



Report of an inspection of a Designated Centre for Disabilities (Adults).

Issued by the Chief Inspector

Name of designated centre:	Rathfredagh Cheshire Home
Name of provider:	The Cheshire Foundation in Ireland
Address of centre:	Limerick
Type of inspection:	Announced
Date of inspection:	02 March 2026
Centre ID:	OSV-0003449
Fieldwork ID:	MON-0041350

About the designated centre

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

Rathfredagh Cheshire Home consists of a large two-storey building and a smaller one-storey building located adjacent to each other in a rural area within a short driving distance to a nearby town. Both buildings are comprised of apartment style individual accommodations all located on the ground floor. The centre can provide for a maximum of 21 residents consisting of full-time residential support for up to 18 residents and respite support for up to three residents. Each resident in the centre has their own bedroom and other facilities throughout the centre include offices, bathrooms, dining rooms, kitchens, exercise room, a laundry room, a prayer room and store rooms amongst others. The centre supports residents of both genders with physical, neurological or sensory disabilities. Residents are supported by care support staff, nurses, a community services co-ordinator and the person in charge.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	17
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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
Monday 2 March 2026	09:55hrs to 18:15hrs	Elaine McKeown	Lead
Monday 2 March 2026	09:55hrs to 18:15hrs	Louise O'Sullivan	Support

What residents told us and what inspectors observed

This was an announced inspection, completed to monitor the provider's compliance with the regulations and to inform the decision in relation to renewing the registration of the designated centre. This centre was registered to provide full-time residential services to a total of 18 adult residents and respite services to a maximum of three residents at a time. The total capacity of the designated centre was 21 residents, there were 17 residents in the designated centre on the day of the inspection. There was one vacancy and no residents in receipt of respite care at the time of this inspection. The centre was previously inspected in February 2025 as part of the current registration cycle which had been fully compliant in the regulations reviewed.

A high level of compliance with the regulations was identified on the inspection day. Residents were supported by a consistent staff team familiar to the residents to receive a high quality of care and support in their home. It was evident that residents had been supported with the management of health care conditions, to make connections in their local community, and that they were included in decisions relating to their care and support.

The inspectors met with a total of 10 residents during the inspection at different times that best suited their routines. One resident had left to attend their day service and met with one of the inspectors on their return in the afternoon. The inspectors were informed one resident had left for a short break to another city with staff support. This was described as being part of their goals for 2026. Another resident invited an inspector to visit their apartment where they proudly spoke about their personal possessions, hobbies and interests. The inspectors met with seven of the residents in different locations in the main house. This included the sitting room, residents smoking room, dining room as well as apartment areas. All residents spoken to outlined positive aspects to their lives in the designated centre. Residents felt safe and well supported by the staff team. If they needed anything staff responded very quickly. Inspectors were informed of the many activities that were available to support meaningful days this included social outings, attending day services and being supported by personal assistants in-line with their will and preferences. In addition, residents were supported to attend music sessions, movie nights, craft and computer classes in the designated centre. One resident did comment that the computers were old and could do with updating. Residents spoken to felt their voice was heard and they were being listened too. If there was an issue or concern it was usually dealt with quickly and resolved locally by the staff team.

One inspector met with three residents who were living in the courtyard part of the designated centre in the afternoon. One resident was watching a programme on their television in their apartment when introduced to the inspector. They chatted with the inspector about the supports they had from their personal assistant, how

they usually preferred their own company but would exchange greetings with other peers living in nearby apartments. The resident outlined how they were independent in many aspects of daily living and managed their own finances, medications and laundry. The resident spoke of how they did not require staff to check on them at night time as they were able to seek assistance if needed but this would be a rare occurrence. The resident stated staff respected this decision. The resident spoke of having regular contact with family members. In addition, members of the management team called to visit them regularly to ensure there were no issues or concerns. These were also similar experiences of other residents spoken to during the inspection.

One resident living in the courtyard greeted the inspector in a communal area but declined to engage any further. The inspector was introduced to a third resident in their apartment. The resident liked listening to music and explained they needed full support from the staff team with activities of daily living due to mobility issues and blindness. The resident was observed to manage activities with some independence such as having a drink and choosing their preferred music once the staff supporting them had placed the items within the resident's reach and explained what they were doing. The resident also had a voice activated speaker on which they could listen to their music. The resident told the inspector they were looking forward to getting a new motorised wheel chair in the weeks after this inspection. They spoke of increased opportunities that would then be available to get out in the community more often with greater ease. The resident did enjoy going to the main house when the music sessions were on each week and participated in physical therapy sessions regularly with the staff.

Through the conversations held with the residents during the inspection, it was evident residents were supported to be aware of their rights and make informed decisions. This included having access to specialists/professionals attending residents meetings in areas such as advocacy services, community gardai and safeguarding to name but a few. Residents were also being supported in-line with their preferences to think ahead and develop end-of-life plans, if they wished to do so.

The person in charge and the staff team were met during the inspection. It was evident from their interactions that they knew the residents well. The staff were observed and heard to be kind, respectful and unhurried in their interaction with the residents.

The premises was a large old building requiring ongoing maintenance which the provider was actively addressing and prioritising. Upgrade works had been completed during 2025 which included repairs to the roof and improvements to the CCTV system. Commencement of window upgrades had commenced in 2025 with plans to continue during 2026. The hydrotherapy pool had been decommissioned for a number of years and area was not in use. At the time of the previous HIQA inspection in February 2025, a review by the provider of the use of the space was in progress. The person in charge advised that a number of options had been

considered during 2025 but no decision had been made to date by the executive management team.

As this inspection was announced, residents were given the opportunity to complete residents surveys. One inspector reviewed 17 completed questionnaires. Overall, there were positive responses, particularly about the high quality of the meals provided. The supports from the core staff team meant a lot to residents and having dedicated apartment style dwellings suited the assessed needs of the residents very well to help maintain their independence. Additional positive aspects to living in the designated centre included residents found the residents meetings a great way to have a group discussion about a variety of topics. While a resident who did not speak English was very happy to be supported by a personal assistant who spoke their native language.

In summary, residents were being supported by a core group of staff members and local management who were familiar with individual preferences and routines. Residents were in receipt of person centred care while being supported in-line with their assessed needs. Residents were being supported to make decisions and choices in their everyday lives which included budgeting, planning holidays and social activities. However, some gaps in documentation including progress of personal goals for residents and completing weekly fire safety checks were identified during the inspection. In addition, minimal staffing fire drills had not been completed in the previous 12 months, with all residents present/participating. These will be discussed in the quality and safety section of the report. The inspectors noted that the duties required to be completed by the local management team at the time of this inspection resulted in some gaps in the monitoring required to be completed by the provider. This will be discussed in the capacity and capability section of this report.

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.

Capacity and capability

Overall, this inspection found that the residents were in receipt of care and support from a consistent staff team. There was a management structure in place in the designated centre. The person in charge was knowledgeable of the residents and their needs. There was a staff team in place with the skill mix to support the residents and were also knowledgeable of the residents. The staff team had received training to support them in their roles. Oversight of training was well managed and future training dates for staff were planned.

Documentation associated with the designated centre was current and under review such as the directory of residents, statement of purpose and contracts of care.

The provider was aware of the regulatory requirements to complete an annual review and internal provider-led audits every six months. Internal provider-led audits had taken place in July 2025 and February 2026. The annual review for 2025 had been completed in February 2026 by the person in charge. Where actions had been identified during the audits these had been addressed and updated when completed by the person in charge. For example, reviews of sections of residents personal plans to ensure consistent information was available to all staff. In addition, where additional training for staff was identified regarding the correct completion of medical transfer documentation this was provided. Where documentation was identified as requiring further review this had taken place.

The inspectors were informed of the local protocol that was in place regarding monitoring and oversight in the designated centre. The local management team which was comprised of the person in charge, a clinical nurse manager and a service co-ordinator were responsible for completing a large range of documentation, identifying personal goals, regular safety checks and other administrative duties for all of the residents. Where some of the gaps in up-to-date documentation/electronic records had been identified during this inspection, the inspectors were informed this was the responsibility of the local management team. However, this approach resulted in not all areas of supports provided to residents being monitored and updated as required. The inspectors were informed that while the electronic system containing residents personal information and plans of care had expanded in the previous 12 months, the local management team retained the responsibility for inputting some information such as personal goals. This was discussed during the feedback meeting at the end of the inspection.

The inspectors were informed that access to additional allied healthcare professional services had become available during 2025 which assisted in a timely review for residents when needed. This included occupational therapy, physiotherapy, speech and language therapy. In addition, residents who required dietetic input had also been supported to access these services during 2025. The provider had also successfully recruited other roles which included an administrator, bus driver, maintenance assistant and domestic staff. These were described as having positive outcomes for residents and ensured consistency in the services being provided

Registration Regulation 5: Application for registration or renewal of registration

The provider had ensured a complete application to renew the registration had been submitted as per regulatory requirements. A review of the floor plans was undertaken during the walk around at the start of the inspection. It was identified that a door into one of the sitting rooms was no longer present as reflected on the plans. Another location near the dining room was also not correctly reflected on the floor plans submitted with the application to renew. These issues were shown to the

person in charge. The inspector advised during the feedback meeting that revised floor plans that accurately reflected the whole designated centre were required to be submitted by the provider to the Chief Inspector of Social Services to support the renewal of registration decision.

Judgment: Compliant

Regulation 14: Persons in charge

The registered provider had ensured that a person in charge had been appointed to work full-time and that they held the necessary skills and qualifications to carry out their role. Their remit was over this designated centre.

- They demonstrated their ability to effectively manage the designated centre.
- They were familiar with the assessed needs of the residents and consistently communicated effectively with all parties including, residents and their family representatives, the staff team and management.

Judgment: Compliant

Regulation 15: Staffing

The staff skill mix was appropriate in supporting the residents. There was a planned and actual staff rota in place which showed the staffing levels available to the residents on a given day. A selection of dates of the staff rota, both actual and planned, were viewed for four months from November 2025 to March 2026. This review showed consistent staff members and staff levels were working in the designated centre. Staffing levels match those as set out in the designated centre's statement of purpose. The staff members working with residents during the inspection knew them well and spoke with the inspectors about their interests and how they supported them with their daily routines and activities. Staff present on the day spoke about engaging with each resident to hear their voice, listen to their requests and provide support as requested by each resident.

Due to the provider's ongoing recruitment drive there were no agency staff working in the designated centre at the time of this inspection. Where relief staff were required to fill gaps in the rosters, these staff were familiar to the residents. In addition, staff who were working for the provider in another designated centre had been re-deployed to work in this designated centre. An inspector met one of these staff during the inspection and they outlined how they had been supported with the re-deployment by the staff team and local management.

Judgment: Compliant

Regulation 16: Training and staff development

The provider had ensured there were effective systems in place for the training and development of the staff team. The person in charge, the CNM2 and service coordinator maintained a training matrix to monitor the training needs of staff and ensure these were addressed promptly.

The training matrix for all 66 staff working in the centre was reviewed. Four staff were on unplanned leave at the time of this inspection. The person in charge had ensured all of the staff team had completed a range of mandatory training courses to ensure they had the appropriate levels of knowledge and skills to best support the residents. These included training in areas such as fire evacuation, positive behaviour support and manual handling. One staff member was required to complete refresher training in safeguarding, their training had expired on the day of the inspection. This was followed up by the person in charge during the inspection and expected to be addressed before the staff member was scheduled to be on duty again in the days following this inspection.

Centre specific training for nurses had also been identified by the provider and all the required staff had completed these training courses which included first aid, wound assessment and management as well as aseptic technique.

Some non-mandatory training courses remained outstanding for staff, a number of these were staff that had recently commenced working in the designated centre but dates for these training sessions were noted on the matrix to be scheduled in the weeks following the inspection. For example, food safety training was scheduled for five staff to be completed by the end of March 2026.

The person in charge had ensured effective measures were in place for the appropriate supervision of staff. There was a schedule shown to one of the inspectors on the day for the completion of supervision for staff members for the current year.

Judgment: Compliant

Regulation 19: Directory of residents

The registered provider had established and maintained a directory of residents in the designated centre. This was made available to the inspectors on the day of the inspection. The information required under Schedule 3 of the regulations was included in the directory for example, the name and address of the full time residents and the dates they were admitted to this designated centre. The

inspectors acknowledge a typing error had been made on the date of admission for one resident and this was rectified during the inspection with the revised document shown to the inspectors once updated.

In the format shown to the inspectors not all of the residents availing of respite services had the date they first availed of respite services in the designated centre documented. The inspectors were informed this information was contained in other personal documents pertaining to the individual residents and this would be added to the format of the directory.

Details of residents who had availed of both respite or residential services in the designated centre and died during 2024 and 2025 were also available for review during the inspection.

Judgment: Compliant

Regulation 22: Insurance

The registered provider had submitted documentary evidence of insurance as part of the application to renew the registration of the centre. This was reviewed prior to the inspection. The document showed that the registered provider had in place insurance in respect of the designated centre which was appropriate and in-line with the regulation. The inspectors advised during the feedback meeting that an updated insurance certificate would be required to be submitted once available as the current certificate was due to expire within the next two months of this inspection.

Judgment: Compliant

Regulation 23: Governance and management

The provider was found to have governance and management systems in place to oversee and monitor the quality and safety of care of the residents living in the designated centre. There was a management structure in place, with staff members reporting to the person in charge. However, due to the current delegation of duties some gaps in monitoring were identified during this inspection. Not all weekly safety checks were being consistently completed due to the local protocol of management completing these checks. Also residents goals were being identified, planned and organised by the local management team which resulted in some goals not progressing or being updated in a timely manner.

The annual review of the quality and safety of care and support in the designated centre was completed in February 2026. This annual review contained information on what the residents were undertaking in the centre such as new activities for

residents. Residents and staff members had completed surveys on their views of the service provided. These surveys reflected positively on the residents' experience in the designated centre. The registered provider's six monthly unannounced visits were taking place with the last two visits completed in July 2025 and February 2026 as required. The reports were made available to the inspectors and contained actions that the person in charge had addressed such as updating health care management plans.

There was an audit schedule in place for 2025 and to complete in the designated for 2026. For example, audits in the area of safeguarding had been completed in December 2025 with further audits scheduled to be completed throughout the coming year.

Staff team meetings were taking place regularly in the designated centre. The person in charge met with different grades of staff such as the nurses, care support workers, personal assistants, drivers, housekeeping and therapy staff. In addition, joint meetings with multiple staff grades were also taking place. Agenda items included topics being discussed such as complaints, training needs and safeguarding.

Judgment: Substantially compliant

Regulation 24: Admissions and contract for the provision of services

The provider had ensured all residents had been provided with a written agreement outlining the services being provided to them. The person in charge had reviewed service agreements with 11 residents since the start of 2026. Nine residents had been supported to review their tenancy agreements since January 2026. These agreements were observed to be reflective of the individual to whom they referred. For example, each stated which room the particular resident was living in the designated centre.

Judgment: Compliant

Regulation 3: Statement of purpose

The registered provider had a statement of purpose in place in the designated centre and was made available to residents. The statement of purpose had been reviewed in February 2026. The current version contained the information set out in Schedule 1 of the regulations including the services and facilities provided in the centre. Some minor changes were made on the day of the inspection and re-submitted by the provider the day after the inspection.

Judgment: Compliant

Regulation 31: Notification of incidents

The person in charge was aware of their responsibility to give notice in writing to the Chief Inspector of Social Services within three working days in the event of adverse events occurring as specified by the regulations. One inspector reviewed notifications of incidents that had occurred since February 2025 in the designated centre. Actions had been taken to reduce the risk of similar incidents occurring. For example, providing additional aids such as a non-slip mat with a resident's consent to reduce the risk of them falling in their apartment.

The Chief Inspector of Social Services had been provided with a written report at the end of each quarter of the calendar year as required by the regulations. The information provided in these reports was found to be consistent with the findings of this inspection. Some of the reported restrictions were in place to support residents availing of respite breaks and were consistent with their preferences/assessed needs such as leg splints and lap belts when using wheelchairs.

Judgment: Compliant

Regulation 34: Complaints procedure

The provider had ensured a policy was in place for the management of complaints.

Details of who the complaint officer was were observed to be available within the designated centre. Easy-to-understand information was available for residents to access, if required, including in another language for one resident.

- There were no open complaints at the time of this inspection. Four complaints had been logged since the start of 2026. Details were documented of the supports provided to one resident to keep them informed of an alternative living arrangement which had been delayed outside of the developer's control. This included the resident attending a recent meeting with members of staff from the Health Service Executive who provided re-assurance and updates on their individual situation.
- The provider ensured ongoing review of issues of concern /complaints raised by residents. This included reviews taking place during internal audits and the annual review. All complaints received since the previous inspection had been appropriately responded to and closed out in-line with the provider's processes.

- A total of 10 positive comments had been received to date since the start of 2026, with the majority relating to the staff team and how they effectively supported residents such as settling in and living their best lives.

Judgment: Compliant

Quality and safety

The person in charge had ensured there where relevant assessments undertaken and personal plans in place for the residents. It was evident through conversations with residents, staff and reviewing a variety of documents that each resident had ongoing input and supports from the multi-disciplinary team and allied healthcare professionals as required. Assessments and plans were subject to regular review. Where actions had been identified during internal audits these had been addressed. This included ensuring up-to-date information relating to healthcare plans was contained in each resident's personal plan. The plans contained information on residents' needs in relation to activities of daily living, social care and also on how they communicate and how they liked to be communicated with. The plans were available in both electronic and paper format. During the inspection, the inspectors reviewed sections of electronic records pertaining to three residents as well as the paper format. The inspectors were also informed progress was being made to provide an electronic version of residents personal plans available to those residents who wished to have access to their plans in this format.

On review of residents personal goals some were recorded as being on hold or in progress but no updates documented since October 2025. The rationale for a number of these was provided to the inspectors during the inspection by the local management team. For example, one resident had been unwell and required admission to hospital which delayed the progression of some of their goals. However, a goal for this resident to visit a relative which was documented as being in progress had not been updated since 13 October 2025. The inspectors were informed that it was the responsibility of the local management team to meet with each resident, discuss and identify goals, document the agreed goals, put measures/actions in place to attain/progress the goals and input updates. This resulted in delays at times with updates and progress notes being added to residents goals.

The premises was well maintained and was providing residents with sufficient communal and private space. The fire safety equipment in the designated centre was serviced by external contractors and was in good working order. Upgrade works including window replacements had been completed since the previous HIQA inspection.

Regulation 10: Communication

The registered provider and the person in charge had ensured the communication needs of the residents were well met. Residents' personal plans contained information on how the residents communicated. These plans also contained information on how residents liked to be communicated with. Staff were seen interacting with the residents in-line with their communication plans. For example, one resident had their menu planner available in another language to ensure they were able to express themselves clearly to staff of their preferences. In addition, the chef had developed a reference guide for staff who may not understand terms used by residents when referring to particular dishes. This had assisted with keeping good communication between the staff team and ensured residents were provided with their meals of choice at all times. One inspector spoke with the chef who explained they regularly met with the residents to discuss changes to the menu planning, discuss new options and recipes and tried to keep a variety of options available to all residents.

Residents were observed to be using smart devices during the inspection. Resident had access to their own televisions and radios and had access to the Internet. Notice boards were used by residents for schedules, for example the staff working that day in the centre were on a visual display near the dining room which was the central hub of activities and all residents were able to view this throughout the day.

Judgment: Compliant

Regulation 12: Personal possessions

The person in charge had ensured each resident was supported in-line with their will and preference to access and retain control over their personal property and possessions. Residents were supported to create a property catalogue/record if they chose to do so. This was subject to regular review with each resident. In addition, personal finances were discussed with each resident and arrangements made to support a resident if they required any supports. However, where a resident declined any support with managing their finances, the person in charge provided them with documentation so a resident could keep their own finance records. Residents had also been provided with the opportunity to meet with representatives from the Money Advice and Budgeting service (MABS)

Judgment: Compliant

Regulation 13: General welfare and development

The person in charge had ensured that residents were supported to access opportunities for education, training and employment. The residents in the designated centre were involved in their care and support. The residents contributed to their personal plans. Residents meetings were occurring on monthly basis in the designated centre with good numbers attending. Topics such as residents rights, complaints, menus and social outings were discussed. The residents were seen undertaking activities of interest during the inspection with the support of staff. From reviewing documentation and discussions with staff and residents, residents were undertaking new activities and returning to old activities that they enjoyed. This included physical therapy. Residents were supported to engage the services of personal assistants and access community services such as beauticians, hairdressers and other shops as required.

Judgment: Compliant

Regulation 17: Premises

Overall, the designated centre was found to be clean, well ventilated and comfortable.

- The registered provider had ensured that the premises of the designated centre was laid out to meet the objectives of the service, and the number and assessed needs of residents. The inspectors completed a walk-around of Rathfredagh during different times of the inspection. For example, the main house walk-about of communal areas was commenced during the morning as residents were engaging in their morning routines. The courtyard was visited in the afternoon when residents had informed the person in charge this would be a more suitable time for an inspector to visit. The person in charge accompanied one inspector to the hydro-pool area in the afternoon. While the space was not being used and the pool had been de-commissioned the provider's executive team were to make a decision on the plans for the room. The inspectors advised during the feedback meeting that the area was still reflected on the floor plans as being a hydro-pool.
- Other issues relating to the floor plans submitted as part of the application to renew the registration of the designated centre have been outlined in the Registration Regulation 5: Application for registration or renewal of registration.
- The provider was actively progressing with ongoing maintenance works and had completed some upgrade works including to bathrooms, the roof of the main house, painting and flooring replacements.
- Residents had access to large dining areas in both the main house and courtyard, all areas were located on the ground floor with ease of access for those who required the use mobility aids.

Judgment: Compliant

Regulation 20: Information for residents

The registered provider had prepared a residents guide in relation to this designated centre. A copy of this guide was available to the residents in an easy-to-understand format. This guide included the information required by the regulation including the services and facilities provided and the arrangements for visitors in the designated centre.

Judgment: Compliant

Regulation 28: Fire precautions

The provider had protocols in place to monitor fire safety management systems which included a requirement for weekly, monthly, quarterly and annual checks being completed. The provider had ensured the checks being completed by external contractors had been consistently completed as required. However, not all weekly checks of emergency lighting had been documented as taking place. For example, in the courtyard part of the designated centre weekly checks were documented for 17 December 2025, 5, 12, 21 January 2026 and 5 February 2026. The inspectors were informed it was the responsibility of one person to complete these checks which had led to the gaps in the weekly checks occurring.

- All residents had a personal emergency evacuation plan (PEEP) in place. These were subject to regular review and were reflective of the supports, prompts and equipment that may be required for each individual. One resident had their PEEP and easy-to-understand information relating to fire safety documented in their native language.
- No exits were observed to be obstructed during the inspection.
- All staff currently reporting for duty had completed up-to-date training in fire evacuation.
- Regular fire drills were taking place with residents during 2025 and to date in 2026. However, on review of the drills completed since the previous HIQA inspection, not all residents had participated in a minimal staffing fire drill. For example, in the courtyard a minimal staffing drill had been completed with four of the five residents in February 2025, no details of how long it took to complete the evacuation was recorded. In addition, the evacuation time documented in a number of drills reported 10 minutes or more and did not reflect if compartmental evacuations had taken place.
- Where actions had been identified during fire drills, these had been addressed such as ensuring all staff working in the courtyard had a master key to access

residents apartments form the outside if required to support a safe evacuation. This was observed to be in place on the day of the inspection when one inspector visited the courtyard. Staff spoken too were aware of the procedure and evacuation plan.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Assessments and personal plans were viewed for three of the residents. Review of the personal plans had taken place in the last 12 months. There was evidence in the personal plans of multidisciplinary team involvement in supporting the residents throughout the year.

Residents undertook both enjoyable activities and also ways of increasing the residents' independence. Residents were undertaking such activities as horticulture, one resident was enjoying a short break that had been planned for a long time, while two other residents were planning to engage in community activities with greater ease once they received their motorised wheelchairs in the coming weeks.

The residents personal plans also contained information how residents like to be interacted with, how they like to communicate and how they wished to be communicated with.

As previously mentioned the residents personal plans were available in both paper and electronic formats. Work was in progress to provide residents with access to the electronic version if they wished to do so. The inspectors were given temporary access to three such plans for the duration of the inspection. The electronic format ensured the staff providing support had access to up-to-date information in relation to the residents health and social care plans. The most recent reports from allied health care professionals were also readily available for staff, this included feeding, eating and drinking plans. However, the progression or attainment by some residents of their goals was not updated in a timely manner. This will be actioned under Regulation 23: Governance and management.

Judgment: Compliant

Regulation 8: Protection

There was no open safeguarding plans in the designated centre at the time of this inspection. One plan was closed to the Health service Executive (HSE) safeguarding and protection team with the plan being monitored in-line with the provider's process.

Training records reviewed showed that the person in charge had ensured that all staff had received appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse. Safeguarding as a topic was discussed at staff meetings and residents forums. Information was available in suitable formats as required by residents in relation to safeguarding.

Residents had intimate care plans in place, which explained what varying degrees of support residents needed in this area. An inspector reviewed three such plans which had been documented to have been reviewed as required. Each resident was being supported to maintain their independence as much as possible.

The person in charge also attended quarterly safeguarding meetings with the safeguarding and protection team.

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	
Registration Regulation 5: Application for registration or renewal of registration	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 19: Directory of residents	Compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 24: Admissions and contract for the provision of services	Compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 12: Personal possessions	Compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Compliant
Regulation 20: Information for residents	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Rathfredagh Cheshire Home OSV-0003449

Inspection ID: MON-0041350

Date of inspection: 02/03/2026

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
<p>Outline how you are going to come into compliance with Regulation 23: Governance and management:</p> <p>Training to be delivered to the nursing staff on the identification, planning and organising of goals and on progressing and updating these goals on the IPlanit system in a timely manner. </p>	
Regulation 28: Fire precautions	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 28: Fire precautions:</p> <ol style="list-style-type: none"> 1. In conjunction with the regular fire drills facilitated throughout the year, a minimum of one Fire Drill will be scheduled with minimum staffing in the Courtyard. 2. The Fire Drill recording document to be updated to include details of compartmental evacuations. 3. The weekly Emergency Lighting check in the Courtyard has been delegated to the maintenance department to facilitate and record. <p> </p>	

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	02/06/2026
Regulation 28(2)(b)(iii)	The registered provider shall make adequate arrangements for testing fire equipment.	Substantially Compliant	Yellow	03/03/2026
Regulation 28(4)(b)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, in so far as is reasonably practicable, residents, are	Substantially Compliant	Yellow	03/05/2026

	aware of the procedure to be followed in the case of fire.			
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