Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	Coolamber House
Name of provider:	St Hilda's Services
Address of centre:	Westmeath
Type of inspection:	Announced
Date of inspection:	07 October 2025
Centre ID:	OSV-0001836
Fieldwork ID:	MON-0039855

About the designated centre

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

The statement of purpose for the centre outlines that this seven day full-time residential community house provides a home for three adults, male and female with moderate intellectual disability, behaviours that challenge and dementia. There is one-to-one staff support provided and two staff available at night-time. Nursing oversight is available within the organisation. The premises is a two-storey detached house, on its own grounds, and comprises a communal kitchen, living room and laundry room. There is one self-contained apartment located in the centre consisting of a large bedroom, en-suite facilities and living room. The second resident's bedroom consists of a large bedroom and en-suite facilities. The third resident's bedroom and separate bathroom are located in the main part of the centre. There is one staff bedroom and one separate office space. The centre is located in large town within easy access to all services and amenities.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	3

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 7 October 2025	11:15hrs to 18:30hrs	Karena Butler	Lead
Wednesday 8 October 2025	09:40hrs to 12:45hrs	Karena Butler	Lead

What residents told us and what inspectors observed

This announced inspection was carried out over two days as part of a group inspection of six designated centres operated by this provider. Each centre was inspected independently and findings will be reported under each centre; however, complaints, policies and procedures, and staff recruitment were reviewed centrally in the provider's main offices.

While in the main good practice was observed and residents enjoyed a good quality of life, some improvements were required particularly in relation to governance and oversight, care planning, and the quality of audits carried out by the provider. Other improvements required related to staff training, staff rosters, and notifications. These matters will be further discussed later in this report.

19 regulations were reviewed during the inspection. Six regulations were identified as requiring improvement, of which four regulations were found to be non-compliant. The non-compliant regulations were: Regulation 5: Individual assessment and personal plan, Regulation 16: training and staff development, Regulation 23: Governance and Management, and Regulation 32: Notification of periods when the person in charge is absent. Two regulations were found to be substantially compliant, Regulation 15: Staffing, and Regulation 31: Notification of incidents.

The inspector had the opportunity to meet and observe the three residents that were living in the centre. One resident for the most part had alternative communication methods and did not share their views with the inspector other than to answer "yes" when asked if the staff were nice. They were instead observed at different times throughout the course of the inspection in their home. They appeared content and comfortable in the presence of the staff on duty.

The inspector had the opportunity to speak with the four staff on duty, and the person in charge. Staff were observed to be person-centred, kind and gentle in their interactions with the residents. They demonstrated they were aware of support requirements for the residents.

The provider had arranged for staff to have training in human rights. A staff member spoken with explained how they had put that training into every day practice. They communicated that they felt the training had cemented what they already knew and believed that everyone should be treated equally and with respect. That residents should have daily choices, for example how they would like to start their day or how to spend their money.

The inspector had the opportunity to speak with a family representative for each resident on day one of this inspection. Feedback was very positive. All three family representatives felt welcome to visit the centre. One representative raised some concerns that their family member was spending a lot of their money on things they felt they didn't need and they were not always eating as healthy as they should

leading to weight gain. They were being facilitated to look into getting a capacity assessment completed with regard to finances for their family member. They communicated that staff were encouraging the resident to budget, make healthy choices, and providing educational information.

As part of this inspection process residents' views were sought through questionnaires provided by the office of The Chief Inspector of Social Services (The Chief Inspector). Feedback from two questionnaires was returned directly by the residents. One was completed by a family representative who completed the questionnaire on behalf of their family member. Feedback was mostly positive about the service and care provided. One resident communicated to the inspector in person that the reason they had marked some questions as 'could be better' or they weren't happy was due to the fact that they wanted to live with their parents or very close to their parents. The provider was trying to facilitate this request and this will be discussed under regulation 9: Rights.

Another resident answered they were happy with many aspects. For example, they felt staff knew what their preferences and that they were afforded time to make calls in private. They communicated to the inspector when elaborating on their answers that they would like more space from their support staff when out in the community. They confirmed that they had not brought this to the attention of the person in charge before. The inspector discussed this with the person in charge and they confirmed that they would explore this with the resident. The resident said they were happy with this outcome.

The inspector observed the centre to be clean and tidy. Both sitting rooms had a television for use as well as each bedroom. Each resident had their own bedroom and they were decorated and laid out in line with their preferences. For example, one resident had pictures of their favourite football club. The residents had personal pictures displayed in different parts of their home. One resident communicated to the inspector that they would like a new sofa and coffee table for their personal sitting room. They also said they would like to have the size of the hearth of their fireplaces in their sitting room and bedroom reduced. They explained they sometimes banged their feet off them. They communicated that they had not raised these identified areas for improvement to the person in charge. The inspector discussed this with the person in charge who confirmed that they would explore the resident's wishes with regard to those areas.

There was a large front and back garden accessible to the residents. The back garden had a table and seating for use to relax in times of good weather.

At the time of this inspection there were no visiting restrictions in place. The person in charge confirmed there were no volunteers used in the centre. At the time of this inspection there were no vacancies and no recent admissions. There were no complaints received in 2025.

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

Capacity and capability

This inspection was undertaken as part of the provider's application to renew the centre's registration. This centre was last inspected in March 2024. The findings of this inspection indicated that while the provider, person in charge, and staff team have the capability to deliver good quality, person-centred care, there were significant deficits in the provider's overarching systems for governance and oversight.

The inspector found that the management systems in place were not sufficiently robust to ensure consistent compliance.

This was evident in several key areas:

- auditing systems were not effective at identifying or resolving known, recurring issues, particularly in staff training, and care planning
- some oversight systems were not effective during periods when the person in charge was absent, which meant key functions like regulatory notifications and team meetings were not consistently completed
- record-keeping practices were inconsistent, with staff rosters not accurately reflecting a number of shifts worked.

The provider had ensured the Schedule 5 policies were in place as required, that the centre was appropriately insured, and had a statement of purpose in place, that was reviewed and updated on a regular basis as required by the S.I. No. 367/2013 - Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (the regulations).

However, the systemic weaknesses identified in auditing and oversight demonstrate a need for significant improvement in the provider's capacity to effectively monitor and manage the service.

Registration Regulation 5: Application for registration or renewal of registration

As required by the registration regulations, the provider had submitted an application to renew the registration of the centre along with the required prescribed documents. For example, the provider had arranged for a revised statement of purpose, and floor plans to be submitted for review.

Judgment: Compliant

Regulation 15: Staffing

The provider was found to be substantially compliant with this regulation. The inspector found that the staffing arrangements in the centre were sufficient in meeting residents' assessed needs. However, improvements were required in how the staff rosters were maintained as they were found not to be an accurate representation of what occurred.

The inspector reviewed the rosters for September and October 2025. There were planned and actual rosters in place as required. Since approximately August 2025 an additional staff sleepover shift each night had commenced in addition to the waking night duty. However, this sleepover shift was not recorded on the rosters reviewed. In addition, five waking night shifts in September and three in October were not recorded on the roster. Subsequent to the inspection, the person in charge confirmed verbally that she had contacted all staff and was able to confirm that all shifts had been worked or scheduled as required. They communicated that the issue had been a documentation issue and confirmed there were no shifts due to be covered.

The inspector noted that while the rosters had presented with many gaps and improvements were required as to how they were being maintained, the identified issues had not posed a risk to the residents at the time of this inspection. However, the system for overseeing rosters required improvement, as it was not sufficiently robust to ensure they were consistently and accurately maintained.

There was a full staffing complement in place which facilitated consistency and continuity of care. The staff on duty on the day of the inspection were observed to be caring and respectful towards the residents. For example, a staff member was observed encouraging a resident to open a food item themselves in order to promote their independence. They reminded the resident that they were present if they required help.

Three staff personnel files were reviewed centrally as part of this inspection. The reviews confirmed the provider's arrangements for safe recruitment practices.

Judgment: Substantially compliant

Regulation 16: Training and staff development

This regulation was found to be not compliant. It was not evident to the inspector, if any formal recorded audits were in place to monitor staff training needs. Therefore, the inspector was not assured that there was appropriate oversight to ensure that adequate training levels were maintained in order to meet residents' needs.

While there was a training matrix in place for the online training that staff were

expected to do, the inspector found that, one staff working in the centre since December 2024 was not included on this matrix. Therefore, it would be difficult for management to have oversight over their training needs and ensure they had the appropriate training to meet the needs of residents.

In addition, the matrix was highlighted red in a number of places, meaning training was not in place or had expired with no date recorded for when this training may have expired. In other cases, the matrix had a date recorded that some staff training had expired.

Examples of training on the matrix that had expired or highlighted red with no date:

- three staff with regard to standard and transmission based precautions
- two staff with regard to cough etiquette and respiratory hygiene
- two staff with regard to hand hygiene, and this training had also been identified as required in the previous inspection
- two staff with regard to personal protective equipment (PPE)
- one staff with regard to children first safeguarding training.

One of the staff mentioned above as requiring hand hygiene, had commenced working in the centre in September 2025 with no evidence having completed hand hygiene training. Their 'basics in infection prevention and control' (IPC) training had expired in November 2024, prior to them commencing their role. In the absence of staff having those trainings, this increased the residents' risk of contracting a healthcare related illness.

The person in charge confirmed that there was a training matrix for in-person training completed; however, this was not made available to the inspector despite it being requested. In the absence of this matrix, the inspector reviewed the certification for 11 trainings. In the case of three trainings, safeguarding of vulnerable adults, epilepsy awareness and buccal (rescue medication) administration, and fire safety, all training certificates were evident.

With regard to the remaining eight trainings, the inspector could not find all staff members' certificates. For example, the inspector found evidence of half of the staff teams' certificates for basics first aid/cardiac first response. In relation to training related to behaviour support, the inspector found evidence of three staff certificates and the remaining seven were not present in the folder.

Staff had received additional training to support residents. For example, staff had received training in human rights. Further details on this have been included in 'what residents told us and what inspectors observed' section of the report.

From speaking with the person in charge and a staff member, they confirmed to the inspector that supervision was occurring as required and that it was an opportunity to raise concerns if any. However, from a review of four staff supervision records and from speaking with the person in charge, no staff member had received their two formal supervisions in 2024 as prescribed by the provider. This was partly due to the absence of the person in charge for an extended period. This demonstrated to the inspector that the systems in place for ensuring appropriate oversight in the

absence of the person in charge were not effective.

Judgment: Not compliant

Regulation 22: Insurance

As per the requirements of the regulations, the provider had ensured that the centre was adequately insured against risks to residents and evidence of the insurance was submitted to the Chief Inspector.

Judgment: Compliant

Regulation 23: Governance and management

This regulation was found to be not compliant. The inspector found that a number of improvements were required to the governance and management systems in place at the time of this inspection. The key issues related to the effectiveness of the provider's auditing and oversight systems and the lack of robust oversight when the person in charge was absent.

The provider's auditing systems were not operating effectively. Audits were completed as required, including an annual review in 2024 and six-monthly provider visits in November 2024 and May 2025. However, the inspector found that audits were not sufficiently robust. They failed to identify the significant shortfalls in staff training and care planning found during this inspection. For example, one audit identified that care plans needed 'updating' but provided this only as an action at the end of the report, with no detail in the main body about what aspects were reviewed or required improvement.

Furthermore, staff training has been an issue in four of the last five inspections, yet the provider's audits of this area remained vague and lacked the detail required to track and ensure compliance.

The inspector also observed some delays in completing identified actions in the provider's own audits, such as sourcing external advocacy for residents which was due for completion by January 2025. Another identified action was the provider's admissions policy required review and this was found to have been completed six months after it was first identified.

The inspector found that the oversight systems for periods when the person in charge was absent were not always effective. This was clearly demonstrated by the repeated failure to submit required statutory notifications on time, a systemic weakness detailed under Regulation 31: Notifications. Additionally, routine team meetings, which normally occurred monthly, did not take place during the person in

charge's absence in January and February 2025. This demonstrated that key aspects of the centre's oversight and team supervision were not being maintained, which had the potential to create a risk to consistency and staff knowledge.

While staff spoken with felt comfortable raising concerns with the person in charge, these systemic failures identified by the inspector demonstrate that the overall governance and management structure requires significant improvement to ensure consistent oversight and safety.

Judgment: Not compliant

Regulation 3: Statement of purpose

The provider prepared a statement of purpose which was up to date, accurately described the service provided and contained all of the information as required by Schedule 1.

For example, it contained information on the facilities and services provided in the centre.

Judgment: Compliant

Regulation 31: Notification of incidents

The provider was found to be substantially compliant with this regulation. The provider had not ensured that a written report was provided to the Chief Inspector within the prescribed time frame at the end of each quarter of each calendar year in relation to all occasions on which a restrictive procedure was used.

The inspector notes previously identified issues with the timely submission of these notifications, during the previous registration cycle. In May 2023, assurances were sought and received that the systems for notification had been strengthened. However, it was found that this issue has reoccurred, with the required notifications for quarter one and quarter four of 2024 not being submitted within the prescribed time frames. While these notification were now submitted, they were not submitted until brought to the attention of the person in charge. For both of those identified quarters, the person in charge had been on two separate absences, highlighting that the provider's systems continue to require improvement during such periods.

Those identified issues demonstrate to the inspector that further improvements were required to the arrangements in place for submission of notifications. This was to ensure that notifications would be submitted as required and within time frames prescribed.

This was further actioned under Regulation 23: Governance and management, due to this being a systematic governance issue.

Judgment: Substantially compliant

Regulation 32: Notification of periods when the person in charge is absent

The provider had not notified the office of Chief Inspector on every occasion in which the person in charge was absent for more than 28 days.

Due to unforeseen circumstances, the person in charge was absent for more than 28 days in quarter one of 2025 and this was not notified as per the requirements of this regulation. The provider had notified the Chief Inspector as required, when the person in charge was absent in 2024.

Judgment: Not compliant

Regulation 4: Written policies and procedures

The provider had prepared in writing, adopted, and implemented all of the policies set out in Schedule 5 of the regulations. In addition, they were all reviewed within the last three years.

Judgment: Compliant

Quality and safety

Overall, this inspection found that the residents living in this service were supported in line with their assessed needs. However, improvements were required with regard to individualised assessment and personal plans to ensure all pertinent information was contained to order to appropriately guide staff and in turn ensure that residents would be supported as per their support requirements. In addition, improvement was required to ensure all recommendations from professionals involved in the residents' care, were followed through on.

There were adequate systems in place to meet the requirements of the regulations associated with: positive behaviour support, communication, and general welfare and development. For example, residents had recorded guidance for staff on how to facilitate communication. They had access to opportunities for recreation and education. Residents had positive behaviour support plans in place as required to

guide staff as to how best to support them should they be experiencing periods of distress.

There were suitable arrangements in place to ensure residents were safeguarded. For example, staff were suitably trained to recognise and escalate any safeguarding concerns.

The inspector observed the premises to be clean and tidy which also facilitated in the arrangements for good infection prevention and control (IPC).

There were suitable risk management and fire safety management systems in place, such as periodic fire practice drills. This was in order to ensure that the residents would be familiar and comfortable in how to evacuate safely in the event of an emergency. There were risk assessments completed for identified risks with controls measures in place to minimise potential impact of the risk. For example, with regard to a resident mobility and their risk a falls. A control measure was to ensure the stairs were highlighted.

In addition, There was a residents' guide that contained the required information as set out in the regulations.

Regulation 10: Communication

Communication was facilitated for residents in accordance with their needs and preferences.

From a review of the three residents' files they had documented communication guidance in order to support staff to better understand and facilitate communication in a manner suitable for the residents. For example, information on communication to guide staff was included in the assessment of need document, as well as behaviour support plans. One resident had specific communication guidelines drawn up to support staff to effectively communicate with them as they had dementia.

The inspector observed there were visuals available in the centre to aid residents' understanding and promote choice of their daily routine, such as pictures of food options. One resident's bedroom had visuals on different drawers and wardrobe doors to demonstrate to the resident where they could find different clothing items.

The inspector observed some easy-to-read documents to help support residents' understanding of section topics. For example, on the assisted decision making act, and information along with visuals of what a resident's medication was for.

In addition, the provider had arranged for the majority of staff members to receive training in communicating with people with an intellectual disability.

The inspector also observed that residents had access to radio, televisions and the Internet while in the centre which would further support their communication and

facilitate compliance with this regulation.

There were communication support plans in place for each resident. A clinical psychologist provided communication guidelines for staff to support one resident with a particular diagnosis.

Judgment: Compliant

Regulation 13: General welfare and development

Residents had access to opportunities for leisure and recreation. Residents engaged in activities of interest in their home and community and were supported to maintain relationships with family. Family representatives spoken with felt welcome to visit the centre and residents regularly were supported to visit their family members. Residents attended day trips or holidays with their family and one resident was due to go on holidays with their family.

The inspector found that residents were facilitated to complete educational courses to improve their knowledge or skills in certain areas. For example, one resident completed a manual handling course in June 2025, they also completed a course across several months from September 2024 to June 2025 on work skills, literacy, and computer skills.

From a review of the two residents' activity logs from September 2025, the inspector observed that residents were participating in activities that interested them. Ranging from going for food out, meeting up with friends, shopping, dance classes, and going for walks. Two residents confirmed that they get offered choice in relation to their activities.

One family representative communicated to the inspector that their family member was 'always encouraged to go out and about'. That staff encouraged and supported the resident to do what they were able for given their health diagnoses and stated "which is exactly what's needed".

Judgment: Compliant

Regulation 17: Premises

The layout and design of the premises was appropriate to meet residents' needs. The premises was found for the most part to be in a state of good repair. Any identified issues found with regard to the premises on this inspection were either fixed on day one or within the days following the inspection with evidence submitted post inspection.

The facilities of Schedule 6 of the regulations were available for residents' use. For example, there was access to cooking and laundry facilities.

There were facilities in place to support hand hygiene, such as hand wash and disposable towels in the staff bathroom, and residents had individual towels for their own bathrooms. There was a colour coded system in place for the cleaning of the centre to minimise the chances of residents receiving a healthcare related illness. For example, there were colour coded mops and buckets in place and they were found to be stored in a manner that would facilitate adequate drying of the equipment.

Each resident had their own bedroom with for the most part sufficient space for their belongings. One resident's bedroom required more storage as a number of items were stored piled on top of one another on the ground. Additional storage was purchased within days of the inspection and due to be delivered in the week following the inspection. This would mean that all residents would then had sufficient storage.

Bedrooms were observed to be individually decorated or set out to suit their preferences or needs. For example, one resident had displayed items related to their favourite football club.

There were some areas requiring attention, for example a radiator and a toilet roll holder in a resident's bathroom were rusty in parts and areas in another resident's en-suite required minor holes to be filled in order to ensure the areas could be cleaned effectively. The main sitting room required one wall to be painted and a small hole to be filled on another wall. The person in charge committed on the day of the inspection to having those areas rectified and these issues were attended to and evidence of the works completed was submitted post inspection.

Judgment: Compliant

Regulation 20: Information for residents

There was a residents' guide that contained the required information as set out in the regulations. For example, it described how to access inspection reports.

Judgment: Compliant

Regulation 26: Risk management procedures

There were systems in place to manage and mitigate risk and keep residents safe in the centre. For example, there was a policy on risk management available last reviewed in May 2023 in addition there was a health and safety statement in place

last reviewed in January 2025.

Each resident had a number of individual risk assessments on file so as to support their overall safety and wellbeing. For example, where a resident may be at risk of falling due to their mobility, they were previously assessed by an occupational therapist (OT) in 2022 and another referral was submitted for the OT to review the individual due to a decline in their health. Other examples, of risk assessments related to residents' road safety. Control measures in place were staff supports on community outings and reminding the resident to wait for the lights prior to crossing the road.

The inspector reviewed incidents that had occurred in the centre since January 2025 and they were being discussed at team meetings for shared learning with the staff team. For example, after a number of medication errors occurring in the centre, the clinical lead for the organisation met with the staff team, at their August 2025 meeting, to discuss the importance of the ten rights of medication management, and to remind staff to always double check medication prior to administration.

On review of other arrangements in place to meet the requirements of this regulation, the inspector observed that the oil boiler had received an annual service in September 2025.

Judgment: Compliant

Regulation 28: Fire precautions

There were suitable fire safety management systems in place, including detection and alert systems, emergency lighting and firefighting equipment, each of which was regularly serviced. Staff had received training in fire safety.

From a review all three residents' personal emergency evacuation plans (PEEPs) it demonstrated to the inspector that there were fire evacuation plans in place for residents in order to guide staff as to evacuation supports required in the event of an emergency. Periodic fire drills were completed in order to assure the provider that residents could be safely evacuated from the building at all times. From a review of five drill records, the inspector found that:

alternative doors were being used for evacuation as part of the practice drills in order to assure the provider that residents could be evacuated from all areas of the building if required
a drill was completed during hours of darkness with maximum residents and minimum staffing participating.
Two fire containment doors were found to not close by themselves. However, the person in charge arranged for an electrician to be called to the centre, on day one of this inspection, to review and fix the doors were required. All doors were observed to have self-closing devices fitted and observed then to close fully. This would help

prevent the spread of fire throughout the centre in the case of an emergency.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

This regulation was found to be not compliant. The inspector found that while residents were receiving care, for the most part in line with assessed needs or recommendations, support and personal plans required significant review. While all residents had up-to-date assessments of need, the personal support plans developed from these assessments were found to have significant deficits.

The inspector identified three key areas that required improvement:

- care and support plans were incomplete and had the potential for care not to be provided in line with the residents' assessed needs
- documented recommendations were not always being implemented
- residents' personal goals were not being effectively progressed.

With regard to incomplete care and support plans, the inspector found that plans that lacked critical information needed to guide staff and ensure residents' safety.

For example:

- one resident’s epilepsy plan was fragmented across several documents without always clear cross-referencing, creating a risk that information could be missed. The plan failed to specify the type of seizures the resident may experience. Furthermore, their emergency medication protocol was last reviewed in February 2024, despite being directed on the plan that the plan required a six-monthly review by a general practitioner (GP) or neurologist. The resident's hospital passport also lacked essential seizure information only stating that the resident had epilepsy and not specifying the type of seizures or the fact the resident was prescribed an emergency epilepsy medication. Together, these gaps placed the resident at risk of not receiving appropriate care during a medical even
- another resident's bowel care plan failed to guide staff that the resident required daily medication for this issue
- a care plan for type 2 diabetes did not state whether the resident's blood sugar should be tested by the resident or staff, what their normal ranges were, or the signs of high or low blood sugar for staff to monitor.

The inspector found instances where clear recommendations contained within the provider's own devised plan as well as some from professionals, were not being followed in practice.

They related to:

- two residents' intimate care plans explicitly stated the requirement the use of non-slip mats in the shower to mitigate a potential falls risk. However, no mats were available in the centre, increasing the residents' risk of falls. While this was rectified by management during the inspection, it raised concerns about the provider's adherence to its own control measures to manage risk
- a resident's plan contained two specific recommendations from a behaviour specialist, a memory book and a daily visual schedule designed to help them to plan and understand their day in order to reduce potential anxiety. Neither of these supports had been fully put in place, meaning the resident was not receiving all the recommended support to prevent potential distress.
- while the inspector found that residents were supported to set personal goals, there was a lack of evidence to show how all goals were being actively progressed. For example, one resident wished to gain work experience in a car dealership, but the documentation showed no clear actions or progress towards supporting this goal. The person in charge confirmed that the information the inspector reviewed regarding the resident's goals was not up-to-date.

While staff spoken with were verbally familiar with residents' needs, the quality of the written plans was not sufficient to ensure safe, consistent, and person-centred care. The documentation failed to provide a reliable and comprehensive guide for all staff, particularly regarding critical health needs and risk management.

Judgment: Not compliant

Regulation 7: Positive behavioural support

Residents were supported to experience best possible mental health. They had access, where required, to the support of allied health professionals, for example a psychiatrist or behaviour therapist.

From a review of the two residents' files, the inspector observed that where required, residents had a positive behavioural support plan in place which was reviewed within the last year by a behaviour specialist to ensure information was still relevant. This in turn ensured that the residents were receiving up-to-date appropriate supports.

Behaviour Support plans were found to outline strategies that staff needed to follow to support the residents in times of distress.

For example:

- proactive responses staff could engage in with the resident
- responses to when the resident is becoming anxious or experiencing behaviour that may cause distress to themselves or others
- the response to be taken and what it may look like when the resident is

returning to baseline, for example 're-engage like nothing had happened'.

Staff were familiar with how to support residents during times of distress. However, the person in charge had not ensured that some recommendations from behaviour support plans were not being followed through in the centre. This was actioned under Regulation 5: Individual assessment and personal plan.

There were some restrictive practices were in place, such as each resident had a locked kitchen press for storage of food items specifically for them in order for other residents to not access them. From a review of two residents' files, both individuals had consented to this practice. Restrictive practices were periodically reviewed by the person in charge.

Judgment: Compliant

Regulation 8: Protection

There were suitable arrangements in place to protect the residents from the risk of abuse. For example:

- there was an organisational safeguarding policy in place which was last reviewed February 2023
- the inspector reviewed the certification for ten staff, this review demonstrated that staff had received training in safeguarding vulnerable adults
- there was a reporting system in place with a designated officer (DO) nominated for the organisation
- two staff spoken with were able to identify who the DO was to the inspector, and the identity of the DO was displayed in the hall and staff office.

The inspector reviewed safeguarding incidents since the last inspection and found that any potential safeguarding risks were escalated, reviewed, and reported to the relevant statutory agencies. There were safeguarding plans in place to minimise the chances of reoccurrence of incidents. One resident raised a concern with the inspector on day one of the inspection. This was escalated to the person in charge who confirmed that the matter would be thoroughly investigated. The resident was satisfied with this response and a member of the senior management team had arranged to meet with the resident on day two of the inspection to gather more information. This demonstrated that safeguarding matters were taken seriously and investigated as required.

All three family representatives and all four staff felt comfortable raising concerns to the person in charge. At the time of this inspection, neither the family representatives nor the staff members spoken with had any concerns. While two residents spoken with said that while they sometimes didn't always get on personally with one another, they felt safe in the centre.

Two staff members spoken with were familiar with the steps to take should a

safeguarding concern arise including a witnessed peer to peer incident or an unwitnessed disclosure.
From a review of the two residents' files, the inspector observed that there were care plans in place that outlined residents' support needs and preferences with regard to the provision of intimate care. These plans promoted dignified care practices.

Judgment: Compliant

Regulation 9: Residents' rights

Residents were facilitated and empowered to exercise choice and control across a range of daily activities and had their choices and decisions respected.

The residents' rights were being protected by the systems for consultation with them, respecting their known preferences and wishes regarding their day-to day lives, their privacy and dignity, support with their monies were required, and consultation with their families who acted as advocates.

Residents meetings were being held where residents were informed about things that were happening in the centre, or things that may affect them. For example, topics included rights, activities, infection prevention and control and house news.

There were easy-to read documents available in the centre on a human rights approach to support access to banking and other institutions, and in relation to the assisted decision making act.

One resident was supported to grow some fruit and vegetables in the back garden and were very proud of this when telling the inspector.

One resident's intimate care plan guided staff to knock to ask if they could enter the bathroom and if the resident requested privacy that staff were to respect this request. It also described the resident's preferences as to where personal care was to take place. For example " I like to sit on a chair in my bedroom for doing my hair and shaving my beard". This demonstrated to the inspector that resident dignity, privacy and known preferences were being supported. The resident's specific support staff spoken with also communicated about giving the time and space to process information and not to rush them. They were observed interacting with the resident in a gentle and respectful manner. Stairs may become a challenge in the future for this resident due to a specific diagnoses. The provider has met with the person's family, and they were trying to source a single-storey property for the resident in order to be able to continue to support them and prevent the need for them to move to a nursing home. The family representative felt very supported. They also felt that staff treated the residents in this centre with respect.

One resident has communicated clearly over the years that they wanted to move to a specific area in the town. The person in charge has encouraged the resident to

search for properties with them. The person in charge had recently found a property that might suit the resident's specific requests and the provider has made enquiries in order to try to secure the property.
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	
Registration Regulation 5: Application for registration or renewal of registration	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Not compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Substantially compliant
Regulation 32: Notification of periods when the person in charge is absent	Not compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Compliant
Regulation 20: Information for residents	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Coolamber House OSV-0001836

Inspection ID: MON-0039855

Date of inspection: 08/10/2025

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: A meeting will be held monthly before the new roster is released between the PIC and the Team Lead to discuss the roster, ensure all shifts are filled and resolve any issues that may arise commencing 24th October 2025.	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: An audit of the Training Matrix will be completed at the end of every month to ensure all trainings are up to date. This will be completed by the PIC supported by Operations Manager. Any classroom based trainings required to be highlighted to HR three months in advance of expiration to ensure staff are trained on time. A full reconciliation of Training Matrix and staff training files to be completed by 12th November 2025.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and	

management:
The Audit practice and procedure has been revised and implemented on the 3rd November 2025. The service provider will implement a tracker to ensure oversight of all actions going forward. This tracker will be an Agenda Item on Senior Management Team Meetings and monitored by the Compliance Manager.

The Clinical Team has scheduled Risk Assessment and Care Planning Training for all staff across the service which is practice based to improve the quality of care planning and understanding of same in the service to begin 7th Jan 2026.

The service provider will create an auditing document / tool for reviewing risk and care planning in order to identify actions and monitor outcomes. This will commence after Q1 2026 to allow time for practice training to be implemented.

An audit of the Training Matrix will be completed at the end of every month to ensure all trainings are up to date. This will be completed by the PIC supported by Operations Manager. Any classroom based trainings required to be highlighted to HR three months in advance of expiration to ensure staff are trained on time. A full reconciliation of training matrix and staff training files to be completed by 12th November 2025.

An external advocate is being addressed within Day Services. Evidence re same will be on the service users own tool for capturing his weekly day activities 25th November 2025

Regulation 31: Notification of incidents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
The PPIM will notify HIQA of any required notifications in the absence of the PIC going forward (11/10/25).

Regulation 32: Notification of periods when the person in charge is absent	Not Compliant

Outline how you are going to come into compliance with Regulation 32: Notification of periods when the person in charge is absent:
The PPIM will notify HIQA of any required notifications in the absence of the PIC going forward (11/10/25). Senior Management Oversight of the Rosters has been changed to include a monthly check to ensure compliance (03/11/25).

Regulation 5: Individual assessment and personal plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
The Clinical Team has scheduled Risk Assessment and Care Planning Training for all staff across the service which is practice based to improve the quality of care planning and understanding of same in the service to begin 7th Jan 2026.

The service provider will create an auditing document / tool for reviewing risk and care planning in order to identify actions and monitor outcomes. This will commence after Q1 2026 to allow time for practice training to be implemented.

A full review of Person Centred Plans will be conducted by the PIC and the Team Lead to ensure that going forward the information is more accessible to all. Goals and the documentation of same will be updated and the PIC will get a weekly update by key workers. In the absence of the PIC the team lead will get this update. The PCP to be updated for all 3 individuals by end November 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 15(4)	The person in charge shall ensure that there is a planned and actual staff rota, showing staff on duty during the day and night and that it is properly maintained.	Substantially Compliant	Yellow	24/10/2025
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Not Compliant	Orange	12/11/2025
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	12/11/2025
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in	Not Compliant	Orange	03/11/2025

	place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.			
Regulation 31(3)(a)	The person in charge shall ensure that a written report is provided to the 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.	Substantially Compliant	Yellow	11/10/2025
Regulation 32(3)	Where the person in charge is absent from the designated centre as a result of an emergency or unanticipated event, the registered provider shall, as soon as it becomes apparent that the absence concerned will be for a period of 28 days or more, give notice in writing to the chief inspector of the absence, including the	Not Compliant	Orange	03/11/2025

	information referred to in paragraph (2).			
Regulation 05(4)(a)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which reflects the resident's needs, as assessed in accordance with paragraph (1).	Not Compliant	Orange	07/01/2026
Regulation 05(4)(b)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which outlines the supports required to maximise the resident's personal development in accordance with his or her wishes.	Substantially Compliant	Yellow	30/11/2025