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:	Clarey Lodge
Name of provider:	Nua Healthcare Services Limited
Address of centre:	Kildare
Type of inspection:	Unannounced
Date of inspection:	13 March 2026
Centre ID:	OSV-0003386
Fieldwork ID:	MON-0049953

About the designated centre

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

Clarey Lodge is a large bungalow in a rural setting in Co. Kildare. Clarey Lodge provides full-time residential services to four adults who require care and support related to their intellectual disability, autism and/ or mental health issues. The centre comprises two standalone apartments, and a communal area. There is a large garden to the rear, and residents have access to transport. The staff team consists of a person in charge, two shift lead managers and a number of health care assistants. Residents have access to a multidisciplinary team.

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
Friday 13 March 2026	09:00hrs to 17:00hrs	Linda Dowling	Lead

What residents told us and what inspectors observed

This inspection was unannounced and carried out with a specific focus on safeguarding, to ensure residents felt safe in the centre they were living in and they were empowered to make decisions on their care and how they wished to spend their time. The inspection was completed by one inspector over one day.

The Inspector had the opportunity to meet and speak with some of the residents in this designated centre and their staff team and management team, observe their living environments, and review documentary evidence of their personal, health and social care supports and how they were consulted and involved in their support, as evidence to indicate the lived experience of people living in the centre.

Overall, the inspection found that residents were in receipt of good care and support and found positive examples of how residents were supported to make decisions, however there were some areas that required improvements under regulations, 17: premises, 7: positive behaviour support and 23: governance and management.

On arrival to the centre at 09:00am, the inspector was unable to make contact with the staff on duty, there was an electric gate in-situ to the front of the property and no call bell on the outside of the gate, on making contact with the person in charge by phone they arranged for the staff who were in the house to open the gate. On entering the property the inspector initially met two staff on duty and one resident who was just getting up for breakfast they were seen to put their laundry into a basket in the bathroom, they briefly acknowledged the presence of the inspector and carried on with their task.

The centre has the capacity to accommodate four residents and on the day of inspection there were no vacancies. The shift lead manager came to meet the inspector and they completed a walk around of the property.

The centre comprises a bungalow style house that is divided into three living spaces. The middle section of the property is home to two residents who share a kitchen, living and dining area there is also an additional sitting room that one resident utilises. Each resident had their own private bedroom and shared a main bathroom. There was access to the rear of the property that was set to lawn and some storage sheds were off the living room. As mentioned one resident was up when the inspector arrived, they were engaging in community activities throughout the day and the inspector briefly saw them again on their return to the centre.

On either end of the property there were individualised living arrangements for two residents. One resident had a kitchen, living, dining area, a bedroom and bathroom, they also had an external shed where they stored all their music equipment. They

had access to the main garden through a gate. This resident was away in the UK visiting family on the day of inspection.

The other resident had a sitting room with a dining table, bedroom and newly renovated bathroom with Jacuzzi bath. This resident had their own enclosed back garden with artificial grass, a large basket swing and trampoline, the inspector observed several footballs around the garden area also. This resident was asleep when the inspector was completing the walk around and subsequently choose to spend a lot of their day in bed therefore the inspector did not get to spend much time with them.

The second resident living in the middle section of the house was asleep when the inspector arrived, the inspector called into them later in the day although they did not wish to speak with the inspector. The resident asked the inspector to go away, so the inspector respected their wishes and went into the hallway, the resident followed the inspector pointing to the main door and said 'go home'. The inspector left the building and returned to what is referred to as a staff area. This area has a kitchen and an office. The staff member supporting the resident reported they settled and were happy once the inspector had left.

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

Capacity and capability

Overall, the findings from the inspection were positive, the service was striving to ensure residents' human rights were upheld.

While there was a clearly defined management structure in place and regular management presence in the designated centre, with a full time person in charge and two shift lead managers, improvements were required in areas such as premises, quality of provider audits and restrictive practices.

There was a core staff team in place and regular supervision and team meetings held to support the team. Team members had access to training relevant to their role. The provider was seen to engage in meetings with staff as part of any safeguarding concerns alleged to have taken place in the centre.

Regulation 15: Staffing

The inspector observed the centre to be resourced with a knowledgeable staff team, who gave good examples of how they understood residents' support needs and advocated for their wellbeing.

The inspector reviewed the planned and actual rosters in place since January 2026. They were found to be kept up -to -date and reflective of the staffing requirements of the centre as set out in the provider's statement of purpose. There was an open vacancy of 0.5 whole time equivalent (WTE) in the centre. The inspector observed core staff members taken on additional shifts to ensure this gap was filled, no agency personnel were used in this centre.

All of the residents were observed to be comfortable in the presence of staff and the staff were observed to be person centred in their approach to residents. Staff were seen to offer choice to residents for example, in activities and meal choices.

The inspector did not review staff files and documentation on staff members' qualifications, references and Garda vetting, as per Schedule 2 of the regulations, on this occasion as this information was not available for inspection.

Judgment: Compliant

Regulation 16: Training and staff development

From review of training records, the inspector found that staff members were provided with the required training to ensure they had the necessary skills to respond to the needs of the residents and to promote their safety and well being. For example, staff had undertaken training in safeguarding vulnerable adults, children's first, positive behaviour support and human rights. One member of staff who spoke with the inspector said they felt they had an enhanced awareness of residents rights and were confident about how to identify abusive interactions as a result of the training provided.

The staff team was also supported to have access to centre specific training such as effective communication and active listening and Lámh, this training was completed to ensure all staff could effectively communicate with the residents in line with their assessed needs and preferences.

Judgment: Compliant

Regulation 23: Governance and management

The provider had accountable and suitable management structures in place, with a core front-line team of staff led by a person in charge who demonstrated a good knowledge of their role and responsibilities under the regulations. They were

supported by two shift lead managers at centre level and by an area chief operations officer at provider level.

The provider had an auditing system in place including provider and local audits to review the quality and safety of care and support provided to the residents.

The inspector reviewed the provider's most recent six-monthly unannounced audit completed in July 2025, for the most part the report was generic in nature and did not outline the specific evidence and findings gathered or observations in this centre, to evidence compliance, or to highlight areas of good practice and areas in which opportunities for improvements were identified. For example, under regulation 8 : Protection, the auditor stated " all residents know what to do in the event they experience abuse" although no residents had been consulted with on the day of the audit and no other evidence was provided to support this statement. This required review to ensure audits were reflective of the centre and residents lived experience.

An annual audit of the centre was completed by the person in charge in June 2025 this review reflected more of the residents' lived experience in the centre, it demonstrated a decrease in incidents and identified specific goals residents were actively working on. The person in charge was also completing local audits on medication, infection prevention and control and health and safety.

Judgment: Substantially compliant

Quality and safety

There was outstanding premises work required in the centre, improvement was also required in the use of restrictive practice and providers audits. However, the provider was ensuring residents were safe through the identification and reporting of safeguarding concerns, appropriate risk management and communication with residents.

The provider had a policy in place on risk management and each resident had a number of individual risk management plans on file so as to support their overall safety and well being.

The staff team were striving to provide person centre care to the residents in this centre. This meant that residents were able; to express their views, were supported to make informed decisions about their care and that the staff team listened to these views.

Regulation 10: Communication

Residents were assisted to communicate in accordance with their assessed needs and wishes.

Easy-to-read information was available on topics such as safeguarding, advocacy and complaints and some of these were seen on display around the centre for ease of access. In addition, residents were supported to understand these topics and their rights through key working sessions and resident meetings.

The staff team had been supported to have effective communication and active listening and Lámh training which supported residents to effectively communicate their needs and wishes. Other communication supports observed included visual activity planners and choice boards.

All residents were supported to have communication passports in place that detailed, their family, things they like to talk about, dos and don'ts and identified specific communication requirements for the individual resident such as, predictable routine, one question at a time, short clear sentence, allow me time to process the request. These were seen to effectively guide staff practices.

Residents were also seen to have access to a range of communicative devices such as mobile phones, laptops, music player, TV and the Internet.

Judgment: Compliant

Regulation 17: Premises

The inspector found the centre was presented well, nicely decorated and for the most part clean, although maintenance work was required in some areas.

It was evident that some work had recently been completed to the centre such as new gutters fitted to the property, painting of external walls, new wet room installed, improved enclosed garden with artificial grass and sensory equipment for one resident.

On arrival to the centre the inspector observed that the driveway was flooded from the pathway across to the lawn at the front of the property. It was observed that one of the provider's cars was inaccessible from one side due to this flooding. On completing the walk around of the property the inspector observed pathways to the front of the property be green and slippery, the access to one residents front door was restricted with pooling of water across the majority of the pathway.

While the inspector was made aware that the person in charge had reported the front driveway, there was no definitive plan of works scheduled.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

There were systems in place to identify, manage and review risks in the centre with a focus on residents' safety.

The provider had centre specific and individual risk assessments per resident in place. The inspector reviewed two of the three residents' risk assessments and found them to be detailed and contain appropriate control measures and risk ratings. All resident risks were divided into personal, environmental or medical, examples of identified risks included, intimate care, restrictive practices, money management and fire.

All risk assessments were in-date and were seen to be reviewed in line with the severity of the risk, the higher the risk the more frequent the review.

The person in charge was aware of the risks in the centre and their level of risk, they were actively working on reducing risks where possible and staff were seen to implement control measures identified on the day of inspection. For example, one resident requires 2:1 support due to the level of behaviours they can present with, staff always entered the apartment as a pair and never alone.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The provider was actively reviewing residents' clinical needs, developing support plans and offering support in line with these plans.

The inspector reviewed a sample of residents' needs assessments related to safeguarding, positive behaviour support and communication and the support plans developed from these assessments. These assessments and plans were seen to be person-centred and evidence based. Assessments had been supported by clinicians involved in the residents' lives and care plans were guiding staff practice.

Residents were supported to identify goals they would like to achieve. From observations on the day of inspection, residents were choosing how they wanted to spend their time, one resident spent a prolonged period in bed and while staff were seen to encourage them to get up and to give them choices around activities they choose not to. While this was respected the person in charge had requested a

review with the resident's multi-disciplinary team (MDT) to ensure they were getting the best opportunities for engagement and not spending too much time in bed or remaining awake too late at night.

From review of documentation, the use of professional and respectful language was used throughout residents assessments and plans.

Judgment: Compliant

Regulation 7: Positive behavioural support

The provider had ensured that residents had access to regular behaviour support reviews, and reviews informed comprehensive behaviour support plans. The inspector reviewed two behaviour support plans and found that both were reflective of resident needs in terms of appropriate supports and helped guide staff practice. Staff spoken with on the day of inspection were informed and knowledgeable on the behaviour support plans for residents.

There were a number of restrictive practices in place in the centre at the time of inspection. While restrictions were documented, reviewed regularly and reported as required to the Chief Inspector of Social Services, the inspector was not assured the least restrictive measures were in place for all residents.

One resident had a restriction in place in relation to food and fluids, this resident had no food stored in their apartment, they had no access to food or snacks unless provided by staff. The inspector was not assured this was the least restrictive option and no evidence was available of alternatives explored or trialled, it was unclear how the resident requested food or snacks if this was outside of scheduled mealtimes.

Each resident had a restrictive practice passport in place, this was an easy-to-read document that outlined the restrictions in place that affected them. On review of the passports the use of physical restraints, although prescribed and in used, these were not identified in the residents restrictive passport.

Judgment: Substantially compliant

Regulation 8: Protection

The provider had policies and procedures in place to ensure residents living in the centre were safeguarded from abuse.

All staff had received training in the safeguarding of residents, and were aware of the various types of abuse and the signs of abuse that might alert them to any issues, in addition to their role in reporting and responding to those concerns. From

speaking with staff members it was evident that staff recognised different forms of abuse, including observing how people spoke to or about the residents, or where residents' needs were not being met in a safe or appropriate manner.

Residents were also kept informed about their right to raise a concern or make a complaint to the staff team or the person in charge through key working sessions and resident meetings. The inspector reviewed samples of intimate and personal care and found them to be person-centred and suitable to protect the dignity and autonomy of the residents. Systems were also in place for the oversight and monitoring of residents' incoming and outgoing finances.

Overall, inspectors found that safeguarding concerns were being identified and raised in a timely manner. All concerns were reported to the relevant authorities and managed in line with the providers policy, there were comprehensive review of all safeguarding plans in the centre to ensure they were effective or whether further actions were necessary to inform future practice and reduce the impact on residents in the centre.

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	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Substantially compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Compliant

Compliance Plan for Clarey Lodge OSV-0003386

Inspection ID: MON-0049953

Date of inspection: 13/03/2026

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: 1. The PIC and Quality Assurance Officer will review the July 2025 unannounced visit reports to ensure actions are SMART and centre-focused, incorporating inspection findings, individual feedback, and evidence of compliance. 2. The Quality Assurance Department will implement a revised Regulation 23 reporting process with a HIQA DCD1-aligned template, supported by training, to ensure reports are centre-specific, evidence-based, and include stakeholder feedback.	
Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: 1. The maintenance department will ensure that all moss-affected footpaths within the designated centre are pressure-washed to eliminate slip hazards. 2. The Person in Charge will ensure that all work vehicles are relocated to a designated alternative parking area within the premises, pending completion of groundwork. 3. The maintenance department will ensure that all necessary groundwork to resolve the flooding issues on the driveway is completed.	
Regulation 7: Positive behavioural support	Substantially Compliant
Outline how you are going to come into compliance with Regulation 7: Positive behavioural support: 1. The Person in Charge, in conjunction with the Behavioural Specialist, will complete a review of all restrictive practices. This will ensure that the function of behaviour is	

documented, all less restrictive alternatives have been trialled, and any restriction in use is justified as the least restrictive option for the shortest duration necessary. All outcomes will be clearly documented with MDT input.

2. An MDT review will be completed to assess the food and fluid restriction, ensuring the rationale is clearly documented, all less restrictive alternatives (including supported snack access) are evidenced, and a clear process is in place for the resident to request food or fluids outside mealtimes. A 6-week review period will be implemented to evaluate the effectiveness of the restriction, with the aim of reducing or removing it where possible, and all outcomes documented.

3. The Person in Charge will ensure all restrictive practice passports are up to date, accurately reflecting all restrictions in use, including physical restraints, in an accessible and person-centred format.

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 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Substantially Compliant	Yellow	31/05/2026
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Substantially Compliant	Yellow	12/05/2026
Regulation 07(5)(c)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under	Substantially Compliant	Yellow	15/06/2026

	this Regulation the least restrictive procedure, for the shortest duration necessary, is used.			