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:	Bray Supported Accommodation
Name of provider:	The Rehab Group
Address of centre:	Wicklow
Type of inspection:	Unannounced
Date of inspection:	23 April 2025
Centre ID:	OSV-0002642
Fieldwork ID:	MON-0046579

About the designated centre

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

Bray Supported Accommodation is a designated centre operated by RehabCare and located in County Wicklow. The aim of Bray Supported Accommodation is to provide a community-based accommodation service for four adults, both male and female with mild to moderate intellectual disabilities. The aim of the service is to provide a homely, comfortable and safe environment to support each individual's specific needs. The service supports each resident to maximise their independence taking into account their specific needs and abilities. Residents have access to external day services during the day-time. The service provides a social model of care and therefore cannot support the needs of those experiencing complex medical conditions that require significant levels of daily nursing care. The house is a two storey semi-detached property with five bedrooms, two bathrooms and a sleepover room for staff. There is also a kitchen/dining area, office, sitting room, conservatory and an external laundry room. The service is currently staffed 24/7. This includes day-time staff and sleep-over staff. This is a lone-working service which means one staff on shift at anytime. The centre is staffed by a person in charge, team leader, support workers and relief support workers.

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
Wednesday 23 April 2025	08:45hrs to 17:00hrs	Kieran McCullagh	Lead

What residents told us and what inspectors observed

This unannounced inspection was carried out to assess the quality and safety of care provided to residents. It focused on how residents were being safeguarded in the centre and was prompted by solicited information that raised concerns about care standards at this designated centre. For instance, since August 2024, a total of 19 safeguarding notifications had been submitted to the Office of the Chief Inspector.

The inspector determined that, overall, residents received high-quality care provided by a familiar staff team who delivered it with kindness and respect. However, there were areas of non-compliance found relating to training and staff development, governance and management and individual assessment and personal plans. Furthermore, improvements were required under a number of other regulations, including staffing, premises, and risk management procedures. These are all discussed further in the main body of the report.

The inspection was carried out over a single day and was facilitated by the team leader and project executive. At the time of this inspection, a new person in charge had recently assumed the role but was on planned leave. To assess the quality of life for the residents the inspector relied on a combination of observations, discussions with residents, a review of relevant documentation, and conversations with key staff members.

The centre was registered to accommodate four adult residents. During the inspection, the inspector was able to meet with three of the residents living in the home. According to the centre's Statement of Purpose, its aim was to provide a community-based accommodation service for adults with mild to moderate intellectual disabilities. The centre strived to offer a homely, comfortable, and safe environment tailored to meet the specific needs of each individual. Additionally, the service was designed to support residents in maximising their independence, while taking into account their unique needs and abilities.

The designated centre was a two-storey semi-detached property situated in close proximity to various public amenities. It comprised four single-occupancy bedrooms, a kitchen and dining room, a sitting room, a sunroom, a staff sleepover and office room, and two bathrooms. Additionally, the property offered both front and back gardens, which provided outdoor space for residents to use as they wished.

The inspector conducted a walk-through of the premises accompanied by the team leader. Overall, the inspector observed that the designated centre was clean and well-maintained. The inspector noted that the out-of-hours on-call arrangements were made accessible to staff and were displayed in the kitchen, ensuring they were available for use if needed. Additionally, a comments, compliments, and complaints box was placed in the sunroom, allowing residents and staff to provide feedback on the service. However, a number of maintenance issues remained unresolved, some

of which had been identified in the provider's own internal audits and during the June 2023 inspection. For instance, the inspector observed the flooring in the kitchen was extremely uneven in some sections, which created a trip hazard and required replacement. This is discussed in full under Regulation 17: Premises.

The inspector observed that residents could access and use available spaces both within the centre and garden without restrictions. There was adequate private and communal space for them as well as suitable storage facilities and the centre was found to be in good structural and decorative condition.

The inspector had the opportunity to meet with three residents during the inspection. Residents were observed to lead busy and active lives, expressing satisfaction with their home and the staff who supported them. They shared their enjoyment of activities such as setting the table for dinner, going out for coffee, and their love of history. One resident was observed reading through a history book at the kitchen table and told the inspector they enjoyed looking through old photographs of where they used to live. Throughout this inspection, residents appeared comfortable and at ease with staff, demonstrating a relaxed and happy demeanor in their home. It was evident that they had a strong rapport with the staff. The centre itself presented as a calm, relaxed environment, free from any sense of restriction.

The inspector did not have an opportunity to speak with the relatives of any of the residents, however a review of the provider's annual report on the quality and safety of care provided in the centre, report that residents were happy with the care and support they received.

The inspector also had the opportunity to meet with a care worker, who had started in their role in November 2024 and working the day of the inspection. The care worker shared that they really enjoyed working in the centre and had developed a strong connection with the residents they supported. They were knowledgeable of residents' needs and the supports in place to meet those needs. They also discussed some of the challenges they had encountered, including difficulties accessing the provider's online system for recording and reporting incidents. Later in the inspection, the inspector asked the team leader to demonstrate how to log onto the system. However, this proved difficult, and the issue is discussed further in the report under Regulation 23: Governance and management.

The inspector engaged in detailed discussions with the team leader and project executive who facilitated the inspection, with a particular focus on the changing needs of one resident. The resident's assessed needs had increased after they experienced a serious medical condition in late 2023, that had resulted in neurological and behavioural changes for the resident. This, in turn, had led to an increase in peer-to-peer safeguarding incidents within the centre.

The provider responded appropriately, ensuring that all incidents were fully investigated and reported in accordance with national safeguarding policy and procedural requirements. It was acknowledged by the provider that the resident's current living arrangement was no longer suitable in light of their changing needs.

In response, additional staffing had been deployed to work in the centre to maintain a safe and supportive environment for all residents. The inspector reviewed and confirmed the presence of formal safeguarding plans and positive behaviour support guidelines on file. In addition, the provider was actively liaising with their funder and had identified a more suitable alternative living arrangement to better support the resident's evolving care needs.

From speaking with residents and observing their interactions with staff, it was evident that they felt very much at home in the centre, and were able to live their lives and pursue their interests as they chose. The service was operated through a human rights-based approach to care and support, and residents were being supported to live their lives in a manner that was in line with their needs, wishes and personal preferences.

The next two sections of the report present the findings of this inspection in relation to the governance and management arrangements in place in the centre and how these arrangements impacted on the quality and safety of the service being delivered to each resident living in the centre.

Capacity and capability

Safeguarding is a critical responsibility for providers in designated centres. All residents have the right to safety and to live free from harm, which is essential for delivering high-quality health and social care. Residents should be able to trust the provider, person in charge, and the staff to help them feel secure. Therefore, effective safeguarding depends on collaboration among individuals and services to ensure that residents are treated with dignity and respect, and are empowered to make decisions about their own lives.

There was a clearly defined management structure in place and staff were aware of their roles and responsibilities in relation to the day-to-day running of the centre. There was a regular core staff team in place and they were knowledgeable of the needs of the residents and had a good rapport with them. The staffing levels in place in the centre were suitable to meet the assessed needs and number of residents living in the centre. Warm, kind and caring interactions were observed between residents and staff and staff were observed to be available to residents should they require any support and to make choices. However, improvements were required concerning the staff rosters, specifically regarding the recording of the full names of relief and agency staff members on duty.

Appropriate training is fundamental in supporting staff to understand behaviours that challenge and promoting environments that respect residents' rights and dignity. The provider had not ensured that all staff who worked with residents who needed behaviour support had up-to-date skills or training in positive behaviour support. Additionally, enhancements were required to the supervision arrangements for all staff to ensure they received appropriate support and supervision from

qualified and experienced personnel. Furthermore, improvements were necessary in the induction and probationary procedures for all new staff members to ensure they were in receipt of all relevant support, information, and training necessary to enable them to carry out their duties responsibly.

During the course of this inspection, the inspector observed several critical areas where the governance and management structures required improvement. Specifically, the provider's failure to address a significant number of actions from their own provider-led audits (out of 60, only 13 were completed), indicated a lack of effective oversight.

Key areas such as staff team meetings, staff training, staff usability of the provider's online system to record incidents, local auditing systems and resident key working were of particular concern, suggesting poor management control and insufficient governance mechanisms in place to ensure continuous improvement and compliance with regulatory requirements.

The next section of the report will reflect how the management systems in place were contributing to the quality and safety of the service being provided in this designated centre.

Regulation 15: Staffing

On the day of this inspection, the provider ensured there were sufficient staffing levels with the appropriate skills, qualifications, and experience to meet the assessed needs of the residents at all times, in accordance with the statement of purpose and the size and layout of the designated centre. The inspector noted that the staff team were well qualified, and dedicated to delivering care that upheld residents' rights and ensured their safety.

The staff team was comprised of the person in charge and care workers. The inspector examined the planned and actual staff rosters for January, February, March and April 2025. It was found that the provider was committed to ensuring continuity of care for residents within the service by utilising a small group of regular relief and agency staff to cover vacant shifts. However, the inspector observed that improvements were needed in the staff rosters. Specifically, the full names of relief and agency staff were not consistently recorded, and in some instances, the agency worker's name was missing or their first name recorded only and the name of the agency worked for. This area required improvement by the person in charge to ensure accurate and complete documentation.

During the inspection, the inspector spoke with a number of staff members on duty and found that all were highly knowledgeable about the residents' support needs and their responsibilities in providing care. Residents were familiar with the staff and felt comfortable interacting and receiving care. It was clear that staff had developed

and maintained therapeutic relationships with residents, helping them feel safe, secure, and protected from all forms of abuse.

Judgment: Substantially compliant

Regulation 16: Training and staff development

The inspector reviewed the most recent staff training records maintained in the designated centre, which documented that the staff team had current training in mandatory areas including, fire safety and safeguarding. However, four of the staff team had not completed recent training in positive behaviour support. It was observed that refresher training had not been arranged for these staff members by the time of this inspection. This presented a risk to the staff members providing person-centred, safe, and effective support to residents with identified positive behaviour support needs.

The person in charge was responsible for the provision of supervision and support to all staff members within the designated centre. According to the provider's policy, staff were to receive four formal supervision sessions per year. The inspector requested supervision records for two staff members covering Q3 and Q4 of 2024, as well as Q1 of 2025. However, these records were not made available for the inspector to review on the day of this inspection and the inspector was not assured that staff were in receipt of supervision and support relevant to their roles.

In addition to the supervision records, the inspector also requested documentation of the induction and probationary meetings from the provider's Human Resource department for a staff member who commenced in their role in November 2024. During this inspection, the requested records were not made available for review. This absence raised concerns about whether new staff members had received a comprehensive understanding of their roles and responsibilities, and the necessary practical training in order to best support and work with residents. This required considerable review and improvement by the provider and person in charge.

Judgment: Not compliant

Regulation 23: Governance and management

The inspector noted that while clear lines of authority and accountability were in place within the designated centre, this inspection highlighted a number of key areas where improvements were required in oversight and local management systems. Specifically, enhancements were needed in training and staff development,

in the documentation and reporting of incidents, and individual assessment and personal plans.

In compliance with regulatory requirements, unannounced visits were conducted biannually of the designated centre. The inspector reviewed the report following the latest unannounced visit. Following the review, the inspector noted that a total of 60 actions were identified during this visit. Of these, only 13 actions had been marked as completed. The remaining outstanding actions pertained to key areas including staff team meetings, staff usability of the provider's online system to record incidents, risk management, resident key working, as well as infection prevention and control, and maintenance issues.

Staff members informed the inspector that monthly staff team meetings were intended to occur on a regular basis. Upon request, the inspector reviewed the minutes of staff team meetings held at the designated centre. The most recent meeting minutes available were dated November 2024. This did not provide sufficient assurance to the inspector that all staff were being adequately updated and informed about the evolving needs of residents within the service and this posed a risk to the staff members providing person-centred, safe, and effective support to residents.

Staff members conveyed to the inspector the challenges they faced when attempting to log onto the provider's online system to record incidents. When asked to demonstrate the process, one staff member explained that accessing the system required the use of a mobile phone to complete the two-factor authentication process. It was observed that not all staff members had access to a work mobile phone, necessitating the use of their personal mobile phones to download and access the required application. This practice was not in alignment with the provider's policy on the use of personal mobile phones at work. As a result, not all incidents were accurately recorded on the provider's online system. Staff members informed the inspector that handwritten notes were taken, with the responsibility of uploading these notes resting with the team leader or the person in charge. This necessitated thorough review and consideration by the provider and person in charge to ensure that all relevant adverse incidents were accurately recorded and documented.

The inspector conducted a comprehensive review of the local auditing systems in place at the designated centre. It was required that the person in charge completed a monthly audit to inform the management team about critical information related to safeguarding, staffing, and accidents and incidents. However, the last completed monthly audit on file was dated October 2024. As a result, a number of actions identified from previous internal audits remained outstanding. For instance, actions related to infection prevention and control (IPC), housekeeping and maintenance remained incomplete. The lack of recent auditing did not provide the inspector with sufficient assurance that that the provider had robust arrangements in place to ensure the delivery of a high-quality, safe service to residents and that national standards and guidance were being effectively implemented.

Judgment: Not compliant

Quality and safety

This section of the report provides an evaluation of the quality of services delivered and the effectiveness of measures implemented to ensure the safety of residents. Regulations pertaining to safeguarding were specifically assessed as a part of this inspection.

Overall, a good quality of service was provided to all residents, and during this inspection, the inspector observed residents expressing their choices to staff regarding what they wanted to do and when they needed support. However, improvements were required in relation to premises, risk management procedures and individual assessment and personal plans.

The provider recognised that the premises can have a significant impact on residents' quality of life, including their changing needs over time. They took into account safeguarding measures and ensured that the facilities at the designated centre were appropriate for the number and assessed needs of the residents. This alignment was in accordance with the Statement of Purpose as required under Regulation 3. The inspector found the atmosphere in the centre to be warm and relaxed, and residents appeared to be very happy living in the centre and with the support they received. However, a number of maintenance issues were identified that required attention including the need for flooring repairs in the kitchen and dining room, as well as repainting in the staff office.

The provider acknowledged that fostering positive risk-taking was crucial for delivering high-quality care and significantly contributed to the growth and development of all residents. The provider had a risk management policy in place, scheduled for review in December 2026. However, a review of the policy evidenced that essential information, as mandated by regulations, was absent from the policy. Furthermore, the inspector highlighted that the individual centred risk assessment in place for one resident, concerning safeguarding, needed updating to explicitly incorporate an existing formal safeguarding plan and positive behaviour support guidelines.

During this inspection, the inspector observed that substantial improvements were necessary concerning the individual assessments and personal plans for the residents living in this designated centre. The inspector found it challenging to ascertain whether residents' individual assessments and personal plans were being consistently reviewed in the provider's electronic system. Improvements were also necessary concerning the assignment of key workers and the implementation of goals for residents. For instance, during this inspection it was noted that one resident had not been assigned a key worker and goals established for residents did not reflect any measurable progress or positive outcomes.

Where required, positive behaviour support guidelines were developed for residents and staff members spoken with on the day of this inspection were knowledgeable about guidelines in place. The provider and person in charge ensured that the service continually promoted residents' rights to independence and a restraint-free environment.

The provider and person in charge were endeavouring to ensure that residents living in the centre were safe at all times. Good practices were in place in relation to safeguarding. Any incidents or allegations of a safeguarding nature were investigated in line with national policy and best practice. The inspector found that appropriate procedures were in place, which included safeguarding training for all staff, the development of personal intimate care plans to guide staff and the support of a designated safeguarding officer within the organisation.

The inspector saw that staff practices in the centre were upholding residents' dignity and were supporting residents to have control over their lives. Residents were continually consulted about and made decisions regarding the ongoing services and supports they received, and their views were actively and regularly sought. Information was made available to residents in a way that they could understand in order to support them to make informed choices and decisions.

Overall, residents were provided with safe and person-centred care and support in the designated centre, which promoted their independence and met their individual and collective needs.

Regulation 17: Premises

The provider had considered safeguarding in ensuring that the premises of the designated centre was appropriate to the number and assessed needs of the residents living in the centre and in accordance with the statement of purpose prepared under Regulation 3. The inspector observed that the premises conformed to the standards outlined in Schedule 6 of the regulations, with consideration given to the safeguarding needs of the residents living in the centre.

Residents were able to freely access and use the available spaces within the centre and its gardens. Facilities were well maintained and in good working order. There was sufficient private and communal space for residents, along with appropriate storage facilities.

Each resident had their own bedroom, which was decorated according to their personal style and preferences. For example, bedrooms featured family photos, artwork, soft furnishings, and memorabilia that reflected their individual tastes and interests. This approach supported the residents' independence and dignity, while acknowledging their uniqueness. Additionally, every bedroom was provided with ample and secure storage for residents' personal belongings.

However, during the walk through of the designated centre, a number of maintenance issues were identified that required attention. These issues had previously been identified during the last inspection in 2023 and were also noted in the provider's own internal audits. For instance, improvements were necessary for the exterior of the service area, specifically the lawns, weeding, and hedging, which had become overgrown and unkempt. Additionally, the kitchen and dining room flooring was extremely uneven in certain areas, posing a trip hazard and necessitated replacement. A brighter light was required in the back corridor, which was observed to be very poorly lit and the staff office required repainting. Lastly, the sitting room fireplace was chipped and damaged, requiring repair and replacement to restore its condition.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

The provider had a risk management policy in place which was due for review in December 2026 and was reviewed by the inspector. The inspector noted that the provider had not ensured that the policy included all necessary information in accordance with regulatory requirements. For instance, it did not contain or signpost staff to information pertaining to the unexpected absence of a resident, accidental injury to residents, visitors, and staff, aggression and violence or self-harm. This required review by the provider.

The risk management policy had arrangements for the identification, recording, investigation and learning from safeguarding incidents. Safeguarding risks were identified, assessed, and necessary measures and actions were in place to control and mitigate risks. In line with the risk management policy, there was a risk register in place which detailed potential risks in the centre as well as the measures in place to reduce or eliminate them.

On the day of this inspection, the inspector found that each residents' safety, health and wellbeing was supported through individual centred risk assessment and action forms. Risk assessment forms included appropriate measures and actions in an attempt to control and mitigate identified risks. For example, where risks were identified for a resident relating to slips, trips and falls, the provider had put a number of appropriate controls in place which included an up to date falls management plan.

However, the inspector noted that one resident's individual centred risk assessment pertaining to safeguarding required updating to explicitly reference an existing formal safeguarding plan and positive behaviour support guidelines in order to assist staff deliver the most appropriate care and support for the resident.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

All residents had current assessments of need on file. These assessments were used to develop their care plans, which were documented in the provider's electronic care management system. The inspector conducted a detailed review of three residents' care plans. However, it was challenging to determine whether these plans were being consistently reviewed on the provider's electronic system. For instance, some care plans had review dates recorded in 2022 and 2023. Although staff members indicated that annual reviews were completed, there was no evidence that these updates were recorded or entered into the system. Consequently, the inspector could not confirm that regular updates or reviews were being performed for all residents.

The inspector was informed that all residents actively participated in the person-centred planning process and regularly took part in monthly key working meetings. During a thorough review of three residents' person-centred plans, it was found that one resident did not have a key worker assigned to support or work with them and another resident's last recorded note from a key working meeting was dated 24 September 2024. Additionally, while goals were documented for residents, some of these goals, set in 2022, showed no evidence of regular updates or reviews. The inspector could not ascertain whether the established goals were achieved or in progress or if they had a positive impact on the residents involved.

Further improvements were needed for the care plans entered into the provider's electronic care management system. For example, one resident's mental and emotional care plan indicated that the resident was not connected with the multidisciplinary team, specifically the psychologist and behaviour specialist. However, the inspector observed that the resident was actively engaged with both professionals and had positive behaviour support guidelines in place. This presented a risk to the clarity and accuracy of documentation, which was essential for ensuring residents were provided with safe and person-centred care and support at all times and required considerable review by the provider and person in charge.

Judgment: Not compliant

Regulation 7: Positive behavioural support

The inspector found there were arrangements in place to provide positive behaviour support to residents with an assessed need in this area. For example, positive behaviour support guidelines reviewed by the inspector were detailed and comprehensive. In addition, the guidelines included information pertaining to antecedent events, proactive and preventive strategies for staff to follow in order to reduce the risk of behaviours that challenge from occurring.

Residents were connected with members of the provider's multidisciplinary team, including a psychologist and a behaviour specialist, who actively monitored incidents and collected data in order to inform interventions and provide positive behaviour supports to residents.

Staff members spoken with on the day of this inspection were knowledgeable about guidelines in place, and the inspector observed positive communication and interactions between residents and staff throughout the inspection. Additionally, systems were in place to regularly monitor the behavioural support approach, and staff avoided practices that could be seen as institutional abuse.

There were no restrictive practices used in this designated centre and the inspector found that the provider, person in charge. and staff team were promoting residents' rights to independence and a restraints free environment.

Judgment: Compliant

Regulation 8: Protection

The registered provider and person in charge had established systems to safeguard residents from abuse. For instance, a clear policy was in place, providing staff with explicit guidance on the appropriate actions to take in the event of a safeguarding concern. Furthermore, all staff had completed safeguarding training equipping them with the skills necessary for the prevention, detection, and response to safeguarding issues.

Since August 2024, a high number of safeguarding notifications had been submitted to the Chief Inspector. The inspector observed that there were ongoing safeguarding concerns in the designated centre and confirmed that preliminary screening forms were completed and submitted to the National Safeguarding Office.

At the time of this inspection there were no safeguarding concerns open. However, the inspector's review of preliminary screening forms evidenced that the information provided was both comprehensive and detailed. Additionally, interim and formal safeguarding plans, where necessary, were incorporated as part of this process.

The provider acknowledged that the current living arrangement for one resident was not suitable, following a recent change to their medical needs, and had made a decision in order to address this issue. For instance, a more appropriate residence was identified. The provider was proactively planning for the resident to transition to a male-only residence, following consultations with their clinical and multidisciplinary teams and was actively engaging with their funder as part of this process.

Judgment: Compliant

Regulation 9: Residents' rights

There was evidence that the centre was operated in a manner that respected residents' rights, needs, and choices, thereby supporting their welfare and promoting self-development.

The provider had fostered a culture where a human rights-based approach to care was central to how residents were supported. Throughout the inspection, the use of this approach was evident, empowering residents to live lives of their choosing, guided by human rights principles. For example, residents had control over their daily routines, making choices based on their personal values, beliefs, and preferences. The inspector saw that staff interactions with residents were in a manner which upheld residents' dignity and provided residents with choice and control. Staff were seen offering residents choices, responding to residents needs and requests by providing direct assistance in a manner which respected residents' right to dignity and privacy.

During the previous inspection conducted in June 2023, concerns were identified regarding the existing procedures for paying utility bills. For instance, expenses associated with groceries and bi-monthly utility bills were observed to very high, and there was a lack of clear justification or consultation regarding why residents were contributing to the utility expenses related to the operation of the staff office and sleepover room. Since the previous inspection, the provider had submitted two business case proposals to their funder regarding this matter. Additionally, they commenced contributing towards the cost of utility bills. The inspector spoke with residents regarding this matter, and they expressed satisfaction with the recent reduction in utility costs.

Residents attended weekly resident meetings. The inspector reviewed resident meeting minutes held throughout March 2025, which evidenced residents discussed health and safety, infection prevention and control (IPC), meals for the week, shopping duties, grocery and utility bills, activities and compliments and complaints.

Overall, it was clearly demonstrated residents received a high standard of support, person-centred and rights-informed care, which was upholding their human rights. Residents were observed to engage in meaningful activities in line with their assessed needs, likes and personal preferences throughout the inspection.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Bray Supported Accommodation OSV-0002642

Inspection ID: MON-0046579

Date of inspection: 23/04/2025

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • Rota's are now completed with full names of all staff including relief staff and agency staff with their job title clearly stated. Completed on 30/04/25.	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • Positive Behaviour Support Training will be completed by all staff before 01/08/25. • Going forward the PIC will monitor staff training on a monthly basis as part of the monthly audit and upcoming training will be booked as required. • Supervision with all staff has now been completed and all sessions have been scheduled for the rest of the year. Completed 30/04/25. • Going forward, PIC will ensure that all staff are facilitated with a formal induction and induction & probation meeting documentation will be available on request on site.	
Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
• Staff meetings are now held every 3 weeks and are scheduled for the remainder of this year, they are documented on the rota. Completed by 30/04/25
• The provider is currently engaged in a procurement process to purchase a new incident management system. Issues relating to two factor authentication will be addressed discussed with the Providers Head of IT and alternative solutions will be explored. This will be completed by 30/08/2025.
• Staff also got retrained on the 21/05/25 on how to log into the system and how to complete an incident from start to finish from the viclarity team.
• Monthly Audits to review key aspects of service delivery are now being completed on a monthly basis by PIC, this was implemented by 30/05/25.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• A yearly schedule with a gardening contractor to look after the outside of the house. Lawns and weeding has been completed, hedging has been scheduled for September when it is safe to cut them.
• Kitchen and dining room flooring will be replaced by the landlord before 31/08/2025.
• New lighting in back corridor will be installed by 31/07/2025.
• Painting was completed in staff office on 10/05/25.
• Fireplace surround will be replaced by 30/06/25.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
• Risk assessment has now been updated, this was completed on 27/05/25.
• On the day of the audit the most recent version of the Providers Risk Management policy was not available on site. An appendix in the most recent version of the policy signposts staff to information pertaining to the unexpected absence of a resident, accidental injury to residents, visitors, and staff, aggression and violence or self-harm. This version of the policy has been printed and is now available in the service this was completed on 03/06/2025.

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:

• Staff are being retrained on the provider system for recording residents support plans. This will be completed by 30/06/25.

• PIC has met with each keyworker and gone through the online recording system demonstrating how to update support plans. These are now updated, this was completed 27/05/25.

• Key workers were reviewed and reassigned. This was completed by 30/04/25.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(4)	The person in charge shall ensure that there is a planned and actual staff rota, showing staff on duty during the day and night and that it is properly maintained.	Substantially Compliant	Yellow	30/04/2025
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Not Compliant	Orange	01/08/2025
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	30/04/2025
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre	Substantially Compliant	Yellow	31/08/2025

	are of sound construction and kept in a good 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.	Not Compliant	Orange	30/05/2025
Regulation 23(3)(a)	The registered provider shall ensure that effective arrangements are in place to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.	Not Compliant	Orange	30/04/2025
Regulation 23(3)(b)	The registered provider shall ensure that effective arrangements are in place to facilitate staff to raise concerns about the quality and safety of the	Not Compliant	Orange	30/08/2025

	care and support provided to residents.			
Regulation 26(1)(c)(i)	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 following specified risks: the unexpected absence of any resident.	Substantially Compliant	Yellow	03/06/2025
Regulation 26(1)(c)(ii)	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 following specified risks: accidental injury to residents, visitors or staff.	Substantially Compliant	Yellow	03/06/2025
Regulation 26(1)(c)(iii)	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 following specified	Substantially Compliant	Yellow	03/06/2025

	risks: aggression and violence.			
Regulation 26(1)(c)(iv)	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 following specified risks: self-harm.	Substantially Compliant	Yellow	03/06/2025
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.	Substantially Compliant	Yellow	03/06/2025
Regulation 05(1)(b)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out subsequently as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.	Not Compliant	Orange	30/06/2025

Regulation 05(4)(a)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which reflects the resident's needs, as assessed in accordance with paragraph (1).	Not Compliant	Orange	30/06/2025
Regulation 05(4)(b)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which outlines the supports required to maximise the resident's personal development in accordance with his or her wishes.	Not Compliant	Orange	30/06/2025
Regulation 05(4)(c)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which is developed through a person centred approach with the maximum participation of each resident, and where appropriate his or her representative, in accordance with	Not Compliant	Orange	30/04/2025

	the resident's wishes, age and the nature of his or her disability.			
Regulation 05(6)(b)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall be conducted in a manner that ensures the maximum participation of each resident, and where appropriate his or her representative, in accordance with the resident's wishes, age and the nature of his or her disability.	Not Compliant	Orange	30/06/2025
Regulation 05(6)(c)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall assess the effectiveness of the plan.	Not Compliant	Orange	30/06/2025
Regulation 05(6)(d)	The person in charge shall ensure that the personal plan is	Not Compliant	Orange	30/06/2025

	the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall take into account changes in circumstances and new developments.			
Regulation 05(7)(a)	The recommendations arising out of a review carried out pursuant to paragraph (6) shall be recorded and shall include any proposed changes to the personal plan.	Not Compliant	Orange	30/06/2025
Regulation 05(8)	The person in charge shall ensure that the personal plan is amended in accordance with any changes recommended following a review carried out pursuant to paragraph (6).	Not Compliant	Orange	30/06/2025