



Report of an inspection of a Designated Centre for Disabilities (Adults).

Issued by the Chief Inspector

Name of designated centre:	Serenity Care Rathdrum
Name of provider:	Serenity Supported Homecare Ltd ta Serenity Care
Address of centre:	Wicklow
Type of inspection:	Unannounced
Date of inspection:	23 July 2025
Centre ID:	OSV-0008658
Fieldwork ID:	MON-0043408

About the designated centre

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

Serenity Care Rathdrum provides full-time residential care and support for up to five residents with an intellectual disability and other healthcare needs. The centre comprises a large two-storey house outside a small town in county Wicklow. The premises is set on large mature gardens offering vistas of the countryside. The centre is managed by a full-time person in charge, and the staff skill-mix comprises healthcare assistants with some nursing input.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	2
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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 23 July 2025	20:55hrs to 22:25hrs	Michael Muldowney	Lead
Thursday 24 July 2025	10:10hrs to 18:10hrs	Michael Muldowney	Lead

What residents told us and what inspectors observed

This unannounced inspection took place over two days and was carried out as part of the ongoing regulatory monitoring of the centre. The inspector used conversations with residents and staff, observations, and a review of documentation to form judgments on the quality and safety of the care and support provided to residents. The inspector found that improvements were required under most of the regulations inspected, including those related to the governance and management arrangements and the quality and safety of the service in order to meet full compliance, and to ensure that the centre operated in line with a person-centred approach.

The centre was registered in April 2024 to accommodate one resident. Later that year, the provider applied to increase the number of residents to five. At the time of the inspection, two residents lived in the centre and the provider did not have any immediate plans to fill the vacancies.

The centre comprises a large detached two-storey house on the outskirts of a small town. The inspector carried out a walk-around of the house with the provider's clinical governance lead. A resident also showed the inspector their bedroom and the main living space. The house was seen to be spacious, bright, clean, homely, comfortable, nicely decorated, and well maintained. The exterior included a front garden with mature trees and bright flowers and a large back garden with decking that offered nice views of the countryside. Since the previous inspection in July 2024, there was a new porch area with seating furniture and a new wooden gate at the front of the house.

The interior included a large sitting room, an open-plan kitchen and dining room with an adjoining utility room, bathrooms, an office, a large 'recreational' room, and bedrooms. There was also a self-contained apartment that one resident lived in. It comprised a large bedroom with an en-suite bathroom, a dining and living space, and a small kitchen. The apartment required minor upkeep, such as repairs to small holes in the bathroom ceiling.

The inspector observed some good fire safety precautions such as fire detection and fighting equipment. However, some of the fire containment measures required improvement, and associated documentation required better maintenance. For example, the inspector observed a fire door wedged open and a resident's evacuation plan was not reflective of their needs.

The inspector also observed locked presses in the kitchen. The rationale for the restriction was unclear and staff told the inspector that some of the presses contained residents' belongings. This matter required more consideration from the provider. The premises, fire safety and restrictive practices are discussed further in the quality and safety section of the report.

The inspector had the opportunity to speak with both residents separately on the first night of the inspection. Residents were both on outings on the second day of the inspection. One resident was attending a medical appointment and then a barbecue organised by the provider; and the other resident was going to a nearby town for shopping and lunch out.

The first resident, with staff presence, told the inspector that they liked the centre and did not want to move. They said that they liked most of the staff, but did not get on with some of them at times. The resident also made an allegation during this brief conversation. The inspector followed up on this matter during the course of the second day of inspection and found that the allegation had not been reported in line with the provider's associated safeguarding policy. This is further discussed later in the report.

The second resident gave mixed feedback on their experience of living in the centre. They said that the staff were lovely and caring, and accommodated the resident's wishes, and that the management team were fantastic. They felt healthy, safe, and said that the environment was pleasant. They liked their bedroom and had enough space. The resident was very independent in aspects of their care and support needs and told the inspector that could decide their own routine and how they spent their time. Within the local community, they liked to go to the local leisure centre, to mass and to eat out. They also visited family and went on day trips to larger neighbouring towns. They also told the inspector about some of their personal goals such as moving to a more urban area and living more independently.

They said that they could raise complaints with staff. However, they were not fully satisfied with the meals available to them, and would prefer a more diverse staff team to support them. From what the resident told the inspector (and what was also documented in their daily notes), the resident expressed their dissatisfaction with restrictions that were in place for them both within the centre and outside in the community. The resident's representatives were involved in their care planning, and the resident said that they contacted them if and when they needed to.

The inspector also read feedback from residents on what it was like to live in the centre. The provider had consulted in with them in June 2025 as part of their audit systems. One resident declined to offer feedback. The other resident complimented the staff team, and said that they felt safe and were satisfied with the care and support they received in the centre.

The inspector had the opportunity to meet with different staff members throughout the inspection and to observe their practices. The inspector found that staff required better supervision and guidance from the provider to ensure that residents' dignity and living space were respected at all times, and that the centre was recognised as a 'home'. These issues were communicated to the person in charge and clinical governance lead on the second day of the inspection, and to the chief executive officer after the inspection concluded.

The person in charge and governance lead facilitated the inspection. They had commenced in their roles since the previous inspection. They told the inspector that

the provider had no plans to admit more residents until they found a suitable resident(s) that was compatible to live with the other residents. They spoke about the residents' various needs and the associated interventions including behaviour support, restrictive practices, staffing arrangements, input from multidisciplinary services, and specific court orders. They said that the provider and staff team were committed to providing good care to residents, and that the provider planned to enhance the staff skill-mix with the addition of a social care worker. This would help support the delivery of person-centred planning. They said that residents' wishes were respected and that they could choose their activities. For example, they liked to visit family, eat out, swim, walk, go to museums, and go on day trips. They also told the inspector about the initiatives taken to support residents' self-development. For example, a greenhouse was built in the back garden for residents to become involved in horticulture. However, on discussion, it was agreed that one resident may benefit from more involvement in community groups.

The clinical governance lead was aware that improvements were needed to aspects of the service provision, and had developed new systems such as new audit documents and systems for sharing information to strengthen the governance and management structures.

Overall, while the inspector found some examples of compliance, improvements were required under most of the regulations inspected to ensure that the governance and management structures were effective in delivering safe and quality services to residents, particularly in relation to how safeguarding concerns raised by residents were reported and managed.

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

Capacity and capability

While the inspector found that the centre was generally well resourced, the staffing arrangements required enhancement and the oversight systems required improvement to ensure that they were effective.

The person in charge was full-time. They also had responsibility for another centre (in county Kildare), and split their time between these centres. The inspector found that the person in charge had not notified the Chief Inspector of Social Services of all incidents in the centre as specified under Regulation 31.

Since the previous inspection, the provider had enhanced its governance structure with the addition of a governance lead. They formed part of the management team, along with the person in charge and chief executive officer. The governance lead demonstrated a strong understanding of the residents' individual needs and personalities. They were generally satisfied with residents' access to multidisciplinary

team services. They also told the inspector about how they were developing and implementing new systems to strengthen the governance of the centre; for example, better oversight and documentation systems to improve the monitoring of the centre.

The management team meet regularly to share information and review the service in the centre. The inspector reviewed a sample of its 2025 meeting minutes. The minutes noted discussions on matters such as staffing, HIQA, risk management, policies and procedures, the statement of purpose, audit findings, and residents' care needs. The management team also liaised and shared information with the residents' representatives, some of whom were court-appointed.

The oversight systems required improvement to ensure that the quality and safety of the service provided to residents was effectively monitored. For example, the centre was registered in April 2024 and the first annual review was outstanding. Unannounced visits and audits, including audits on cleaning, medication, and health and safety, were being carried out and residents were consulted with as part of these. However, the most recent unannounced visit report was not fully accurate, and a care plan audit was due. Overall, the findings of this inspection demonstrate that the audit systems were failing to self-identify issues as found by the inspector during the inspection.

The staff complement comprised of healthcare assistants. The provider had identified that the skill-mix required enhancement and planned to recruit a social care worker. The person in charge maintained staff rotas and the inspector found that minor improvements were required to ensure that they were accurate and clear. The staff rotas indicated that sufficient staffing levels were maintained.

There were arrangements for staff to raise concerns; for example, there was an on-call system for emergencies, the management team frequently visited the centre, and staff could attend team meetings. The inspector reviewed a sample of the 2025 team meeting minutes. They noted various topics such as safeguarding, risk management, documentation, training, residents' needs and updates, and staff conduct.

Regulation 15: Staffing

The staff skill-mix comprised of healthcare assistants with some nursing input. Four staff were on duty at all times, with two staff allocated to support each resident.

The staff skill-mix required enhancement to ensure that it met the residents' needs. The provider planned to recruit a social care worker to enhance the skill-mix and the quality of care and support provided to residents.

The person in charge maintained planned and actual staff rotas. The inspector reviewed the May, June and July 2025 rotas. They showed that there was a sufficient number of staff on duty in the centre. However, the rotas required minor

improvement:

- The staff changes on the night of the first day of the inspection had not been noted on the actual rota. The inspector brought this to the attention of the person in charge on the second day of the inspection, and they then made the required revision.
- The exact hours of the 'sleep over' shift were not indicated on the rotas.

The inspector did not review Schedule 2 files as part of this inspection.

Judgment: Substantially compliant

Regulation 23: Governance and management

The governance and management of the centre required improvement to ensure that it was effectively monitored and operated in line with the requirements of the regulations.

Generally, the centre was well resourced. For example, the premises were well maintained, and there were vehicles to facilitate residents' activities. However, as noted under Regulation 15, the staff skill-mix required enhancement.

The provider's oversight systems required improvement to ensure they were thorough and effective in identifying and addressing risks and areas for improvement. For example:

- The recent unannounced visit report, dated June 2025, was not fully accurate as it stated that there were no notifiable incidents since the previous report; however, there had been allegations of abuse, an incident of loss of power, and use of restrictive practices.
- The provider had not yet carried out an annual review of the quality and safety of care and support in the centre as required by this regulation.
- The last care plan audit was dated 12 months ago, and the findings in the quality and safety section of the report show that better oversight is needed in this area.

The provider was aware that their oversight systems required improvement, and the clinical governance lead showed the inspector new systems that they planned to introduce to improve audits and documentation standards.

The remit of the person in charge included two separate centres located in different counties and this required review by the provider to ensure that it did not impinge on the person in charge effectively discharging their duties. The findings from this inspection demonstrated that there was a potential impact on the person in charge being able to discharge their duties.

Additionally, as noted under regulation 31, notifiable incidents and events had not

been reported to the Chief Inspector; this showed deficits in the provider's understanding of regulatory responsibilities.

Judgment: Not compliant

Regulation 3: Statement of purpose

The provider had prepared a written statement of purpose that was available in the centre to residents and their representatives. However, it required revision to ensure that all of the information was accurate in describing the centre, its services and the staffing arrangements. For example, it made reference to the previous person in charge and the staff whole-time equivalent was not accurate. Furthermore, the information in relation to residents' social activities, hobbies and leisure interests required expansion as it mainly listed in-house activities such as reading, and referred to older persons and 'seniors' although the current residents were not within those categories.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

The person in charge had not ensured that all incidents, as specified under this regulation, were notified to the Chief Inspector.

The inspector reviewed the incidents notified to the Chief Inspector since the previous inspection, including an allegation of abuse, serious and minor injuries to residents, and loss of power. However, the use of restrictive practices in the first quarter of 2025 had not been notified. Additionally, an allegation of abuse, made on 23 July 2025, was not notified despite the inspector reminding the person in charge and provider of this requirement during telephone conversations on 31 July 2025.

Judgment: Not compliant

Quality and safety

The inspector found that improvements were required to ensure that residents were in receipt of quality and safe care and support, particularly in relation to how safeguarding concerns raised by residents were reported and managed.

The inspector reviewed the residents' assessments and care plans, and found that

some of the care plans required better maintenance to ensure that they were up to date and subject to thorough reviews. The inspector also found that improvements were needed to better demonstrate how residents were supported to be involved in local groups and networks if they wished to.

Behaviour support plans had been prepared for both residents. The inspector found that one plan was not fully implemented, and the other plan required revision to reflect changes since the resident's admission to the centre. These deficits impinged on the effectiveness of the plans. The inspector also found that the provider's oversight and management of all restrictive practices required improvement to ensure that they were implemented in line with evidence-based practice.

The provider had not ensured that safeguarding concerns were being reported appropriately. An allegation made by a resident had not been reported to the person in charge as per the provider's policy, and when the inspector raised this matter with the person in charge during the inspection and during a phone call conversation on 31 July after the inspection, the allegation was not reported to the Chief Inspector as required by the regulations. Overall, it was not demonstrated that the arrangements for managing safeguarding allegations made by residents were given sufficient regard by the provider, and national policy was followed.

The inspector also found from reading residents' daily notes, speaking with staff and observations during the inspection, that enhanced oversight was needed to ensure that residents' rights were respected at all times in the centre.

The maintenance and development of risk assessments required improvement to ensure that risks were subject to written assessment and ongoing review. Associated protocols also required more detail to adequately guide staff on how to respond to emergency situations.

The centre comprises a large two-storey house with large gardens in a peaceful setting close to a small town. Part of the house was converted to a sole occupancy apartment. The premises were bright, clean, homely, nicely decorated and generally well maintained. Some minor upkeep was needed to the apartment: the flooring was slightly damaged in places, the shower base required resealing, and there were three small holes in the bathroom ceiling. The provider's maintenance department was present during the second day of the inspection, and was assessing these matters. Upstairs, the inspector observed that additional storage facilities were required to store a resident's wide array of personal belongings.

The inspector observed good fire safety precautions such as fire detection and fighting equipment. However, one resident's evacuation plan required revision, and the centre's evacuation plan did not reference the fire panel. Additionally, the fire containment measures and practices required monitoring by the provider to ensure that they were effective. Improvements were also needed to demonstrate that all residents could be safely evacuated in the event of a fire.

Regulation 13: General welfare and development

The provider had provided facilities and opportunities for residents to engage in various social and leisure activities. However, the inspector found that improvements were required to ensure that residents had opportunities to engage in local groups and networks.

The inspector read residents' recent daily notes. They recorded that residents had visited family, gone for walks, shopping, attended mass, ate out, used the local leisure centre, had therapeutic treatments (reflexology and massage), and went to neighbouring towns and the seaside for day trips. There were two vehicles to facilitate these activities. Within the centre, the provider had provided facilities for residents to engage in their interests and hobbies. For example, there was exercise equipment and a greenhouse to plant flowers and vegetables.

On the second day of the inspection, one resident was attending a barbecue that was organised by the provider as part of a team building/training day for their staff. The barbecue was also attended by residents from the provider's other centre; those residents were aged under 18 years. The person in charge told the inspector that the resident enjoyed meeting people and attending gatherings. However, it was not demonstrated what efforts had been made to involve the resident in local groups and develop relationships with their peers, for example, persons of a similar age with similar interests.

Judgment: Substantially compliant

Regulation 17: Premises

The premises comprises a large two-storey house with mature and well-maintained gardens offering nice views of the countryside. The house is situated in a peaceful setting and close to a small town.

The inspector walked around the centre with staff and one of the residents. Overall, it was bright, clean, homely, spacious, nicely furnished and decorated, and comfortable. It contained residents' bedrooms, a staff office, bathrooms, a large and comfortable downstairs sitting room, a large upstairs activity room, a utility room, and an open-plan kitchen and dining room. There was also a self-contained 'apartment' used by one resident, comprising of a small kitchen, an open-plan living and dining space, and a large bedroom with an en-suite bathroom. The physical environment was accessible to residents, and ramps were fitted where required for residents with reduced mobility to use.

The outside space was also well presented with a front porch with seating furniture and a large back decking area with space for dining and recreational activities. There is also a new wooden gate at the front of the house and additional flowers

and plants since the last inspection which further adds to the bright and pleasant aesthetic of the premises.

Judgment: Compliant

Regulation 26: Risk management procedures

The provider had implemented procedures and systems for the management of risk in the centre. However, improvements were needed to ensure that all known risks were assessed to ensure that they were being appropriately managed for the safety of residents and staff.

The inspector reviewed written risk assessments pertaining to individual residents and the centre. They found that there were no risk assessments on some known, specific behaviours of concern. Incidents related to these risks had happened recently, including one where An Garda Síochána assistance was required. There was also no written risk assessment related to residents making potentially untrue allegations against staff. These risks required robust assessment and identification of control measures to ensure that appropriate arrangements were in place.

The inspector also found that other risk assessments required updating. For example, one risk assessment related to a resident's specific behaviour of concern was rated as 'high'; however, the person in charge told the inspector that the risk had reduced, and the risk assessment had not been reviewed to reflect this.

The provider had prepared emergency protocols for staff to follow in response to certain emergencies, but improvements were needed to ensure that they were sufficiently detailed to effectively guide staff. For example, the protocols did not define what an 'emergency' was and the appropriate steps to be followed.

Judgment: Not compliant

Regulation 28: Fire precautions

The provider had implemented some good fire safety precautions; however, improvements were needed to the fire containment systems, the upkeep of evacuation plans, and to demonstrate that all residents could be safely evacuated from the centre in the event of a fire.

The inspector observed fire detection and fighting equipment, and emergency lights in the centre. The equipment and lights were up to date with their servicing requirements. Fire doors had been installed to prevent the spread of smoke and fire. However, the inspector observed when he first arrived to the centre that the kitchen door was wedged open with a kitchen stool. This compromised the purpose of the

door. The inspector also observed that there was a large gap between the floor and two doors upstairs. The provider's maintenance department visited the centre during the inspection to assess these doors.

Fire evacuation plans had been prepared to guide staff on how to safely evacuate residents. However, the plans were found to require revision. The main evacuation plan did not refer to the fire panel and indicate that staff should check it if the alarm sounded; this oversight impinged on the purpose of the panel. Furthermore, one resident's individual plan was not accurate as it indicated that the resident required support to mobilise which is not the case. This oversight demonstrated the lack of a robust review of the plans.

The most recent fire drill was poorly recorded. The record sheet did not include the time of the drill, the scenario used, and if the residents were present. The person in charge told the inspector that only one resident had been present, and that the most newly admitted resident (in December 2024) had not been part of a drill since they moved in. Therefore, it was not demonstrated if all residents could be safely evacuated from the centre. However, the resident concerned did tell the inspector that they knew to evacuate if the alarm sounded.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

The previous inspection of the centre found this regulation to be not compliant. This inspection found that improvements had been made. However, some practices were identified which required attention from the provider to ensure that any associated risks were mitigated.

The inspector reviewed one resident's medicine-related documentation, including recent prescription sheets, protocols, and administration records, and checked how their medicines were stored. The medicines were seen to be appropriately labelled and securely stored in a locked press, and the prescription sheets and protocols were up to date. The inspector counted three medicines with the person in charge to check if the balances aligned with the stock take records. It could only be verified that the balance of one medicine was correct as staff working with the resident that day had taken a quantity of the other medicines with the resident on their outing in case they needed them. However, they had not taken the prescription sheet or administration record sheet, and to administer the medicines without these documents posed a risk of an administration error.

The inspector also reviewed the recent administration records for the previous week. The records indicated that the resident had received their regular medicines as prescribed. The resident had also received a certain PRN (a medicine only taken as required) psychotropic medicine on two occasions. However, an associated document, to record additional information such as the effects of the medicine, had

only been completed on one occasion.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

The inspector reviewed both residents' assessments of need and personal plans with the person in charge, and found that improvements were required to the maintenance of the files.

The residents' files reflected input from their representatives, including their court-appointed advocates, and the multidisciplinary professionals involved in their care, such as dietitians, psychiatrists, chiropodists, specialist services, and general medical practitioners. The care plans were also influenced by courts orders. The plans related to health, personal and social care needs, including communication, behaviours of concerns, finances, mobility, intimate care, and safety. There was also important information for staff to read about the residents' interests, preferences and important people in their lives.

One resident had personal goals related to their hobbies, social activities, and personal development. The progress and achievement of the goals was poorly documented. For example, the person in charge told the inspector that while the resident was doing household chores as part of their associated goal, it was not being recorded. This impinged on how effectively the goal could be reviewed.

Some of the other resident's plans also required updating to reflect changes since they moved into the centre in December 2024; for example, information related to the changes of management, support they required when accessing the community independently, and the local services they used.

Additionally, the provider's quality management framework document stated that residents were to have a personal wellbeing care plan, but only one of these titled plans was made available to the inspector during the inspection.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

Both residents required support to manage their behaviours of concern. Written behaviour support plans were in place to guide staff practices. However, the inspector found that one resident's plan was not being fully implemented as the directions regarding allegations made by the resident had not been followed. The second resident's plan had not been updated since they moved into the centre, and required updating to reflect their new residence and the associated interventions to

be in place. It also did not refer to all behaviours described by staff to the inspector.

Restrictive practices, including rights restrictions, that were stipulated through legal orders, were implemented for both residents. The oversight of some restrictions required improvement. For example, on the first night of the inspection, the inspector observed seven locked kitchen presses. The following day, only three of the presses remained locked. They contained an electrical appliance, sharps, and a radio, vase and paper. The other presses contained miscellaneous items and food.

It was not clear why all of these items were inaccessible to residents. This restriction required management in line with the provider's associated policies and evidence-based practice.

Judgment: Substantially compliant

Regulation 8: Protection

The provider had implemented systems to protect residents from abuse. The systems were underpinned by its written safeguarding policy. However, improvements were required to ensure that safeguarding concerns were appropriately recorded, reported and responded to and managed in line with national policy.

Since the previous inspection, there had been one safeguarding incident reported to the Chief Inspector and the national safeguarding office. The provider had prepared an associated safeguarding plan that outlined the measures to protect residents.

However, it was not demonstrated that all allegations made by residents were being appropriately reported, assessed and notified to the relevant stakeholders. On the first day of the inspection, during a brief conversation with the inspector, and with staff present, a resident made an allegation of potential abuse. The following day, the person in charge told the inspector that staff had not informed her of the resident's allegation. The inspector later read reference to the allegation in the resident's daily notes.

This was in contradiction to the resident's behaviour support plan as well as the provider's and the national safeguarding policy. The inspector also read an incident form dated 20 June 2025 that made reference to the resident making an allegation against staff. This incident and the allegation made during the inspection were not notified to the Chief Inspector or national safeguarding office.

Staff told the inspector that some allegations stemmed from the resident's psychiatric presentation. However, the inspector found that there was a lack of comprehensive written support plans on this matter. This matter required improvement to ensure that the provider fully adhered to their safeguarding reporting responsibilities.

Judgment: Not compliant

Regulation 9: Residents' rights

Improvements were needed to ensure that residents' rights, privacy and dignity were promoted and upheld at all times in relation to their living space and personal information.

The inspector reviewed residents' daily notes from a two-week period in July 2025, and found examples of wording that was unprofessional; for example, a resident's behaviours was described as 'childlike', and a term for intimate care equipment was not appropriate. Furthermore, staff used a phrase when talking to the inspector to describe residents' mental health that was unprofessional.

Observations and conversations with staff during the inspection also demonstrated a need for improved understanding from staff that the centre served as the residents' home.

The inspector also read a risk assessment with a control measure stating that there was a no-alcohol policy in the centre. This potential restriction on residents' rights required recognition as such from the provider.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 31: Notification of incidents	Not compliant
Quality and safety	
Regulation 13: General welfare and development	Substantially compliant
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Serenity Care Rathdrum OSV-0008658

Inspection ID: MON-0043408

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 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: "The staff changes on the night of the first day of the inspection had not been noted on the actual rota. The exact hours of the 'sleep over' shift were not indicated on the rotas. - o The rota has to be amended by the PIC or by the delegated person during out of hours for any changes once confirmed and approved. - o Sleep-over and shifts now display exact hours and labels with no abbreviations on rosters. - o Completion Date: 12 Aug 2025. "The staff skill-mix required enhancement to ensure that it met the residents' needs". - o CORU Registered Social Worker has been appointed to support the Person in Charge with Centre management. Commenced on 15th Aug 2025. - o Induction programme for the Social Worker is ongoing and to be completed within 4 weeks of start date. - o The Social Worker will support the PIC to enhance oversight of the service to ensure the quality of care and support provided to residents in a timely manner.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • Notifiable Incidents & Events - o All outstanding incidents have been reviewed and notifications have been submitted on	

the HIQA and Safeguarding portals. Date Completed: 22.8.25

- o Copy of Guidance on Managing Notifiable Events in Designated Centres made available for staff and managers to read and to be used as reference if required.
- o Excel tracker has been introduced for all incidents/events to ensure accuracy in reports and notifications. This will also help the PIC to identify trends when analyzing the data received.
- Audit
 - o An audit schedule has been developed (weekly, monthly, quarterly & 6 monthly) to have a better sight of the service. PIC will ensure that the action plans have been developed and achieved within acceptable timeframe.
 - o The audit is shared between the Governance Lead, Person in Charge and the Social Worker
 - o Care plans are reviewed every 4 months and or as required. Updated as applicable.
 - o Satisfaction Survey for the residents will be done more regularly and will be part of key working sessions monthly. Date of Completion: 30 September 2025
 - o Review the audit tools being used in the service. Date of Completion: 26 September 2025
- Annual Report
 - o Annual review of quality and safety of care from 2024 has been completed. Copy of the Annual Report will be made available to the residents to read. Date of Completion: 02 September 2025
- Governance
 - o For the PIC effectively discharge their duties, the Provider reviewed the needs of the service.
 - o To support the PIC in looking after two separate centres, a Social Worker has been recruited in Rathdrum to enhance operational support to PIC to ensure duties can be discharged effectively while the other centre has Clinical Nurse Manager. Social Worker will support PIC in completing documentation of audits; monitoring tracker system introduced to monitor staff reporting, notifications, and audit compliance
 - o Quality Assurance Committee is being developed to ensure the needs of the residents are met. The group will consist of the Provider or representative, Clinical Lead, Person in Charge, Social Worker and a HCA representative. The group will meet quarterly to review the Incidents, HIQA notification, Safeguarding, Clinical Audits, Trainings, Fire Safety, Meaningful Activities, and others.

Date of Completion: 25 September 2025

Regulation 3: Statement of purpose	Substantially Compliant
Outline how you are going to come into compliance with Regulation 3: Statement of purpose: The current Statement of Purpose has been revised to reflect the following: - o Name of the new Person in Charge - o the staffing complement and organisational chart - o the community-based activities relevant to the residents	

o reference to the residents was change to the right category Date completed: 02 September 2025	
Regulation 31: Notification of incidents	Not Compliant
Outline how you are going to come into compliance with Regulation 31: Notification of incidents: - o Copy of Guidance on Managing Notifiable Events in Designated Centres made available for staff and managers to read and to be used as reference if required. - o All outstanding incidents have been reviewed and notifications have been submitted on the HIQA and Safeguarding portals. Safeguarding Team confirmed closure. Date completed: 22 Aug 2025. - o Excel tracker has been introduced for all incidents/events to ensure accuracy in reports and notifications. This will also help the PIC to identify trends when analyzing the data received. - o Daily log, quarterly and annual notification schedule introduced to ensure full compliance. - o Social Worker to support PIC in monitoring incidents, preparing notifications, and ensuring timely submissions. - o All incidents to be reviewed quarterly by Governance Lead to confirm notifications are accurate and complete. Completion Date: 22 Aug 2025 • Complaints & Safeguarding - o Complaints and safeguarding log introduced; all concerns recorded by staff, reviewed daily by PIC and Social Worker, investigated, escalated, and notified. - o Visual complaints process to be displayed for residents (officers' names/photos). PIC responsible, in place from 08 Sept 2025.	
Regulation 13: General welfare and development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 13: General welfare and development: • Community engagement - o The service has identified and contacted other relevant community groups such as walking, art, reading and awaiting confirmation of enrolment. - o The service will continue engaging with local groups (classes, library, leisure centre) to identify and facilitate suitable activities for residents. - o The service will introduce monthly Key-working meetings to explore and identify new interests with individual residents.	

- o Person in Charge and Keyworkers responsible 30 Sept 2025. • Activity expansion - o Increase opportunities for residents to join local community groups and networks, focusing on peers of similar age and interests. - o Person In Charge & Keyworker responsible, by 30 Sept 2025. • Organisational review - o The centre will ensure activities are meaningful based on residents' preferences and interests. - o Person In Charge 30 Sept 2025.	
Regulation 26: Risk management procedures	Not Compliant
Outline how you are going to come into compliance with Regulation 26: Risk management procedures: - o PIC to update the Risk Management Policy to align with HSE Enterprise Risk Management Policy & Procedures 2023 - Completion Date: 12 Sept 2025 - o All existing risk assessments to be reviewed and updated as applicable to reflect the current risk levels. Completion Date: 12 Sept 2025 • Risk assessments - o The service will develop specific risk assessments for behaviours of concern, potential false allegations against staff, aggression and violence, and self-harm. - o The service will ensure that risk control measures are proportional and considered to the risks identified and of the adverse impact of such measures might have on the residents quality of life. - o Person In Charge & Provider responsible, by 12 Sept 2025. • Ongoing monitoring - o Risk assessment audit to be carried out monthly; risks to be a standing agenda item at monthly management meeting. - o Person in Charge and Management responsible, from 30 Sept 2025. • Emergency protocols - o Revise protocols to clearly define what constitutes an emergency and outline step-by-step staff actions. - o Person In Charge responsible, by 05 Sept 2025.	
Regulation 28: Fire precautions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions:	

Fire doors - o The gaps between the floor and fire doors upstairs have been addressed. - o Staff have been reminded through a companywide memo and at staff meeting not to wedge doors open. - o Service Provider & Person In Charge responsible, completed 21 Aug 2025. • Evacuation plans - o Review and update centre-wide fire evacuation plan to include fire panel checks and clearer step-by-step procedures. - o The PEEP for SCR02 has been amended to reflect current resident needs. - o Person In Charge responsible, by 20 Sept 2025. • Fire drills - o Monthly fire drills to be conducted with all residents included. - o Drill record format revised to include time, scenario, and resident participation. - o Person In Charge & Fire Warden responsible, 05 Sept 2025. • Fire officer/warden - o Appoint and train designated staff as Fire Officer for the service. - o Provider responsible, by 15 Oct 2025.	
Regulation 29: Medicines and pharmaceutical services	Substantially Compliant
Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services: Outing medicines protocol - o Introduce outing medicines procedure requiring staff to bring prescription and administration record sheets when medicines are taken off-site. - o Person In Charge responsible, protocol in place by 02 Sept 2025. • Outing medicines template/box - o Provide secure, labelled box and template for recording medicines taken on outings. - o PIC responsible, by 02 Sept 2025. • PRN documentation - o PRN rationale form to be completed for each administration; PIC approval required before use. - o Person In Charge and Staff responsible 02 Sept 2025. • Audit - o Weekly medicines audit to include checks of PRN documentation and outing medicines compliance. - o Person In Charge responsible 02 Sept 2025.	

Regulation 5: Individual assessment and personal plan	Substantially Compliant
Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan: Goal monitoring - o Introduce a structured system (e.g., Goal Attainment Scaling) to record, track and review residents' progress against personal goals. - o Person In Charge responsible, in place by 30 Sept 2025. • Plan updates - o Review and update all support plans to reflect changes since Dec 2024 (e.g., community access supports, local services, management updates). - o Person In Charge responsible, by 30 Sept 2025. • Audit - o Include support plan review in the audit schedule to ensure timely updates and accuracy. - o Clinical Governance Lead responsible, from 30 Sept 2025. • Personal Wellbeing Care Plan (PWCP) - o Update care plan template to include PWCP for all residents. - o PIC responsible, by 30 Sept 2025.	
Regulation 7: Positive behavioural support	Substantially Compliant
Outline how you are going to come into compliance with Regulation 7: Positive behavioural support: Implementation of Positive Behaviour Support Plan (PBSP) - o Positive behaviour support plans are fully implemented and are discussed at fortnightly staff meetings, with any clinical updates as a standing agenda item. - o 60% of staff team have been trained in the low arousal Studio III training approach. - o The rest of the staff team are scheduled to complete the training by 5 Sept 2025 - o Person In Charge responsible, in place from 5 Sept 2025. • Plan updates - o 6 monthly audits of plans to ensure if they are reflecting current needs, residence, and full range of behaviours. - o Person In Charge & Clinical Lead responsible, by 15 Oct 2025. • Restrictive practices - o Make the restrictive practice register accessible to staff, add weekly audits to ensure restrictions are justified and minimised as required. - o Person In Charge responsible, ongoing from 02 Sept 2025. • Restrictive practices - o Restrictive register in place with justification, staff signatures, and review dates. Weekly audits and staff meeting agenda item. - o Risk assessments developed for specific issues (hitchhiking, aggression, fire drill non-	

cooperation, driving, suicidal thoughts).

- o Person In Charge responsible, 08 Sept 2025.
- Risk assessments
- o Complete risk assessments for all identified restrictions (e.g., locked presses) to ensure proportionality and compliance with policy.
- o Person In Charge responsible, by 30 Sept 2025.

Regulation 8: Protection	Not Compliant
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Outline how you are going to come into compliance with Regulation 8: Protection:

Safeguarding/complaints log

- o Daily Safeguard/ Complaints log introduced for both units to record, track, and escalate safeguarding concerns and complaints daily.
- o Person In Charge responsible, in place from 28 August 2025.
- Reporting & escalation
- o All allegations to be reported immediately to the PIC and Management then investigated and notified to HIQA and the Safeguarding Office.
- o Person In Charge & Provider responsible, 28 August 2025.
- Support plans
- o Update residents' support plans and risk assessments to include management of allegations linked to psychiatric presentation.
- o Person In Charge & Clinical Lead responsible, by 12 Sept 2025.
- Training
- o In addition to the mandatory training on Safeguarding of Vulnerable Adults; supplemental Onsite Safeguarding Awareness training has been completed by 75-80% of the staff team with newer staff being scheduled.
- o Person In Charge 30 Oct 2025

Regulation 9: Residents' rights	Substantially Compliant
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Outline how you are going to come into compliance with Regulation 9: Residents' rights:

- Staff supervision & training
- o Supervision meetings, staff meeting and documentation/report writing training to be provided to ensure person-centred, respectful language in records and conversations.
- o Person In Charge and Management, training by 13 Oct 2025.
- Home environment awareness
- o Staff meetings to reinforce residents' rights to dignity and privacy, recognising the centre as their home.
- o Person In Charge responsible, from Aug 2025.

- Policy review (alcohol)
 - o Review no-alcohol policy with GP input to assess individual risks, tolerance, and rights. Update policy to ensure proportionality and rights-based approach.
 - o Provider & Person In Charge responsible, by 31 Oct 2025.
- Residents' rights
 - o Key-working sessions to be introduced for each resident; rights to be displayed prominently in the centre.
 - o Social Worker to support supervision and implementation of rights-based practice throughout the service.
 - o Person In Charge & Social Worker responsible, from 02 Sept 2025.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 13(2)(c)	The registered provider shall provide the following for residents; supports to develop and maintain personal relationships and links with the wider community in accordance with their wishes.	Substantially Compliant	Yellow	30/09/2025
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.	Substantially Compliant	Yellow	12/08/2025
Regulation 15(4)	The person in charge shall ensure that there is a planned and actual staff rota,	Substantially Compliant	Yellow	12/08/2025

	showing staff on duty during the day and night and that it is properly maintained.			
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	25/09/2025
Regulation 23(1)(d)	The registered provider shall ensure that there is an annual review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards.	Not Compliant	Orange	02/09/2025
Regulation 26(1)(a)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: hazard identification and assessment of risks throughout the designated centre.	Not Compliant	Orange	12/09/2025
Regulation 26(1)(c)(iii)	The registered provider shall ensure that the risk management	Substantially Compliant	Yellow	12/09/2025

	policy, referred to in paragraph 16 of Schedule 5, includes the following: the measures and actions in place to control the following specified risks: aggression and violence.			
Regulation 26(1)(c)(iv)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: the measures and actions in place to control the following specified risks: self-harm.	Substantially Compliant	Yellow	12/09/2025
Regulation 26(1)(e)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: arrangements to ensure that risk control measures are proportional to the risk identified, and that any adverse impact such measures might have on the resident's quality of life have been considered.	Substantially Compliant	Yellow	12/09/2025
Regulation 26(2)	The registered provider shall ensure that there	Substantially Compliant	Yellow	12/09/2025

	are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.			
Regulation 28(1)	The registered provider shall ensure that effective fire safety management systems are in place.	Substantially Compliant	Yellow	20/09/2025
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	21/08/2025
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.	Substantially Compliant	Yellow	20/09/2025
Regulation 28(4)(b)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, in so far as is reasonably practicable, residents, are aware of the	Substantially Compliant	Yellow	05/09/2025

	procedure to be followed in the case of fire.			
Regulation 29(4)(a)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that any medicine that is kept in the designated centre is stored securely.	Substantially Compliant	Yellow	02/09/2025
Regulation 03(2)	The registered provider shall review and, where necessary, revise the statement of purpose at intervals of not less than one year.	Substantially Compliant	Yellow	02/09/2025
Regulation 31(1)(f)	The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: any allegation, suspected or confirmed, of abuse of any resident.	Not Compliant	Orange	22/08/2025
Regulation 31(3)(a)	The person in charge shall ensure that a written report is provided to the	Substantially Compliant	Yellow	22/08/2025

	chief inspector at the end of each quarter of each calendar year in relation to and of the following incidents occurring in the designated centre: any occasion on which a restrictive procedure including physical, chemical or environmental restraint was used.			
Regulation 05(6)(a)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall be multidisciplinary.	Substantially Compliant	Yellow	30/09/2025
Regulation 05(6)(c)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall assess the effectiveness of the plan.	Substantially Compliant	Yellow	30/09/2025
Regulation 05(6)(d)	The person in charge shall ensure that the personal plan is	Substantially Compliant	Yellow	30/09/2025

	the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall take into account changes in circumstances and new developments.			
Regulation 07(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.	Substantially Compliant	Yellow	05/09/2025
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.	Substantially Compliant	Yellow	02/09/2025
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Substantially Compliant	Yellow	28/08/2025
Regulation 08(3)	The person in charge shall initiate and put in	Not Compliant	Orange	28/08/2025

	place an Investigation in relation to any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.			
Regulation 09(3)	The registered provider shall ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.	Substantially Compliant	Yellow	28/08/2025