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:	Radharc Nua
Name of provider:	Health Service Executive
Address of centre:	Wexford
Type of inspection:	Announced
Date of inspection:	07 August 2025
Centre ID:	OSV-0002633
Fieldwork ID:	MON-0039197

About the designated centre

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

Radharc Nua is a designated centre located in a rural area in Co.Wexford. The centre provides long-term residential care to five adult residents, with intellectual disability, dual diagnosis and significant high support physical and behavioural support needs. Residents living in the centre require full-time nursing care. The staff team consists of nursing staff and support workers. The residents attend day-services attached to the organisation and also have in-house individualised activities. The centre comprises of a large two-story house located in rural location. It has five single bedrooms with two living rooms, a kitchen, dining room, sensory room, five bedrooms, adapted bathrooms and a large accessible garden.

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
Thursday 7 August 2025	09:30hrs to 17:30hrs	Sarah Mockler	Lead
Thursday 7 August 2025	09:30hrs to 17:30hrs	Conan O'Hara	Support

What residents told us and what inspectors observed

This was an announced inspection completed to monitor the ongoing compliance with the regulations and to inform a decision regarding the renewal of the centre registration. The inspection was completed by two inspectors across a one day period.

In 2024 the designated centre was subject to regulatory enforcement and a number of inspections to ensure that the centre was operating in line with the requirements of the Health Act 2007 (as amended). Overall, the findings of the current inspection indicated that the service had sustained improvement in a number of areas. However, there remained areas of care and support that required more focus and input to ensure that the requirements of regulation were met and that residents were afforded the best quality of care. The improvements were required in positive behaviour support, assessment and implementation of residents' personal goals, residents' rights and medication management.

The designated centre was home for five male residents. There were no vacancies on the day of inspection.

On arrival at the centre, the inspectors met with a staff nurse who was outside getting items ready for a day trip out with the residents. They explained that all residents were heading to a sea-side location for the day. Due to this, the inspectors only got to briefly meet with the five residents.

The inspectors observed three residents in their home as they were preparing for the day. One resident was being supported to have their breakfast in the kitchen alone as per their assessed needs. The inspectors observed a second resident try to go to the area of the home where the communal areas were located. However, the communal areas were locked by a keypad mechanism and the inspectors heard a member of staff explain to the resident that they could not enter this part of the home as another resident was having their breakfast. The resident was redirected. The third resident was observed sitting in the multi-sensory room. The inspectors met the final two residents in the driveway as they were already seated in their vehicle. The residents remained out of the home for the majority of the inspection day and only returned as the inspectors were leaving.

The residents primarily used non-verbal means to communicate their specific immediate needs. Although inspectors greeted the residents, the residents choose not to directly engage in return with the inspectors. The inspectors also reviewed five questionnaires completed by the residents with the support of staff. These questionnaire described their views of the care and support provided in the centre. Overall, the questionnaires contained positive views with many aspects of service in the centre such as activities, bedrooms, meals and the staff team.

The residents lived in a large detached dormer bungalow in a rural area in Co. Wexford. The home was subject to a high level of restrictive practices which were evident on the walk around of the premises. This included keypad locks on doors, bedroom doors locked and a kitchen door on keypad lock and areas of the garden surrounded by a large metal fence with areas sectioned off with gates and locks.

A number of improvements had been completed to the premises to ensure it was more homely in presentation. This included the installation of new storage presses, flooring, painting and replacement of a metal shutter in the kitchen with doors. All residents bedrooms were nicely presented and well kept. However, to the rear of the house there was an secure garden with swings, balance beams and other playground type equipment which was surrounded with multi-coloured soft tiling. The appropriateness of an area such as this required review. Staff confirmed with the inspectors that the residents did not used the equipment in this area of the garden. Overall, the garden area was well kept and maintained.

The previous inspections had identified that the residents had limited access to their community and activities outside the home. The provider had made improvements in this area by ensuring there were sufficient vehicles available to residents at all times. Residents were now getting out for drives, walks, attending local pubs and cafes for preferred drinks. Residents were also facilitated to maintain good relationships with their families. However, further improvements were required in the how activities were chosen for residents to ensure it was in line with their specific interests.

The next two sections of the report present the inspection findings in relation to the governance and management arrangements in the centre, and how these arrangements impacted on the quality and safety of residents' care.

Capacity and capability

As previously stated following a number of inspections in 2024 the provider had sustained improvement in a number of areas of care and support following the implementation of more robust and comprehensive systems of oversight. For example, the oversight systems in relation to risk management were effective in reducing incidents within the centre. However, further improvements were needed in relation to the annual review process to ensure the provider was identifying quality improvement initiatives and consulting with residents around their views of the service.

There was a clear management structure in place. The centre was managed by a full-time person in charge. They reported into the Clincial Nurse Manager (CNM3) and Assistant Director of Nursing (ADON).

Consistent staffing had improved in the centre. All vacancies were now filled with permanent staff with a much lesser reliance on the use of agency staff. This directly improved the continuity of care available to the residents.

Registration Regulation 5: Application for registration or renewal of registration

The registered provider had submitted an application seeking to renew the registration of the designated centre to the Chief Inspector of Social Services. The provider had ensured information and documentation on matters set out in Schedule 2 and Schedule 3 were included in the application. This included submission of up-to-date floor plans which outlined the layout of the designated centre.

Judgment: Compliant

Regulation 15: Staffing

Overall, the inspectors found that the provider had ensured that the number, qualifications, skill mix and experience of staff was appropriate to the assessed needs of the residents. The staff team comprised of nursing staff and multi-task attendants. In the morning of the inspection, the staff team were observed treating and speaking with the residents in a dignified and caring manner.

The five residents were supported by six staff members during the day which reduced to five staff members in the evening. At night, the five residents were supported by two staff on waking night shifts. The five residents did not attend a day service and were reliant on the staff team to support them in activation and staff supervision of residents was essential to ensure the safety of the residents.

At the time of the inspection, the centre was operating with no vacancies and two staff on long term leave. The leave was managed through the staff team, regular relief and regular agency staff. From a review of two months of rosters for June and July 2025, while there was use of agency staffing it was demonstrable that the provider was striving to ensure the majority of the shifts were covered by regular relief and agency staff. The inspectors found that the provider had ensured there were sufficient staff rostered at all times.

Judgment: Compliant

Regulation 16: Training and staff development

There were systems in place for the training and development of the staff team. From a review of the training matrix and a sample of training certificates, it was demonstrable that the staff team had up-to-date training in fire safety, de-escalation and intervention techniques, safeguarding, manual handling and safe administration of medication. In addition, the staff team were supported to undertake training in human rights and feeding, eating and drinking supports. Refresher training was scheduled as required to ensure the staff team had up-to-date knowledge and skills to support residents.

The staff team were engaged in supervision systems in the centre. While a review of supervision records for four of the staff team showed that one staff member had not received supervision in 2024, this had been addressed and supervision had been provided to the staff team for 2025. A supervision schedule was in place for the remainder of the year.

Judgment: Compliant

Regulation 22: Insurance

The service was adequately insured in the event of an accident or incident. The required documentation in relation to insurance was submitted as part of the application to renew the registration of the centre. This was reviewed by the inspectors prior to the inspection.

Judgment: Compliant

Regulation 23: Governance and management

Overall, it was found that the management systems in place were sustaining levels of care and overall ensuring that care was delivered in line with residents' specific needs. However, further improvements were needed to ensure audits and reviews were identifying quality improvement initiatives and to ensure that residents' views were accounted for as required by the regulations.

Substantive work had been taken by the provider to ensure that that the capacity and capability Regulations were meeting the requirements of The Act. However, Regulations in relation to quality and safety now required this level of oversight, review and improvement to bring around the necessary changes and ensure compliance with regulations. For example, oversight of restrictive practices and behaviour support plans needed a number of improvements as detailed under Regulation 07: Positive behavioural support.

There were clearly defined management systems in the centre. The staff team reported to the person in charge who was supported by the Clinical Nurse Manager (CNM) 3 and Assistant Director of Nursing.

The provider had in place a series of audits both at local and provider level. For example, at local level, regular hand hygiene, medication management and environmental audits were completed. The provider had implemented a system in 2024, whereby the ADON of the centre would review the actions of each audit on a quarterly basis to ensure that they were completed. This system remained in place and was effective in ensuring actions were completed in a timely manner.

However, audits were not always identifying areas for improvement. For example medication audits which had recently been completed had not identified the areas of improvement as detailed under Regulation 29: Medicines and pharmaceutical services. In addition, the most recent annual review did not identify any areas of improvement within the service. Considering the complex needs of the residents and ongoing incompatibility of the resident cohort, there were a number of areas that required improvement as identified on this and previous inspections. The annual review did not document consultation with residents or their representatives. Although residents' views were sought through other purposes, they were not included in the report as outlined in the requirement of the regulation.

Judgment: Not compliant

Regulation 3: Statement of purpose

The provider had submitted a statement of purpose which accurately outlined the service provided and met the requirements of the regulations.

Inspectors reviewed the statement of purpose and found that it described the model of care and support delivered to residents in the service and the day-to-day operation of the designated centre.

Judgment: Compliant

Quality and safety

Overall, the inspectors found that the registered provider was striving to provide care in line with residents' specific needs. Residents were safe and due to the stabilisation of the staff team more consistent care was available to the residents. However, improvements were needed in relation to positive behaviour support, management and reduction of restrictive practices, assessment and implementation

of resident's goals, medicine management and promoting a rights based approach to care and support.

As previously described there was a number of restrictive practices in place in the designated centre. For the most part the restrictive practices were subject to a specific rationale, assessment and review process. The purpose of some of the restrictive practices was to ensure that residents were not present in the same space at certain times or to allow residents time and space to de-escalate if they engaged in behaviours of concern. This had a direct impact on residents' freedom of movement around the home. Improvements were required in relation to the review process of the restrictions and concurrently updating behaviour support plans to ensure a least restrictive approach to care and support was adopted at all time.

Although improvements were noted in residents leaving the centre to engage in activities on a more regular basis, further improvements were required in this area.

Regulation 13: General welfare and development

The residents were supported with activation from the centre. While the residents did not attend a formal day service, they had the opportunity to attend sessions of interest in the day service. From a review of two residents' activation and daily records for July 2025, there was evidence that residents were accessing the community, going on drives and meeting with family members.

However, continued work was required to ensure that residents needs were sufficiently assessed in this area and that meaningful activities were chosen for the residents. For example, an interest checklist had been completed for each resident which indicated areas of interest. However, on review of personal goals it was not clear how they were aligned to the information in the interest checklist. On discussion with the staff members present it was unclear on how goals were assessed and determined for each resident. Personal goals included daily step counts, tasks in the house and promoting independence with finances. In addition, the inspectors found that not all goals had been reviewed to ensure the goal was achieved. For example, developing independence skills had been identified for residents including hand washing and use of Lámh signs. However, it was not evident that the progress in developing a number of identified skills had been reviewed.

Overall, the development of skills and goals required review to ensure they were in line with residents' interests and assessed needs and were appropriately monitored.

Judgment: Substantially compliant

Regulation 17: Premises

As part of the inspection process the inspectors completed a walk around of all areas of the home. The residents lived in a large two-storey detached dormer bungalow. Internally each resident had their own bedroom which was nicely decorated and the spaces were kept very clean. Residents had access to bathrooms with showers and baths. In terms of communal spaces residents had access to a snug room which was located near the bedrooms. At the other side of the home there was a sensory room, a kitchen, a dining room and conservatory area. Off the hall area there was a sitting room. Residents often congregated in the large hall and there was seating available to residents in this area.

Outside there was a very large garden area surrounding the majority of the home. Due to the provider identifying specific safety risks, a high fence surrounded the majority of the garden area. There were also outside structures available to some residents, this included a music shed where one resident like to listen to their music and a separate sensory room, which had a seating area and a separate toilet.

For the most part the internal and external areas of the home were well maintained. As previously described one section of the garden required review to ensure it was in line with the assessed needs and preferences of the residents. This area of the home was a large soft tiled area with equipment that was not used by the residents on a frequent basis. In addition, the snug room in the home required further development to ensure it was adequately furnished and decorated. The provider had identified the need for improvement in these areas, but the works remained outstanding on the day of inspection.

Judgment: Substantially compliant

Regulation 20: Information for residents

The provider had prepared a residents guide which contained all of the information as required by Regulation 20: Information for residents including a summary of the services and facilities available, the terms and conditions of living in the centre, the arrangements for consultation with residents, how to access inspection reports, the complaints procedure and the arrangements for visits.

Judgment: Compliant

Regulation 26: Risk management procedures

The registered provider ensured that there were systems for the assessment, management and ongoing review of risk. The inspectors reviewed the risk register

and found that general and individual risk assessments were in place. The risk assessments were up-to-date and reflected the control measures in place.

The inspectors reviewed individual risk assessments in relation to specific medical needs, safeguarding, behaviours of concern, hospital admissions and slips trips and falls. All risk assessments had been reviewed in April 2025. It was found that control measures had been updated accordingly. For example, a risk assessment in relation to a bathroom had been updated following the restructuring of the environment and this change had been accounted for in the control measures and relevant risk rating.

The inspectors found that there were good arrangements for the recording and review of incidents and adverse events. This included trending incidents and accidents on a regular basis to ensure that emerging trends could be identified in a timely manner. There was evidence that senior management had oversight of incidents through sign off of incident reports and monthly and quarterly trending. Overall, there had been a significant reduction in incidents due to a number of measures taken by the provider.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

The provider had systems in place for the receipt, storage and administration of medications. However, the systems were not effective in ensuring medicine management was in line with best practice and the provider's policy.

For example,

- On review of the Medicines prescribed as required (PRN) there was an absence of maximum dosages on relevant documentation
- There was a collective approach to PRN medication with the medicines having a prescribing label on the box of medicine that indicated it was prescribed for one resident, however, the medicine was utilised for all residents (please note all residents had a prescription in place for the relevant medicine)
- On review of the PRN medicines in place there were two bottles of medicine out of date. One label indicated the medicine was out of date since March 2025 and the second bottle expired in June 2025. Although this medicine had not been administered there was no in date medicine on site for this resident if they needed. The storage of this medicine was also not in line with the requirements of the relevant regulation
- PRN protocols in relation to specific medicines had not been updated on a minimum of an annual basis. For example, the inspector reviewed one PRN medicine protocol that was dated August 2023.
- Over the counter medicines were stored in the medication press and had no prescription or guidelines in place.

Cumulatively, these practices were not indicative of good practice in relation to medicine management. Review of practices and audits in place to identify relevant issues required improvement to ensure safe practices were in place at all times.

Judgment: Not compliant

Regulation 7: Positive behavioural support

A number of the residents in the home were assessed as requiring significant input in relation to positive behaviour support. In addition, there a number of restrictive practices in place in the home. Therefore it was essential that a robust and comprehensive approach to positive behaviour support and review of restrictive practices was occurring on a regular basis. Although some input was noted in relation to this care need, from the information in place the inspectors were not assured that plans were updated on a regular basis and that restrictions were reviewed in line with an evidence based approach

The inspectors reviewed the positive behaviour support plan in place for one resident. Due to their assessed needs there were a number of documents in place which detailed the supports in place around specific behaviours. None of these documents were dated and it was unclear when these were reviewed by the relevant health and social care professional. In addition, there was a function based assessment which was completed in February 2022 with stated actions. Again it was unclear when this was reviewed or updated in it's entirety. For example, one goal of the plan was to reduce a specific behaviour to a frequency of 20% in a six month period. There was no indication if this was achieved and if not, what changes were made to the plan on foot of this. It was essential that the plan was reviewed on a regular basis due to the risk posed by the behaviours that challenge and the restrictions that were in place on foot of this.

The inspectors reviewed the systems in place to review restrictive practices within the centre. As part of this process the provider had established a Right's Review Committee. The restrictions in the designated centre were discussed on 5 November 2024. At this meeting three new restrictive practices had been discussed and approved. However, these restrictions were not on the current restrictive practice log or any other documentation in relation to recording the use of restrictions. The inspectors saw that that two of the restrictions were in place on the day of inspection. This was not in line with the provider's policy or best practice in terms of a least restrictive approach to care and support. In addition, all other restrictions discussed indicated that they were to remain in place. It was unclear on what information, data or incident review was utilised to inform this decision The notes also failed to include what alternatives had been trialled or considered.

Judgment: Not compliant

Regulation 8: Protection

Notwithstanding the identified compatibility concerts as detailed in Regulation 09: Residents' Rights, the registered provider and person in charge had implemented systems to safeguard the resident. There was evidence that incidents were appropriately reviewed, managed and responded to.

All staff had completed safeguarding training to support them in the prevention, detection, and response to safeguarding concerns.

At the time of inspection there were no open safeguarding concerns in the centre.

Following a review of two residents' care plans inspectors observed that safeguarding measures were in place in the form of safeguarding plans which guided staff on how to support residents, and report safeguarding incidents if they occurred within the centre.

Judgment: Compliant

Regulation 9: Residents' rights

All residents in the home were assessed as needing a low arousal environment. This assessed need was well known to the provider and was documented throughout assessments of needs, risk assessments and behaviour support plans. However, due to the specific needs of each resident and the large cohort of staff required to meet their needs, the designated centre could not provide care and support in line with this approach. Although the provider had put in a number of measures to address this, such as the use of restrictive practices. The long term compatibility of the resident cohort required review to ensure a right's based approach to care and support could be provided.

For example, a number of restrictive practices were in place to manage the compatibility of the resident group such as staggered meal times and keypad locks on doors to keep residents separate from each other at certain times. The inspectors were informed of a long-term plan to reduce the number of residents in this centre. However, at the time of the inspection, this was still in the planning stage and no definitive decision had been made.

As part of the inspection process the inspectors followed up on the actions taken by the provider in relation to a resident who had no family or other legal representative in place due to bereavements. This had been the position for this resident for approximately 24 months and had been highlighted in previous inspection reports. Although the provider was aware of this, the staff present on inspection were unaware if the resident been referred to advocacy services or other relevant services such as supports around the Assisted Decision Making Act (2015) despite the fact

they had no nominated person to help them make decisions around finances, healthcare or other care related matters including restrictive practices. The resident was recently diagnosed with a serious health condition and it was unclear how this resident was supported to make decisions.

Residents meetings took place on a weekly basis. The inspectors reviewed four weeks of resident meeting notes. In this meeting, menu planning, activities and changes with care and support was discussed with residents. For example, a recent meeting discussed plans for updating a communal area in the house.

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	
Registration Regulation 5: Application for registration or renewal of registration	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Compliant
Quality and safety	
Regulation 13: General welfare and development	Substantially compliant
Regulation 17: Premises	Substantially compliant
Regulation 20: Information for residents	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Radharc Nua OSV-0002633

Inspection ID: MON-0039197

Date of inspection: 07/08/2025

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	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The content and layout of the Positive Behaviour Support Plans have been revised to incorporate documented evidence of review within each section. The Positive Behaviour Support Plan now identifies the specific stage within the 'CPI Crisis Development Model' at which any restrictive practices may need to be utilized. The provider will ensure a more comprehensive approach is utilized when completing the Annual Review to ensure compliance and the identification of actions for improvement while also showing evidence of consultation with residents. The Medication Auditing documentation has been reviewed and enhanced	
Regulation 13: General welfare and development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 13: General welfare and development: The provider is working with the ADON and PIC to develop an educational element for all staff to enhance Skills and Goal identification for residents. Some of the Activity planning documentation has been reviewed to ensure areas which could be ambiguous were improved.	

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
The soft play area of the garden has been scheduled for design and upgrade in line with residents identified change in needs

Regulation 29: Medicines and pharmaceutical services	Not Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
The medication management policy is been updated and all PRN medications will now state maximum dose in 24 hours.

The form recording PRN medications has now been adapted and nurses now have the responsibility of checking and signing the expiry date of all PRN medication on a weekly basis.

Whilst all PRN protocols are reviewed on at least an annual basis, keyworkers have now the responsibility to ensure the updated and reviewed protocols are presented in all relevant places i.e. MPARS, support plans and personal plans.

Any over the counter medication brought in by family members will be returned to the family member immediately or brought to the attention of the individuals GP for a prescription

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
The content and layout of the Positive Behaviour Support Plans have been revised to incorporate documented evidence of review within each section.

The Positive Behaviour Support Plan now identifies the specific stage within the 'CPI Crisis Development Model' at which the sensory garden gate restriction becomes necessary.

A protocol governing the restriction of the left hallway door to the dining/MSR area and

the conservatory door has been established and and will be reviewed annually—or more frequently if needed—by the Rights Review Committee (RRC)

A comprehensive review of all restrictions was undertaken and all restrictions are now recorded in the restrictive practices log.

A three-month trial period is currently underway for the removal of water restrictions in both bathrooms. Data collected during this period will be analysed and the findings will be presented to the RRC for review at the November 2025 meeting.

The RRC has revised its referral form to include additional information, detailed context, and relevant data from incident reviews. The updated form will also capture key points from the RRC meeting discussion to support and justify the decision regarding the imposed restriction. RRC minutes also available to reflect discussions at review meetings.

A multidisciplinary team (MDT) review is scheduled to take place

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
All resident's compatibility assessments are continuously under review influenced by change in need. A service wide review is scheduled for Q4 2025, the findings from same will inform the next phase of our downsizing plan.

An MDT review is scheduled for completion in Q3 and all recommendations will be initiated by year end.

The Rights Review Committee are meeting on 22/09/2025. Following a comprehensive desk top review over a 2 week period the intention is to propose to works towards a reduction / removal of a number of restrictions over a period of time.

The next phase of housing and subsequent moves for the service is due for completion in Q3 2026 at which point one of the residents from the Centre will move as part of this reconfiguration reducing the number of residents in the Centre to 4 at that time.

The provider and PIC are actively progressing an application for the assignment of a DMR for one resident. A HSE solicitor had been engaged and completed a capacity application to the Circuit Court on behalf of the resident in 2024 and the process is near completion. In the interim the DON, PIC and Keyworker are acting as interim supports and ensuring the resident is fully supported and has all of his needs met. Currently the focus is on his changing health care needs.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 13(2)(b)	The registered provider shall provide the following for residents; opportunities to participate in activities in accordance with their interests, capacities and developmental needs.	Substantially Compliant	Yellow	31/10/2025
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Substantially Compliant	Yellow	31/03/2026
Regulation 23(1)(d)	The registered provider shall ensure that there is an annual review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards.	Not Compliant	Orange	09/09/2025

Regulation 23(1)(e)	The registered provider shall ensure that the review referred to in subparagraph (d) shall provide for consultation with residents and their representatives.	Substantially Compliant	Yellow	15/10/2025
Regulation 29(4)(b)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine which is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.	Not Compliant	Orange	09/09/2025
Regulation 29(4)(c)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that out of date or returned medicines are stored in a secure	Not Compliant	Orange	09/09/2025

	manner that is segregated from other medicinal products, and are disposed of and not further used as medicinal products in accordance with any relevant national legislation or guidance.			
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.	Not Compliant	Orange	09/09/2025
Regulation 09(2)(b)	The registered provider shall ensure that each resident, in accordance with 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.	Not Compliant	Orange	30/11/2025
Regulation 09(2)(d)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability has access to advocacy	Not Compliant	Orange	30/10/2026

	services and information about his or her rights.			