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:	Ballycullen
Name of provider:	Cheeverstown House CLG
Address of centre:	Dublin 6
Type of inspection:	Unannounced
Date of inspection:	18 July 2026
Centre ID:	OSV-0008360
Fieldwork ID:	MON-0050719

About the designated centre

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

Ballycullen provides a residential service for male and female adults with an intellectual disability who may also have autism, mental health difficulties or behaviours of concern. The objective of the service is to empower individuals with new opportunities and the necessary skills to live full and satisfying lives and to help to support them to become equal citizens of their community. The residents are supported by a team of social care workers and care staff. The designated centre consists of a two-storey house in a suburban residential area of Dublin.

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
Saturday 18 July 2026	09:30hrs to 15:30hrs	Caroline Meehan	Lead
Saturday 18 July 2026	09:30hrs to 15:30hrs	Florence Farrelly	Support

What residents told us and what inspectors observed

This risk inspection was carried out in response to solicited information received by the Office of the Chief Inspector of Social Services (Chief Inspector). The provider had notified the Chief Inspector of a number of safeguarding incidents in the centre, and in response the provider was requested to completed a provider assurance report outlining the measures they were taking to ensure the needs of residents were met, their rights were upheld, and they were protected in the centre.

The provider had also notified the Chief Inspector of an incident that required a resident to be hospitalised in May 2026, and the provider subsequently had outlined to an inspector the arrangements that were being put in place to meet the resident's needs following discharge from hospital. This inspection reviewed the progress of the measures outlined in the provider assurance plan, and on the arrangements post-hospital discharge for a resident.

Overall, the inspectors found there was a lack of urgency in progressing the plans communicated by the provider including, ensuring suitable accommodation for residents, and completing upgrade works to the premises. There was limited evidence that the works the provider had stated were required, had been put in place. This included upgrading the sensory room, replacing swings and completing works to the garden. While the centre was spacious, it was not homely, and in particular the front and rear garden were observed to be unkempt.

In addition, a number of risks in the centre observed by inspectors, had either not been identified as risks, or had not been attended to by the provider. This meant that the environment itself was posing risks to residents. A significant concern was identified on the day of inspection regarding a hazard in the centre, and an immediate action was issued to the provider to make the environment safe. This was completed by the provider by the end of the inspection.

The centre comprised a two-storey property located in the suburbs of Dublin, and the centre could accommodate four residents. There were two residents living in this centre on the day of inspection and there were two vacancies. Two residents had moved out of the centre in recent months in response to peer-to-peer safeguarding risks. The provider had indicated these transitions to a campus-based setting were a temporary measure, and it was anticipated these residents could move back to a community-based setting in the future. In the meantime, peer-to-peer safeguarding incidents had continued to occur in the centre.

The inspectors visited the centre at the weekend and had the opportunity to meet one resident in the morning and one resident later in the day. While there were three staff on duty, it was observed there was minimal engagement with one resident who was up and about in the morning, and while staff did say they were bringing the resident out for a drive this did not happen for approximately two

hours. In the meantime, while the resident did watch some television, they spent a significant amount of time wandering around the house without any engagement from staff. This was not in line with the resident's assessed needs to have an active day.

The second resident had gone back to bed earlier that morning as they had not slept well the previous night and the inspectors briefly met this resident early in the afternoon. The inspectors did observe some engagement with the resident on the trampoline at the end of the inspection.

The next two sections of the report outlined the governance and management arrangements and how these arrangements had negatively impacted the quality and safety of care and support residents were receiving in the centre.

Capacity and capability

The provider had not ensured safe and consistent systems were in place to meet the needs of residents in the centre, and high levels of non-compliance were found on this inspection. There was poor oversight of this centre, and this was impacting the quality of experiences for residents in this centre.

Staffing in the centre required improvement to ensure the numbers and names of staff on duty were accurate, were reflective of the stated requirements of residents, and of the planned roster. The provider had not ensured staff had the required knowledge of residents' personal plans to meet their needs, and as a result plans were not being effectively implemented so as to ensure residents received the required support, and to ensure residents were kept safe.

The current arrangement for the person in charge to manage two centres was not effective in ensuring the operational and administrative management of the centre.

The provider had not ensured the service provided to residents was safe and appropriate to their needs, and the plans the provider outlined in a provider assurance report and following adverse incidents in the centre were not wholly implemented or planned for within a stated timeframe.

Regulation 14: Persons in charge

There was a fulltime person in charge employed in the centre, and they had the appropriate management experience and qualifications for the role.

At the time of the inspection the person in charge was responsible for this and one other centre; however, this arrangement was not ensuring the effective operational management and administration of this centre. The registered provider representative told inspectors a person had been recruited to fill the position of person in charge in the other centre and it was anticipated they would commence in their role in approximately six weeks time. This meant that for this centre, the person in charge would then be responsible for this centre only.

Judgment: Substantially compliant

Regulation 15: Staffing

Staffing arrangements in this centre were not adequately planned for to ensure consistency for residents and to ensure the staff numbers and skill-mix were in line within the needs of residents.

A core component of the identified needs of both residents was to have consistent familiar staff who were knowledgeable on the support residents needed. However, it was not evident that consistency was being maintained in the staffing of the centre. There were aspects of residents care and support that staff were not knowledgeable on, and this is discussed further in the report in Regulation 5: Individualised assessment of need and personal plan.

The roster is intended to be planned around the needs of the residents, and to provide assurances that the skill-mix and numbers of staff are appropriate to the needs and numbers of residents living in the centre. However, from a review of the roster, it was not always evident that the numbers required to be on duty were reflective of the stated requirements of three staff during the day.

Significant improvement was required in rostering in the centre. A planned roster was available in an online system in the centre; however, an actual roster was not maintained to reflect the staff who had completed shifts. This meant it was not consistently evident who had completed shifts in the centre. Instead, staff recorded in the house diary, the staff due to be on duty the following day. A staff member explained this system to an inspector; however, from a review of the diary, either staff names did not correspond with the planned roster, not all staff names were documented, or staff names were only recorded by initials or first names.

The hours the person in charge was rostered to work were not recorded on the centre roster, but were recorded on a separate management roster, and from a review of the management roster it was not clear when the person in charge was working in this centre. The management roster was not accurate, as the person in charge was rostered to work the week of the inspection; however, was on planned leave.

Judgment: Not compliant

Regulation 23: Governance and management

The management systems were not ensuring the service provided to residents was safe and was effectively meeting their assessed needs. The oversight in this centre required significant improvement to ensure the centre was suitable to meet the needs of residents, to ensure the systems in place were known by the team and implemented in practice, and to ensure the recommended interventions to keep residents safe, to mitigate risks, and to meet their needs were in place.

There was an on-call management system in place; however, staff were not clear on how to operate this system, and as a result were not able to make timely contact with a manager on the day of inspection. The inspectors discussed this with two staff on the day of inspection; however, staff were not knowledgeable on who to contact and did not have up-to-date information on who was due to be on-call. This was of concern, as the on-call system formed part of the response in the event of an emergency, and given the safety risks in the centre, it was imperative that staff were clear on this system.

The provider had not ensured the service was safe and appropriate to residents' needs. The provider had acknowledged that the current arrangement for these two residents to live together was not appropriate. This arrangement was putting residents at ongoing risk to their safety and wellbeing. This was discussed with the registered provider representative on the day of inspection, and while alternative accommodation was being explored for both residents, there was no timebound plan for any transition of residents to be completed. In the meantime, the provider had not ensured that measures which could be implemented within the centre were in place. This included ensuring the environment was safe, and ensuring a timely plan was in place to upgrade the centre in line with professional recommendations. The provider had not ensured professional recommendations to reduce distress to residents and thereby reduce a risk of harm, were implemented in practice. This included ensuring all recommended sensory equipment was available for residents' use, and ensuring that staff were knowledgeable on how to implement sensory strategies.

While risks to residents had been assessed, environmental risks in the centre were evident on the day of inspection and had either not been responded to in a timely manner to make the environment safe, or were evidently not identified. An immediate action was issued to the provider on the day of inspection and this is discussed further in Regulation 26: Risk Management.

Overall inspectors found there was poor oversight in this centre, and the systems the provider had in place were not effective to ensure residents needs were met and the risks to their safety were mitigated.

Judgment: Not compliant

Quality and safety

The safety and wellbeing of the residents living in this centre was at ongoing risk, and arrangements were not in place to meet the needs of the residents and to protect them.

The arrangements for these residents to live together was not appropriate, and one resident required their own single-occupancy accommodation. While the needs of the residents had been assessed and comprehensively planned for, the required care and support was not consistently implemented in line with recommendations.

The living arrangements and the environment were putting residents at ongoing risk of injury and harm, and included hazards throughout the premises, and an ongoing risk of peer-to-peer safeguarding incidents.

Regulation 26: Risk management procedures

Residents were at ongoing risk of injury and of abuse in this centre, and the arrangements to ensure residents were safe were not implemented in practice.

The inspectors observed exposed wires on the wall in the hallway, which had been covered by a piece of paper and sticking tape. The staff explained that the gate camera had been knocked off the wall, and estimated this happened approximately 10 weeks prior to this inspection. Staff stated it had been reported to the maintenance department and subsequently staff were informed the camera would need to be replaced. Staff told the inspector in the meantime they had covered the area with paper and sticking tape, as they understood the wires were live, and a resident was at risk of touching or banging into the wall. An immediate action was issued on the day of inspection requiring the provider to attend to this environmental hazard and this was completed and made safe by the end of the inspection.

There were ongoing safeguarding risks in this centre, and this is further discussed in Regulation 8: Protection. The inspectors walked around the premises and observed the environment was not safe. Residents were identified as likely to engage in PICA, and there were a number of hazards easily accessible for residents. These included household chemicals stored on the handrail in the bathroom; chemicals, insect repellent and paint, and stagnant water in a mop bucket in an open storeroom outdoors. The storeroom held mop buckets and handles; however, the room was observed to be visibly unclean. Similarly the hot press was kept locked and identified

as a restrictive practice due to exposed pipes which could not be made safe and posed a risk to a resident. However, the door to an external heat pump room could not be closed on the day of inspection, exposed wires were observed in this room, and the room was also visibly unclean.

One resident was assessed as at risk of falls, and from records reviewed had sustained 13 falls in 2026. However, the paving in the back garden was observed to be uneven in places. The swings in the back garden also needed to be replaced and this was part of the overall plan to improve the garden area for residents.

There was a small grass area in the garden and this was identified by an allied healthcare professional as an area a resident was able to access for their sensory needs. However, the inspectors observed this grass area had stones and gravel throughout, and while it was specified the resident liked to lie in grass engaging in sensory seeking input, this was not a safe area for the resident.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

While residents' needs had been comprehensively assessed, arrangements were not in place to meet the needs of residents, and as a result residents' wellbeing and safety were put at risk.

The inspectors reviewed two residents' files, and assessments of need had been developed and reviewed regularly. Assessments included review by multidisciplinary team members and healthcare professionals as needed. Detailed plans and guides were in place for most of the needs of residents to guide the practice in providing care and support to residents. However, a recent sensory assessment that was a key feature of a resident's support, only had 2 pages of the report available in the resident's file. An inspector asked a staff member about this report; however, they were unable to retrieve the report from the online personal planning system on the day of the inspection. When asked, the staff indicated archive files were stored in a box in an upstairs office, and the inspector subsequently located the recent report, as well as a housing report, both of which were filed for archiving. This was of concern, as this report gave specific detailed guides on how to provide sensory input to the resident to prevent distress, and was referenced in the resident's behaviour support plan as a preventative measure.

It was very clear from reviewing plans and allied healthcare professionals' reports, how care and support should be provided to residents; however, this support was not consistently provided. For example, some sensory equipment was not available, the back garden was not safe, and staff were not knowledgeable on the specific techniques outlined in an occupational therapist sensory recommendations. This was of concern, as these interventions were recommended to reduce a risk of injury to a resident. Similarly, another resident's sensory profile indicated they required access

to quieter spaces, and total quiet while eating. However, given the compatibility issues in the centre this could not be provided.

Inspectors observed one resident was up and about on arrival to the centre, and recommendations included providing a fairly active day for the resident with some downtime. However, inspectors observed there was minimal engagement by staff with the resident, and while a television programme was on that the resident was reported to enjoy, it was approximately two hours before a meaningful activity was provided. This was compounded by the fact that the centre bus was being repaired and staff were required to collect another bus from the campus setting.

Similarly, the measures to ensure residents could be kept safe could not be implemented due to required works to the centre, the upkeep of the centre, and the known compatibility risks between residents. This is discussed in Regulations 26 and 8.

The inspectors met the registered provider representative during the inspection, who outlined some of the planned works to the centre; however, while the registered provider representative understood there was a timebound plan to complete work to the sensory room, the work required in the garden, and to ensure suitable accommodation was provided for residents, they were unable to clarify the proposed dates of completion.

Furthermore, the provider acknowledged that one resident required to live alone, and the current arrangement for these two residents to live together was not appropriate.

Judgment: Not compliant

Regulation 7: Positive behavioural support

Behavioural support planning had been completed and was subject to regular review. However, given the issues with the environment, the lack of some equipment in the centre, and a lack of staff knowledge, the recommendations outlined in a behavioural support plan could not be wholly implemented.

Residents could access the services of a psychologist and mental health team, and regular reviews were completed. The inspectors reviewed a resident's behaviour support plan, and this had been reviewed in April 2026, and clearly outlined the behaviours of concern. Given the ongoing risk of injury to the resident, the behaviour support plan provided step by step guidance on how to prevent incidents of behaviour and how to minimise distress for the resident.

However, as mentioned, the environment had not been adapted to meet the sensory needs of the resident, staff were not familiar with the preventative sensory recommendations, the sensory grass area was not safe, and an oral sensory item

the occupational therapist had provided was not available in the centre on the day of inspection.

Of significant concern was the ongoing high risk of injury for the resident due to behaviours of concern which had resulted in a recent hospital stay. While significant work had been done by allied health care professionals to assess and recommend the required support for the resident these were not consistently evident in practice on the day of inspection.

Judgment: Not compliant

Regulation 8: Protection

Residents were not protected in the centre and there was ongoing risk of abuse. While the provider had initiated some improvements in the centre, these were either not complete, or there was no timebound plan for completion.

There were ongoing safeguarding incidents occurring in this centre. Since the last inspection in July 2025, there had been 17 allegations of abuse notified to the Chief Inspector, most of which related to peer-to-peer incidents. As a result, the provider had made the decision to move two residents out of the centre to their campus-based setting on a temporary basis. These transitions had happened in December 2025 and April 2026. Two residents remained living in the centre.

However, the impact of one resident's behaviour on the other resident had resulted in both physical and psychological allegations of abuse, and had caused distress to the resident affected. The was further compounded by the identified need of the resident affected to have a quiet environment and to avoid rushing around the resident; however, given the presentation of their peer this could not be achieved.

The provider had identified the need for one resident to live alone, however, plans to achieve this required a clear and timebound direction. In the meantime the provider had not ensured the interventions to reduce the likelihood of behavioural incidents were implemented in practice.

Judgment: Not 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	Substantially compliant
Regulation 15: Staffing	Not compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 26: Risk management procedures	Not compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Not compliant

Compliance Plan for Ballycullen OSV-0008360

Inspection ID: MON-0050719

Date of inspection: 18/07/2026

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 14: Persons in charge	Substantially Compliant
Outline how you are going to come into compliance with Regulation 14: Persons in charge: During this inspection it was noted that the person in charge was responsible for this and one other centre and that this arrangement was not ensuring the effective operational management and administration of this centre. A NF30A has been submitted for the appointment of a new pic for the oversight and governance of the other centre ensuring that the PIC has effective operational management and administration of this centre. 17/08/26 The person in charge has sole responsibility of this centre and is based in this location.	
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: A full review of this designated centres Employment Control Framework (ECF) will be completed by the PPIM, HR Team and the Workforce Planning Manager to ensure that the staff numbers and skill-mix are in line with the identified needs of residents and promote continuity of care by 31/08/26. There will be an increase in the staff nurses and social care workers to this centre to ensure appropriate skill mix to support the residents assessed needs. A guidance document has been devised to support staff teams on the roster process. Staff within this Centre will receive training on the rostering system to ensure that they can effectively login in to their house roster, generate a roster report, which accurately	

reflects all staff and PIC working in this location.
Staff have ceased recording of staffing in house diary and will now refer to the online rostering system only by 31/08/26.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
A NF30A has been submitted for the appointment of a new pic for the oversight and governance of the other centre ensuring that the PIC has effective operational management and administration of this centre. The person in charge has sole responsibility of this centre and is based in this location.

A schedule will be devised to ensure that a manager is present each morning during handover for a period of a month to ensure local supervision, oversight and that systems in place are known by local team and implemented in practice inclusive of night time supervision by the night management team twice per week.

A review of our current induction process will be completed to ensure that it contains the necessary information to ensure that it guides staff in supporting the residents in line with their assessment of need and safely manage risks in the Centre. Each staff member will receive one to one training from the CNS supporting mental health relating to supporting the resident in a positive manner and enacting the MDT guidance.

A structure of responsibility and escalation pathway document has been reviewed for this Centre to ensure all staff are aware of structure of responsibility and escalation pathway in the event staff need support or guidance during shift. This will form a key agenda item during staff team meetings and staff supervisions.

The inspector noted on the day of inspection that the service was not safe and appropriate to residents' needs. Whilst the provider had acknowledged that the current arrangement for these two residents to live together was not appropriate to the needs of the residents there were discussions and considerations in process regarding the need for an alternative living accommodation which was being explored for both residents. Both residents remain on the agenda with the providers AT&D and the provider has engaged with the HSE to further explore alternative living options.
Further assessments and review have been completed to explore alternative living accommodation for one resident with a proposed timeframe for the 31/08/26
A detailed transition plan will be devised to support this resident to their alternative living accommodation with the support of their circle of support.

The provider will ensure all recommended sensory equipment is available for residents'

use, and ensure that staff are knowledgeable on how to implement sensory strategies. Training/guidance sessions will be held with all staff from this Centre on the use of the sensory items/ strategies to support the resident in this Centre who experience distress. Immediate improvements have been made to provide the residents with sensory options. The sensory grass section of the garden will be completed by the 31/08/26.

A bespoke sensory room for the resident (inclusive of LED lighting, Ceiling Light panels, Textured panels) will be completion with a time frame of 30/11/26. In the interim sensory items have be installed as advised by the providers OT

Further improvements will be made to the back garden inclusive of the paving and swings, to maximise the sensory use of the outdoor space with the completion date of 16/10/26

All environmental risks identified during this inspection have been reviewed and actions have been taken by the provider to ensure the residents are safe.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
The inspector noted on the day of inspection that the service was not safe and appropriate to residents' needs. Whilst the provider had acknowledged that the current arrangement for these two residents to live together was not appropriate to the needs of the residents there were discussions and considerations in process regarding the need for an alternative living accommodation which was being explored for both residents. Both residents remain on the agenda with the providers AT&D and the provider has engaged with the HSE to further explore alternative living options.
Further assessments and review will be completed to explore alternative living accommodation for one resident with a proposed timeframe for the 31/08/26.
A detailed transition plan will be devised to support this resident to their alternative living accommodation with the support of their circle of support.

An immediate action was sanctioned on the day of inspection where the inspectors observed exposed wires on the wall in the hallway, which had been covered by a piece of paper and sticking tape caused from a broken camera device used for the electronic gates. This environmental hazard was made safe by the end of the inspection and a camera device for the electronic gates was installed 24/07/26.

The Risk manager and Quality Practice Nurse completed a walk around of the Centre with the PIC to ensure immediate risks are identified and actions taken to ensure a safe

environment on the 24/07/26. A full review of all environmental risks have been reviewed and actions have been taken by the provider to ensure the environment is safe for the residents in this Centre.

Staff in this Centre will receive Cheeverstown Risk Training to help mitigate risk and ensure safe practices within this Centre by 31/08/26

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:
Each staff member will receive one to one training from the CNS supporting mental health relating to supporting the resident in a positive manner and enacting the MDT guidance.

The provider will ensure all recommended sensory equipment is available for residents' use, and ensure that staff are knowledgeable on how to implement sensory strategies. Training/guidance sessions will be held with all staff from this Centre on the use of the sensory items/ strategies to support the resident in this Centre who experience distress by the 30/11/26 (in line with new sensory items added to the environment).

Training/guidance sessions will be held with all staff from this Centre on the use of the sensory items/ strategies to support the resident in this Centre who experience distress. Immediate improvements have been made to provide the residents with sensory options. The sensory grass section of the garden will be completed by the 31/08/26.

A bespoke sensory room for the resident (inclusive of LED lighting, Ceiling Light panels, Textured panels) will be completion with a time frame of 30/11/26. In the interim sensory items have be installed as advised by the providers OT

Further improvements will be made to the back garden inclusive of the paving and swings, to maximise the sensory use of the outdoor space with the completion date of 16/10/26

A review of the resident's meaningful activities/My Life Plans will be completed to ensure residents are supported to participate in activities in line with their My Life Plan goals, interests and preferences by 31/09/26.

Weekly audits will be completed by the PIC/PPIM to ensure that these experiences are reflected and implemented will commence on the 17/08/26.

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
The provider will ensure all recommended sensory equipment is available for residents' use, and ensure that staff are knowledgeable on how to implement sensory strategies. Training/guidance sessions will be held with all staff from this Centre on the use of the sensory items/ strategies to support the resident in this Centre who experiences distress.

Immediate improvements have been made to provide the residents with sensory options. The sensory grass section of the garden will be completed by the 31/08/26.

A bespoke sensory room for the resident (inclusive of LED lighting, Ceiling Light panels, Textured panels) will be completion with a time frame of 30/11/26. In the interim sensory items have be installed as advised by the providers OT

Further improvements will be made to the back garden inclusive of the paving and swings, to maximise the sensory use of the outdoor space with the completion date of 16/10/26

Regular circle of support meetings will commence from the 10/08/26 with the PIC, PPIM and staffing team of this Centre to ensure ongoing MDT supports, regular implementation, monitoring and review of behavioral support for residents.

A training needs analysis will be completed to compliment and support the needs of the residents and the staffing team of this Centre by the 31/08/26.

SLT intensive interaction, Autism and Sensory training will take place to help support the resident who experiences distress and provide support and guidance to the staff team. The full staff team will be fully trained by 30/11/26.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
Both residents remain a priority on the agenda with the providers Admission Transfer & Discharge committee and the provider has engaged with the HSE to further explore alternative living options.

Further assessments and reviews have been completed by the resident's circle of support team to explore alternative living accommodation for one resident with a proposed temporary living option identified with a transition timeframe for the 31/08/26.

A detailed transition plan will be devised to support this resident to their alternative living accommodation with the support of their circle of support.

In the interim there are the safeguarding plan in place. Safeguarding is prioritized at each staff handover. There are weekly staff team meeting where safeguarding is discussed.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 14(4)	A person may be appointed as person in charge of more than one designated centre if the chief inspector is satisfied that he or she can ensure the effective governance, operational management and administration of the designated centres concerned.	Substantially Compliant	Yellow	17/08/2026
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	31/08/2026

Regulation 15(4)	The person in charge shall ensure that there is a planned and actual staff rota, showing staff on duty during the day and night and that it is properly maintained.	Not Compliant	Orange	31/08/2026
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.	Not Compliant	Orange	30/11/2026
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	31/08/2026
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for	Not Compliant	Red	18/07/2026

	responding to emergencies.			
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	31/08/2026
Regulation 05(3)	The person in charge shall ensure that the designated centre is suitable for the purposes of meeting the needs of each resident, as assessed in accordance with paragraph (1).	Not Compliant	Orange	31/10/2026
Regulation 05(4)(a)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which reflects the resident's needs, as assessed in accordance with paragraph (1).	Not Compliant	Orange	31/08/2026
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	Not Compliant	Orange	30/11/2026

	support residents to manage their behaviour.			
Regulation 7(5)(a)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation every effort is made to identify and alleviate the cause of the resident's challenging behaviour.	Not Compliant	Orange	31/08/2026
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	31/08/2026