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:	Rose Lodge
Name of provider:	Resilience Healthcare Limited
Address of centre:	Kildare
Type of inspection:	Unannounced
Date of inspection:	24 July 2025
Centre ID:	OSV-0008576
Fieldwork ID:	MON-0046825

About the designated centre

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

Rose Lodge is a designated centre which can provide full-time residential services for up to four male or female adult residents. It is situated on the outskirts of a large town in Co. Kildare. There are a number of vehicles available in the centre to support residents to visit their family and friends and to access their local community. Rose Lodge can provide a high support service for adults with Prader-Willi Syndrome who may present with complex needs. The house is sub divided into four self-contained apartments and there are a number of communal areas such as a living room, sun room, kitchen, utility room, and office. Residents' apartments have a living room, kitchenette, bedroom and bathroom. There is a driveway at the front of the house and a garden to the back. Residents are supported 24/7 by a staff team consisting of a person in charge, service manager, and support workers.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	4

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Thursday 24 July 2025	11:00hrs to 18:00hrs	Erin Clarke	Lead
Thursday 24 July 2025	11:00hrs to 18:00hrs	Tanya Brady	Lead

What residents told us and what inspectors observed

The previous inspection of this centre was completed in February 2025 following receipt of unsolicited information of concern. The findings of that inspection were of non-compliant findings in all regulations reviewed. This unannounced inspection found that the provider had focused on establishing a stable local management and staffing team in order to improve the oversight and management arrangements. Findings of this inspection were that while the governance and management arrangements had improved more focus was now required in areas such as risk management, restrictive practice and management of resident finances.

This centre comprises a large two storey house in a rural setting close to a small town. This centre is registered for a maximum of four residents and is currently at capacity.The layout of the centre provided each resident with their own apartment-style accommodation within the house, comprising a bedroom, bathroom, kitchenette, and living area. This arrangement supported residents to maintain their independence while also offering opportunities to engage with others in the shared communal areas. The communal areas included a large living room, sun room and there is a kitchen used by staff for food preparation. Externally the provider had completed a number of works in the garden since the last inspection to make it safe and more appealing to use. Inspectors observed items such as a pool, balls and other activity equipment on the lawn for use.

Inspectors met and spoke with four members of staff, the current person in charge and an individual who was to shortly take on the person in charge role, over the course of the day. The staff team were familiar with the residents and outlined plans that were in place for the day of inspection, in addition they spoke of care plans and outlined procedures they followed to support residents during their day.

Inspectors had the opportunity to meet and speak with two residents, one resident was also present in the centre but getting ready to go out for the day and choose not to engage with inspectors. One resident had already left the centre when inspectors arrived with support staff. On arrival, inspectors met with one resident in a communal area of the centre. The resident shared that they were planning to meet a friend to play bowling later that day and expressed that they were looking forward to the outing. They appeared comfortable in the presence of both staff and inspectors. The resident left the centre with staff support to travel by train to meet their friend and remained out for the duration of the inspection.

One resident had moved into the centre since the previous inspection. Inspectors were informed that this was a planned transition, carried out at a pace that suited the resident over a four-week period. This included visits to the centre to meet staff and other residents, as well as an overnight stay before fully moving in. Their apartment was personalised with their own belongings and displayed numerous cards from family and friends congratulating them on their new home.

Two residents present during the inspection invited inspectors into their individual apartments, showing personal items that were important to them, such as photographs of a family pet and soft furnishings they had chosen themselves. Both residents stated that they were happy living in the centre and expressed that they liked the staff who supported them.

Due to the complexities associated with residents' diagnoses of Prader-Willi Syndrome, residents did not have access to the main kitchen. Meals and snacks were prepared by staff and brought to residents' individual apartments. During the walkaround of the centre, inspectors observed that residents also did not have access to the utility room, where the washing machine and dryer were located, which limited opportunities for those who wished to undertake their own laundry.

Inspectors found that the frequency of incidents in the centre impacting other residents due to behaviours of concern had significantly reduced since the previous inspection. This improvement was attributed to a combination of environmental modifications and the consistent implementation of positive behavioural support by the provider. Inspectors were informed that residents were now more settled and that relationships among them had improved. However, inspectors noted that further improvement was required to ensure all elements of positive behavioural support plans were implemented consistently and communicated clearly to staff.

In summary, inspectors found that the provider had strengthened the systems in place to monitor the care of residents living in the centre; however, further improvements were required to fully ensure the quality and safety of the service. A number of risks had been reduced or eliminated since the previous inspection, including absconding risks and safeguarding concerns, through environmental adaptations made both within and outside the centre. Interactions between residents had become more positive, with a noted reduction in safeguarding-related incidents. However, inspectors noted other existing and emerging risks that required further attention.

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 affects the quality and safety of the service being delivered.

Capacity and capability

The provider had placed an emphasis on establishing a consistent local management team for this centre since the last inspection. This had supported the provider in recruiting and retaining a staff team in addition to ensuring that the staff team were in receipt of the training and supervision required to carry out their role.

A senior manager had assumed the role of person in charge since the previous inspection to stabilise the staff team and address areas of concern identified at that time. These concerns included governance and management of the centre, training

and staff development, and risk management processes. Inspectors found that the person in charge was regularly present in the centre, providing oversight and support to staff.

A new person in charge had been appointed during the week of the inspection; however, the provider was awaiting the completion of a thorough handover and induction to the centre before formally notifying the change of person in charge.

Staffing arrangements were stable, with part-time staff available to take on additional hours to cover planned and unplanned leave, reducing the reliance on agency workers. Inspectors found that the use of agency staff had ceased, and rosters consistently reflected the required staffing ratios

Regulation 15: Staffing

Inspectors found that the provider had recruited a full staff team in line with the assessed needs of residents and the requirements outlined in the statement of purpose. Staffing arrangements ensured that residents received the appropriate level of support, with some residents requiring one-to-one assistance and others requiring two-to-one support for specific activities, including community access. Part-time staff were available to take on additional hours to cover both planned and unplanned leave, which had eliminated the need for agency staff in the centre.

A review of rosters for the previous two months showed that six staff were consistently rostered daily until 8:00 or 9:00 pm, ensuring continuity of care and support throughout the day. Rosters were subject to ongoing review by the management team to ensure they continued to meet residents' needs at all times.The appointment of a team leader, who worked a combination of floor-based and supernumerary hours, had enhanced on-the-job supervision, facilitated effective handovers between shifts, and contributed positively to staff morale.

Judgment: Compliant

Regulation 16: Training and staff development

Training and staff development had been an area of focus for the provider since the last inspection, with all staff having received training and education to support them in carrying out their roles. Mandatory training requirements had been met, and staff had also completed training specific to the needs of the residents living in the centre. Examples of training completed by staff included fire safety, positive behavioural support, human rights, safeguarding, and Prader-Willi syndrome awareness.

New staff to the centre had completed the provider's induction process. Inspectors

reviewed a sample of induction records and found these to be fully completed and signed by both the staff member and the person in charge. The provider also delivers a range of internal courses aimed at developing staff skills in areas such as team leadership and key management competencies. Inspectors were informed that these courses had enhanced staff performance, and staff reported feeling supported in their roles.

All staff had been in receipt of supervision from the person in charge or team leader in line with the provider's policy. Inspectors reviewed a sample of these and found that they were focused on the staff members role and encouraged the setting of goals and targets for improvement while also acknowledging areas of good practice. A number of topics were discussed during individual staff supervision sessions to support staff in their professional roles. These included safeguarding, behavioural support plans, and keyworking responsibilities. Inspectors found evidence that staff were encouraged and supported to raise concerns regarding any aspect of care provision. For example, staff had highlighted the limited number of available drivers and the need to increase the range of activities within each apartment.

The inspectors found that these issues were being addressed, with the number of staff qualified to drive having increased. Additional staff were also undergoing driving assessments to ensure they could undertake driving duties as part of their role.

Judgment: Compliant

Regulation 23: Governance and management

Since the last inspection of this centre in February 2025 the provider had appointed a senior manager into the role of person in charge who had maintained a consistent presence in the centre. In addition a team leader had been appointed who had 20 supernumerary hours to support in the completion of identified actions. The staff team were as stated a core team who were familiar with the lines of authority and accountability and were clear on who they reported to.

The provider had completed the required audits of the quality and safety of the service provided in the centre and these were found to be detailed and guiding the local management team's practice. Inspectors reviewed the six monthly unannounced visit report from July 2025 in addition to the preceding report dated 28 February 2025. These reports contained reviews of previous actions set and reviewed the timeliness of actions arising from the previous inspection of the centre in addition to provider identified actions.

Centre based audits were also being completed as required and these had associated action plans developed with a timeframe for completion and an assigned staff member. The inspectors found that some of these audits had not been effective in identifying all areas that required an action and this is reflected under

Regulation 26: Risk management procedures and Regulation 7: Positive behavioural support

Judgment: Compliant

Quality and safety

Inspectors found that, although the provider had made progress in improving the culture of the centre and creating a more relaxed atmosphere for residents, significant improvements were required in the recognition, assessment, and management of risk. Key risks in the environment were not always identified or effectively controlled, and there were gaps in safeguarding measures, incident management, and the consistent implementation of positive behaviour support. Risk-related documentation was not always accurate, comprehensive, or aligned with staff practice, leading to inconsistent approaches to resident support. In addition, several restrictive practices were in place that had not been identified or assessed, and associated risk assessments required review to ensure that restrictions were proportionate, justified, and subject to appropriate oversight.

Regulation 26: Risk management procedures

The assessment and management of risk required review in this centre as the inspectors found a number of areas not assessed for or where control measures were not effective. Inspectors acknowledge that the provider had worked to improve the centre culture and that there was a relaxed atmosphere in the centre with residents more engaged in positive risk-taking in their home and in the community. The recognition of the risk present required improvement.

In one apartment, inspectors observed a broken television screen with broken glass, posing a risk of injury due to sharp edges. The staff reported that this had been broken for about a month, and inspectors found that it was not recorded as an incident nor identified on a health and safety audit or premises audit. This was of particular concern given the potential for high-risk behaviours that may present within the apartment. The television was removed on the day of inspection.

An internal fire door from one apartment into the main house was found to be locked with a key, and inspectors were informed that all staff carried the keys on a lanyard so the door could be opened in the case of an emergency. The control measure for the presence of the key was ineffective, as inspectors found, through staff interviews and observations, that staff did not carry a key for the door.

Inspectors found that the risk for financial misappropriation had not been identified as required for a resident in the centre who had no access to their finances. The

service was failing to safeguard the resident by not identifying this as a risk and putting measures in place. For example, checks and balances were being completed against receipts each day, but no balance was recorded of monies available on the resident card. While inspectors were told that the card had a specific amount uploaded by the resident's representative in the absence of the resident accessing their own money, the management team at no point checked or verified the balance amount.

Judgment: Not compliant

Regulation 7: Positive behavioural support

Residents had positive behaviour support plans in place, outlining behaviours that may present, their potential functions, possible triggers, and strategies for staff to implement. Plans also included information on individual sensory profiles and skill-development opportunities, and were viewed alongside other care and support plans, details of important routines, and incident reviews. However, inspectors found conflicting guidance within some plans. For example, instructions for supporting one resident when requesting space varied between standing outside the door and checking every five minutes, leaving the area and remaining available by phone, and guidance recorded in staff meeting minutes stating the resident should not be left unattended between 08:00 and 21:00. This inconsistency was reflected in staff practice on the day of inspection.

While incident reporting and review had improved since the previous inspection, inspectors found they were not consistently recorded or reviewed in a way that facilitated learning from accurate information. There was also a significant number of restrictive practices in use, some of which had not been identified or recorded. For example, the locked kitchen also restricted access to the utility room and laundry facilities; this had not been recognised by the provider as a restrictive practice. Within this area, a freezer and a cupboard labelled as locked at all times were found open. A bathroom for staff or visitors and two ground-floor storage areas were also locked without an assessed rationale. Associated assessments and risk assessments for restrictive practices required updating, with some reviewed during the inspection by a person in charge from another of the provider’s services, such as the encasing of the communal television in perspex.

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 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Compliant
Quality and safety	
Regulation 26: Risk management procedures	Not compliant
Regulation 7: Positive behavioural support	Not compliant

Compliance Plan for Rose Lodge OSV-0008576

Inspection ID: MON-0046825

Date of inspection: 24/07/2025

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 26: Risk management procedures	Not Compliant
Outline how you are going to come into compliance with Regulation 26: Risk management procedures: The provider acknowledges the findings regarding risk management procedures, and we recognise the importance of accurate assessments and effective control measures of risks. To address these concerns, we have taken the following actions: • The broken TV was removed on the day of inspection and has since been replaced. • Education has been provided to staff in relation to completion of incident forms and reporting of broken/damaged equipment/furnishings in staff meeting on 20/08/2025 • An action plan template has been added to the auditing program to ensure comprehensive oversight of the auditing system. • Key boxes have been ordered to be fitted to the walls outside the service user's apartments to allow staff to gain access to apartments in the event of an emergency, with service users' consent. • Internal fire door, with locked access to the main house, will have a key box fitted internally to allow egress in the event of an emergency. • Risk assessment regarding financial misappropriation completed for all service users in Rose Lodge. • Access to bank statements have been requested for all service users to facilitate accurate checks and balances within the financial auditing system.	
Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
The provider acknowledges the findings regarding positive behaviour support, and we recognise the importance of consistency within support plans, the use of accurate recording in the use of restrictive practices and the implementation of the least restrictive approach.

To address these concerns, we have taken the following actions:
• A meeting was held with the behaviour support specialist on the 29/7/25 and she is in the process of developing a single document for each of the service users to guide staff.
• Behavioural support specialist will provide training to support staff on the 20/8/25 in relation to the importance of a consistent approach to supporting service users.
• A review of all restrictive practices was completed with the restrictive practice committee on the 13/8/25. All risk assessments are in the process of being reviewed following this review.
• Monthly meetings are held with Rose Lodge staff, this meeting includes key worker reports, with emphasis on reviewing all incidents over the last month, these incidents, outcomes and actions are discussed with all staff.
• Incidents are also reviewed as part of a trend analysis by the behaviour specialist on a quarterly basis
• Access to the utility room and laundry area will be made available to all service users following works to ensure the service users safety will be maintained – new lock for chemical press, blinds for door accessing kitchen.
• Store rooms are now cleared of any items that may be a risk to service users and are no longer locked.
• Upstairs bathroom is no longer locked

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 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.	Not Compliant	Orange	30/09/2025
Regulation 07(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.	Not Compliant	Orange	30/09/2025
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures	Not Compliant	Orange	30/09/2025

	including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.			