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: | Broadleaf Manor |
|---|---|
| Name of provider: | Nua Healthcare Services Limited |
| Address of centre: | Kildare |
| Type of inspection: | Unannounced |
| Date of inspection: | 18 March 2026 |
| Centre ID: | OSV-0003397 |
| Fieldwork ID: | MON-0049745 |

## About the designated centre

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

Broadleaf Manor provides 24-hour care to seven adults with autism, acquired brain injuries, intellectual disabilities, mental heath issues and challenging behaviours. It is a large house located in a rural setting close to a village in Co. Kildare. The house is subdivided into six supported living environments which are self-contained spaces comprising a bedroom, en site, sitting room, and some have access to a kitchen area. Two residents have their own bedrooms with en suite and share a kitchen and sitting room. To the rear of the house are large gardens, many of which are separate and in line with residents' assessed needs. There is a games room for residents to use in the garden. Residents have access to their own vehicles.The staff team comprises of a person in charge, team leaders, deputy team leaders, social care workers and assistant social care workers. Residents have access to a range of health and social care professionals in line with their assessed needs.

**The following information outlines some additional data on this centre.**

| Number of residents on the date of inspection: | 7 |
| --- | --- |

## 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 18 March 2026 | 19:00hrs to 22:00hrs | Linda Dowling | Lead |
| Thursday 19 March 2026 | 08:30hrs to 16:30hrs | Linda Dowling | Lead |
| Wednesday 18 March 2026 | 19:00hrs to 22:00hrs | Marie Byrne | Lead |
| Thursday 19 March 2026 | 08:30hrs to 16:30hrs | Marie Byrne | Lead |

## What residents told us and what inspectors observed

This unannounced risk-based inspection was completed by two inspectors over two days. It was carried out to ensure residents were in receipt of a good quality and safe service as the Chief Inspector of Social Services had received information of concern relating to the centre. The findings of this inspection were positive, with the majority of regulations reviewed found to be compliant. Some improvements were required to the provider's six-monthly and annual reviews and to ensure staff were appropriately training in safeguarding. This will be discussed later in the report.

During the inspection, inspectors had the opportunity to meet and speak with a number of people about the quality and safety of care and support in the centre. This included meeting six of the seven residents living in the centre, the person in charge, a deputy person in charge, a shift lead manager, four day staff, two sleepover staff and five night staff. Documentation was also reviewed throughout the inspection about how care and support is provided for residents, and relating to how the provider ensures oversight and monitors the quality of care and support in this centre.

This centre is a large two-storey house in a rural setting outside a town in Co. Kildare which is home to seven residents. The house comprises a communal kitchen and dining area, a bathroom, a utility room, office and six self-contained apartments, one apartment is occupied by two residents. In each apartment residents have their own bathrooms, bedroom and living area. There were large self-contained gardens to the back of the property. There was a games room out in the garden which was equipped with a television, comfortable furnishings, and a boxing bag. Outside the games room was an enclosed communal space with basketball hoop, goal posts and a smoking shed. Upstairs also had two staff sleepover rooms and an office.

Most apartments were not equipped with cooking facilities inspectors were informed that kitchen equipment such as air fryers / portable hobs could be brought into residents apartments as required. Inspectors were informed that staff prepared meals in a communal kitchen although this was not centrally located and some residents would have to go outside to enter the kitchen. It was not evident that residents were utilising this space to cook and preparing their own meals. Additionally, on reviewing residents' meetings, meal planners and food and nutrition charts, resident were not always guaranteed to get the meal they had chosen.

When the inspectors arrived to the centre they completed a walk around of the property and met with six of the seven residents, one resident did not want inspectors to go into their apartment and this was respected. The other five residents were happy to show the inspectors around their apartments. One resident proudly told the inspectors about many restrictions that had been removed from

their environment such as the removal of the TV box, new blinds fitted, replacement of their plastic bed base with a regular bed base and mattress.

Another resident was observed spending time watching a movie with their support staff in the games room which is located in a large garage on the same site as the main house. This resident spoke about how they were managing their incidents, had a reduction in restrictive practices and they were very proud of the progress they have made. They reported they were receiving good care and support within the centre.

Another resident invited an inspector into their sitting room where they were on their mobile electronic device and watching TV. They spoke to the inspector about how they were working towards independent living and the goals they were working on to make this happen, they spoke positively about the staffing and management of the centre and how they have been a great support to them.

Throughout the inspection, staff were observed to be very familiar with residents' communication styles and preferences. They were observed to listen to residents and to encourage them to tell inspectors about their skills and some of their recent achievements. During the inspection residents were observed to have the opportunity to spend time in the house or to leave the house with the support of staff. For example, on the first evening one resident was on a day trip with the support of staff and had not yet returned when inspectors visited their apartment at 19:30. On day two of the inspection, another resident went for a day trip and other residents left the centre with the support of staff at various times to go for meals or snacks in the community and to complete shopping for personal items.

Based on a review of documentation and discussions with staff, some residents were choosing to take part in the upkeep of their home. For example, they were cleaning or being supported by staff to clean their apartments, preparing snacks, baking and doing their laundry. During the inspection, one resident was observed coming back to their apartment after completing their laundry in one of the communal laundry areas.

There are five vehicles available to support residents to go to appointments and to access their local community. There were three vehicles available during the inspection as one required repair and one was being serviced. However, inspectors did not find this was impacting residents as staff were ensuring that each resident had an opportunity to leave the centre, if they wished to. They were organising staffing arrangements and discussing suitable times with residents prioritising medical appointments and then social events.

In the next two sections of the report, the findings of this inspection will be presented in relation to the governance and management arrangements and how they impacted on the quality and safety of service being delivered.

## Capacity and capability

The findings of this unannounced inspection were that residents were in receipt of a good quality of care and support. For the most part, the provider was identifying areas of good practice and areas where improvements were required in their own audits and reviews. However, the provider's six-monthly and annual reviews for this centre required review to ensure they were specific to this centre and clearly guiding staff on the specific actions needed to bring about the required improvements.

There was a clear management structure in the centre which was outlined in the statement of purpose. The person in charge provided supervision and support to the staff team. The person in charge received supervision and support from their area chief operations officer. There was also an on-call service available to residents and staff out-of-hours.

The centre was staffed in line with residents' assessed needs. Staff were in receipt of supervision and support to ensure they were carrying out their roles and responsibilities to the best of their abilities. They had opportunities to discuss issues and share learning at supervision, handover and at team meetings.

## Regulation 14: Persons in charge

Inspectors reviewed the Schedule 2 information for the person in charge in advance of the inspection and found that they had the qualifications and experience to fulfill the requirements of the regulations. They were full-time and present in this centre on a regular basis. Over the course of the two days they were found to be very familiar with residents' care and support needs and their likes, dislikes and preferences.

There were systems in place to monitor the care and support provided to residents in the centre and they were found to be effective in identifying areas of good practice and areas where improvements were required in this centre.

Residents were observed to be very familiar with them and appeared very comfortable and content in their presence. Staff members who spoke with the inspector were complimentary towards the support they provided to them. Through discussions and a review of documentation, inspectors found that they were focused on implementing a human-rights based approach to care and support for residents. They were working with residents and the staff team to ensure that residents were happy, safe, engaging in activities they find meaningful, exploring their community and developing valued roles in their community.

Judgment: Compliant

## Regulation 15: Staffing

Based on what inspectors were told and what they reviewed in documents, there were enough staff to meet the assessed needs of residents.

While there had been staff vacancies in the months before the inspection the centre was now fully staffed. Three new staff had commenced and three were due to commence in the coming weeks.

The person in charge and staff team spoke about numerous occasions during the day and at night in the months before the inspection when minimum staff levels were in place. This was evident on the sample of rosters reviewed from January to March 2026. They described how the team manage presenting risks while ensuring residents had opportunities to engage in activities they find meaningful. There was a risk assessment developed to identify the minimum safe staff levels for this centre. The staffing levels at full capacity during the day is assessed as 15 and at night is five waking night staff and two sleepover staff. The minimum safe staff levels for the day midweek is identified as 12 or 10 at the weekends. At night the minimum safe staffing level is identified as four waking night staff. Inspectors were informed that the recent increase in staff employed in this centre, would result in staffing levels being at full capacity.

Inspectors reviewed a sample of three staff files and found that they contained the information required under Schedule 2 of the regulation.

Inspectors reviewed a sample of minutes of two recent staff meetings. These had a variety of topics and were found to be focused on residents' care and support and their access to meaningful activities and opportunities to achieve their goals. Discussions were being held on areas such as, risk, safeguarding, incidents and learning, safeguarding, health and safety and staff training. Actions were developed at these meetings and reviewed and followed up on at the next meeting.

Judgment: Compliant

## Regulation 23: Governance and management

Inspectors found that action was required by the provider to ensure that the six-monthly and annual reviews for this centre were specific to this centre and clearly identifying specific actions required to bring about the required improvements.

The management structure on the day of the inspection was in line with the centre statement of purpose. From a review of documentation and discussions with staff, there were clearly identified lines of authority and accountability amongst the team.

This meant that all staff were aware of their roles and responsibilities to deliver a safe and good quality service.

Inspectors reviewed the latest six-monthly and annual review completed by the provider for this centre. While these were lengthily documents they were both found to be generic in nature and not specific to this centre in many areas. For example, there had been a significant reduction in restrictive practices in this centre since the last inspection. In the six monthly review dated December 2025, this was not reflected under the commentary relating to Regulation 7: Positive Behaviour Support and did not reflect the positive impact described by residents and staff when speaking with inspectors during the inspection. Another example related to Regulation 8: Protection. There had been six safeguarding concerns reported to the Chief Inspector of Social Services during the period covered by that six-monthly review. The report did not capture the steps taken or their effectiveness in safeguarding residents. Across the six-monthly review, the findings referred to "gaps" in documentation but did not guide the person assigned to bring about improvements on what specific actions were required. For example, "on review of personal plans, gaps identified require attention by the person in charge".

In the annual review dated 30 June 2025, areas for improvement were recorded under the commentary relating to Regulation 17: Premises as "some areas of the centre need structural repair and review". This did not clearly identify the actions required to bring about improvements. Regulation 17 or these areas for improvement did not feature in the audits action plan.

Judgment: Substantially compliant

## Quality and safety

Overall, the inspectors found that the centre provided a comfortable home that was in good state of repair both internally and externally. The house was suitably designed and equipped to support the residents, It had a homely feel and was clean and warm. Residents had the opportunity to be part of the local community and were supported through person centered planning. Although, improvement was required to ensure all staff were suitably trained to safeguard residents effectively.

The provider and local management were actively seeking to manage residents behaviours and reduce restrictive practices. This was seen to be very successful and residents spoke openly to inspectors throughout the inspection about their their achievement and reduction in restrictions.

### Regulation 17: Premises

Overall, the designated centre was designed and laid out to meet the needs of the residents. The inspectors found the house was decorated in a homely manner.

As mentioned previously, the centre was a large two story property divided into six living arrangements. The centre was found to be warm and clean on arrival. A substantial amount of work had been completed to the centre including new flooring throughout, all bathrooms utilised by residents had been renovated, with new tiling and sanitary wear where required. Residents had decorated their own apartments in line with their preferences and wishes.

The centre was a large property and was found to be cleaned suitably, residents' own apartments and communal areas and hallways all appeared to be cleaned regularly. Minor maintenance works were required in some areas, for example, where one resident had a secure box removed from their TV the back wall required painting, these works had been identified by the provider and were scheduled to be completed.

Judgment: Compliant

## Regulation 26: Risk management procedures

Residents, staff and visitors were protected by the risk management policies, procedures and practices in the centre. The safety of residents was promoted through risk assessment and learning from incidents.

The inspectors reviewed the centre specific risk assessments and three residents' individual risk assessments. They were all found to be up -to -date and reviewed regularly in line with the level of risk posed, the higher the risk the more frequent the review.

Inspectors found that risk assessments had appropriate control measures in place that specifically guided staff practices. For example, one resident's risk assessment risk rating and control measures were updated when the use of travel harness restriction was reduced, this reflected the increased risk and new controls in place to protect the resident and support staff.

Local management had identified the top five risks in the centre including, behaviour, mental health, self harm, safeguarding and allegations and absconding, these risks were seen to be discussed at all handovers, team meetings and supervision meetings with staff to ensure they understood the risk and the control measures in place to manage the risk.

Judgment: Compliant

## Regulation 7: Positive behavioural support

The person in charge reported that the staff team had the knowledge and skills required to support the residents in managing their behaviour. From reviewing the training matrix all staff were up -to -date on relevant training allowing them to support residents who present with behaviours of concern.

Some residents had multi-element behaviour support plans, others had a detailed section in their personal plan outlining their individual supports. All plans were found to be regularly updated and reviews were happening regularly with their behaviour support specialist where required. The inspectors reviewed three plans and found that they detailed proactive and reactive strategies to support the residents' accordingly. They included details on precursors, triggers and setting events along with a traffic light system in relation to levels of behaviours, each level included the action to be taken by staff in an attempt to bring the resident back to baseline.

When reviewing these plans inspectors observed they were also being linked to residents' own personal goals. For example, one resident wanted to get their tongue pierced, a plan was put in place to improve their skills around oral hygiene and once this was met the resident was supported to get their piercing done.

From speaking with residents, staff and management, the level of incidents had significantly decreased over the previous twelve months, staff reported residents to be more settled and focused on their goals, they attributed this to consistent staff approach along with the guidance provided from management and clinicians.

From review of the incidents and accidents in the centre a total of 42 physical holds were implemented to manage behaviours of concern in 2024, in 2025 this had reduced to 21 physical holds with only two holds in quarter four and none so far in 2026.

As previously mentioned there had been a significant reduction in the use of restrictive practices within the centre. This included the removal of travel harness, reintroduction of ligature fitting and fixtures in one apartment including, installation of new blinds, shower hose and removal of box around their TV. Two residents spoke about how they can carry their own money in the community now and other residents are now supported to use crockery and metal cutlery.

Judgment: Compliant

## Regulation 8: Protection

Residents were protected by the provider's policies, procedures and practices in relation to safeguarding and protection.

Overall in this designated centre the residents were found to be kept safe and well protected at the time of the inspection. Although not all staff were trained in safeguarding training. Three staff were outstanding refresher training and at the time of reviewing the matrix they were not booked to attend a refresher course. Given the high level of allegations, safeguarding concerns and investigations happening in the centre staff needed to be aware and have appropriate training to support residents with allegations and concerns.

The person in charge had a system in place that allowed staff and management to discuss incidents, accidents, residents specific support plans and any changes to risk assessments, restrictive practices and safeguarding plans as part of handover. When speaking with staff over the course of the inspection they found this particularly helpful to keep refreshed on any changes happening in relation to the care and support of residents.

Inspectors reviewed samples of intimate and personal care and support plans which were found to be person-centred and suitable to protect the dignity and autonomy of the residents.

Judgment: Substantially compliant

## Appendix 1 - Full list of regulations considered under each dimension

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

| Regulation Title | Judgment |
|---|---|
| **Capacity and capability** | |
| Regulation 14: Persons in charge | Compliant |
| Regulation 15: Staffing | Compliant |
| Regulation 23: Governance and management | Substantially compliant |
| **Quality and safety** | |
| Regulation 17: Premises | Compliant |
| Regulation 26: Risk management procedures | Compliant |
| Regulation 7: Positive behavioural support | Compliant |
| Regulation 8: Protection | Substantially compliant |

# Compliance Plan for Broadleaf Manor OSV-0003397

## Inspection ID: MON-0049745

## Date of inspection: 19/03/2026

**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:**

<table>
<tr><th>Regulation Heading</th><th>Judgment</th></tr>
<tr><td>Regulation 23: Governance and management</td><td>Substantially Compliant</td></tr>
<tr><td colspan="2">Outline how you are going to come into compliance with Regulation 23: Governance and management:<br><br>1. The Person in Charge will review the Centre's Annual Review to ensure it clearly identifies required service improvement actions. All actions will be documented, assigned, and progressed within agreed timeframes, with outcomes monitored and reviewed by the PIC<br><br>2. The PIC and Quality Assurance Officer will review the December 2025 unannounced visit reports to ensure actions are SMART and centre-focused, incorporating inspection findings, individual feedback, and evidence of compliance.<br><br>3. 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.</td></tr>
<tr><td>Regulation 8: Protection</td><td>Substantially Compliant</td></tr>
<tr><td colspan="2">Outline how you are going to come into compliance with Regulation 8: Protection:<br><br>1. The Person in Charge, in conjunction with the Training Department, will ensure all staff safeguarding training is current and compliant, with any expired training addressed through immediate enrolment. A live training matrix will be maintained and reviewed monthly by the PIC to ensure training remains in date.</td></tr>
</table>

## 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 23(1)(c) | The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored. | Substantially Compliant | Yellow | 30/05/2026 |
| Regulation 08(1) | The registered provider shall ensure that each resident is assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection. | Substantially Compliant | Yellow | 30/05/2026 |