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 Lorcán
Name of provider:	The National Association for the Deaf T/A Chime - The National Charity for Deafness and Hearing Loss
Address of centre:	Dublin 9
Type of inspection:	Unannounced
Date of inspection:	15 April 2026
Centre ID:	OSV-0008368
Fieldwork ID:	MON-0049764

About the designated centre

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

Teach Lorcán aims to provide individualised, person-centred, community-based residential supports through Irish Sign Language to maximise the quality of life of each individual living with deafness and hearing loss while fostering autonomy, personal growth, and development. Teach Lorcán consists of two two-storey properties in north Dublin. The centre can accommodate a maximum of 5 residents. Residents present as having an intellectual disability, or complex needs which may include mental health support or physical and sensory needs. Residents are supported by residential community facilitators and a person in charge.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	5

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 15 April 2026	10:00hrs to 17:40hrs	Erin Clarke	Lead
Wednesday 15 April 2026	10:00hrs to 17:40hrs	Lisa Walsh	Support

What residents told us and what inspectors observed

This unannounced risk-based inspection was carried out to follow up on concerns identified during two previous inspections in August and November 2025. At that time, inspectors had identified significant failures in governance and management arrangements, which had impacted the provider's implementation of safeguarding and complaints procedures. As a result, residents' concerns had not always been adequately identified, responded to, or used to inform effective risk management arrangements. Following the findings of those inspections, a notice of proposed decision to cancel the registration of the designated centre was issued to the registered provider in January 2026. The provider subsequently submitted written representations to the Chief Inspector.

During this inspection, inspectors found that improvements had been made to governance and oversight arrangements at both Board and executive levels. There was evidence of a more planned and structured approach to reviewing the service, with systems being developed to ensure that residents' complaints, concerns and expressed preferences were identified and used to inform service delivery. While these arrangements required time to become fully embedded, inspectors found that the provider had taken action to strengthen oversight and accountability in the centre.

Teach Lorcán comprises two two-storey houses located a short distance apart in an urban area of County Dublin. The centre is registered to accommodate five residents. Residents living in the centre primarily communicated through Irish Sign Language (ISL). As such, staff working in the centre were required to be proficient in ISL or to be actively working towards developing this manual based language. During the inspection, inspectors spent time meeting with all five residents and observed the importance of ISL in supporting meaningful communication, choice and participation in day-to-day life in the centre.

Using ISL, inspectors spoke with all residents briefly and in more detail with three residents. Residents spoken with said that there had been some improvements in the centre since the last inspection and the relationships between residents had improved a little. Residents said the compatibility issues, in one house in particular, remained and they were still not happy to remain living in the centre. Residents spoke about their wishes to either live independently or move closer to their family home instead. Inspectors were informed that these options were now being explored with the residents, with one resident excitedly telling the inspector that they were looking at accommodation options available to them.

Inspectors spoke with one staff member on arrival to the first house, who described a number of improvements that had taken place since the previous inspections. These included changes to make one resident's bedroom more accessible, following concerns that had previously been raised. Staff also described how known

compatibility issues between residents were being reviewed, and how potential transitions were being discussed with residents. Inspectors were informed that there had been an improvement in one resident's mood and wellbeing, and that another resident was pleased that active steps were being taken to identify alternative accommodation in line with their wishes.

There had also been some slight improvement in staffing arrangements. Previously, only one staff member had been rostered after 18:00 in one house, which limited residents' opportunities to leave the house for activities or personal interests during the evening. At the time of this inspection, a second staff member was now rostered for two evenings each week. While this represented progress, further review was required to ensure staffing arrangements consistently supported residents' assessed needs, choices and social opportunities. From discussions with staff, inspectors found that there were times when additional staffing was still required, particularly where residents needed two-to-one support to safely access the community. This was not consistently available, which restricted the times that some residents could leave the centre or take part in activities.

Overall, it was found that the provider had taken a number of actions to strengthen governance and management arrangements in the designated centre following the serious concerns identified during previous inspections. While these improvements demonstrated a more structured and accountable approach, some arrangements were still interim in nature and required further time to become fully embedded and sustained.

The next two sections of this report present the inspection findings in relation to governance and management in the centre, and how governance and management affected the quality and safety of the service being delivered.

Capacity and capability

There had been a clear increase in oversight measures and evidence of improvement in the provider's understanding of the regulations and the areas requiring further development. Actions were being identified, measured and progressed through the provider's governance structures. There was also evidence that systems and culture were beginning to align more closely with the provider's policies, regulatory requirements and practices that promoted residents' lived experience in the centre. However, these governance systems were still in the process of being strengthened and were not yet fully embedded to consistently assure sustained monitoring and compliance. This was particularly relevant given the continued absence of a full-time person in charge, staffing deficits and the interim nature of some senior management arrangements, including the role of the person participating in management.

There had been changes to the local management structure since the previous inspection. One team leader had left, and a new team leader had been appointed. An interim team leader remained in post to cover statutory leave and was found to be competent in their role. They were familiar with the centre, facilitated the inspection effectively, and spoke about the positive changes and learning that had taken place since the previous inspection. This included improved staff awareness of what constituted a complaint and the importance of identifying and escalating residents' concerns appropriately.

There was evidence of improved oversight and action planning. The provider had developed an ongoing compliance tracker to monitor progress against identified actions, which had last been updated on 27 March 2026. A full audit of staff files had been completed, and an action plan was in place to address any gaps identified. Efforts had also been made to standardise and implement regular staff supervision, and training had been provided to support managers and staff in this area.

While the provider had taken some action to review staffing and oversight arrangements, this had not yet resulted in sufficient or sustained improvement in the centre. Staffing levels remained inadequate to consistently meet residents' assessed needs, including in the evenings, at weekends and where residents required additional support to access the community.

Overall, inspectors found that complaints management had improved. There was clearer oversight, better recording and follow-up, and evidence that complaints and residents' concerns were being used to inform service planning and improvement.

Regulation 14: Persons in charge

The registered provider had not ensured that a person in charge was appointed to the designated centre at the time of this inspection. While the provider had identified plans to appoint a new person in charge, these arrangements had not yet been formalised.

Judgment: Not compliant

Regulation 15: Staffing

Inspectors were informed that some minor changes had been made to the roster on two evenings a week with an additional staff located in one of the houses. In addition, the provider has recently recruited staff to improve the skill mix in the centre. However, some posts had also become vacant. From speaking with staff and management, significant changes have not been made to the roster and overall, staffing levels have not improved. Inspectors reviewed staff rotas for February,

March and April 2026 and were not assured that the registered provider had the appropriate number of staff to meet the assessed needs of the residents.

The provider had completed a review for residents' assessed needs and identified that two additional staffing resources were required. While the provider had recruited additional staff to ensure that the skill mix of staff had improved, no additional staff was yet in place. The provider informed inspectors that a business case had been completed for the additional staff required. There were also two staff vacancies on the day of inspection, with one post recently recruited for and recruitment ongoing for the second vacancy.

There had been a period of significant staff leave in March 2026. Inspectors found that on at least five occasions, insufficient staff were rostered to meet the assessed needs of residents. This impacted on the provider's ability to deliver consistent and responsive care. In addition, it was identified that one resident required two-to-one staffing if out in the community to meet their needs, this was not in place. This limited residents' being able to engage in activities or leave the centre. Staff also reported that the staffing levels in the evenings and weekends impacted residents' engaging in the community.

Judgment: Not compliant

Regulation 23: Governance and management

Overall, inspectors found that the provider had made meaningful progress in strengthening governance and management arrangements. There was now clearer oversight from local, executive and Board level, and actions were being tracked in a more structured way. However, as key management posts were still being recruited to, some arrangements were interim, and the provider needed to ensure that the improvements made were sustained and consistently embedded in practice.

Governance meetings were taking place weekly between the person participating in management and the person in charge. Monthly incident review meetings had also commenced, supporting improved oversight of adverse events, risks and learning. Further training needs had also been identified, including report writing and completing antecedent-behaviour and consequence (ABC) charts.

The provider's six-monthly unannounced visit had taken place in December 2025 and included resident and staff feedback. The interim team leader told inspectors that they felt comfortable raising issues, including the need for additional training and supervision. Other policies had also been reviewed and updated, including the visitors' policy and restrictive practice policy, to support improved and more rights-based practice in the centre.

At provider level, a subcommittee of the Board had been established to review compliance and escalation in the centre. Inspectors reviewed detailed meeting records which showed oversight of the compliance plan, risk register, identified

actions, responsible persons and progress updates. The chief executive officer had presented the annual review summary report and provided updates on key areas of concern. An overarching work plan had been developed, with eight areas of focus including roster changes, staffing and regulatory compliance. Minutes of residential services management meetings were also reviewed and demonstrated further oversight of areas such as staff supervision, performance management, incidents and implementation of the provider's internal inspection findings.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

The provider had taken action to improve the management of complaints since the previous inspection. Inspectors found that there was now a clear policy and procedure in place for the identification, recording, investigation and follow up of complaints. A new complaints officer had been appointed, and their contact details were clearly displayed in the centre so that residents, representatives and staff were aware of who to contact if they wished to raise a concern.

There was evidence that complaints were being reviewed and followed up, and that appropriate actions had been taken in response to issues raised. The provider had also reviewed the previous failure to identify and respond to some complaints through an investigation process. This supported learning and helped to strengthen staff understanding of what constituted a complaint and how concerns should be escalated.

Staff told inspectors that they had attended training on the provider's revised complaints and safeguarding policies. This supported improved awareness of the procedures to be followed where residents raised concerns or where safeguarding issues were identified. Some complaints remained open at the time of inspection; however, these were linked to ongoing transition planning and longer-term compatibility arrangements for residents. Inspectors found that these matters were being actively monitored through the provider's governance structures.

Judgment: Compliant

Quality and safety

Overall, the provider had taken action to strengthen safeguarding, risk management and residents' rights, with improved systems for identifying concerns, reviewing restrictions and responding to known risks. However, some arrangements required further development and oversight, particularly in relation to resident compatibility

and ensuring that all identified risks were supported by clear assessments and effective control measures.

The provider had made significant progress in strengthening risk management systems since the previous inspection, including the introduction of a comprehensive risk register. This register accurately identified key risks in the centre, including risks arising from resident compatibility and previous inspection findings. However, some identified risks did not yet have corresponding risk assessments in place, and some risk ratings required review to ensure they reflected the level of risk and effectiveness of controls. The provider had also reviewed restrictive practices and removed restrictions that were not supported by documented risk assessments.

There had been a clear improvement in the provider's safeguarding arrangements since the previous inspections. Systems for identifying, responding to and escalating safeguarding concerns had been strengthened, and staff had received training on the revised safeguarding procedures. This supported improved awareness of safeguarding responsibilities, particularly in the context of a group living environment where compatibility, communication needs and residents' expressed concerns required careful oversight. While compatibility-related risks remained, these were known to the provider and were being actively reviewed in consultation with residents.

Regulation 26: Risk management procedures

Since the previous inspection in November 2025 the provider had made a significant effort to implement systems to assess, manage and review risk in an ongoing manner in the centre.

The provider had implemented a new comprehensive risk register which clearly sets out risks that had been identified through previous inspections and through the providers' self-review of risks. The risk register accurately reflected the risks in the centre. This ensured the delivery of safe care while balancing the right of residents to take appropriate risks to maintain their autonomy and fulfilling the provider's requirement to be responsive to risk. While the risk register was accurate some risk assessments had not been completed for listed risks. For example, the registered provider had accurately identified that the compatibility of residents was a risk. However, there was not risk assessment in place to detail the mitigating measures to be put in place to reduce this risk.

In addition, the associated risk level given to the risk required review as the mitigating factors put in place did not reduce any of the risks. The rating of these risks was also inaccurate. For example, some risk were identified as a green risk, meaning that the risk of this was low. However, some of them were classed as major risks.

The provider had reviewed restrictive practices and had taken steps to remove restrictions that were not supported by documented risk assessments. For example,

the centre's standard operating procedure had been updated to remove a blanket restriction relating to alcohol in the centre. The provider had also reviewed the visitors policy and the restriction that was in place not allowing visitors into resident's bedroom had been reassessed and removed as a restriction.

Judgment: Substantially compliant

Regulation 8: Protection

The provider had taken action to improve safeguarding systems in the centre following the concerns identified on previous inspections. These improvements had led to a greater understanding among managers and staff of safeguarding responsibilities, particularly in the context of a group living environment where residents' rights, choices and compatibility required careful and ongoing oversight.

A new safeguarding process map had been introduced, which set out the stages to be followed where a concern was identified. This included clearer guidance on response times, responsibilities, reporting pathways and escalation arrangements. Staff had also received training on the revised safeguarding arrangements, and inspectors found that there was improved awareness of the need to recognise and respond to concerns in a timely and consistent way.

The provider was aware that compatibility concerns had not yet been fully resolved. While the response to these concerns had improved, and longer-term options were being actively reviewed in consultation with residents, some risks associated with the group living arrangements remained. This meant that the safeguarding arrangements required continued oversight to ensure that residents were protected from harm and that actions taken were responsive to their needs and wishes.

Judgment: Substantially compliant

Regulation 9: Residents' rights

The provider had taken action to review arrangements relating to residents' rights, including their right to receive visitors. A new visitors' policy, dated January 2026, had been developed and was available in the centre. This policy had been reviewed in response to feedback from residents and included consideration of previous restrictions that had been in place. The revised policy and associated review of restrictions supported residents to maintain personal relationships and to have visitors in line with their wishes.

Residents had been referred to independent advocacy services, which supported their right to express their views and to be involved in decisions affecting their living

arrangements and wellbeing. Residents told inspectors that, while some issues remained, they felt happier that their concerns were now being taken seriously. They also described that compatibility issues were being addressed, and that the provider was actively considering longer-term options with them. Overall, inspectors found that the provider had taken appropriate action to strengthen residents' rights in these areas.
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	Not compliant
Regulation 15: Staffing	Not compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 26: Risk management procedures	Substantially compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Teach Lorcán OSV-0008368

Inspection ID: MON-0049764

Date of inspection: 15/04/2026

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	Not Compliant
Outline how you are going to come into compliance with Regulation 14: Persons in charge: Registered Provider Response A full-time interim Person in Charge is scheduled to commence on 2 June 2026. This appointment is expected to address the current compliance gap, and oversight arrangements are in place to support a smooth transition and ongoing regulatory compliance. A full-time Person in Charge has accepted an offer of employment and is due to commence in mid-June. This person is currently a PIC with a designated centre.	
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: Registered Provider Response The Registered Provider has secured additional funding to support the required staffing. Recruitment is actively underway, and current vacancies will be filled with suitably qualified staff, including at minimum QQI Level 6, to strengthen safe and consistent service delivery. The new Director of Specialist Services, who will act as Person Participating in Management, is scheduled to take up post on 2 June 2026 and will provide additional management capacity and oversight.	

In parallel, a full-time interim Person in Charge will commence on 3 June 2026, further strengthening local leadership and day-to-day oversight.

Regulation 23: Governance and management	Substantially Compliant

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

The new Director of Specialist Services, who will act as Person Participating in Management, is scheduled to take up post on 2 June 2026 and will enhance governance capacity across the service.
A full-time interim Person in Charge is also scheduled to commence on 2 June 2026, supporting strengthened operational oversight and leadership within the centre.

The registered provider continues to embed improvements to governance and management arrangements. A comprehensive governance matrix, together with an updated risk management policy, is scheduled for implementation by July 2026 to support sustained oversight and accountability.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
Registered Providers Response

The registered provider has aligned individual risk assessments with the risk register and updated the register to reflect current risk levels. A comprehensive governance matrix and updated risk management policy are scheduled for implementation by July 2026 to further strengthen oversight and risk management arrangements.

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection: Registered Providers Response

The registered provider will continue to review safeguarding risks on an ongoing basis and take timely action where concerns arise. The awareness and reaction to immediate safeguarding concerns have been improved. Longer term planning has also progressed, and transition planning remains a priority to support residents' will and preferences, alongside the continued implementation of positive behaviour support plans. The registered provider is working closely with residents, their advocates and relevant local authorities and funders to put a long-term solution in place.

The appointment of a Team Leader for Safeguarding will provide additional leadership and support the continued strengthening of safeguarding arrangements across the service.

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(1)	The registered provider shall appoint a person in charge of the designated centre.	Not Compliant	Orange	30/06/2026
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	30/09/2026
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.	Substantially Compliant	Yellow	31/08/2026

Regulation 23(1)(b)	The registered provider shall ensure that there is a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.	Substantially Compliant	Yellow	30/06/2026
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 responding to emergencies.	Substantially Compliant	Yellow	31/07/2026
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Substantially Compliant	Yellow	31/12/2026