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:	Ballytrim House
Name of provider:	Health Service Executive
Address of centre:	Donegal
Type of inspection:	Unannounced
Date of inspection:	30 September 2025
Centre ID:	OSV-0002523
Fieldwork ID:	MON-0047353

About the designated centre

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

Ballytrim House provides residential care and support to adults with a disability. The designated centre comprises an seven bedded one-storey building located in a residential housing estate in a small town. Residents living at the centre have access to communal facilities such as sitting rooms, a sensory room, dining room, kitchen and outdoor area. Each resident has their own bedroom with en-suite bathroom. The centre also has additional communal bathroom and toilet facilities. Ballytrim House is located close to local amenities such as shops, public houses and cafes. There are three vehicles available which enable residents to access other amenities in the surrounding area such as swimming pools and other leisure facilities. Residents are supported night and day by a staff team of both nursing and care staff.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	4

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Tuesday 30 September 2025	10:45hrs to 17:10hrs	Alanna Ní Mhíocháin	Lead

What residents told us and what inspectors observed

The inspector found that the provider had implemented new strategies and systems to improve the governance and oversight of the quality of the service in this centre. Staff had received training in modules that were relevant to the care of residents. The change in the residents' living arrangements had reduced the risk of safeguarding incidents and negative interactions between residents. However, improvement was required to ensure that the premises were suitable to meet the needs of resident and to ensure that their rights were respected. The systems in place to manage risk required review. Though there had been improvement in the systems in place to support residents to communicate their needs and wishes, further improvement to documentation was required. There was also further improvement required in relation to the documentation and guidance to staff in relation to supporting residents to manage their behaviour.

During the inspection of this centre, it was noted that the provider had identified the need to complete an urgent fire safety assessment. This was identified through a report that had been completed by the provider on 27 May 2025. One the day of inspection, this assessment had not been completed and there was no definite plan for this assessment to take place. As a result, the provider was required to submit an urgent compliance plan in relation to this issue. This compliance plan was received by the Chief Inspector of Social Services on 6 October 2025.

This was an unannounced follow-up inspection of this centre. The centre was inspected on 24 April 2025 and, at that time, nine regulations were found to be not compliant. This showed that significant improvement was required in relation to the governance and management of the service to ensure that the needs of residents were met and to ensure the residents' safety. Due to the level of non-compliance, the provider was required to attend a warning meeting where a warning letter was issued outlining that the provider was required to come into compliance. Failure to do so would result in the cancellation of the registration of the centre. Following that meeting, the provider submitted a plan outlining how they would come into compliance and the timelines by which that would be achieved. The purpose of this inspection was to review the implementation and effectiveness of that compliance plan.

Ballytrim House was a very large building in a housing estate on the edge of a town. One section of the building had been fitted with padding on walls as recommended by members of the multidisciplinary team. This was to meet the needs of one resident. Since the last inspection, the resident had moved into this part of the centre. The resident who had been living in that section of the building had moved to a new part of the building. Also, since the last inspection, three residents had moved to a new designated centre. There were now four residents living in Ballytrim House and the person in charge reported that there were no plans for any residents to move in.

With the reduction in the number of residents in the centre, new living arrangements had been put in place. The centre was now divided into three separate living areas by magnetically locked doors with keypads. Each resident had their own bedroom and there were additional rooms that could be used as sitting rooms. Each resident now had their own sitting room. This meant that residents had more space and this had reduced negative interactions between residents. However, the lay out of the centre meant that residents could not freely access all rooms in the building as they wanted or as they needed. For example, the kitchen was located in a section of the building that was only accessible to two residents. The other two residents would need to be let into that part of the building by staff. In addition, the sensory room was located in a section of the building that was only accessible by one resident. Other residents would need to ask staff to let them into that part of the building if they wanted to access the sensory room.

The inspector noted that refurbishment works had been completed since the last inspection. The sensory room was completely refitted with new equipment. This included sensory lights, a projector and sensory plinth. Panelling had been added to the walls in residents' bathrooms. New couches and armchairs had been purchased for some of the new sitting rooms. The large dining room had been redecorated to include a lounge area with large couch, panelling on the wall and a large television. This made for a more homely and relaxing area for residents to spend time. In the section of the building that had padding on the walls, the person in charge reported that an additional room had padding added to the walls since the resident moved into that section of the building. A room within that section of the building remained without padding. This will be discussed further under regulation 26; risk management procedures.

The inspector had the opportunity to meet two of the four residents during the inspection. A third resident did not want to meet the inspector and the fourth resident was at their day services. One resident showed the inspector their new bedroom and living rooms. The resident told the inspector that they liked their new bedroom and that they were happy in their new rooms. The inspector observed residents relaxing in different parts of the centre.

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

Capacity and capability

The provider had introduced new oversight systems in the centre to monitor the quality of the service. These included regular unannounced visits to the centre by members of senior management. Quality improvement reports were generated from these meetings. These were added to the centre's quality improvement plan. The

person in charge provided weekly updates to senior management on the progress of this plan.

The provider had completed an assessment of the suitability of the centre to meet the needs of residents. A report from this assessment indicated that the centre was not suited to meet the needs of residents. It identified that the building required significant refurbishment works. In response, the provider had developed a risk assessment and there were some actions underway at the time of inspection. However, a clear plan to address all of these issues had not yet been developed.

Staff training was largely up to date in this centre. Staff had completed refresher training in supporting residents to manage their behaviour. Additional training in communication had been completed by some staff with additional dates planned. Some staff had also completed training in human rights.

Regulation 16: Training and staff development

Staff training in this centre was largely up-to-date in areas that the provider had identified as mandatory. Additional training had also been delivered to some staff with further training dates booked for the remainder of staff.

The inspector reviewed the staff training records that were maintained by the person in charge. These showed that staff training was largely up to date. Specifically, refresher training in supporting residents to manage their behaviour had been arranged for five staff members. One remaining staff member was booked onto an upcoming course.

Following the last inspection, the provider had arranged training from a speech and language therapist. The inspector reviewed the attendance sheet from that training session and noted that 11 staff had completed the training. There were two further dates booked for the remainder of staff to complete the training.

Judgment: Compliant

Regulation 23: Governance and management

Following the last inspection of this centre, the provider's compliance plan outlined a number of additional oversight measures that were planned for the centre. These were to strengthen the governance and management of the centre. The inspector found that these actions were completed but some improvement was required to ensure that action plans for all identified risks, issues and urgent items were devised in a timely manner.

The provider had committed to completing unannounced visits to the centre on a monthly basis, at a minimum. The inspector noted that these visits were happening. The reports generated following these visits were reviewed by the inspector. These showed that the provider had completed an unannounced visit of the centre on six separate dates between 29 April 2025 and 25 August 2025. Action plans with clear goals were developed following each of these visits. These goals were added to the centre's quality improvement plan.

In the compliance plan, the provider said that the centre's quality improvement plan would be submitted to senior management on a weekly basis. The inspector viewed emails from the person in charge to senior management that showed that this was happening as outlined. It was also noted that there had been an improvement in the information recorded on the centre's quality improvement plan. The inspector reviewed the most recent quality improvement plan dated 30 September 2025. The goals and actions to improve the service were clearly defined and progress towards their achievement was recorded.

The provider had committed to completing audits of residents' care plans and providing feedback to staff in relation to this. The inspector noted an email to staff in May 2025 that showed that this action had been completed. In addition, the person in charge reported that further auditing of care plans was planned for future dates with input from nursing staff external to the service. Relevant staff had completed training in care planning as noted by the inspector when reviewing the centre's quality improvement plan.

The provider had committed to an assessment of the centre by the maintenance manager and members the infection prevention and control team. This occurred on 27 May 2025 and a report was prepared for senior management. The inspector reviewed this report. The specifics of the report will be discussed under regulation 26: risk management procedures and regulation 17: premises. The report highlighted a number of areas that needed to be addressed. Some were outlined as urgent actions. Despite the identification of urgent actions, the person in charge reported that this report was only made available in July 2025 and senior management completed a risk assessment in response to the report on 8 August 2025. In addition, the urgent action relating to the assessment of fire safety had not been completed on the day of inspection as will be discussed under regulation 26; risk management procedures. In response to the findings in the report, the provider had developed a general risk assessment relating to all issues. The risk assessment that had been completed outlined some of the actions that were taken to address the findings in the report and the planned actions that needed to be undertaken. There were target dates in place for these actions to be completed. However, the overall plan to address all of these findings had not been devised on the day of inspection.

Judgment: Substantially compliant

Quality and safety

Significant improvement was required to ensure that the premises were laid out and suited to the needs of residents. Residents were prevented from accessing communal rooms in the centre due to the lay-out of the building. This impacted on their rights to exercise choice and control in their daily lives. Further, the addition of padding in one section of the building had not been in keeping with best practice and was found to impact on the dignity of the resident. In addition, significant refurbishment works had been identified by the provider. Though meetings between senior management had commenced, there was no definite plan in place on the day of inspection to address these issues.

Significant improvement in relation to the systems in place to manage risk was required. As outlined in the opening section of the report, the provider was required to submit an urgent compliance plan in relation to their assessment of fire safety in the building following findings from their own report.

There was an improvement to the safeguarding arrangements in the centre. This was achieved through the reduction in the number of residents living in the centre and the increased space available to residents to spend time apart. The provider had also followed the recommendations of the safeguarding team and followed their own procedures in relation to safeguarding to process any incidents appropriately.

Improvement was also noted in the support available to residents in relation to their communication. However, some improvement in documentation relating to residents' communication supports required improvement. Improvement was also needed in relation to the guidance to staff when supporting residents to manage their behaviour to ensure that written documentation was in line with practice.

Regulation 10: Communication

The inspector noted improvement since the last inspection in the information provided to staff regarding residents' communication. This was achieved through staff training and reports from relevant professionals. However, further improvement was required to ensure that information to staff was always clear and consistent.

The training records reviewed by the inspector showed that 11 staff had completed training in supporting residents with their communication. In addition, two further training dates were booked for the remaining staff in the centre to receive this training from a speech and language therapist.

The inspector reviewed the files of two residents in relation to their communication needs and supports. These showed that the residents had been assessed by a speech and language therapist since the last inspection. The speech and language

therapist had provided written guidance to staff on the supports that should be offered to residents. The person in charge and a nurse manager gave clear examples of how these strategies had been introduced and said that the use of the communication strategies was discussed with staff on a daily basis.

Some improvement was required in relation to the information contained within residents' notes and guidance documents to ensure that clear and consistent information was available to staff. For example, the inspector reviewed one resident's behaviour support plan and speech and language therapy report. Information within these reports did not give specific guidance to staff on the use of picture-based communication supports. As a result, it was unclear if picture-based communication should be used and if so, when and how to use it.

Judgment: Substantially compliant

Regulation 17: Premises

Significant improvement was required to ensure that the premises were in keeping with the needs of residents and that it was laid-out to meet their needs.

As outlined previously, the centre was divided into three distinct sections separated by magnetically locked doors. This lay-out limited residents' access to communal rooms in the centre, for example, the kitchen. This impacted on the rights of residents and will be discussed further under regulation 9; residents' rights.

The provider had undertaken a review of the premises since the last inspection of this centre. The centre was assessed by the provider's maintenance department and members of the infection prevention and control (IPC) team in May 2025. The report generated from this assessment was reviewed by the inspector. The report highlighted the need to complete an urgent fire safety assessment. This will be discussed under regulation 26: risk management procedures.

This report also found numerous areas for improvement in the centre. The report stated that 'in an overall capacity, the house lacks suitability to meet the needs of all the current residents'. Some specific areas highlighted in the report included the presence of mould, dampness in rooms, issues with hot water, damage to areas of flooring, the upgrade needed in the centre's kitchen, and IPC risks relating to wash hand basins and the decommissioning of unused toilets/showers. The report also highlighted that the cushioned padding added to the walls in one section of the building posed an IPC risk as it was difficult to clean and maintain. The report advised other cushioning for internal walls to meet the resident's needs that is easier to clean and maintain.

The report also highlighted the possibility of the presence of mica in the building and highlighted that a mica test was required. This may impact the long-term

viability of the building. On the day of inspection, there was no definite date in place for this assessment to be carried out.

In response to the report, members of senior management had met and drafted a risk assessment. This assessment was viewed by the inspector. Some control measures had been completed by the day of inspection. For example, extractor fans in bathrooms had been replaced and mould had been removed, air quality tests had been conducted and were found to be within acceptable limits. However, a complete specific plan to address the entirety of the issues had not yet been developed with numerous issues remaining outstanding.

Judgment: Not compliant

Regulation 26: Risk management procedures

Improvement was required to ensure that all identified risks in the centre were addressed in a timely fashion to protect the safety of residents.

As discussed, the provider was required to submit an urgent compliance plan following this inspection. This was in response to the identified urgent need to complete a fire safety assessment outlined in the provider's report following the assessment of the premises as discussed under regulation 17: premises. Though this risk had been identified, on the day of inspection, there was no plan for this fire safety assessment to take place. In addition, the risk assessments relating to fire on the centre's risk register had not been updated in light of the risk identified in the provider's report.

The inspector reviewed the risk assessments in place for the resident who lived in the section of the building with padding. As mentioned in the opening section of the report, additional padding had been added to one room in the centre. This was as a result of an incident where the resident suffered an injury having accessed an area in their section of the building that was not padded. A further room in this section of the building remained without padding. This risk was not fully reflected in the resident's risk assessments. It was unclear what risk this room posed to the resident and whether further padding was required in this area.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

Improvement was noted in relation to the completion of assessments of the residents' needs and the development of guidance documents for staff. Residents were also now residing in rooms within the centre that met their assessed needs.

On the previous inspection of this centre, it was identified that two residents were living in parts of the centre that did not meet their assessed needs. Since that time, two residents had transitioned to new bedrooms and living rooms that were in keeping with the needs of the residents as assessed by members of the multidisciplinary team. However, as highlighted and discussed under regulation 17: premises, further improvement in this regard was required.

The inspector reviewed the assessments of need and care plans that had been developed for two residents. These showed that a comprehensive assessment of the residents' health, social and personal care needs was completed in the last 12 months. Where a need was identified, there was a corresponding care plan in place that gave clear information on the supports that should be offered to residents. The care plans had either been recently devised or updated. The inspector noted that care plans were regularly audited. One residents' care plan had been audited by two separate auditors on 24 and 25 September 2025 and this had identified areas for improvement. The nurse manager was aware of these issues and there was a plan in place to address them. This demonstrated that the strengthened oversight systems in relation to residents' assessments and care plans had been implemented and were effective.

Judgment: Compliant

Regulation 7: Positive behavioural support

The provider had implemented new systems in the centre to improve oversight of the supports offered to residents in relation to the management of their behaviour. However, improvement was required to ensure that information for staff in relation to the support of residents was clear.

Since the last inspection, the provider had introduced a multidisciplinary committee to review the restrictive practices in the centre. This committee met on a quarterly basis and were meeting in the centre on the day of inspection to review the restrictive practices in use. The person in charge had developed restrictive practice protocols that identified the rationale for the use of restrictive practices. These formed part of the review process. A sample of three restrictive protocols were reviewed by the inspector and they were found to be comprehensive.

The inspector reviewed the behaviour support plan that had been developed for one resident. This had been recently reviewed by a suitably qualified professional. The plan outlined the supports that the staff should offer the resident to maintain their behaviour and how to respond if the resident became agitated. However, the information within the plan was not always consistent with the practice in the centre. For example, the plan outlined that a particular technique should be used with the resident if they became self-injurious. When speaking with the person in charge and nurse manager, it was not clear that this technique was always implemented in these cases. In addition, the inspector reviewed the incidents that

had been recorded for this resident since May 2025 and found that there were seven occasions where the resident had engaged in self-injurious behaviour without the use of this technique. Further, six of these incidents happened when the resident accessed hard surfaces within the section of the building that had been fitted with padding on the walls.

Judgment: Substantially compliant

Regulation 8: Protection

The provider had implemented systems to protect residents from the risk of abuse. The input and advice from the safeguarding teams were implemented fully. This was an improvement since the previous inspection of this centre.

As outlined in the opening section of the report, new living arrangements had come into effect in the centre in recent weeks. This was due to residents moving bedrooms within the centre and three residents moving out to a new house. This meant that the remaining residents in the centre had more space. Residents lived in separated sections of the building and, as a result, there were less interactions between residents. This meant that negative interactions between residents was reduced also. These individualised living spaces were in keeping with the residents' behaviour support plans.

The inspector reviewed the open safeguarding plan that was in the centre on the day of inspection. This showed that the provider had identified the incident, reported it, taken action to avoid a reoccurrence and was following their own policies. There was evidence of correspondence with the national safeguarding team and that the provider was responsive to any requests from this team.

The inspector read correspondence between the person in charge and the national safeguarding team in relation to particular incidents relating to one resident. The advice of the safeguarding team had been implemented by the person in charge. This meant that safeguarding incidents were identified and recorded appropriately while other incidents were processed through more appropriate systems, for example, the provider's complaints system.

Judgment: Compliant

Regulation 9: Residents' rights

The provider completed the actions outlined in their compliance plan following the previous inspection of this centre. This included residents moving to new rooms within the centre. It also included a new system to meet with residents on a weekly

basis to support them to make choices in relation to their daily lives. However, the effectiveness of these actions in relation to the promotion of human rights required further improvement.

The provider supported two residents to move locations within the designated centre. This was to meet the needs of residents as outlined by members of the multidisciplinary team. However, the follow-up assessment of this centre by the provider's maintenance manager and members of the IPC team found that the new padding in one section of the building was not in keeping with best practice. The report on this assessment stated that the current cushioning 'intrudes into the overall space of the room. And, while its rationale is to maintain safety, it encroaches on the dignity of the individual'. Alternative and more appropriate solutions were outlined in the report.

In addition, the lay-out of the building impacted on the rights of residents. Residents were living in three separate sections of the building to reduce negative interactions and in keeping with their behaviour support plan. However, this meant that residents were not able to freely access all rooms within the house and needed to ask staff for access to the kitchen, sensory room and other shared facilities in the building. This impacted on their ability to exercise choice and control in their daily lives. These restrictions were not required to support residents to manage their behaviour but rather were as a result of the building's poor lay-out and design to meet the residents' needs.

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 16: Training and staff development	Compliant
Regulation 23: Governance and management	Substantially compliant
Quality and safety	
Regulation 10: Communication	Substantially compliant
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Ballytrim House OSV-0002523

Inspection ID: MON-0047353

Date of inspection: 30/09/2025

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:
To ensure compliance with Regulation 23: Governance and Management the following actions will be undertaken;

• The Disability Services Management Team and the HSE maintenance department have completed a scheduled of works for the centre which will be completed on a phased basis. Works agreed were put out for tender. This tendering process was completed and returned to the maintenance department. Completed 12.11.25.
• Once the tenders have been reviewed escalation for the approval for funding will be undertaken. Date for completion: 21/11/25
• A formal action plan of works with agreed timeframes will be completed by 30/11/25.
• Works will commence on a phased basis with a completion date for all works to be identified for quarter 2 of 2026. Date for completion: 30/06/26
• The formal action plan will be monitored weekly by Person in Charge, Assistant Director of Nursing and Director of Nursing through the centre's Quality Improvement Plan (QIP) until closed out. Date for completion: 30/06/26
• The PIC will ensure that all risks are reviewed on a quarterly basis or sooner if required. Date completed 31/10/25
• The PIC has reviewed and updated the risk assessments in relation to fire to ensure that they are reflective of the current status. Date completed 23/10/25
• An urgent compliance plan completed in relation to risk management on the 06/10/25, and all centre risk assessments have been reviewed and updated. Date completed 06/10/25.
• The need for alternative accommodation for residents has been agreed by Disability Service Management Team and documentation to seek national funding to support this has commenced.

Regulation 10: Communication	Substantially Compliant

Outline how you are going to come into compliance with Regulation 10: Communication:
To ensure compliance with Regulation 10: Communication the following actions have been undertaken;

• The Person in Charge in consultation with residents named nurses have reviewed the nursing interventions for 2 residents to ensure it is clear and consistent. Date completed 22/10/25
• A nursing intervention has been updated and redrafted to ensure that the information contained is clear in relation to the use of visual communication for one resident. Date completed 22/10/25

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
To ensure compliance with Regulation 17: Premises the following actions will be undertaken.

• The Disability Services Management Team and the HSE maintenance department have completed a schedule of works for the centre which will be completed on a phased basis. Works agreed were put out for tender. This tendering process was completed and returned to the maintenance department. Completed 12.11.2025
• Once the tenders have been reviewed escalation for the approval for funding will be undertaken. Date for completion: 21/11/25
• A formal action plan of works with agreed timeframes will be completed by 30/11/25.
• Works will commence on a phased basis with a completion date for all works to be identified for quarter 2 of 2026. Date for completion: 30/06/26
• The formal action plan will be monitored weekly by Person in Charge, Assistant Director of Nursing and Director of Nursing through the centre's Quality Improvement Plan (QIP) until closed out. Date for completion: 30/06/26
• The PIC will ensure that all risks are reviewed on a quarterly basis or sooner if required. Date completed 31/10/25
• The PIC has reviewed and updated the risk assessments in relation to fire to ensure that they are reflective of the current status. Date completed 23/10/25
• The need for alternative accommodation for residents has been agreed by Disability Service Management Team and documentation to seek national funding to support this has commenced.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
To ensure Compliance with Regulation 26 Risk Management the following actions have been undertaken:
• An urgent compliance plan was submitted to the Authority on the 06/10/25 addressing immediate issues under Risk Management.
• A further update was submitted by the provider on 24/10/25
• Further follow-up with the manufacturer has taken place in association with the HSE Fire Officer. The manufacturer has presented classification documentation of the various tests their products have been subject to in relation to surface spread of flame characteristic. While it has not been subjected to Euroclass 'classification I.S. EN 13501-1' research would indicate that a product achieving classification M1 on the NF P 92-507:2004 test typically achieves Class 1 or Class 0 Surface Spread of Flame Characteristics in accordance with BS476 part 7 test (equivalent to class C or B – Euroclass).

A number of internal control measures are in place within the centre from a risk management perspective:

• A wall cladding fire safety risk assessment with control measures has been developed in relation to areas where padding has been erected on the walls for safety. This has been reviewed by the HSE's E states Fire Officer.Completed: 02/10/2025 and updated following review by the Estates Fire Officer and the CNM3 for Quality, Risk & Service User safety on 06/10/2025 & 11/11/2025.
• An individual risk assessment with control measures has been developed for the resident who resides in the area of the centre where padding has been erected on the walls as a safety measure. Completed: Reviewed and updated 06/10/2025
• A general fire risk assessment with control measures has been developed for the centre. Completed: 14/02/2025 reviewed and updated 06/10/2025.
• All staff undertake fire safety training and participate in a practice fire evacuation drills reflective of both day and night time scenarios annually.
• Up to date Personal Emergency Evacuation Plans are in place for all residents residing in the centre.
• Four practice fire evacuation drills have been undertaken in the centre in 2025 year to date - three daytime fire evacuation drills and one simulated night time fire evacuation drill with the resident who resides in the padded area of the centre with full cooperation and no issues identified.
• A fire exit is immediately adjacent to the resident's bedroom and sitting room in the padded area of the centre and is in close proximity to the centre's Fire Assembly Point
• Appropriate fire equipment has been installed within the centre. There are two fire extinguishers within close proximity of the resident's bedroom and sitting room door (O2

& Water).
• All residents' risk assessments are reviewed quarterly within the centre or sooner if required.
• A fire policy is in place within the centre which has been read and signed by all staff.
• The centre is staffed 24/7 with two dedicated staff daily and one nightly to support the resident residing in the area of the centre where padding has been erected.
• The Disability Services Management Team and the HSE maintenance department have completed a schedule of works for the centre which will be completed on a phased basis. Works agreed were put out to tender. This tendering process was completed and returned to the maintenance department. Completed 12.11.2025
• Once the tenders have been reviewed escalation for the approval for funding will be undertaken. Date for completion: 21/11/25
• A formal action plan of works with agreed timeframes will be completed by 30/11/25.
• Works will commence on a phased basis with a completion date for all works to the identified for quarter 2 of 2026. Date for completion: 30/06/26
• The formal action plan will be monitored weekly by Person in Charge, Assistant Director of Nursing and Director of Nursing through the centre's Quality Improvement Plan (QIP) until closed out. Date for completion: 30/06/26
• The PIC will ensure that all risks are reviewed on a quarterly basis or sooner if required. Date completed 31/10/25
• The PIC has reviewed and updated the risk assessments in relation to fire to ensure that they are reflective of the current status. Date completed 23/10/25.

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
• The multidisciplinary team, inclusive of CNS in positive behaviour support and senior clinical psychologist, have met and are currently reviewing the identified resident's positive behaviour support plan to ensure that the guidance for staff is clear in relation to the implementation of the required techniques and interventions. Date: 20/10/2025 – BSP completed 30/10/25.

• Clinical psychologists and CNS in positive behavior support will schedule a meeting with all staff to discuss the contents of the behaviour support plans. Dates scheduled 24/11/25 and 12/12/25

• The Person in Charge will continue to monitor the incidents of self-injurious behaviour that the identified resident engages in on a weekly basis, or sooner if required, and will respond to identified actions from this review.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
In order to achieve compliance with Regulation 9 Resident's Rights the following actions will be undertaken:
• The Disability Services Management Team and the HSE maintenance department have completed a scheduled of works for the centre which will be completed on a phased basis. Works agreed were sent out to tender. This tendering process was completed and returned to the maintenance department. Completed 12.11.2025
• Once the tenders have been reviewed escalation for the approval for funding will be undertaken. Date for completion: 21/11/25
• Works will commence on a phased basis with a completion date for all works to the identified for quarter 2 of 2026. Date for completion: 30/06/26
• Internal environmental accommodations have been implemented within the centre to ensure the needs of residents are met. This has required the implementation of additional restrictive practices to ensure each residents safety and minimize the potential for safeguarding incidents. Restrictive practices have been assessed, discussed and agreed with the MDT and a restrictive practice protocol is in place outlining the rationale for each restrictive practice. Each restriction is strictly monitored and reviewed on a quarterly basis or sooner if required
• Each resident has an individualised care plan and nursing intervention that includes information on how to maintain a safe environment, inclusive of access to the kitchen area.
• An individual risk assessment in place for each resident which clearly states the level of support they require to access the kitchen within the centre.
• Each resident has an individualised care plan and nursing intervention that includes information on what activities the residents wish to access, and this includes the use of the snoozelan room within the centre.
• All residents have been assessed as requiring 1:1 support level and receive this support in the centre. This ensures each resident has supported access to all areas they wish to use when requested of indicated.
• The need for alternative accommodation for residents has been agreed by Disability Service Management Team and documentation to seek national funding to support this has commenced.

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(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	22/10/2025
Regulation 17(1)(a)	The registered provider shall ensure the premises of the designated centre are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.	Not Compliant	Orange	30/06/2026
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good	Not Compliant	Orange	30/06/2026

	state of repair externally and internally.			
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	30/06/2026
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Not Compliant	Red	30/06/2026
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	30/10/2025
Regulation 09(2)(b)	The registered provider shall ensure that each resident, in accordance with	Not Compliant	Orange	30/06/2026

	his or her wishes, age and the nature of his or her disability has the freedom to exercise choice and control in his or her daily life.			
Regulation 09(3)	The registered provider shall ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.	Not Compliant	Orange	30/06/2026