had been escalated internally and externally to the providers funding body. However, this was not evident in the designated centre and there was no plan or possible solutions to the absence of compatibility despite the findings of the compatibility assessment and the provider-led annual review.

In addition, there was evidence of inconsistent positive behaviour support strategies between the residential and the day service and there was no formal daily handover process between the day service and the residential service. There was documentary evidence that local management and the positive behaviour support team had sought to address the inconsistency and the handover process. However, based on these inspection findings these matters were not addressed and the inconsistency had, based on an incident report seen, negatively impacted on a resident and residential staff.

Judgment: Not compliant

Regulation 24: Admissions and contract for the provision of services

In the personal plan reviewed by the inspector there was a contract for the provision of a service. The contract was current and had been signed by the resident's representative as provided for in the regulations. The contract set the services to be provided to the resident, any fees payable, what was included in those fees and what was not.

Judgment: Compliant

Regulation 34: Complaints procedure

The provider had policies and procedures on the receipt and management of complaints. Feedback was sought from representatives and that feedback was, as appropriate, managed through the complaint process. The provider-led reviews monitored the receipt and management of complaints and there were no open complaints at the time of this inspection.

There were limitations to the degree to which residents could access and use the complaint process. However, the personal plan clearly outlined how each resident would communicate their dissatisfaction and unhappiness including the use of behaviour. For example, a resident might discard a meal if they did not want it or take off their shoes if they did not want to leave the house.

Judgment: Compliant

Quality and safety

On the day of this inspection both residents presented as well and content. Residents had access to off-site day services Monday to Friday and had consistent access to home and family as appropriate to each resident's circumstances. However, as discussed in the opening section of this report there was an acknowledged absence of compatibility between the needs and abilities of the residents that was reflected in the support and care provided. As discussed in the previous section of this report, while the provider was responding to the absence of compatibility the provider had no a plan in relation to the ongoing appropriateness and sustainability of this current living arrangement.

Each resident had a personal plan. The inspector reviewed one personal plan and aspects of another. The inspector saw that the personal plan was based on a comprehensive assessment of each resident's health, personal and social care

needs. Staff used tools such as social stories as they sought to support residents to have input into and to participate in their plan. Families were consulted with in relation to the personal plan as were others such as the day service.

The plan included for example, residents' specific communication needs, the vocabulary used by the residents, its meaning and how it should be interpreted by staff and other ways in which the residents communicated.

It was evident from the personal plan and other records seen such as the minutes of staff meetings that resident wellbeing was monitored and, the care and support provided was informed by input from the wider multi-disciplinary team (MDT) such as each resident's general practitioner (GP), psychiatry and positive behaviour support. The personal plan was subject to an annual review and the goals for 2025 had been agreed. However, the inspector again found that there was a functional dimension to the goals and the plans for progressing one residents goals were not available on the day of inspection.

From the assessment of needs the provider knew that there was an absence of compatibility between the needs and abilities of the residents. For example, one resident preferred and needed an environment with minimal stimuli while the other resident had a preference for and a good tolerance of a range of personal, therapeutic and sensory items. Both residents could unintentionally trigger responsive behaviour in the other. The provider had arranged for a compatibility assessment to be completed by an appropriate person of the needs and living arrangements in the designated centre. The assessment concluded that the living arrangements would in the long-term impact negatively on the lived experience of each resident. While the provider tried to manage the absence of compatibility the provider did not have a plan as to how it would address the findings of the assessment and the possible long-term impact on each residents lived experience if they continued to live together indefinitely.

Each resident had a risk for behaviour of concern. This behaviour posed a risk for harm to the resident themselves and others including the staff team. The person in charge described and records seen confirmed good and consistent input from the positive behaviour support team who met directly with residents and with the staff team. The inspector saw records completed by staff of incidents that had occurred. The records were respectful of residents and described what happened, why it may have happened and how staff responded.

In each personal plan there was a detailed positive behaviour support plan. However, while each resident was supported individually positive behaviour support needs were a core aspect of where residents differed. In addition, there was evidence in records seen of inconsistent positive behaviour support strategies between the residential and the day service that had impacted negatively on a resident and residential staff.

The routines of each resident were managed, the environment had to be managed and environmental restrictions were in place that were required by one resident but not the other. For example, access to the controls for the televisions. The provider

did continue to review and had managed to reduce some restrictions but ultimately for as long as they continued to live together one resident would be exposed to environmental and rights restrictions that were not needed as part of their daily support and care.

Regulation 10: Communication

The assessed needs of both residents included communication needs. Arrangements were in place that ensured residents were supported and assisted to communicate in accordance with their needs and wishes.

For example, the personal plans reviewed by the inspector included a communication plan and a communication dictionary of the words used by a resident and what they meant. Records created by staff referred to a resident's use of words, gestures and objects of reference to communicate what it was they wanted or did not want. The communication plan provided guidance for staff on how to communicate effectively and positively such as using positive language and making simple requests of the residents.

Staff used tools such as social stories and visuals to discuss with residents topics such as the daily routine, staying safe and the importance of support such as taking their prescribed medications.

The use of behaviour as a form of communication was acknowledged such as its role in communicating upset, anxiety and frustration. Communication could also be a trigger for behaviour. The role of communication was clearly set out in the positive behaviour support plan and in the records completed by staff such as incident records.

Both residents had different needs and abilities in relation to how they accessed and used media. They had access but there were restrictions. This will be discussed in Regulation 26: Risk management procedures.

Judgment: Compliant

Regulation 11: Visits

Arrangements were in place that ensured both residents had ongoing access to home and family as appropriate to their individual circumstances. These arrangements were in the personal plan and were discussed and agreed with families. The inspector saw that staff maintained a log of family contact and of visits. Staff monitored how residents engaged with these visits. Support for home visits was provided by the staff team as needed.

There were no restrictions on visits, staff reported and the inspector saw that residents tended to use their own "chill-out" room to meet with their visitors. A family met with were happy with the visiting arrangements in the designated centre.

Judgment: Compliant

Regulation 17: Premises

There was an evident need for external maintenance and upkeep. For example, there were weeds in some rain gutters, one gutter over the domestic refuse bins was broken. Drains for taking surface and waste water were blocked and there was evidence of pooling water outside the back door. Ridging was missing from the roof of the garage which was part of the registered footprint of the designated centre and housed the laundry facilities. Internally the garage was in need of general housekeeping with evident cobwebs and debris on the windows and windowsills.

Internally the house was generally well maintained and had recently been redecorated. However, there was significant cracking of the kitchen floor covering just inside the door to the kitchen.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

Improvement was needed in how the risk arising in the designated centre was consistently reviewed, appropriately and adequately managed.

The person in charge advised the inspector that the system for recording the identification and management of risk was undergoing change. The process of change was being supported in the designated centre by personnel from the wider governance structure.

The inspector reviewed the existing register of risks, each resident's individual risk management plan and the risks that were under review. The risks identified largely reflected the risks that presented in the centre such as the risk posed to maintaining adequate and appropriate staffing levels and the risk posed by behaviour of concern.

The inspector reviewed incident records completed by staff. The records were objective, respectful and reported what was happening at the time and how staff had responded. The incident records were reviewed and analysed for example, by the person in charge, by the positive behaviour support team and as part of the provider-led quality and safety reviews.

However, based on these inspection findings the inspector was not assured that the provider always had in place the controls needed to manage the risks identified. For example, while there was a staffing related risk assessment and controls (such as the management of the staff duty rota and the use of relief staff), there were ongoing staff deficits and staff concerns as to the safety of the centres staffing levels.

The annual review had recommended that a risk assessment be completed for the risk of the absence of compatibility between residents. While the risk assessment was reported to be in progress the risk assessment, the level of assessed risk and the possible need for additional controls was not yet in place.

The provider needed to consider the proportionality of the existing controls and in particular how they impacted in the short and longer-term on residents' choices and quality in life. For example, the fact that residents needed very different environments, could trigger behaviours in each other, the fact that one resident could not put on the television as they wanted, listen to their music without the need for headphones or have ready access to personal items in their home.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Good oversight was maintained of the designated centres fire safety arrangements. For example, there was documentary evidence that equipment such as the fire detection and alarm system and fire-fighting equipment was inspected and tested at the appropriate intervals.

The provider demonstrated through regular simulated evacuation drills that it had suitable arrangements for evacuating residents and staff. The inspector saw the reports of three drills completed since February 2025. Six different staff members and both residents had participated in these drills and had evacuated the house in good time. The inspector saw that a recommendation had been made after one drill for footwear to be readily available in the front hall for one resident; the footwear was in the hall. The person in charge advised the inspector that a drill was scheduled for two staff members who had yet to participate in a simulated drill.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

There was evidence that the shared living arrangement in the designated centre was not suited to the needs of the residents. Many of the arrangements in the

designated centre were responsive to the absence of compatibility between the needs of the residents rather than meeting the assessed needs of each resident.

The findings of a compatibility assessment completed on behalf of the provider were shared with the inspector. The assessment looked at each resident's needs and overall individuality, their direct and indirect impact on others. The assessment concluded that the interventions put in place were unlikely to be successful in supporting residents to live well together in the current shared living arrangement.

The environment and environmental factors such as noise and each resident's routine had to be consistently managed by the staff team. There was a risk for behaviour of concern including responsive behaviour and environmental restrictions that potentially would not be necessary if residents were not living together. For example, one resident required a minimalist environment while the other did not. This meant that one resident could not freely have and access personal items and belongings in shared areas of the house.

While the arrangements put in place were effective in the prevention of incidents such as peer-to-peer incidents the matter for the provider was the sustainability of this living arrangement and whether it promoted or not the appropriateness, safety, quality of life and the general welfare and development of both residents.

The personal plan was detailed with good evidence of MDT input. However, the inspector again found a functional dimension to the goals to be achieved with and for residents. For example, some goals had a general health and well-being focus for residents who were of a younger profile and generally enjoyed good physical health. The plan for progressing one resident's personal goals and objectives was not available for inspection.

Judgment: Not compliant

Regulation 6: Health care

The provider had arrangements in place so that residents enjoyed good health and had access to the healthcare services that they needed.

Residents were of a younger age profile and were reported to generally enjoy good health. In the personal plan there was good documentary evidence that residents had access as needed to their general practitioner (GP) and to the MDT including, psychiatry, psychology, positive behaviour support and speech and language therapy.

Judgment: Compliant

Regulation 7: Positive behavioural support

Each resident had a risk for behaviour of concern that posed a risk to the residents themselves and others including staff. Staff had completed training including training in de-escalation and intervention techniques. There was evidence of ongoing input from the positive behaviour support specialist. The records that staff created of incidents that had occurred conveyed an understanding of the behaviours, why they may have occurred and how they were responded to. It was evident from records seen that well-intended staff actions such as redirection could escalate rather than resolve a behaviour.

This was of concern given the evidence of inconsistent behaviour support strategies between the residential and day services. For example, the person in charge reported that as required medicines were administered in the day service but not in the residential service where the focus was on therapeutic support. The different approaches and strategies for the management of behaviour of concern required better oversight and management as there was evidence of negative impacts.

The inspector reviewed a recent incident that had occurred in the residential service. The resident was preparing to leave for their day service and residential staff had followed the instruction of the day service not to facilitate a residents request for copies of certain pictures.The resident had not responded well to the staff request. The inspector reviewed the minutes of a meeting held in November 2024 between the residential and day services where it had been clearly set out by the positive behaviour support therapist that accessing pictures was to be facilitated as they were an important ongoing support for the resident.

That meeting had also referred to the need to review the daily handover between both services and consideration of the introduction of a formal handover. The person in charge confirmed that this was not in place. The handover was still verbal and the person in charge was not for example, assured that they were always informed and aware when an as needed medication had been administered to a resident in the day service.

The centre was not consistently adequately staffed to ensure the residents had appropriate support at all times.

The provider did have systems for the sanctioning and review of interventions that were restrictive in nature. Each resident had assessed needs and risks that warranted the use of interventions. For example, alarms to alert staff if a resident left the premises without their knowledge, devices that ensured residents and staff were safe while travelling in the service vehicle, fencing and gates so that residents could safely access and use the external grounds. There was evidence that the provider sought to reduce and had reduced the level of restrictions that were in use. However, the difference in their needs and abilities meant that there were restrictions in place that were needed for the safety of one resident but not for both.

In summary, there was different factors that impacted on how residents were supported to manage behaviour of concern. These factors impacted on the appropriateness, quality and safety of each residents service and they are addressed in the different regulations. For example, the unnecessary restrictions and the absence of compatibility that could inadvertently trigger responsive behaviours in the other is addressed in Regulation 5: Individualised assessment and personal plan and Regulation 26: Risk management procedures. The need for better oversight of the arrangements in place and the consistency of the support provided between different services in addressed in Regulation 23: Governance and Management.
Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Admissions and contract for the provision of services	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 11: Visits	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant

Compliance Plan for Teach Rua OSV-0007972

Inspection ID: MON-0043263

Date of inspection: 30/07/2025

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • The PIC and Regional Manager (PPIM) have completed a review of the total staffing compliment for the designated centre to ensure the compliment always supports the allocation of the required staff ratios. The review assessed the number, qualifications and skill-mix of staff to ensure it is appropriate to the number and assessed needs of the residents. This review was completed on 19/08/2025. • As far as is practicable permanent staff are used to provide support. Regular relief staff known to the residents are used to provide cover for staff leave or during periods of increased staffing requirements. • The PIC will ensure that new staff are inducted alongside existing staff to give residents an opportunity to become familiar with the new staff member and for the staff member to become familiar with the needs and choices of the residents. • The provider will ensure that all staff including agency receive a suitable induction to include core service information and resident needs/concerns in keeping with the organisation's induction pack. • A recruitment process has been completed to fill vacant positions with two 35 hour positions now on boarded. Induction commenced for one of these staff member on the 26/08/2025 and the other on 01/09/2025. A new relief staff member commenced their induction on the 18/08/2025. Since the 26/08/2025 three staff have been on duty up to 8pm each evening as required and this will now remain in place with the addition of the new staff.	
Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
• The service compatibility assessment will be reviewed and updated by 30/09/2025.
• The compatibility risk assessment has been reviewed outlining all controls in place throughout the service to manage the current risk and this will be further reviewed following meeting with the HSE on 16/09/2025.
• The provider has included this service in its internal escalation process, and it will remain in this process until all actions identified in the compliance plan are resolved. A Governance Group comprised of the PIC, Regional Manager and senior staff from the Operations and Quality & Governance Teams will meet at minimum monthly, with the initial meeting took place on 01/09/2025.
• The HSE has been made aware of the compatibility concerns, all stakeholders will meet to review the current placement and formalize a plan to resolve the compatibility issues. Initial meeting scheduled with the HSE on 16/09/2025.
• PIC met with the Day Service Manager and Behaviour Therapist to address inconsistency in behaviour support strategies between the residential and day service provisions. These meetings were facilitated on the 07/08/2025 and 14/08/2025 for the respective residents and plans to move forward were agreed.
• A formal daily handover process between the day service and residential service has been implemented for one resident to date. This involves the PIC and Team Leader having access to daily handovers generated on Microsoft Forms and shared with them by the day service team daily at 16:00. Information includes how the individual presented on collection, how the individual was supported throughout the day, activities they participated in including daily routines, displays of behavioral expressions of need, personal care needs and whether PRN medication was administered. This commenced the week of the 18/08/2025.
• It was agreed at the meeting on 07/08/2025, should the individual require the administration of PRN medication while at day service, a photocopy of their PRN MAR evidencing of the administration of same will be provided to the residential service on their return that evening.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• The Facilities Co-ordinator of the Housing Association visited on the 14/08/2025 to evaluate works to be undertaken; they are arranging a contractor to come onsite to assess the work required to the ridging on the roof of the garage and the floor covering just inside the door of the kitchen. They confirmed to the PIC on the 26/08/2025 they were working on organizing a builder. The builder and facilities co-ordinator of the Housing Association will be onsite on 05/09/2025. It is anticipated that these works will be completed by 31/12/2025.
• Flooring company are due onsite before the 05/09/2025 to measure the kitchen floor and provide a quote for replacement flooring. It is anticipated that these works will be completed by 31/10/2025.

• Rain gutters on perimeter of the building were cleared with weeds removed. This was completed on 02/09/2025.
• Broken gutter over the domestic refuse bin was replaced on the 02/09/2025.
• Drains for taking surface water were cleared, pooling water outside the back door has subsided and area cleaned of debris on the 26/08/2025. Remedial works to rectify the issue and prevent future instances of same has been completed on the 03/09/2025.
• Garage cleaned internally, cobwebs and debris removed from windowsills on 27/08/2025.
• Team Leader to carry out environmental checks internally and externally as part of their weekly audit, with any maintenance issues logged and followed up on. This has been captured on the weekly residential audit tool from the week commencing the 25/08/2025
• PIC to carry out environmental checks internally and externally as part of their monthly audit. This has been captured on the monthly residential audit tool for August. 29/08/2025.
• Housekeeping of the garage has been included in the weekly cleaning schedule week commencing 01/09/2025.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
• At the time of submission of the compliance plan staffing deficits have been resolved, and suitable staffing levels are restored. There are currently no vacancies.
• The Person in Charge completed a full review of the centre's Risk Management Framework. This included updating individualised and workplace risk assessments and revision of risk ratings, ensuring that documented control measures are in place in practice. This was completed 03/09/2025.
• One resident's behaviour support plan was reviewed and updated with input from the Behaviour Therapist on 26/08/2025 and further reviewed after a psychiatric review on the 29/08/2025.
• The compatibility risk assessment has been reviewed outlining all controls in place throughout the service to manage the current risk and this will be further reviewed following meeting with the HSE on 16/09/2025.

Regulation 5: Individual assessment and personal plan	Not Compliant

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

• The HSE has been made aware of the compatibility concerns, all stakeholders will meet to review the current placement and formalize a plan to resolve the compatibility issues. Initial meeting is scheduled with the HSE on 16/09/2025. It is anticipated that this situation will be resolved by 31/12/2026.

• PIC and TL have reviewed current action plans with Keyworkers this was completed by 03/09/2025.

• Keyworkers to review support plan and action plans. This will be completed by 17/10/2025. Additional training workshops to support staff have been scheduled for 30/09/2025.

• TL will review action plans weekly as part of Team Leader audit to ensure progress/barriers are captured. PIC to review monthly as part of the PIC monthly audit. This was implemented week commencing 01/09/2025

• PIC/TL to discuss goals, objectives and action plans with staff team at staff meeting on 30/09/2025.

• All staff to complete PCP Training – HSELand online module 'Towards Excellence in PCP' by 30/09/2025.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Not Compliant	Orange	28/08/2025
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	31/12/2025
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the	Not Compliant	Orange	28/08/2025

	effective delivery of care and support in accordance with the statement of purpose.			
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	16/09/2025
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Substantially Compliant	Yellow	30/09/2025
Regulation 05(2)	The registered provider shall ensure, insofar as is reasonably practicable, that arrangements are in place to meet the needs of each resident, as assessed in accordance with paragraph (1).	Not Compliant	Orange	31/12/2026
Regulation 05(7)(c)	The recommendations arising out of a	Substantially Compliant	Yellow	30/09/2025

	review carried out pursuant to paragraph (6) shall be recorded and shall include the names of those responsible for pursuing objectives in the plan within agreed timescales.			