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:	Sonas Bungalows - Sonas Residential Service
Name of provider:	Avista CLG
Address of centre:	Dublin 15
Type of inspection:	Short Notice Announced
Date of inspection:	17 September 2025
Centre ID:	OSV-0003738
Fieldwork ID:	MON-0048067

About the designated centre

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

In Sonas Bungalows, residential care and support is provided on a 24 hour basis for up to 18 residents over the age of 18 with an intellectual disability. The centre consists of three purpose-built bungalows on a campus in an outer suburb of Dublin. Two of the houses have six single bedrooms, and one of the houses has five single bedrooms, and a self-contained one bedroom apartment. Each of the houses have suitable private and communal space to meet the needs of up to six residents. Residents are supported by a person in charge, clinical nurse managers, care staff and household staff. Residents have the option to attend day activity sessions on the campus, or they are supported to partake in meaningful home or community based activities in line with their wishes. There are good public transport links and local access to restaurants, shops, cinema, churches and libraries.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	18

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 17 September 2025	10:00hrs to 17:30hrs	Gearoid Harrahill	Lead
Wednesday 17 September 2025	10:00hrs to 17:30hrs	Karen Leen	Support
Wednesday 17 September 2025	10:00hrs to 17:30hrs	Tanya Brady	Support

What residents told us and what inspectors observed

This inspection outlines the findings of a short notice announced risk inspection to assess the provider's regulatory compliance with the regulations in this designated centre. Over the course of one day, inspectors of social services completed inspections of three designated centres on one of the provider's campus settings. This included meeting with senior management to discuss oversight and governance systems in place for the wider campus. In this centre, the inspectors found that the provider had systems in place to keep residents safe in their home. However, improvements were required in a number of regulations including staffing, staff training and development, governance and management and fire precautions.

This designated centre is located on a congregated mixed-use campus setting with five other bungalows, and an overall capacity of 72 residents. This centre comprises three purpose-built houses which are located in close proximity of each other on the campus and is registered for 18 adult residents. On the day of this inspection there were no resident vacancies in the centre. The centre provides services for adults with an intellectual disability with complex health and social care needs related. The provider and person in charge had identified a number of support needs for residents in relation to age-related conditions such as bone health and falls risk, and related to medical conditions such as respiratory concerns and epilepsy. Residents had access to additional supports such as multidisciplinary input and clinical nurse specialists in behaviour support. Two of the houses in the designated centre required the support of nurses during the day and night time, while the third house in the centre was supported by health care assistants. The nurse was required to provide support in this third house in areas such as medication management and evening time support.

The inspectors completed a walkthrough of each of the houses in the designated centre with the person in charge. The inspectors found that the houses were laid out and decorated in line with each resident's personal taste. The person in charge and support staff explained that a number of residents had set individual goals to refurbish their bedrooms, and that this was part of their person centred goals for 2025. This would also address some rooms which were observed to have blinds and curtains which required repair or replacement. In the afternoon, the three inspectors visited one house each in the centre and met with 17 of the 18 residents. Inspectors observed warm interactions between residents and support staff. One resident had just returned from a visit to a local nail bar and was showing support staff and the inspector their newly polished nails. Support staff advised that the resident like to visit the nail bar once a week. Inspectors observed another resident relaxing in the living room of their home, they were in the process of getting their hair styled prior to attending mass and choir group on campus.

One resident greeted the three inspectors on arrival to their home. The resident took one inspector's hand and walked them to their sitting room. The resident sat with the inspector and their peer and pointed out a number of pictures which hung

in their living room. The resident also showed the inspector a poster which they had created with support staff which portrayed a number of the goals they had completed during the year and some goals which they were working on completing. One resident had recently undergone a surgical procedure which required a period of physical therapy, and the inspectors were shown pictures in their bedroom of their progress in mobility, which supported that resident to feel assured that they were making progress and getting better.

Residents had been advised that inspectors would be coming to visit, and some of the residents demonstrated that they understood the purpose of inspections. Two of the residents told inspectors that staff were lovely and they did their best for the residents. Inspectors met one resident who had recently moved into this centre from another house, who commented that they liked living here because there were no stairs and they felt safer. The residents commented that in the main, they got along with their housemates, but liked having space in which they could be alone if they wished. One resident commented that they loved having their own apartment and a private space that was theirs. Inspectors observed that residents were using different communal spaces and hangout spots on corridors to engage in sensory activities and watch television.

In one house a number of residents liked to knit and were observed sitting together in their living room knitting. One of the residents brought an inspector to their bedroom to look at a blanket they had made. They used a photograph album and pictures to support their communication and engagement with the inspector. Another resident was observed coming in from an outing and requesting staff support to get into bed for a rest; they told the inspector that they got tired easily and loved a nap. Other residents were observed in the dining area of their home engaging with staff and having a cup of tea.

From speaking with residents and reviewing documentary evidence, inspectors were provided examples of what residents enjoyed in their day on the campus or in the local community. Residents enjoyed shopping trips, salon visits, retirement clubs, celebrating mass, and going for drinks or meals out. Some residents' personal goals included going on hotel breaks and planning birthday parties. One resident showed the inspector a photo of them on a boat trip, and another showed off their pictures from a recent holiday in Spain. Some residents had personal objectives of being supported to go to the local shopping centre at least two days in their week, or being supported to go on bus trips. The inspectors discussed with the person in charge the importance of staff effectively using the logs provided so they could be assured that the frequency of these activities and outings was in line with the residents' wishes.

The provider had recently moved the preparation of food from a central kitchen on campus into the residents' homes and staff were observed preparing snacks and dinner in the kitchens which opened into the living room. While this was a positive change for residents it was observed to have placed an additional time pressure on the staff where no additional allocation of resources had been put in place. Staff spoken with discussed how they felt that this was a positive move for residents, with

residents being able to smell fresh cooking in the home and to support an increase in appetites.

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

The purpose of this announced inspection was to monitor and review the arrangements the provider had in place to ensure compliance with the Care and Support Regulations (2013), and to follow up on solicited and unsolicited information which had been submitted to the Chief Inspector of Social Services.

The inspectors found that there was a clearly defined management structure in the centre with which staff could engage through team meetings and individual supervision. Inspectors met teams of committed and consistent staff in place which ensured residents were cared for at all times. However, the inspectors found that the number of staff employed in the centre was not sufficient to meet all residents' needs at all times. This resulted in instances in which the provider could not implement risk controls on a consistent basis. Inspectors also found examples of tasks increasing in the houses which were not accompanied by a concurrent increase in staffing resources. At a provider level, the impact of staffing and the formal plan of action to address same were not clear as audits had not identified regulatory deficits in staffing and resources.

Staff had been provided with appropriate training, in respect of safeguarding and a human rights based approach to care. The staff were knowledgeable about the care and support needs of each resident, and of the reporting procedures in place should concerns arise in the centre. Staff had attended formal training in safeguarding with some completing additional in-person sessions.

Inspectors were provided evidence of how the management monitored timely completion of mandatory training, which indicated evidence of staff not having completed training based on the assessed needs of residents. This included training in managing and administering medicines, and in supporting residents requiring support with dysphagia (eating, drinking and swallowing difficulties) or seizure risk.

Regulation 15: Staffing

The centre was operating on four staff nurse vacancies and a vacant clinical nurse manager grade one (CNM1) post. The inspectors reviewed rosters in place for the

three houses which make up the designated centre from July, August and September 2025. On review of the rosters, inspectors found that the centre was attempting to utilise regular agency and relief staff. However, the use of agency staff was having an impact on the continuity of care and support for residents in the centre. The inspectors acknowledge that the provider had completed a number of recruitment campaigns and had successfully filled one of the vacant staff nurse positions, with an identified start date of October 2025.

Inspectors took a sample of five residents' support plans, in which it was identified that residents required support of two staff for a number of care needs including personal care and manual handling supports. Furthermore, each resident required the support of one staff when having meals. On review of the rosters, inspectors found a number of occasions where the support level of staff decreased to two staff across all three houses in the centre. For example, inspectors identified dates from the 08 August to the 08 September 2025 where from the hours of 17:00 to 20:00 each house had two staff present to support residents until the arrival of a night time support staff from 20:00 to 23:00. Inspectors found that this reduction in staff presented as a risk to residents in the centre; risks highlighted included if residents required support of two staff to retire to bed or assistance with personal care the centre would have to call for assistance in order to ensure the remaining residents in the centre would have access to support staff should they required assistance.

Inspectors also found that for one house, one resident had a positive behaviour support plan in place that required the support of one staff on identified days of the week. This support was required for up to three hours in the day, as a result of this necessary support this meant that for the residents remaining in the centre there was support of two staff. Each of the residents in the centre required the support of two staff for activities of daily living and required support of staff during meal times. Residents had access to the provider's day service which was based on the campus during periods of the day. A number of residents in the centre were of retirement age and were enjoying a drop in arrangement with the day service.

Judgment: Not compliant

Regulation 16: Training and staff development

Inspectors were provided information on training provided to staff which was mandatory due to provider policy, regulatory requirement, or due to the assessed support needs and risk control measures identified for residents. Inspectors were provided the training matrix dated September 2025 informing of the dates staff last attended this training and when they were due to complete a refresher course.

This evidence indicated that staff were up-to-date on their training in fire safety procedures and practices, and in identifying and responding to potential safeguarding concerns. Eleven staff had also attended in-person training in adult safeguarding. Inspectors observed some gaps in staff completing training in

supporting residents with identified risks related to responsive behaviours, with eight staff having not yet completed same. 12 staff members had not attended training in management of medicines. The inspectors were advised this gap was due to training taking place during the day, so night staff did not have the opportunity to attend, however of the 12 staff with these gaps, nine worked during the day. Six staff members had not attended training in managing risk related to dysphagia to support residents identified as at risk of choking, and 12 staff had not been trained to administer emergency intervention medicine for residents with epilepsy. The gaps in these mandatory training courses meant that the provider could not effectively implement control measures to mitigate identified risks in the centre.

Judgment: Not compliant

Regulation 23: Governance and management

The provider had recently made changes to how residents were supported with meal time in the centre. In August 2025, the provider had implemented that all houses in the designated centre would be responsible for meal preparation for all residents. Prior to this change dinner time meals were made in a central kitchen and delivered to the houses. Staff spoken with discussed how they felt that this was a positive move for residents, with residents being able to smell fresh cooking in the home and increase in appetites. The inspectors were informed of a formal review of the resources in the centre prior to the implementation of the additional cooking responsibilities to staff. However, this review was not made available to the inspectors when requested during the course of the inspection. The inspectors acknowledge that the provider had increased the whole time equivalence of nursing staff from 5.5 to 12, on the day of the inspection there was four staff nurse vacancies. As previously discussed, a number of residents in the designated centre require the support of two staff to complete a number of activities of daily living. The additional time and resources required in order to complete meal preparation was leading to staff preparing and cooking dinners earlier for residents and then reheating them. For example, on arrival to one of the houses in the designated centre at 10:30, inspectors found that staff were in the process of cooking dinner time meals. On discussion with staff, it was identified that most residents like to have their dinner time meal at 13:00.

Staff meetings were occurring regularly in the designated centre, with the person in charge in attendance for each meeting. Inspectors found that staff meetings included discussion of items such as the change in meal planning, residents' changing needs, aging living and healthy lifestyles, staff training, fire safety and incidents and accidents.

Inspectors reviewed the most recent quality and safety inspection report carried out by the provider, dated June 2025. This report highlighted actions for the coming months, including ensuring that the kitchens in the bungalows were equipped to do their own meal preparation, rolling out restrictive practice reduction plans, and

ensuring that staff had attended individual supervision meetings with their line managers. However, this audit had not identified risks observed during this inspection. For example, risks arising from staffing shortages had not been identified and actions solely related to documentation being accurate. The provider had identified a small number of gaps in mandatory training for medicine, but had not identified the number of staff who were outstanding in other courses required based on residents' support needs. A separate action plan identified that some quality improvement actions had been open for number of years.

Judgment: Not compliant

Regulation 24: Admissions and contract for the provision of services

Since the previous inspection of this centre the provider had supported one resident to transition into this centre. The move was found to have been completed in line with the provider's policy and there was a clear transition plan that the resident had been part of developing. The resident's move had been guided by a change in their assessed needs and they had a photographic plan for their recovery and the reason for the move on display in their room.

The inspectors found that the resident had a contract for care in place that clearly identified what they could expect to be provided in their new home and outlined any charges or costs that were in place. There was evidence that this had been discussed with the resident and they had made their mark on the contract as a signature. Inspectors viewed two other contracts of care for residents who had lived in the centre a long time and these were also updated regarding changes in costs that may be incurred and signed by the service manager and marked by residents.

Judgment: Compliant

Quality and safety

Inspectors observed evidence to indicate that in the main, residents were being protected from harm or abuse, encouraged to stay active, and were adequately supported in their health, personal and social care needs.

Staff had guidance in supporting residents who may become anxious or distressed was personal, evidence-based and appropriate to protect them and others. Inspectors reviewed a sample of personal support plans which were informed by comprehensive assessments of needs and included social and life enhancement objectives reflecting what residents wished to do with their time.

In the main, the rationale for restrictive practices was clear where related to keeping safe residents who were at risk of accidental falls injuries. Some enhancement was required to the review and assessment of other restrictive practices such as doors locked from the inside to ensure that restrictive practice reduction strategies were progressing and the rationale for retaining restrictions was consistent.

While some risk controls measures could not be fully implemented due to risks detailed elsewhere in this report, the provider had kept risks under review and taken action where possible to mitigate risks. Information related to procedures in evacuating residents in an emergency and in the practice followed in practice scenarios of highest risk required review to ensure the information was consistent, clear and unambiguous.

Regulation 26: Risk management procedures

The provider had a risk policy in place to guide the process of risk assessment and management in the centre. Inspectors reviewed the centre risk management matrix that outlined all centre based risks including environmental risks such as the possibility of roof tiles slipping and falling from the bungalows, and practice based risks such as management of manual handling and use of assistance equipment. The risk of damage from the centre roof was assessed as being high risk and as such inspectors observed safety netting and remedial works in place.

Each of the centre houses had specific risks identified such as restrictive practices in use, or slips, trips and falls and lone working. Each of these risks were considered a low risk when control measures were implemented. Inspectors also reviewed resident based risks which included falls risks, choking risks and risks arising from epilepsy. It was noted that some of the risks identified were reliant on staffing levels being in place to support and this finding is reflected under Regulation 15.

Judgment: Compliant

Regulation 28: Fire precautions

Inspectors reviewed the person emergency evacuation plans (PEEP) for nine residents in the designated centre. Inspectors identified that improvements were required in relation to the level of detail documented on residents' PEEPs. For example, in the event of a fire for three residents the provider had identified that the individuals required the support of one or two staff in order to safely transfer from a bed to a wheelchair. On further discussion with regular staff, inspectors were informed that each of the residents identified required the full support of two staff for all transfers and to safely evacuate the centre. In some examples, staff advised inspectors that the staff and equipment requirement described in the PEEP was

dependent on how the resident was feeling on the day. Inspectors found that the evacuation plans did not clearly guide staff practice in order to ensure that residents could be evacuated in a safe and timely manner. This risk related to safe evacuation was further enhanced due to the level of staff vacancy and the need for increased levels of agency and relief staff.

Inspectors reviewed a sample of reports for recent fire evacuation drills in the bungalows. This included evacuations which took place during night hours when residents required maximum support and when house staffing was at a minimum of one person. Some of these reports indicated that night staff could support all residents out of bed and out of the building to the assembly point in between 1.5 to 2.5 minutes after the alarm is triggered, including those requiring multiple staff, ski sheets, walking frames or wheelchairs to transfer out of bed and out of the building. Drill reports noted that between five and seven staff from other houses supported the evacuation to achieve these times, but as the reports did not contain sufficient detail on the procedure being practiced, it was unclear if these staff were present from the start of the drill or if the time taken to be alerted and travel from multiple other houses across campus was taken into account. Staff who spoke with the inspectors were not sure of this when reading these reports for clarification.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

The inspectors reviewed eight residents' assessments of needs, and found that they were comprehensive and up to date. The assessments were informed by the residents, their representatives and multidisciplinary professionals as appropriate.

Care plans were derived from these assessments of need. Care plans were comprehensive and inspectors found were written in a manner that could guide staff practice in supporting residents. Residents' needs were assessed on an ongoing basis and there were measures in place to ensure that their needs were identified and adequately met.

Supported plans in place included communication needs, bone health, feeding, eating, drinking and swallowing (FEDS), and mobility. For example, FEDS plans included details on safe positioning, texture modification with links to appropriate risk assessments and outlined the staff supports required. Associated 'health action plans' were developed for residents providing guidance for staff.

Residents had 'quality of life action plans' in place that included supports required by individuals to make decisions and outlined personal goals that residents were working towards. These included wanting to decorate bedrooms, flower arranging, playing bingo and going for walks.

Other residents had plans in place related to big events such as holidays and birthday parties. These plans included notes and dates from staff indicating the

steps towards the completion of these arrangements, for example dates for the resident to buy new outfits and book a venue for their party. Other residents' wishes were to ensure they were guaranteed preference days in their supported routine, for example one resident wanted to lock in a minimum two days a week to go to their local shopping centre. While the inspectors observed evidence they had gone, they discussed with the person in charge the importance of staff consistently using the diary sheet attached to the plan to assure the key staff that it was occurring in line with the frequency chosen by the resident.

Judgment: Compliant

Regulation 7: Positive behavioural support

During review of residents' personal support plans, inspectors observed examples of guidance for staff in supporting residents who may express anxiety or distress in a manner which presented a risk to themselves or others. This included personal notes on how to retain a low arousal environment and examples of the subjects or triggers which may upset residents. Guidance included antecedent presentations which may precede an episode of distress and how to respond to these to keep the resident safe and reassured.

There were a number of physical and environmental restrictive practices in effect in this designated centre. The majority of practices in this centre had been implemented as a risk control measure to protect residents at risk of falls, including positioning harnesses, bed rails and bed sensor alarms. For locked doors around the centre, the inspectors observed evidence of these being reviewed to determine their continued necessity as the least restrictive option to control risks, and strategies in progress to phase restrictions out. For example, some doors locked from the inside were deactivated for specific hours in the day on a trial basis with a view to retire them. However, some internally locked doors were not included in this reduction plan. Inspectors reviewed documentary evidence and spoke with front-line and management staff regarding the rationale for retaining full-time locks on the inside of some doors, and were provided various conflicting information on the reason they were not considered for reduction. In addition, some restrictions were reviewed collectively rather than being broken down per method used, and some restrictions in effect were applied across all houses regardless of the level of identified risk. For the restrictive practices which were being trialled for reduction, it was not clear how their effectiveness was being monitored to provide assurance that the provider could progress to the next stage of the restriction reduction plan.

Judgment: Substantially compliant

Regulation 8: Protection

The registered provider had ensured that arrangements and procedures were in place to protect and safeguard residents from abuse. The arrangements and procedures were underpinned by a policy on safeguarding people at risk of abuse.

The provider had appropriate tracking and monitoring systems in place for each resident in order to ensure that incidents or events in the centre were appropriately monitored. For example, the person in charge had implemented a bruise monitoring protocol for a number of residents to ensure the incidents of bruising were appropriately reviewed and environmental assessments completed to ensure that possible cause of bruising could be eliminated or minimised.

Staff spoken to during the course of the inspection were knowledgeable of residents' support needs and could discuss open safeguarding concerns in the centre. Staff also discussed how they would respond to an allegation of abuse or a suspected incident of concern. Furthermore, staff discussed that they were in receipt of training which was further demonstrated on the provider's training matrix.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Admissions and contract for the provision of services	Compliant
Quality and safety	
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Compliant

Compliance Plan for Sonas Bungalows - Sonas Residential Service OSV-0003738

Inspection ID: MON-0048067

Date of inspection: 17/09/2025

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: To ensure that Residents receive continuity of Care and Support the provider continues to engage in Recruitment to fill current vacancies. Since inspection; One Staff Nurse commenced on 7th Oct 2025 Two further Staff Nurses and one Care staff have been recruited and are currently undergoing recruitment boarding process. Open Day held on November 19th all current vacancy posts secured and are under HR recruitment process. To support continuity of Care and support Residents in the Centre Regular Relief Staff and agency Staff are utilized for vacant posts at present. Provider will further review current staffing resources to ensure adequate 24 hour staffing arrangements are in situ and that the number, qualification and skill mix of staff is appropriate to the number and assessed needs of the Residents and Statement of Purpose.	
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 will be reviewed to ensure no gaps are present and all training identified will be scheduled in line with Service Policy.

Staff will be supported to attend required training.

All staff training will be recorded and updated weekly in the training Matrix.

Staff Training Matrix will be evaluated monthly with Person in Charge and Person Participating in management to ensure compliance and mitigate training risk within the center.

Eight Staff were identified as not having completed training in Responsive Behaviors.
Three Staff have completed in Oct 2025.
Two staff are scheduled to attend Dec 2025.
The remaining three staff will be booked in Jan 2026.

The designated center is supported with Nursing staff twenty-four hours to provide the administration of emergency medication to two individuals who are prescribed rescue medication for Epilepsy.

Non-Mandatary training course in relation to Epilepsy awareness and the administration of Buccal Midazolam medication is currently under review. Care staff will be selected for attendance.

The Provider is currently reviewing the storage of Oxygen therapy in the Designated Centre. Oxygen will only be provided on site, where prescribed by Medical Doctor.
Staff Nurses are available twenty-four hours for the
administration of oxygen therapy within the centre and will be administered, as outlined by the Nursing and Midwifery Board of Ireland (NMBI).

All Staff have now completed training in Dysphagia to support residence at risk of choking.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The provider will ensure that the designated center is resourced to ensure the effective delivery of care in accordance with the Statement of Purpose. Provider will commence a further review of current staffing resources to ensure adequate 24-hour staffing arrangements are in situ and that the number, qualification and skill mix of staff is

appropriate to the number and assessed needs of the Residents and will support on site cooking and Statement of Purpose.

To ensure that Residents receive continuity of Care and Support the provider continues to engage in Recruitment to fill current vacancies.

Since inspection.

One Staff Nurse commenced on 7th Oct 2025

Two further Staff Nurses and one Care staff have been recruited and are currently undergoing recruitment boarding process.

Open Day held on November 19th all current vacancy posts secured and are under HR recruitment process.

To support continuity of Care and support Residents in the Centre Regular Relief Staff and agency Staff are utilized for vacant posts at present.

The Provider will ensure that the management systems are in place in Designated Centre to ensure the service provided is safe and appropriate to the Residents needs

The Provider will ensure that the six monthly Provider audit will identify and accurately reflect all risks relevant to the center.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
The Provider will ensure all Individual fire Evacuation Plans are reviewed to ensure they are specific to how each Individual Resident will evacuate in the event of fire.

Individual PEEP will clearly identify the level of staff support and what equipment is required to support Residents to evacuate in a safe and timely manner safely

All Staff will be knowledgeable in individual fire Evacuation plans.

Person In Charge will have Fire Safety on agenda for Monthly staff meetings.

All new staff will be introduced to Fire safety and Fire evacuation plans.

The Provider shall ensure by means of Fire Safety management that Fire Evacuation drills will contain sufficient detail in relation to the procedures carried out and have clear detail in relation to support staff from other areas.

All Fire Evacuations will be accurately recorded from Time Alarm is activated until Fire Evacuation is completed.

All fire Evacuation Drills will be reviewed by the Person in Charge and Individual Peeps will be further updated in event issues arising.

Evacuation plans will be reviewed three months or sooner where required due to changing needs and updated by the PIC.

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
The person in Charge shall ensure that where a Residents behaviour necessitates intervention under this regulation the least restrictive procedure for the shortest duration necessary is used.

The PIC is reviewing documentation in relation to reduction plans; there is now a recording sheet in place to monitor effectiveness of the Reduction plans this will be reviewed every 3 months.

All Restrictive Practices and Reduction plans will be discussed with all Staff during Staff Handovers, Staff Meeting, during Staff Supervision and induction of new staff to ensure all staff are aware of Restrictions in place and Rational for Reduction plans.

The Registered Provider shall ensure that where Restrictive Procedures including Physical, chemical or environmental restraint are used, such procedures are applied in accordance with National Policy and evidence-based practice.

All Restrictive Practices in place will be reviewed individually by Full MDT on Dec 10th, 2025, and will be reviewed individually going forward.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(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	01/02/2026
Regulation 15(3)	The registered provider shall ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.	Not Compliant	Orange	01/03/2026
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate	Not Compliant	Orange	01/03/2026

	training, including refresher training, as part of a continuous professional development programme.			
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	01/03/2026
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	01/03/2026
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	Not Compliant	Orange	01/03/2026

	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.			
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.	Substantially Compliant	Yellow	15/11/2025
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 aware of the procedure to be followed in the case of fire.	Substantially Compliant	Yellow	30/01/2026
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and	Substantially Compliant	Yellow	30/12/2025

	evidence based practice.			
Regulation 07(5)(c)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation the least restrictive procedure, for the shortest duration necessary, is used.	Substantially Compliant	Yellow	30/12/2025