Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	Pine Lodge
Name of provider:	Lotus Care Limited
Address of centre:	Kildare
Type of inspection:	Announced
Date of inspection:	23 June 2026
Centre ID:	OSV-0008685
Fieldwork ID:	MON-0042001

About the designated centre

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

Pine lodge provides support for up to four children aged between six and 18 years old. The provider has outlined in their statement of purpose that they can provide care and support for children with an intellectual disability and autism, attention deficit hyperactivity disorder and obsessive compulsive disorder. Pine lodge is a five bedroom house in a rural area of County Kildare. It is a short drive from a number of towns and there are three vehicles available to support children to attend school and activities of their choice in the community. There are four resident bedrooms, two of which have ensuite bathrooms. There is also a bedroom identified for sleepover staff and a staff office. There are a number of communal areas including a living room with a play area, a dining room and a large kitchen. There is a large front and back garden. Children are supported 24/7 by a staff team comprising of a person in charge, a team leader, a deputy team leader, social care workers and heatlthcare assistants.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	2

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Tuesday 23 June 2026	14:00hrs to 18:30hrs	Jennifer Deasy	Lead
Wednesday 24 June 2026	10:30hrs to 15:00hrs	Jennifer Deasy	Lead

What residents told us and what inspectors observed

This was an announced inspection scheduled to inform decision making in respect of an application to renew the centre's certificate of registration. There had been a high number of safeguarding relating incidents reported to the Chief Inspector in the service in recent months and so the inspection focused on the provider's safeguarding mechanisms, risk management systems and their governance and management arrangements. Overall, this inspection found that the provider had effective governance and management systems that were responsive to risk and were endeavouring to protect young people from harm.

The inspection took place over the course of two days. There were two young people living in the service at the time; however, both of the young people were reluctant to engage in conversation with the inspector and declined to complete a resident questionnaire. Therefore their views on the service are not reflected in this inspection report. However, one young person did tell the inspector that they liked the staff team and they were seen to be comfortable and relaxed in their home and in the presence of staff. The inspector did not meet with the second young person as they declined to engage with the inspector.

The inspector spoke with three staff members in detail, one guardian ad litem, a social worker and a parent over the course of the inspection. Conversations with these staff members and representatives highlighted the complex needs of the young people living in the service and the challenges that the staff team faced in endeavouring to ensure these needs are met, while also safeguarding young people from potential risks.

Representatives stated that they felt that the staff team were doing their best; however, it was difficult to engage young people in order to support their development and promote their wellbeing, for example in pursing further education or in attending medical appointments. Representatives spoke positively of the support that the staff team offered young people, through respecting their decisions, continuing to make further medical appointments if they were declined or in supporting young people to engage in education programmes in line with their interests, such as completing the driver theory test.

Staff members and representatives spoke of how they took a low arousal approach, respecting the wishes of the young people and endeavouring to uphold young people's autonomy even when restrictive practices were required for safety. The inspector saw, over the course of the two days, that the staff team communicated in a calm manner with the young people and that the routines of the centre were adjusted in line with the young people's preferences.

However, it had been recently determined by the provider, that the placement was no longer suitable to meet one young person's needs and that an alternative

placement was required. The provider was working with the young person's representatives to inform a transition and discharge plan at the time of inspection. The second young person was due to transition to aftercare as they were turning 18 in the coming months. This aftercare plan was in progress at the time of inspection.

The premises of the centre was seen to be large, homely and well-maintained. Each young person had their own en-suite bedroom which was decorated in line with their preferences. They also had access to plenty of communal spaces including a kitchen and sitting room. There was little personalised décor in the centre, such as photographs of the young people, as this was their preference.

The next two sections of the report will describe the governance and management arrangements of the centre and how effective they were in ensuring the quality and safety of care.

Capacity and capability

This section of the report describes the governance and management arrangements of the centre. This inspection found that there were effective leadership arrangements and that there were information governance arrangements to ensure that the residential service was complying with Regulations and to support the delivery of effective services to the young people living there. The centre was suitably resourced and staff members had access to suitable training and were performance-managed. There was one area for improvement noted in respect of validating one staff member's qualifications.

There were clearly defined governance structures in the centre that set out lines of authority and accountability. Leadership was demonstrated by the managers of the centre and they had ensured that there were sufficient resources directed to the service to ensure the care and welfare of the young people living there. Information governance arrangements were in place to assess, evaluate and improve the provision of services.

There was a statement of purpose which clearly described the model of service provision and the supports provided for within the service.

Garda Siochana vetting was carried out on all staff and references were checked to ensure that the staff working there were suitable to work with young people. The inspector saw, on reviewing staff records, that one staff member's qualifications required validating.

Orientation and induction training was provided to all staff when they started working there and staff had access to an ongoing programme of professional development to ensure they had the necessary skills and competencies to support

the young people in their care.Staff members were supervised and their performance was appraised on an ongoing basis.

Regulation 14: Persons in charge

The designated centre was overseen by a full-time person in charge. They were employed in a supernumerary position and had oversight of another designated centre. They were supported in their role by the appointment of a team leader and deputy team leaders in the designated centres. The person in charge understood the needs of the young people and the service, and demonstrated a commitment to ensuring ongoing service improvement.

Judgment: Compliant

Regulation 15: Staffing

The inspector reviewed the rosters of the centre from December 2025 to June 2026. It was seen that there was continuity of care provided to the young people living there, with very few changes to the staff team within those months. There was very low reliance on agency staff with gaps in the roster often filled by relief staff from other of the provider's designated centres.

Each of the young people was supported by two staff during the day, and there were three staff on duty by night. The rosters showed that these staffing levels were maintained. Across eight dates explored from February 2026 to June 2026, staffing levels were appropriate and suitable to meet the needs of the young people.

The inspector reviewed the Schedule 2 files for all staff working in the centre. All 15 staff files reviewed showed that these staff had an up-to-date Garda vetting disclosure on file. Eight staff files were reviewed in more detail and were seen to contain the documents as required by the Regulations including, for example, two validated references, copies of qualifications and photographic identification.

However, the inspector found that the qualifications for one staff member had not been verified and validated by the associated regulatory authority. This required review by the provider.

Judgment: Substantially compliant

Regulation 16: Training and staff development

There was a high level of compliance with mandatory training; for example, all staff were up-to-date with training in fire safety, crisis prevention interventions, safeguarding and children first. Staff members has also completed additional training in areas relevant to the young people's needs, including intellectual disability, human rights, trauma informed care and autism awareness.

Staff members were supervised and performance managed. Each staff member received one to one supervision on a regular basis. Monthly team meetings were also held with keep the staff team informed of any updates to service needs, restrictive practices, risks or training needs.

Two staff members spoken with told the inspector that they felt supported in their roles. They were aware of the management arrangements and of how to escalate concerns or risks through the management systems. Staff members were informed of the local operating procedures and protocols in respect of known risks.

Judgment: Compliant

Regulation 22: Insurance

A certificate of insurance was submitted as part of the provider's application to renew the centre's certificate of registration. This demonstrated that the provider had effected a contract of insurance against injury to young people living in the centre.

Judgment: Compliant

Regulation 23: Governance and management

There were clearly defined management systems in the centre with lines of authority and accountability. The staff team reported to two team leaders on a day to day basis who, in turn, reported to the person in charge. The staff team were informed of the reporting arrangements and of how to escalate any concerns through the management systems.

There were a suite of local and provider level audits to monitor compliance with the regulations and to ensure the timely identification and response to any risks to the quality or safety of the service. Locally, weekly health and safety checks were completed along with a review of accidents or adverse incidents. The person in charge completed a monthly audit which reviewed risks, safeguarding issues, staffing levels or changes to health and social care needs. The person in charge also compiled a monthly governance report. The records of these reports from February, May and June 2026 were reviewed. These reports were comprehensive and

documented presenting risks or needs, such as the need to commence aftercare planning, to review staff training requirements or restrictive practices. Action plans were implemented in response to those needs and risks identified.

The provider level audits included six monthly unannounced visits to review the quality and safety of care, along with an annual review of the service. These audits were completed in consultation with the young people and reflected their views on the service. The six monthly audits were comprehensive and clearly identified actions required to bring the service into compliance. The inspector saw that actions were progressed across these audits, which showed that they were an effective tool in driving service improvement.

The provider had enhanced their oversight of the service in response to recent safeguarding risks. There were regular documented meetings with relevant senior managers including, for example, the director of services and the director of quality. The records of these meetings showed the provider's response to serious adverse incidents and detailed actions to be taken, including, for example, implementing provider policies and liaising with relevant representatives of the young people and other statutory bodies, where required.

Judgment: Compliant

Regulation 3: Statement of purpose

A statement of purpose was maintained in the centre. This was reviewed by the inspector. There were minor amendments required to the staffing whole time equivalents and to the information on the specific care needs that the centre was intending to meet. These changes were made over the course of the inspection

Judgment: Compliant

Quality and safety

This section of the report describes the quality of the service and how safe it was for the young people who lived there. Overall, this inspection found that young people were living in a homely, clean environment and that there were suitable risk management procedures in place to protect them from harm while they were in the centre and in the care of the staff team. However, one young person presented with behaviours of concern which posed a serious risk to their well-being and to the well-being of others. Due to these risks, the provider had determined that the placement

was no longer suitable to meet their needs and was engaging with representatives to support the discharge of this young person to another service.

The premises of the designated centre was homely and promoted the privacy and dignity of each young person. Each young person had their own bedroom with en-suite bathroom. Additional environmental restrictive practices had been implemented for one young person due to known serious risks; however, the inspector saw, and was told, that these were implemented in a manner which upheld the autonomy of the young person as best as possible.

Young people were provided with care which supported their emotional wellbeing. There was a positive approach to behaviour support and the inspector saw that staff communication with young people was respectful. However, improvements were required to one behaviour support plan to ensure that staff had consistent guidance on how to respond to one behaviour of concern. Additionally a review of one restrictive practice was required to ensure it was the least restrictive possible.

Regulation 17: Premises

The designated centre was homely, clean and well-maintained. It provided each young person with their own bedroom which had an en-suite bathroom. Their bedrooms were decorated in line with their preferences and had sufficient storage for young people's possessions. Young people had access to a large kitchen, a sitting room and a dining room. The centre also had a large garden for recreation.

All areas of the centre were clean and were homely. The furniture and fittings were well-maintained and were comfortable.

Judgment: Compliant

Regulation 26: Risk management procedures

There was a comprehensive centre risk register which detailed the risks presenting in the centre and the control measures to mitigate against these. There were a number of high (red-rated) risks, due to the behaviours of one young person with complex needs. Due to these risks, a number of restrictive practices had been implemented including environmental and personal checks. The staff team told the inspector of how they complete these in a manner which respects the young person's wishes and autonomy.

There were also a number of moderate (orange-rated) risks again due to the behaviours and assessed needs of one young person. The controls included

additional environmental restrictive practices and the provision of personal protective equipment to staff.

The inspector saw that control measures were proportionate to the risk identified. Control measures were implemented and staff members were informed of these. Standard operating procedures were also devised for particularly high risks to ensure that staff were fully informed of the procedures to be followed.

Judgment: Compliant

Regulation 7: Positive behavioural support

The young people in the centre presented with assessed needs in behaviour support. All of the staff team had received training in crisis prevention interventions. The inspector reviewed the file of one young person, in particular, and saw that there was a behaviour support plan on file which detailed proactive and reactive strategies to assist staff in preventing and responding to behaviours of concern. However, the inspector found that the reactive strategies required review as there was contradictory information given in respect of the function of absconscion behaviours and how staff should respond.

There were a number of restrictive practices in place in the centre. These were logged and reviewed regularly. There was a clear rationale for the majority of the restrictive practices, and a restrictive practices passport was in place, to explain to young people the rationale for these. However, the inspector queried the rationale behind restricted access to all cutlery and was not assured that this was the least restrictive practice required or that it was warranted or effective. The kitchen's cutlery drawer did not have any cutlery in it; however, the inspector observed that used cutlery was stored in the dishwasher in the kitchen which could be easily accessed and therefore warranted the restrictive practice ineffective. This required review by the provider.

Judgment: Substantially compliant

Regulation 8: Protection

There had been a high number of safeguarding concerns reported to the Chief Inspector in respect of this centre in the weeks preceding the inspection. The inspector reviewed the records of these safeguarding incidents, and the provider's response and investigations into them. The inspector found that each safeguarding incident had been reported to the relevant statutory authorities and to the young

person's representatives. The provider had demonstrated effective communication with important representatives in respect of these incidents.

Staff members spoken with demonstrated a comprehensive understanding of the safeguarding plans which had been implemented in respect of these incidents. The staff team described to the inspector the procedures to be followed in respect of a similar safeguarding concern arising. Staff members spoken with were clearly informed of their responsibilities in keeping the young people safe from harm. However, staff members expressed concerns for one young person in particular, and the potential for this young person to be harmed. The inspector saw that the provider's admissions, discharge and transition meeting had met in June 2026 and had agreed that the service was unable to meet this young person's needs and a decision had been made to issue a notice of discharge.

Safeguarding plans had been implemented to assist the staff team in protecting young people from abuse. The person in charge had also implemented a centre specific safeguarding plan which detailed the reporting procedures, tracked safeguarding incidents and detailed preventive strategies implemented at organisation level and service level.

There were mechanisms in place to provide education to young people in order to enable them to protect themselves from abuse; for example, the keyworking notes for both young people were reviewed and it was seen that individualised education was provided to each young person in respect of risks such as vaping, sexual relationships, the dangers of online gaming and transitioning to aftercare.However, the effectiveness of these interventions could not be determined as it was documented that young people regularly chose not to engage in conversations on these topics.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Compliant
Regulation 3: Statement of purpose	Compliant
Quality and safety	
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Compliant

Compliance Plan for Pine Lodge OSV-0008685

Inspection ID: MON-0042001

Date of inspection: 24/06/2026

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: A comprehensive review of all current staff personnel files has been undertaken to ensure that qualifications requiring validation are appropriately verified and clearly documented. The recruitment and onboarding checklist has been revised to incorporate a mandatory qualification verification step, to be completed prior to a staff member commencing employment or, where applicable, prior to confirmation of appointment. Verification of the individual staff member's qualification is currently in progress with the relevant regulatory/awarding body. Upon completion, formal evidence of validation will be retained on the staff member's personnel file in line with regulatory requirements. As of the 13.07.2026 the staff member's qualification has been validated with the awarding body, and this action is now closed. Action Completion Date: 13/07/2026	
Regulation 7: Positive behavioural support	Substantially Compliant
Outline how you are going to come into compliance with Regulation 7: Positive behavioural support: The Behaviour Support Plan for the identified young person is currently under review and being updated by the Behaviour Support Specialist to ensure that all proactive and reactive strategies are clearly defined, consistent, and aligned with the assessed function of the behaviours of concern.	

The previously implemented restrictive practice relating to access to cutlery has been formally reviewed and discontinued. In addition, all restrictive practices in place within the designated centre have undergone further review to ensure they are effective, proportionate, represent the least restrictive option, and are supported by clear, documented rationale and decision-making processes in line with best practice and regulatory requirements.

Action Completion Date: 31/07/2026

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(5)	The person in charge shall ensure that he or she has obtained in respect of all staff the information and documents specified in Schedule 2.	Substantially Compliant	Yellow	13/07/2026
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	31/07/2026
Regulation 07(5)(c)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under	Substantially Compliant	Yellow	31/07/2026

	this Regulation the least restrictive procedure, for the shortest duration necessary, is used.			