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:	Cara Residential Service
Name of provider:	Avista CLG
Address of centre:	Dublin 15
Type of inspection:	Unannounced
Date of inspection:	20 February 2026
Centre ID:	OSV-0003733
Fieldwork ID:	MON-0048364

About the designated centre

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

Cara Residential Service is a designated centre operated by Avista CLG. The designated centre forms part of a campus based service for persons with intellectual disabilities and is located in west Dublin. The centre is comprised of three individual bungalows and provides full time residential services to up to 14 adults. The layout of all three houses is very similar with a spacious entrance hallway, an open plan living and dining area with kitchen space, resident bedrooms, main bathroom and smaller toilet areas. Residents are supported 24 hours a day, seven days a week by a person in charge and a staff team of nurses, carers and house hold staff.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	14

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 20 February 2026	09:30hrs to 17:45hrs	Brendan Kelly	Lead

What residents told us and what inspectors observed

This unannounced inspection was completed in Cara Residential Services to monitor the providers ongoing compliance with The Health Act 2007 (Care and Support of Residents in Designated Centres (Children and Adults) with Disabilities) Regulations 2013.

Cara Residential Service comprises of three bungalows located on a congregated campus in Co. Dublin. On the day of inspection the inspector spent time in each of the bungalows. Cara residential is currently registered to accommodate up to 14 residents. All three bungalows are located in close proximity to each other on the providers campus.

On the day of inspection there were no resident vacancies in the centre. The inspector had the opportunity to meet with and speak to the person in charge, two members of the providers senior management team, staff in each of the bungalows that made up the designated centre, and also spoke with a residents family member. In addition, the inspector carried out observations of the day-to-day operation of the centre, including interactions between staff and residents and the care and support provided to them.

This inspection found the provider did not have effective systems in place to ensure that each bungalow, that made up the designated centre, was adequately resourced to meet the assessed needs of all residents. The provider's governance and management arrangements were ineffective in identifying areas of concern within the centre. In addition, the guidance provided to the front line staff team did not sufficiently promote resident safety and well-being at all times.

On arrival at the first bungalow the inspector was greeted by two staff members. The two staff members were supporting five residents with their morning routines when the inspector arrived. It was evident that staff were very busy attempting to support the residents as best they could but the staffing levels in the bungalow were not adequate to meet the needs of the residents. For example, one resident required required two-to-one staff supports for personal care and getting ready for the day. The inspector observed the resident was not yet up and remained in their room.

Staff told the inspector the reason for this was they were short staffed that morning. They told the inspector that generally in two of the bungalows there was an allocation of three staff, and in the third bungalow, an allocation of two staff. Across the three bungalows that made up the centre, an additional staff was assigned referred to as a 'runner'. Staff told the inspector, when required, they could call on that additional staff member for support with the residents. The inspector asked what the arrangements were if the additional staff member was unavailable or busy.

Staff told the inspector in those instances the residents needed to wait until they were available.

For the majority of the inspection, the inspector was based in one of the bungalows. Throughout the day, the inspector observed occasions where staffing levels were not sufficient to meet the needs of residents. For example, on two occasions one staff member was left supporting five residents, including one resident wo required two-to-one staff support. This occurred while a nurse attended the other bungalows to administer medication to residents.

Later in the afternoon, the inspector observed a safeguarding incident between two residents in the sitting room. The incident was also witnessed by a staff member and the inspector brought this matter to the attention of the senior staff member on duty. The inspector observed, that due to inadequate staffing levels, the staff team experienced difficulty ensuring residents were appropriately supervised and protected at all times.

During the course of the inspection, the inspector completed a walk-through of the three bungalows, in the company of the person in charge, and observed a number of issues relating to poor storage arrangements for residents' personal hygiene and mobility equipment. It was noted the provider had not completed all of the improvement actions required to the premises as identified in a previous inspection of this centre.

For example, the inspector observed commodes being stored in the bathrooms of each of the three bungalows. This matter had been identified on a previous inspection but, was not assigned a regulatory non-compliance as the provider had arrangements in place to address the issue and were in the process of building an additional space for their storage. The inspector enquired why the commodes were not being stored in the storage space the provider had put in place. The person in charge informed the inspector that the storage space that had been built was too small, no further initiatives or arrangements had been undertaken by the provider in response to this issue despite the insufficient additional storage space being in place since 2024.

Furthermore, the inspector observed in each of the bungalows residents; wheelchairs were stored in the sitting rooms and resident bedrooms due to the lack of sufficient storage space. The wheelchairs had caused marks and chipped paintwork on the walls beside where they were stored.

The inspector also observed that the provider had not created an office space in one of the bungalows despite being identified as required in the provider's own audit of the centre in November 2024. The person in charge's office was located in another building away from the premises. This impacted on their ability to be present in the centre to ensure on-site supervision of the care and support to residents. Additionally, the bungalow's computer, which all staff used frequently during the day, was inappropriately positioned as it was located directly outside a bathroom used by residents and therefore impacted on resident's privacy arrangements while using the bathroom facilities. In one bungalow the inspector observed a box labelled

'Emergency PPE' (Personal Protective Equipment) on the floor in the main entrance area, it had been placed there due to a lack of appropriate storage.

The inspector observed that each resident had their own bedroom which were decorated to the residents preferences. The inspector observed photographs of residents' families and friends and evidence of residents' hobbies.

The inspector observed the residents in each of the locations as they went about their morning routines. Residents appeared happy and comfortable in the presence of the staff teams in each location. The inspector observed one resident having a cup of tea in one location and sat down with the resident to talk about their home. The resident told the inspector that they like their home. They told the inspector that they like their bedroom and that the staff were very good to them. They spoke positively about the food in the centre and also the company of their housemates. The resident told the inspector they did not have any plans for the day of the inspection but that they might go out tomorrow if they felt like it.

Later during the inspection, a residents family member arrived to the centre to bring them for lunch. The inspector had the opportunity to meet with and speak to the resident's family member. They told the inspector they were very happy with the care and support the staff team provide to their loved one. They told the inspector that they visited every week to bring their loved one for lunch. The family member told the inspector they were very happy with the staff team and said that they could bring any issue to the team and that the matter would be dealt with. The family member told the inspector that they are happy with the activities their loved one engages in giving examples of knitting and shopping. The resident often stays in their family home and is brought home and collected by the staff team. The family member spoke positively regarding the care of the residents assessed medical needs.

The inspector observed the staff team to be warm and caring towards the residents at all times during the inspection. The residents were comfortable in the presence of the staff team. However, the inspector observed that due to the inadequate staffing numbers on duty it was difficult for the staff to engage with residents in a meaningful manner and provide meaningful activities within and outside of the centre. For example, the inspector observed in one bungalow, all residents were present from lunch time and for the remainder of the day, the inspector did not observe any activities offered to the residents and no resident was offered the opportunity to leave the premises from the afternoon onwards.

In response to the high levels of non-compliance found on this inspection, the provider was required to attend an escalation meeting with the Chief Inspector.

The next two sections of this report will outline in greater detail the providers capacity and capability to oversee the day to day management of the centre and the impact these systems have on the quality and safety of residents lived experiences.

Capacity and capability

The providers governance and management systems were not effective in ensuring residents' assessed needs were being met at all times.

Evidence gathered by the inspector showed that the staffing numbers in the designated centre were not sufficient to meet the needs of the residents.

The inspector observed that the provider had ensured that while all staff had been in receipt of mandatory training improvements were required. The inspector noted mental health conditions were an assessed need for many residents living in the centre and which impacted on their daily lives. Despite this, the provider had not ensured all staff were in receipt of specific mental health training to support the resident group living in the designated centre.

The provider had a number of audits and meetings that were aimed at improving service delivery. However, the inspector observed that the systems in place were not effective in identifying ongoing issues or rectify areas of concerns identified in a timely manner.

Regulation 15: Staffing

While there were no staffing vacancies for the centre, the provider was required to review the staffing resource arrangements for the designated centre in it's entirety to ensure residents assessed needs could be met in the most effective way possible and on a consistent basis.

The staff team consisted of nurse and care assistants and there was a planned and actual staff working roster in place. The roster comprised of a central roster that outlined to staff which of the three locations they will be working in each day. On the day of inspection, the inspector reviewed the rosters for the month of January 2026.

From a review of the staffing rosters the inspector observed that the provider had staffing numbers that reduced across the day.

The three bungalows were staffed with a maximum of eight staff across the three locations from 08:00 to 16:00 to support 14 residents.

This number reduced to a maximum of seven staff from 16:00 to 18:00 to support all residents and reduced again to a maximum of four staff for all residents from 18:00 until the following morning.

In reviewing the rosters for the month of January 2026 the inspector did not observe any week where the numbers of staff were maintained at the maximum number of planned staff.

For example;

- on week commencing 04/01, seven staff were noted in the morning on two days and the numbers from 16:00 to 18:00 dropped to five on one day.
- on week commencing 11/01, on one day the number of staff from 16:00 to 18:00 was at six staff
- on week commencing 18/01, three days were observed to have six staff from 16:00 to 18:00
- on week commencing 25/01, two days were observed to have six staff from 16:00 to 18:00

The inspector was informed that staffing numbers were reduced on days of unplanned leave. This was due to a provider decision that that centre would not be in a position to use agency or relief staff to cover unplanned leave as they had a full compliment of staff.

The inspector enquired if the provider had completed an assessment of needs to support the rationale in reducing the staff numbers by half each day. The inspector was informed that no assessment of need was in place in this regard.

The inspector also observed a need for more drivers in the staff team. The centre was resourced with a staff team of 32; however, only five were qualified drivers, and of these, two did not work full-time hours. This shortage of drivers limited residents' access to off-site activities and community engagement.

Judgment: Not compliant

Regulation 16: Training and staff development

While staff had received training in mandatory areas, some further improvements were required to ensure staff had received guidance and training to support all residents' assessed needs.

Staff training records were available in the bungalows that made up the designated centre. The training records demonstrated the staff team had received required mandatory and refresher training in most areas but some further improvements were required.

Not all of the staff team had completed the required training in the following:

- Food, Eating, Drinking, Swallowing (FEDS)
- Person centred planning

- Infection prevention and control

In addition, a number of residents, across each of the three bungalows that made up the centre, had significant mental health diagnosis. On review of the training in place no staff had received specific mental health training to ensure they had the most optimum skills to support the assessed needs of the residents.

The inspector observed throughout the day of inspection the significant impact residents' mental health diagnosis had on their day to day lives.

Judgment: Not compliant

Regulation 23: Governance and management

The provider's governance and management systems were not effective in identifying concerns or, where concerns were identified, that they were rectified in a timely manner.

The provider had a system of internal audits and governance meetings intended to review the service offered to residents. This included provider led six monthly unannounced audits, governance meetings, team meetings and an annual review. On the day of inspection, the inspector reviewed the last two provider led six monthly audits, the providers annual review and a sample of the meetings held in the centre.

In reviewing the annual review the inspector observed that the provider had found themselves compliant in a number of regulations that have been judged as non-compliant in this inspection. The annual review did not identify the reduction in staff numbers and inadequate number of staff drivers for the centre's transport vehicle as a deficit under Regulation 15: Staffing.

The annual review had also not identified the requirement for staff training in mental health, an assessed diagnosis and need for a number of residents living in each of the three bungalows that made up the centre.

The provider's annual review commented that residents watching television or talking to staff were not to be considered a quality of life activity. However, despite this, in one resident's Quality of Life recording sheet reviewed during the inspection, the resident's quality of life activities included watching television and talking to staff as quality of life activities and was listed throughout the record. This demonstrated that where deficits were identified in the provider's audits of the centre, changes did not come about to improve the quality of service for residents in response to these audits.

Furthermore, the annual review of 2024 identified the lack of storage as in issue to be rectified, however, despite the storage arrangements in the centre still not being sufficient, the provider's annual review of the centre in 2025 found Regulation 17:

Premises substantially compliant with some improvement actions identified that did not address the storage concerns. The findings from this inspection showed there were considerable storage deficits in the centre.

The providers six-monthly audit from July 2025 identified the need for a training analysis to be completed,. On the day of inspection no analysis had yet been completed. The provider led audit from January 2026 had also failed to identify ongoing concerns. For example, the staff team had been tracking one residents behaviours of concern in their care plan. Behaviours were frequent and in one case directly involved a peer, however, this was not identified in the audit under Regulation 8: Protection which was listed as reviewed in the audit and judged as compliant with no improvement actions required.

The inspector reviewed the team meeting minutes from December 2025 and January 2026. The inspector observed that agendas were not consistent. For example, the December 2025 meeting consisted of 32 agenda items with the January 2026 meeting listing 18 agenda items. It was evident that not all agenda items were discussed or had sufficient actions arising from discussions. For example in the January meeting safeguarding was on the agenda but there was no discussion on safeguarding. The December meeting had 23 actions listed as 'staff to be aware' or 'all staff to complete' with the January meeting having two actions arising one in relation to hand hygiene and the other in relation to collection of post.

Governance and management oversight meetings in the centre were not effective. The last governance meeting available to the inspector was dated October 2025. Actions identified in this meeting were not completed in a timely manner. For example, one action was that all staff are required to complete person centred planning training. On review of the training log available 26 staff were still outstanding with the required training.

Judgment: Not compliant

Quality and safety

The provider was failing to ensure residents were being supported in a way that met their assessed support and supervision requirements. The inspector observed that the guidance for staff in regard to food, personal care and risk assessments required review to ensure residents are cared for in a safe manner.

Safeguarding incidents were occurring in the centre that were not being identified and reported. Reactive strategies in place were commented in documents by staff as not effective. The inspector observed that guidance had not been updated despite this evidence.

In previous inspections the provider had identified that they had plans to address the ongoing issues with storage in each premises. The inspector observed that the actions taken by the provider were not effective and lack of suitable storage arrangements continued to be an issue in the centre.

Regulation 13: General welfare and development

Residents were not being effectively supported to have a meaningful day with activities of their choosing provided to them.

The inspector reviewed resident care plans weekly planners and residents quality of life recording sheets.

The inspector observed a document for special dates and events for one resident. The document contained four entries, one for their birthday, one for St Patrick's Day, one for Easter, however the date for Easter was not mentioned and a final entry for Christmas. There was no guidance for staff in terms of what is the importance for each of these events. The document did not guide staff in what the resident likes to do to celebrate these events.

The inspector reviewed a quality of life indicator audit for one resident. The activities listed in the audit that residents should be engaging in were visits to shopping centres, grocery shopping, coffee shop, restaurant, fast food take away, social event in the evening or weekend, mass on campus and cinema. However, the audit showed the resident had not engaged in many of the activities listed. For example, the resident had not been grocery shopping, had not went to the cinema, had not visited a restaurant and, had not been for fast food takeaway.

Overall, the audit showed the resident had not been on any social outings in the evenings or weekends.

The inspector reviewed this residents behaviour support plan which outlined that the resident would benefit from one-to-one activities. The residents activity tracking for the week of the inspection showed the resident had two hand massages and once engaged in singing with staff.

The inspector reviewed a second residents documentation regarding their weekly planner and new experience activities for the months of January and February up to the day of inspection.

The residents weekly planner documentation outlined the resident engaged in beauty therapy, music, bingo, movies at home and had been on three bus drives.

The residents new experiences in January and February were identified as follows:

- One-to-one chat with staff
- Watching television in the sitting room area

- Participating in Ash Wednesday
- Singing.

Judgment: Not compliant

Regulation 17: Premises

The provider was not ensuring residents were being provided with suitable storage arrangements for their personal hygiene and mobility equipment. In addition, the provider was not ensuring staff had suitable administration areas in order to do their work in a manner that ensured resident's privacy and dignity was promoted at all times and to ensure on-site supervision and presence of management staff during times when they needed to do administrative tasks.

On completing a walk around of the three bungalows that made up the centre, the inspector observed storage arrangement deficits. In each of the three locations residents' aids and appliances were inappropriately stored.

The inspector observed residents' commodes were stored in all bathrooms which was impacting on IPC arrangements and impacting on the circulation space in the bathroom areas due to the storage of the commodes.

For example, the inspector observed in one bathroom four commodes and a shower chair were observed as stored in this space. Residents' wheelchairs were stored either in their bedrooms or in sitting rooms due to a lack of storage. This again meant that sitting rooms were observed to be cluttered and cramped as wheel chairs were stored against the walls, when not in use, which in turn was causing damage to the paintwork on the walls.

The provider had committed to building storage areas for the various aids used in each location. The storage areas that were built in 2024 were not sufficient as they were too small to store commodes and wheelchairs. Centre management outlined the concerns to the provider, however, no alternative had been discussed or put in place since 2024.

The inspector observed one resident's chair, in their bedroom, to be badly torn and ripped on the arms and seat of the chair.

As discussed in the body of the report, the provider was required to review the locations of the staff's administration and the person in charge's office spaces to ensure they were the most effective and accessible arrangements possible for staff while also taking into consideration the needs of residents.

Judgment: Not compliant

Regulation 26: Risk management procedures

Risk management arrangements, to ensure personal risks for residents were effectively managed and controlled for, required considerable improvements. The inspector observed practices that indicated that the provider had not ensured staff were aware of key risk assessments and resident plans.

For example, the inspector observed staff preparing dinner for residents. The inspector had reviewed one residents care plan, in the care plan stated the resident did not like large plates of savory meat. The dinner prepared for the day was a savory meat. The inspector brought this to the attention of the staff team but no alternative was provided to the resident.

The inspector also observed that the resident required their food to be modified. In conversation with staff it became apparent that the staff were not aware of the guidelines in place to safely modify the residents food. While risk assessments were in place for the resident regarding the risk of choking, it was clear that the assessment had not been shared with all members of the staff team.

The inspector relayed their concerns to centre management who confirmed that guidance was in place regarding the safe modification of the residents food, however, staff on duty confirmed they had not seen the guidance.

The inspector also noted that a key risk control measure, such as staff training in FEDS (Feeding, Eating, Drinking, and Swallowing) was not in place as not all staff had received this required training. This is discussed under Regulation 16: Staff training and development.

The inspector reviewed a risk assessment for a second resident who required two-to-one supports for manual and people handling. The provider had scored this risk assessment as a red or high risk. The risk assessment identified that the resident required hoisting for all transfers, toileting and personal care. The inspector also reviewed the residents fire evacuation assessment. This assessment stated that if the resident was in bed at the time of the alarm they would require the support of two staff to safely evacuate. The risk control measures in place relied on the availability of effective staffing supports for the resident.

However, from 6pm each evening, only one staff member was assigned to work in the resident's bungalow. As a result, the staffing supports required to mitigate identified risks and to meet the resident's assessed mobility support, toileting assistance and two-to-one staffing for hoisting, was not consistently available during this time.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

The provider had individual assessments and personal plans in place for each of the residents. The person in charge and front line staff team provided updates to plans and assessments to evidence resident outcomes. On the day of inspection the inspector reviewed two of the resident care plans from one of the locations.

The provider had not ensured that the staff team had been made aware of all aspects of residents care plans. For example, one care plan that was reviewed by the inspector showed 12 staff have not signed to show they had read and understood the plan. The second plan showed 11 staff had not signed the signature sheet.

The provider had also not ensured that the individual plans for residents were being implemented and evidencing a increased quality of life for the residents.

For example, one resident's mental health care plan was reviewed by the inspector. The plan was last updated in February 2026, however, the review was not using all the evidence gathered by the staff team to ensure the plan was effective in meeting the residents mental health needs. The staff team had been tracking resident behaviours since the start of January 2026. The resident was engaging in behaviours such as screaming, shouting, biting and displaying signs of fear and anxiety. None of the behaviours mentioned in the tracking documents led to a change in the mental health plan in place for the resident. It was also noted by the inspector that this resident did not have a behaviour support plan in place despite overwhelming information and data gathered that this was a required support. The behaviours displayed by the resident also regularly occurred at times when the provider had reduced the staffing numbers in this location.

The resident had an Individual Preference and Needs assessment in their care plan that was dated with a post it note as April 2025. The inspector noted that the action plan developed from this document had not been completed. The provider had not identified any supports or preferences for the resident. The provider had also not identified any rationale for reducing the staff supports in line with resident needs.

The inspector reviewed a second resident's care plan. The provider had evidenced that while in their home the resident enjoyed listening to calming music on their I-pad or television, having a hand massage or engaging in water therapy activities. Throughout the day of inspection the inspector observed the resident was not offered any of these preferred activities.

The inspector observed that the guidance in place for staff in terms of the residents medical needs was limited. For example, the inspector reviewed a resident's bowel movement care plan. The plan stated to offer the resident a high fibre diet, however, there was no guidance on what high fibre foods the resident preferred or should be offered. Another action was to offer prune juice if required, however, there is no guidance on what is the threshold for prune juice to be offered or how much was required. The guidance carried additional importance as the resident

required their food to be modified and a thickener added to all drinks or fluids provided to the resident, including juices.

Judgment: Not compliant

Regulation 8: Protection

The provider was failing to ensure they had effective oversight of safeguarding arrangements in the centre.

As identified earlier in the report, the provider had been tracking resident behaviours and these were reviewed by the inspector. Behaviours were noted as screaming, shouting, throwing of items and vocalisations. The behaviours were noted as occurring in various areas of the premises including at the dinner table. The information provided by staff showed the reactive strategies in place were not effective and resulted in behavioural incidents that were prolonged. None of the incidents noted in the logs were reported to the Office of the Chief Inspector as required by the regulations.

The resident also had an Individual Preference and Needs Assessment in their care plan that was dated April 2025. The document stated that there were no safeguarding concerns regarding the resident. This is despite evidence being gathered by the staff team that suggested a number of safeguarding incidents were occurring.

One of the incidents noted some made specific reference to a resident shouting at another peer. On the day of inspection, the inspector witnessed a safeguarding incident of this nature between a resident and their peer. The inspector brought the incident to the attention of the senior staff on duty and this incident was notified to the Chief Inspector.

The provider had not ensured the required staffing supports in place to ensure all residents were protected. In review of the behaviours noted by the staff team, a number were occurring when the staff team numbers were reduced to their minimum. In relation to the incident that the inspector witnessed, twenty minutes after the incident occurred one of the staff was required to leave the premises to administer medications in other locations. This meant that one staff member remained to support all five residents after the incident.

The inspector also reviewed an intimate care plan in place for a resident who required two-to-one supports and hoisting for all personal care needs. The guidance offered to staff regarding supporting the resident was not detailed. For example, the intimate care plan offered one sentence of written guidance followed by a series of ticked boxes. The inspector did not observe any indicators of resident preferences such as their favourite toiletries, the time of day the resident preferred to have their

shower or bath, a description on how staff should speak to the resident or how staff offer direction during intimate care provision.

The inspector also observed night time supports guidance in place. The guidance outlined that a resident could awaken at night time due to soiling and engage in behaviours of concern. As already identified two-to-one supports were required in order to support with effective hoisting and provision of intimate care, however the provider had staffed the location with one waking night staff only.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 13: General welfare and development	Not compliant
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 8: Protection	Not compliant

Compliance Plan for Cara Residential Service OSV-0003733

Inspection ID: MON-0048364

Date of inspection: 20/02/2026

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 15: Staffing	Not Compliant

Outline how you are going to come into compliance with Regulation 15: Staffing:
The registered provider is committed to ensuring the designated centre is adequately resourced to meet the assessed needs of the individuals supported.

The provider will undertake an assessment of need of the individuals who reside in Cara by 31st May 2026. The outcome of this review will inform the staffing needs within the centre which will be effectively managed through rostering.

The findings of this review will be reported and discussed with the executive team

The Provider will develop a plan to address any deficits identified to ensure that the number, qualification and skill mix of staff is appropriate to the number and assessed needs of the residents.

The current roster will be reviewed to ensure Standard operating procedure in place to ensure governance and oversight of staffing is provided in maintaining staffing levels as per SOP. This will include oversight of staffing levels during planned, unplanned staff absences and supporting residents' external appointments.

The Rosters will ensure to support Quality of life for Residents and in line for their will and preference.

The provider will ensure Quality of life initiatives will be supported on site and to access off-site activities and engage in community activities of their choosing. Transport will be supported by designated centre, on site transport arrangements and use of public transport.

The designated Centre will also have the Day Activation planner for supported individual on site and ensure one person one plan is in operation for recordings of all quality-of-life information.

The provider will have driving for work to remain a competency requirement for recruitment.

PIC will have increased visibility across the centre and will ensure and issues arising in relation to provision of daily staff are escalated to Senior Management Team immediately to ensure plan is put in place to provide alternative staffing supports.

Regulation 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
Staff Training Needs Analysis has been completed and has identified and planned for additional training including Mental Health to provide guidance and support for all individuals' assessed needs.

All Mandatory and additional training needs have been scheduled for 2026

All Staff will have completed FEDS training on HSE land by April 17th.
Speech and Language therapist providing additional support workshop

All staff have completed Personal centered plan training by April 17th

All staff have completed all required training for Infection, Prevention and control by April 17th

CNS in positive Behaviors has completed three on site workshops for staff to support on site Positive support plans. Further workshops scheduled to ensure all staff have received guidance and training to support resident's needs.

Consultant Psychiatrist will provide workshops for staff in relation to Mental Health awareness to support residents in the designated Centre.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
An annual provider review will be conducted by 30 April 2026 to review regulation compliance levels across the Centre.

The six-Month Nominee Provider will be completed by 1st June 2026

All reviews will ensure to reflect accurately compliance level within each Regulation.

Identified non-compliances will be addressed in compliance plans to ensure implementation and evaluation of action plans to include quality of life, storage arrangements, premises, rosters, training and safeguarding review.

All identified deficits will have an action plan implemented by the PIC and will have governance of PPIM to ensure evidence of implementation and ensure changes occur in

line with recommendations

Team meetings will be SMART, with a set agenda, actions assigned and audited to ensure actions are implemented.

Safeguarding will be discussed at all team meetings.

Governance and Management meetings are held monthly, and all minutes will be available on site for all staff to read and sign.

PPIM will hold weekly meetings with PIC or deputy to ensure governance and oversight of the Centre. Same commenced post inspection on 20th February.

Provider will meet with PPIM and PIC Monthly to track progress of all action plans.

Provider will also visit site weekly to enhance oversight and governance.

Regulation 13: General welfare and development	Not Compliant

Outline how you are going to come into compliance with Regulation 13: General welfare and development:
All Personal Plans are under review and will be updated for all residents to ensure all have a meaningful day and support to engage in activities of their choice.

Transforming lives Coordinator is supporting the Centre with monthly focus group on quality-of-life initiatives and supporting compliance via audit.

Quality of life for residents will include a discovery section to try new activities within the local community and within their home. This will guide staff in what each resident likes to do and identify how they wish to celebrate important events.

Weekly planning meetings will be held with all residents to ensure they are supported to participate in meaningful activities for the coming week in their community, their home in line with their will and preference.

Quality of life recording sheets will be completed for each activity and identify residents' participation and their level of enjoyment and reviewed accordingly.
Quality of life will also reflect activation supported by Day Activation team.

Monthly audits will be completed to ensure quality of life indicators for each individual has been met.

All staff have completed Person Centered planning.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
A review of storage arrangements has been completed for the three bungalows

Alternative solutions discussed with OT and sensible options re use of furnishing supports.

Following a review of storage areas with CNS in Infection Prevention and Control, all commodes are now stored in assigned storage areas.

A review has been completed of communal areas and office space in each bungalow to ensure Person in Charge and staff are provided with suitable administration area.

A plan of work will be implemented for renovation to be completed.

Maintenance Monthly Tracking log implemented to ensure all Maintenance works are identified and completed.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
Risk Management processes are under review in the designated Centre to ensure all staff are aware of all personal risks for individuals.

All individual risk assessments to include FEDS and Choking Risk Assessments, have been reviewed and updated and will continue to be updated as necessary in personal plans.

All staff are required to sign they have read and understood all personal plans.

All staff will sign all guidelines and policies to ensure they have read and understood the contents.

Staff awareness will be evaluated during supervision meetings and during governance visits to the designated Centre.

All staff will have completed FEDS training on Hseland by 17th of April. Speech and language therapist is providing additional workshops to the designated Centre.

FEDS Information Folder is now available in the kitchen area as guidance for staff and includes information on individual FEDS guidelines and Individual SALT reviews and individual likes and dislikes.

Management structure in place that can be contacted immediately in event additional support required to the centre.

The designated Centre has a bleep emergency response system for emergency situations to mobilise additional support in event of an emergency

Regulation 5: Individual assessment and personal plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
The provider will ensure that all staff will have signed that they have Read and understand individuals Care Plans.

All individual support plans for residents will be implemented and ensure quality of life is reflective in line with Individual needs and preferences.

All Careplans will be audited yearly.

Individual Mental Health plan of care are currently under review by Consultant Psychiatrist and CNS in positive Behavior Support to ensure that it is effective in meeting individuals' mental health needs.

All individuals identified will have a behavior support plan in situ to support their needs and ensure that reactive strategies that are in place are effective and will be reviewed and updated as required.

A referral has been submitted to CNS in Mental Health to support one resident.

The individuals coping strategies section of their care plan has been updated.

Staff meeting agenda and daily report systems will reflect the importance of engaging in preferred activities for residents in their home/community. Each resident will have daily offer of their preferred activities and a record maintained on site.

Individual Preference and Needs Assessment and action plans will be completed where a person requires a change to their living accommodation or their day service and will provide information on individual support needs.

Nursing review will take place of all medical care plans to ensure clear and detailed guidance is available to support Individual preferences and to support residents' medical needs.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
The provider will ensure that there is effective and oversight of safeguarding arrangements within the centre.

All staff have completed Safeguarding in HSELand.

The provider has ensured that all incidents of safeguarding that had not been identified or reported as per Regulations have been completed and submitted.

The provider will ensure that All incidents of Safeguarding will be identified and reported in accordance with Regulation.

Site Specific safeguarding refresher training has been scheduled for staff by the Social Worker Team on 31st March and 6TH May 2026

Further Practical training sessions on Safeguarding will continue to be scheduled for staff in accordance with Service Policy

Safeguarding will be an agenda item on every local team meeting agenda.

Standard operating procedure in place to ensure governance of staffing is provided in maintaining staffing levels as per SOP. This will include oversight of staffing levels during planned, unplanned staff absences and supporting residents' external appointments.

All intimate care plans are currently being reviewed and updated to include Individuals preferences and offer staff direction during intimate care provision to support each Individual requirement

Roster review is being completed to ensure that the number, qualification and skill mix of staff is appropriate to the number and assessed needs of the residents and in line with the Statement of Purpose.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 13(1)	The registered provider shall provide each resident with appropriate care and support in accordance with evidence-based practice, having regard to the nature and extent of the resident's disability and assessed needs and his or her wishes.	Not Compliant	Orange	30/06/2026
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Not Compliant	Orange	30/06/2026

Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Not Compliant	Orange	30/06/2026
Regulation 17(1)(a)	The registered provider shall ensure the premises of the designated centre are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.	Not Compliant	Orange	30/07/2026
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.	Not Compliant	Orange	30/07/2026
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.	Not Compliant	Orange	30/06/2026
Regulation 23(1)(c)	The registered provider shall	Not Compliant	Orange	30/06/2026

	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.			
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.	Not Compliant	Orange	20/06/2026
Regulation 23(3)(a)	The registered provider shall ensure that effective arrangements are in place to support, develop and performance manage all members of the workforce to exercise their	Not Compliant	Orange	30/06/2026

	personal and professional responsibility for the quality and safety of the services that they are delivering.			
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Not Compliant	Orange	30/05/2026
Regulation 05(6)(c)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall assess the effectiveness of the plan.	Not Compliant	Orange	30/06/2026
Regulation 05(6)(d)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall take into account	Not Compliant	Orange	30/06/2026

	changes in circumstances and new developments.			
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	30/05/2026
Regulation 08(6)	The person in charge shall have safeguarding measures in place to ensure that staff providing personal intimate care to residents who require such assistance do so in line with the resident's personal plan and in a manner that respects the resident's dignity and bodily integrity.	Not Compliant	Orange	30/04/2026