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:	Coolfin
Name of provider:	St Michael's House
Address of centre:	Dublin 9
Type of inspection:	Announced
Date of inspection:	27 May 2025
Centre ID:	OSV-0002375
Fieldwork ID:	MON-0038258

About the designated centre

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

Coolfin is a designated centre operated by St Michael's House. The centre provides residential care and support for up to six adults with intellectual disabilities. The designated centre comprises a detached two-storey house located in North County Dublin located near a large community park and within a short walking distance to nearby shops and public transport routes. The designated centre consists of six individual bedrooms for residents, two living room spaces, a kitchen and separate dining area and a staff office. St Michael's House operate a separate day service to the rear of the designated centre. The centre is managed by a full-time person in charge who is supported in their role by a nurse manager. The staff team comprises of nurses, social care workers, and care assistants.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	5

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Tuesday 27 May 2025	10:00hrs to 17:30hrs	Michael Muldowney	Lead

What residents told us and what inspectors observed

This announced inspection was carried out as part of the ongoing regulatory monitoring of the centre and to inform a decision on the provider's application to renew the registration of the centre. The inspector used observations, conversations with residents and staff, and a review of documentation to form judgments on the quality and safety of care and support provided to residents in the centre.

The inspector found that residents received good care and support under some of the regulations inspected. However, the incompatibility of some residents continued to pose an ongoing risk to their safety and wellbeing. These issues were long standing, and following the last inspection of the centre in October 2024, the provider attended a cautionary meeting with the Office of the Chief Inspector of Social Services due to the poor findings in relation to the safeguarding of residents from peer-to-peer abuse. The provider submitted a compliance plan with actions to mitigate these issues.

The centre comprises a large two-storey house located in a busy suburb of Dublin. The house is close to many local amenities and services, including shops, parks, cafés, and public transport. The inspector walked around the house with the person in charge and nurse manager. The house was observed to be bright, warm, clean, comfortable, homely, well equipped and nicely decorated. Each resident had their own bedroom, and the communal spaces included two sitting rooms, a dining room, and a kitchen. A notice board in the hallway displayed information on advocacy services, the upcoming HIQA inspection, and the complaints procedure, and there were nice framed photos of residents and staff. Since the last inspection, some of the residents' bedrooms had been redecorated, and the inspector also observed new staff rotas and menus with pictures on display in the kitchen area.

The inspector also observed good fire safety systems including fire detection and prevention equipment. The premises and fire safety are discussed further in the quality and safety section of the report.

The inspector also visited the new single-occupancy apartment that the provider applied to add to the centre's footprint. The apartment was undergoing renovations, and does not form part of the inspection findings.

There were five residents living in the centre with one vacancy. The provider did not plan to fill this vacancy until the current incompatibility issues were resolved. The residents had varied health and social support needs and levels of independence. One the day of the inspection, three residents attended day services and two retired residents stayed in the centre.

The inspector met three residents. One of the retired residents showed the inspector their newly decorated bedroom and balloons from their recent birthday celebration. They spent time watching television in their bedroom and eating their meals with

staff in the dining room. They said that all was well in the centre. Overall, they appeared to be relaxed and content as they smiled and joked with the inspector.

Another resident spoke with the inspector when they returned from their day service in the afternoon. They said that they enjoyed their day service, and showed the inspector photos from a recent foreign holiday that they went on with staff. They had a great time, and looked forward to planning their next one. The inspector briefly met another resident when they also returned from their day service in the afternoon. They did not communicate their views with the inspector; however, they appeared to be relaxed in their home.

The inspector did not have the opportunity to meet two residents or any residents' representatives; one retired resident was isolating in their bedroom as they were presenting with symptoms of an infectious illness and another resident did not return from their day service until later in the day.

In advance of the inspection, staff supported residents to complete surveys on what it was like to live in the centre. Overall, their feedback was positive, and indicated that most residents were safe, liked the house, staff and food, received good care, and could make decisions in their lives. One resident said that they did not get along with their housemates and was happy about moving to a new house.

The inspector found that the provider and person in charge had implemented good arrangements for residents' voices to be heard and for them to make decisions about their lives. They attended regular house meetings to discuss common interest topics and had individual meetings where they planned personal goals. They were also consulted with during the provider's annual reviews of the centre and had been supported to utilise the provider's complaints procedure.

The provider’s recent annual review of the centre, dated April 2025, had consulted with residents and their representatives, and staff. No written feedback was received from residents’ representatives. Residents said that they were happy in the centre and with the service they received, and complimented the staff team. However, some residents said that other residents could be rude and unkind at times. Staff said that it was challenging to keep residents safe in the centre. The inspector also read open complaints from residents and their representatives about the ongoing incompatibility issues and their concerns for residents' safety and wellbeing.

The inspector met and spoke with staff during the inspection including the person in charge, clinical nurse manager, service manager and social care workers.

The person in charge and clinical nurse manager told the inspector that behavioural incidents in the centre could be unpredictable and difficult to manage. Residents had significant input from relevant multidisciplinary team services, there was additional staffing resources allocate to centre, and staff implemented the associated behaviour plans. However, the plans were not always effective and residents and staff were exposed to regular abusive behaviours. Residents expressed their upset by making verbal complaints and through their body language and facial expressions. Due to the safeguarding risks, some residents could not be

unsupervised with other residents. The management team told the inspector that the plan for one resident to move to another home would be hugely positive for them and the other residents and would resolve the safeguarding issues.

The management team knew the residents' individual needs and personalities well. They told the inspector about how the residents were supported to live active lives in line with their interests, preferences and abilities. For example, they were supported to maintain important relationships in their lives, enjoyed social and leisure events at the weekends, and chose personal goals such as going on holidays.

The management team were satisfied with the staffing arrangements in the centre, and residents' access to multidisciplinary services; for example, some residents' mobility needs were changing and they were receiving assessment and support from the provider's occupational therapy department.

The inspector spoke with one social care worker in depth. They shared the management teams concerns for residents' safety and wellbeing due to the incompatibility issues, and also said that the associated strategies were not fully effective. They said that the planned move would be positive for all residents. They told the inspector that outside of these ongoing issues, residents were well cared for the in centre and had good input from multidisciplinary team services. They said that residents had active lives and were supported to achieve personal goals such as going on holidays and to concerts.

Many aspects of the service provided to residents were to a high standard, and while the provider and person in charge had made extensive efforts to ensure that residents were safe in the centre, their efforts were not fully effective. The incompatibility of residents and associated safeguarding concerns which presented in 2022 had not been resolved, and this meant that residents were living in a centre that did not protect them from potential and actual abuse. The provider hoped to resolve the issues in the coming months by moving one resident to a more appropriate home.

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

Generally, the provider had ensured that the centre was well managed and resourced. For example, the centre was well maintained and sufficient staffing resources were in place. However, the provider had not ensured that the centre was appropriate to all residents' needs (this matter is discussed further in the quality and safety section of the report).

The systems to ensure that the service was effectively monitored required improvement. For example, audits, annual reviews, and unannounced visit reports identified areas for improvement. However, the systems required improvement as the centre's quality enhancement plan did not include all identified improvement actions and this oversight compromised its purpose. Additionally, the inspector found that the provider had not implemented all of the actions following the last inspection of the centre in the manner outlined in its compliance plan.

The management structure in the centre was clearly defined with associated responsibilities and lines of authority. The person in charge was full-time and supported in the management of the centre by a nurse manager. The person in charge managed two designated centres. The person in charge had ensured that incidents in the centre as described under regulation 31 were notified to the Chief Inspector. The person in charge reported to a service manager and Director, and there were effective systems for the management team to communicate and escalate any issues.

The staff skill-mix in the centre comprised nurses, social care workers and care assistants. The skill-mix and complement was appropriate to the needs of the residents, and staff leave was covered by regular relief staff to support residents' continuity of care. The person in charge maintained planned and actual rotas showing staff working in the centre.

Staff completed relevant training as part of their professional development and to support them in their delivery of appropriate care and support to residents. The person in charge provided quality support and formal supervision to staff working in the centre.

Staff also attended regular team meetings which provided an opportunity for them to any raise concerns regarding the quality and safety of care provided to residents. The inspector viewed a sample of the recent staff team meetings from January to May 2025, which reflected discussions on safeguarding, fire safety, risk, training, audits, residents' updates, health and safety matters, staffing matters, and infection prevention and control.

Regulation 14: Persons in charge

The person in charge was full-time and found to be suitably qualified, experienced and skilled for their role. The possessed relevant qualifications in social studies and management. The person in charge demonstrated a good understanding of the residents' individual personalities and needs, and was endeavouring to ensure that they received a good service in the centre.

They were also responsible for another designated centre; however, there were good arrangements to ensure that this did not impact on their management of the

centre concerned. For example, there was a clinical nurse manager and deputy managers in the centre to support the person in charge with their duties.

Judgment: Compliant

Regulation 15: Staffing

The staff skill-mix in the centre consisted of nurses, social care workers and direct support workers which the provider had determined was appropriate to the number and needs of the residents. The provider had provided additional staffing resources as a measure to reduce the safeguarding concerns in the centre. The person in charge told the inspector that they were satisfied with the complement and skill-mix was sufficient. There were vacancies of approximately one whole-time equivalent in the staff complement. However, the vacancies were well managed to minimise any impact on residents and to ensure that they received consistency of care. For example, regular relief staff worked in the centre.

The inspector observed that there was sufficient staff on duty on the day of the inspection to respond to the residents' needs. The inspector also observed staff engaging kindly with residents, and residents appeared relaxed and familiar with staff.

The person in charge maintained planned and actual rotas. The inspector viewed the March and May 2025 rotas and found that they showed the names of the staff and the hours they worked in the centre.

The inspector reviewed six staff Schedule 2 files and found that they contained relevant information including evidence of identity, dates that staff commenced employment, vetting disclosures, references, and evidence of qualifications.

Judgment: Compliant

Regulation 16: Training and staff development

The person in charge had ensured that staff had access to appropriate training as part of their professional development and to support them in delivering effective care and support to residents. The training included, safeguarding of residents from abuse, positive behaviour support, human rights, medication administration, emergency first aid, supporting residents with modified diet, and management of challenging behaviour. The training log showed that two staff required training in managing challenging behaviour; this training had been scheduled and is discussed in the next section of the report.

The person in charge provided effective support and formal supervision to staff. Informal support was provided on an ongoing basis and formal supervision was carried out in line with the provider's policy. The inspector reviewed three staff formal supervision records, and found that they were up to date with their supervision.

In the absence of the person in charge, staff could contact the service manager or on-call system for support and guidance.

Judgment: Compliant

Regulation 22: Insurance

The provider had effected a contract of insurance against injury to residents and other risks in the centre, including loss or damage to property.

Judgment: Compliant

Regulation 23: Governance and management

There was a clearly defined management structure in the centre with associated lines of authority and responsibility. The person in charge was full-time, and demonstrated effective oversight and management of the centre. They were supported in their role by a nurse manager, and reported to a service manager who in turn reported to a Director. There were good arrangements such as regular meetings and sharing of governance reports for the management team to communicate and escalate issues.

The management team had good oversight of the safeguarding risks presenting in the centre, and the provider had plans to mitigate the risks by moving one resident to a more appropriate home. This would ensure that residents were in receipt of safe and appropriate services. The provider had sourced the home, and it was undergoing renovations to ensure that it met the associated regulations.

There were management systems to ensure that the quality and safety of the service provided to residents was monitored, such as various audits on areas including fire safety and infection prevention and control, annual reviews that consulted with residents and their representatives, and comprehensive unannounced visit reports.

However, the arrangements for overseeing the implementation of improvement actions required more consideration from the provider. The person in charge maintained a quality improvement plan that monitored actions from various audits and inspections. The plan was recently reviewed, but the inspector found that the

actions from the HIQA inspection of the centre in October 2024 were not reflected on it. Additionally, the inspector found that not all actions in the inspection report compliance plan, such as actions under regulations 10, had been completed as the provider committed to.

There were effective arrangements for staff to raise concerns. Staff spoken with said that they felt supported in their roles. In addition to the staff supervision and support arrangements, staff also attended regular team meetings which provided an opportunity for them to raise any concerns about the quality and safety of care and support provided to residents.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

The inspector reviewed a sample of the incidents that occurred in the centre since the previous inspection, such as the use of restrictive practices, and found that they had been notified to the Chief Inspector of Social Services in accordance with the requirements of this regulation.

Judgment: Compliant

Quality and safety

This inspection found there were many aspects of residents' wellbeing and welfare that were being upheld by a good standard of evidence-based care and support. However, not all residents' assessed needs were being met in the centre and and this was having an adverse impact on the quality and safety of service provided to them and their peers and resulting in ongoing and protracted incompatibility issues that were contributing to safeguarding concerns.

The person in charge had ensured that assessments of most residents' needs were completed which informed the development of personal plans. The inspector reviewed a sample of residents' assessments and plans. The documents were up to date and reflected input from the residents and varied multidisciplinary team services. However, one resident was awaiting a communication assessment, the absence of which posed a risk that their communication needs were not been fully met.

The provider had arrangements to safeguard residents from abuse, such as staff training, appropriate staffing levels, and reporting systems. However, the risk to residents' safety had not been mitigated, and residents remained at risk of harm from other residents in the centre. Staff told the inspector, and the inspector read

information, such as complaints from residents and their families, about how residents' safety and quality of life was being impinged on.

Improvements were also required to the reporting of some safeguarding concerns. The inspector reviewed two recent incidents with the management team that had not been fully reported in line with the provider's safeguarding policy. Following their review, the person in charge reported the incidents accordingly.

The provider's multidisciplinary team services provided good behavioural support to the residents and the staff team. However, the behaviour support plans were limited in effectiveness due to the needs of some residents' needs being unmet. Additionally, not all staff had completed all relevant behaviour support training and this posed a risk to how effectively they were able to respond to and manage serious behavioural incidents. The risk management arrangements also required improvement to ensure that all risks in the centre were assessed to identify all necessary control measures.

The residents required support to manage their finances. The inspector reviewed the support arrangements for two residents and found that improvements were required to the maintenance of residents' records and personal plans to ensure that they were up to date and consistent.

There were good arrangements for consulting with residents and supporting them to exercise choice in their lives. Residents attended house meetings to discuss common agenda items, and individual meetings to plan personal goals. The inspector reviewed the residents' meeting minutes from April to May 2025. They noted discussion topics including making complaints, the residents' guide, fire safety, menu and activity planning, infection prevention and control, the premises, and the upcoming HIQA inspection. At their individual meetings, residents planned personal goals such as going on holidays and to concerts. Overall, the inspector found that residents received good support from staff to lead active lives in accordance with their individual wishes, interests and abilities.

The centre comprised a large two-storey house. It was observed to be clean, homely, nicely decorated and furnished, and well equipped. Some minor upkeep was needed, and the person in charge was liaising with the provider to enhance the storage facilities.

The inspector also observed good fire safety systems including fire detection and fighting equipment, and emergency lights throughout the house.

Regulation 10: Communication

Residents used various communication means including multi-modal and verbal communication. Communication plans had been prepared to ensure that staff could support residents to express themselves in accordance with their needs.

The inspector saw that staff were committed to reviewing and supporting residents' communication. For example, they had recently prepared new visual aids to help a resident better understand their behaviours, and a visual staff rota and menu were being used in the kitchen to help resident know who was working in the centre and to choose their meals. A 'social story' with pictures had also been prepared by staff to help a resident understand a recent family bereavement.

However, improvements were needed from the provider to ensure that all residents' communication needs were fully assessed by an appropriate professional. One resident was referred to the provider's speech and language department for a communication assessment in February 2024. However, the referral was not accepted as the department no longer accepted communication referrals. This posed a risk that the resident's current communication strategies were not fully effective. Additionally, as noted under regulation 23, an action from the provider's October 2024 inspection report compliance plan had not been completed as described in the compliance plan.

Judgment: Substantially compliant

Regulation 12: Personal possessions

The provider had prepared a written policy and procedures for the management of residents' monies and possessions. The policy viewed by the inspector in the centre was dated May 2021, and overdue review by approximately twelve months.

The inspector reviewed two residents' financial and personal possession records, including recent expenditure sheets, bank statements, financial support plans and audits, and property logs. Both residents required a high level of support to manager their finances. They both had their own bank accounts, and some of their money was securely stored in a staff office. The inspector counted their cash in the office to ensure that it was correct as per the balance on their expenditure sheets.

However, the inspector found that the maintenance of their records required improvement. In the first resident's file, there was no financial support plan despite them requiring specific supports. The person in charge located an older support plan before the inspection concluded, but the information was out of date. The absence of an up-to-date plan posed a risk that the resident may not receive the appropriate supports they required. Additionally, the receipts of three purchases made by the resident using their bank card in February 2025 were misplaced, but later found by staff before the inspection concluded and shown to the inspector.

There was also a discrepancy on the resident's May 2025 expenditure sheet; however, it was rectified during the inspection. The resident's property log was found to be poorly detailed. For example, the dates and value of all the possessions in the log were not recorded, and some of the listed possessions were lacking in detail which would make them difficult to identify .

In the second file, the resident's records were better detailed, and the inspector read some evidence to demonstrate that they had been consulted with about the financial supports they required.

Judgment: Substantially compliant

Regulation 13: General welfare and development

Residents living in the centre were involved in various social and leisure activities, and the inspector found that they received great support from the person in charge and staff team to have an active life that was in line with their individual interests, abilities and needs.

Three residents attended the provider's day services during the week where they enjoyed different activities such as swimming and playing golf. Two residents were retired and were supported by staff in the centre with their daily leisure activities and some of them enjoyed a more relaxed pace of life. For example, on the day of the inspection, one retired resident was relaxing in their home as was their choice.

The inspector found that staff and the person in charge were very committed to supporting and facilitating opportunities for residents to access and engage in their chosen individual interests and hobbies. For example, staff had recently accompanied some residents on foreign holidays, and other residents were planning an upcoming holiday with staff to a holiday village in Ireland. Residents were also supported by staff to plan and achieve individual social goals such as attending cultural events and live music.

Some residents attended community groups such as community 'sheds'. Within the centre, residents could also avail of different activities from external facilitators, such as art classes and reflexology.

Judgment: Compliant

Regulation 17: Premises

The centre comprises a large-storey house. The house contains individual bedrooms, a kitchen, a dining room, two sitting rooms, bathrooms, a staff room, and an office. Since the previous inspection of the centre in October 2024, parts of the centre had been repainted and refurnished.

Overall, the premises was seen to be bright, homely, clean, nicely decorated, well equipped, and comfortable. Some minor upkeep was needed such as repainting in areas due to wear and tear. The person in charge had also identified that additional

storage space was required for residents' mobility equipment, and was liaising with the adjoining day service to source suitable external storage.

The inspector also reviewed a sample of the equipment used by residents, including and electric bed and hoist, and found that they were up to date with their servicing requirements.

Judgment: Compliant

Regulation 20: Information for residents

The registered provider had prepared a written residents' guide. It was up to date, and prepared in an easy-to-read version with the information specified under this regulation.

Judgment: Compliant

Regulation 26: Risk management procedures

The provider had prepared and implemented a written risk management policy, reviewed in June 2023, which outlined the arrangements for identifying hazards and carrying out risk assessments.

The inspector viewed a sample of the risk assessments pertaining to the centre, including those on behaviours of concern. The risk assessments had been primarily completed by the person in charge, and the inspector found that they outlined control measures for implementation in the centre.

However, not all risks in the centre had been assessed. For example, staff told the inspector about a manual handling concern, and while the person in charge had liaised with the provider's relevant department, an assessment of the concern had not yet been carried out. Therefore, it was not demonstrated if all necessary measures were in place. Additionally, as described under regulation 7, not all staff working in the centre had completed necessary behaviour support training, and this risk had not been risk assessed.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The registered provider had implemented effective fire safety precautions and management systems.

There was fire detection, containment, and fighting equipment, and emergency lights in the centre. The inspector viewed a sample of the servicing records in the house, and found that the fire extinguishers, emergency lights, and alarms were up to date with their servicing. Staff also completed daily checks of the fire safety systems and equipment to identify any potential deficits, and the centre's fire safety officer completed additional monthly and quarterly checks.

The inspector observed that the fire panel was addressable and easily found at the front door with information on the zones displayed beside it. The exit doors also had easily-opened locks to aid prompt evacuation of the centre in the event of a fire. The inspector released a sample of the fire doors, including the kitchen and bedroom doors, and observed that they closed properly.

The person in charge had prepared a fire evacuation plan and each resident had their own individual evacuation plan to guide staff on the supports they required. Fire drills were carried out to test the effectiveness of the evacuation plans. Staff had completed fire safety training, and easy-to-read information had been prepared for residents to aid their understanding of the fire safety precautions.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The person in charge had ensured that assessments of residents' needs were completed which informed the development of personal plans. The inspector reviewed a sample of two residents' assessments and plans. The plans, included personal, health, and social care plans, were up to date, sufficiently detailed, and readily available to staff in order to guide their practice, with the exception of a money management plan, referred to under regulation 12. The plans also described the residents' individual personalities, interests, abilities and how they liked to spend their time.

The assessments and plans were reviewed on a regular basis, and included input from the residents and various multidisciplinary team services.

However, the provider had not yet ensured that the appropriate arrangements were in place to meet the needs of each resident. They had identified that the centre was not fully suitable to meet all residents' assessed needs, particularly in relation to the required living arrangements for one resident and their incompatibility with other residents which was resulting in ongoing safeguarding concerns.

The provider had sourced alternative suitable accommodation for the resident and they were planning to move in the coming months once renovations had been completed.

Judgment: Not compliant

Regulation 7: Positive behavioural support

The registered provider and person in charge had implemented measures to support residents to manage their behaviours. However, these measures were not fully effective.

Staff were required to completed positive behaviour support training and management of challenging behaviour training. However, training records showed that some two staff required training in management of challenging behaviour. This gap in training posed a risk to effectiveness of the care and support by staff, particularly as incidents of aggression were a regular occurrence in the centre.

Positive behaviour support plans were up to date and readily available to guide staff. However, the inspector was told by staff that the plans were not fully effective. This was attributed to the residents' living environments that were not in line with their needs.

The inspector did not review restrictive practices as part of this inspection.

Judgment: Substantially compliant

Regulation 8: Protection

There were ongoing safeguarding concerns and incidents, including physical aggression, verbal and psychological abuse, and allegations of sexual abuse, in the centre. These were attributable to the incompatibility of residents, and had been reported in previous inspections of the centre. Staff told the inspector that incidents were happening on a regular basis, and were having an adverse impact on residents' quality of life. Concerns for residents' safety were also noted in the provider's internal audits, meeting minutes, assessments, safeguarding plans, and open complaints made by residents and their families.

Safeguarding plans had been developed outlining the interventions to keep residents safe from abuse. The provided had also responded by allocating additional staffing resources to the centre, and the person in charge arranged regular holidays for a resident to reduce the amount of time they were in the centre. However, staff spoke

about the limited effectiveness of the safeguarding plans, and the challenges they faced in ensuring residents' safety.
Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 10: Communication	Substantially compliant
Regulation 12: Personal possessions	Substantially compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Compliant
Regulation 20: Information for residents	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Not compliant

Compliance Plan for Coolfin OSV-0002375

Inspection ID: MON-0038258

Date of inspection: 27/05/2025

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 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • The Quality Improvement Plan is a historical tool once used by the provider. This tool has been discontinued as a mandatory tool by the provider, but some PICs can continue to use it as a personal quality tool if they choose. This tool has been removed from the centre. • Compliance Plans will be reviewed at two monthly supervision meetings with the PIC and Service Manager. • The Service Manager and Director of Adult Services will review the action plan implementation at two monthly supervision meetings. • The SLT department are reopening communication referrals from September 2025. One resident will receive an SLT review by 2026 Quarter 1. • A risk assessment to be completed by 11.07.2025 by the PIC and Service Manager regarding the outstanding SLT review. • Where a regulation has not come into compliance by the committed date the Provider via the PIC/Service Manager/Director of Services will update the regulator.	
Regulation 10: Communication	Substantially Compliant
Outline how you are going to come into compliance with Regulation 10: Communication: • The SLT department are reopening communication referrals from September 2025. The SLT department have confirmed that one resident will receive an SLT review before 2026 Quarter 1. • A risk assessment to be completed by 11.07.2025 by the PIC and Service Manager regarding the outstanding SLT review.	

• The PIC/KW to review and update existing communication support plan for one resident by 11.07.2025 • The PIC/KW to review and enhance existing communication supports (social stories) for one resident by 11.07.2025 • Where a regulation has not come into compliance by the committed date the Provider via the PIC/Service Manager/Director of Services will update the regulator.

Regulation 12: Personal possessions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 12: Personal possessions: • The providers Policy & Procedures for the Management of Service users Monies and Possessions was due to be reviewed in April 2024. The provider has committed to undertake a review of the policy by 27.07.2025 • A review by the PIC regarding maintaining financial records was completed and a more robust recording system is now in place. • The financial support plan for one resident was reviewed and updated by the PIC and keyworker. • Residents receipt management has been reviewed by the PIC and a more effective system is now in place. • All resident's property logs were reviewed by the PIC and keyworkers and all property is now accounted for on the logs.	

Regulation 26: Risk management procedures	Substantially Compliant
Outline how you are going to come into compliance with Regulation 26: Risk management procedures: • The PIC sent a manual handling hoist review referral to the Health & Safety Manager and this review is scheduled for 02.07.2025. • The Health and Safety Office will issue a manual handling report with an action plan to be completed by 01.08.2025. • A risk assessment is now in place for this hoist and will remain in place until the Health and Safety Manager completes the manual the handling review and action plan is completed by 01.08. 2025. • Two staff have been booked for Positive Behavior Support training and are due to complete it by 20.07.2025. • Two staff have been booked for TIPS training and are due to complete it by 10.11.2025	

• A risk assessment has been completed for staff who are awaiting PBS and TIPS training.

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:

• A new apartment has been identified for one resident and is currently undergoing refurbishment works and registration with the regulator. It is expected the resident will move into this new centre by 01.09.2025, with the assumption of a successful registration visit by HIQA.
• Refurbishment works on the centre will be completed by 11.07.2025.
• The fire officer is due to visit the apartment before 14.07.2025 and provide a fire report and risk assessment.
• The service manager will supply the relevant documentation on fire to the inspector for registration of the centre by 18.07.2025.
• All furniture, kitchen utensils and soft furnishings etc. have been ordered and delivery of these items will begin from 30.06.2025.
• The resident and their family have been informed about the move and the residents has viewed the apartment and is very happy with it, choosing paint colors and furniture etc.
• All residents continue to have a safeguarding risk assessment/support plan in place which is reviewed quarterly or sooner if required.
• To mitigate against further safeguarding issues and in agreement with all residents within the centre., the Provider will continue to provide extra nights away from the centre for one resident. Since September 2024 the resident has had 24 approx. nights away from the centre, which has seen a reduction in NF06/PSF1.
• The provider will continue to update IMR on the ongoing incompatibly at the centre and the progression of registering the apartment and transition planning for one resident.
• The Provider will continue to raise the risks within the centre with HSE local safeguarding team
• Quarterly compatibility meetings with the Director of Adult service, Designated officer, Service Manager and PIC will remain in place until the compatibility issues within the centre are resolved.
• Additional evening hours will remain in place so all residents can access activities in the community if they choose to avail of them.
• Following an incident, residents will continue to be reassured and offered 1:1 support and/or clinical support where required
• Keyworkers will continue to have monthly or as required one to one individual safeguarding meetings with the residents to check in on how they are feeling, supports required and action any outcomes from these meetings.

• Individual ICMs to be scheduled when individual additional supports are identified as requirement.

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support: • Two staff who require Positive Behavior Support training have been booked in and are due to complete it by 20.07.2025. • Two staff have been booked for TIPS training and are due to complete it by 10.11.2025. • A risk assessment has been completed for staff who are awaiting PBS and TIPS training. • A new apartment has been identified for this resident and is currently undergoing refurbishment work and registration with the regulator. It is expected the resident will have moved in by 31.08. 2025, with the assumption of a successful registration visit by HIQA.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection: • A new apartment has been identified for one resident and is currently undergoing registration with the regulator. It is expected the resident will move into this new centre by 01.09.2025, with the assumption of a successful registration visit by HIQA. • All incidents will continue to be escalated via the safeguarding policy (NF06/PSF1). • The Provider will continue to raise the risks within the centre with HSE local safeguarding team • The Provider will continue to complete safeguarding audits within the centre on a six-monthly basis or when required • Following an incident, residents will continue to be reassured and offered 1:1 support and/or clinical support where required. • All residents have a safeguarding risk assessment/support plan which is reviewed quarterly or when required. • To mitigate against further safeguarding issues and in agreement with all residents within the centre, the Provider will continue to provide extra nights away from the centre for one resident. Since September 2024 the resident has had 24 approx. nights away from the centre, which has seen a notable reduction in NF06/PSF1. • The provider will continue to update IMR on the ongoing incompatibly at the centre

and the progression of registering the apartment and transition planning for one resident
• Quarterly compatibility meetings with the Director of Adult Service, Designated Officer, Service Manager and PIC will remain in place until the compatibility issues within the centre are resolved.
• Additional evening hours will remain in place so all residents can access activities outside the centre if they choose to avail of them.
• Ongoing psychology input with PBS remains in place via one-to-one psychology meetings with residents or psychology attendance at ICMs and/or staff meeting) and plans are updated yearly or when requested by PIC/team or Service manager following an incident or change.
• Keyworkers will continue to have monthly or as required one to one individual safeguarding meetings with the residents to check in on how they are feeling, supports required and action any outcomes from these meetings.
• Individual ICMs to be scheduled when individual additional supports are identified as requirement.
• The PIC/KW to review and update existing communication support plan for one resident by 11.07.2025.
• The PIC/KW to review and enhance existing communication supports (social stories) for one resident by 11.07.2025
• Safeguarding to remain a rolling agenda item for staff meeting.
• The Service manager to continue to escalate the impact incompatibility at monthly Area Service Management Team meeting and supervision meeting with the Director of Adult Service.
• The Service manager will meet the residents on 14.07.2025 to provide updates on open complaints. minutes of these meetings will be provided to each resident by the service manager by 31.07.2025.

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 10(1)	The registered provider shall ensure that each resident is assisted and supported at all times to communicate in accordance with the residents' needs and wishes.	Substantially Compliant	Yellow	31/03/2026
Regulation 10(2)	The person in charge shall ensure that staff are aware of any particular or individual communication supports required by each resident as outlined in his or her personal plan.	Substantially Compliant	Yellow	31/03/2026
Regulation 12(1)	The person in charge shall ensure that, as far as reasonably practicable, each resident has access to and retains control of personal property and possessions	Substantially Compliant	Yellow	27/07/2025

	and, where necessary, support is provided to manage their financial affairs.			
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.	Substantially Compliant	Yellow	01/07/2025
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.	Substantially Compliant	Yellow	10/11/2025
Regulation 26(1)(b)	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 risks identified.	Substantially Compliant	Yellow	10/11/2025
Regulation 05(2)	The registered provider shall ensure, insofar as	Not Compliant	Orange	31/08/2025

	is reasonably practicable, that arrangements are in place to meet the needs of each resident, as assessed in accordance with paragraph (1).			
Regulation 05(3)	The person in charge shall ensure that the designated centre is suitable for the purposes of meeting the needs of each resident, as assessed in accordance with paragraph (1).	Not Compliant	Orange	01/09/2025
Regulation 07(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.	Substantially Compliant	Yellow	10/11/2025
Regulation 07(2)	The person in charge shall ensure that staff receive training in the management of behaviour that is challenging including de-escalation and intervention techniques.	Substantially Compliant	Yellow	10/11/2025
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	01/07/2025