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:	Centre 7 - Cheeverstown Community Services
Name of provider:	Cheeverstown House CLG
Address of centre:	Dublin 6w
Type of inspection:	Unannounced
Date of inspection:	26 February 2026
Centre ID:	OSV-0004130
Fieldwork ID:	MON-0048024

About the designated centre

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

The service provides full-time residential care and support to adults with a diagnosis of intellectual disability. The centre consists of four separate houses in the community within the geographical area of South Dublin. There are three two-storey houses and one bungalow. In total, 13 adult residents with an intellectual disability live in the centre within the age range of mid-thirties to mid-seventies. There are gardens to the rear of each house. Each of the residents has their own bedroom which had been personalised to their own taste. Each house has a kitchen/dining area and two bathrooms. The person in charge shared their time between the four houses. There are social care leaders, social care workers, staff nurses and care assistants employed in this centre.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	9

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
Thursday 26 February 2026	10:00hrs to 18:00hrs	Maureen Burns Rees	Lead
Thursday 26 February 2026	10:00hrs to 18:00hrs	Gearóid Harrahill	Support

What residents told us and what inspectors observed

From what the inspectors observed and the individuals spoken with said, there was evidence that the residents living in this centre received quality care, in which their independence was promoted. Governance and management systems were in place which ensured monitoring of the services provided. However, there had been a significant delay in ensuring that one of the houses supported the assessed needs of residents living there, in addition considerable maintenance and refurbishment works were required in another of the houses.

On the day of inspection, the centre was registered for 13 adult residents across four separate houses in the community. There were three two-storey houses and one bungalow located in separate residential estates and a short drive away from each other in South Dublin. At the time of this inspection one of the houses was vacant as the provider had commenced extensive renovation, fire safety and compliance works and the residents had been supported by the provider to move to another designated centre operated by them. The provider had recently submitted their application to renew the registration of the centre and it was noted that this vacant house was no longer to be part of the foot print of this centre and consequently the registered bed numbers were to reduce from 13 to nine adult residents on completion of the renewal.

The inspectors visited each of the three occupied houses and met with each of the nine residents living between the respective houses, the person in charge, the area manager and staff working with residents in each house. There were four residents living in one of the two storey houses with three residents in the second house and two residents living in the bungalow. Each of the residents had been living in their respective home for an extended period and were considered to get along well together.

It had been identified at the time of the last inspection that one of the three houses was not suitable to meet the needs of the three residents living there. A new premises had subsequently been identified for these residents. However, there had been significant delays in progressing the transition of the identified residents to the new premises. However, the person in charge reported that works on the new property were in their final stages and a move for the residents was considered to be imminent but no confirmed date had yet been provided. In addition, it had been identified that significant refurbishment and redesign works were required in another one of the houses which would require the residents to relocate from the premises during the works for a defined period. A date for these works had not yet been confirmed. It was noted that some works had been completed successfully in the preceding period in one of the houses, with fire safety works also being completed in each of the properties. Each of the houses had been tastefully decorated with input from the residents. There was a small garden to the rear of

each of the houses, which could be accessed by residents. There was a table and chairs in each garden for outdoor dining and recreation.

A small number of residents presented, on infrequent occasions, with some behaviours which could be difficult for staff to manage in a group living environment. However, incidents were considered to be well managed and residents were suitably supported. Suitable behaviour support plans were in place to support residents identified to require same.

The inspectors met with each of the nine residents on the day of inspection in their respective homes. A number of the residents were reluctant to engage with the inspectors which was respected. Other residents were unable to verbally tell the inspectors their views of the service but they appeared in good form and comfortable in the company of staff and their peers living with them. Other residents individually told the inspectors that they were happy living in the centre and it was evident that they were proud of their homes. Overall, the residents led active lives in their local communities. Seven of the residents were engaged in a formal day service or active retirement programme a number of days each week whilst the remaining two residents engaged in individualised activities based in the centre. The residents maintained close relations with their respective families with regular visits in the centre and to their respective family homes. Two of the residents were active members of the provider's advocacy committee and had raised issues with the local authorities related to the local traffic, bus accessibility and the state of the footpaths in the local area.

It was found that the residents and their representatives were consulted and communicated with, about decisions regarding the running of the centre. The inspectors did not have an opportunity to meet with the relatives of any of the residents. However, staff met with and the person in charge told the inspectors that the residents' families were happy with the care and support being provided for their loved ones. The provider had completed a survey with the residents and their relatives as part of their annual review of the quality and safety of care. This indicated that the residents' families were happy with the care and support that their loved ones were receiving. Inspectors observed evidence that residents who were due to move house had been supported to understand the move, visit the new local area and amenities, and select their furniture and paint colours they wanted for their new bedrooms. One resident showed the inspectors a scrapbook of design ideas and furniture styles they had pulled from magazines for use in the decoration of their new home.

There had been no recorded complaints in the centre in the preceding period. The person in charge outlined to the inspectors, how staff supported the residents in a respectful manner and advocated on their behalf. Information on resident rights, complaints process, decision making capacity and the national advocacy service were available in each of the homes.

The residents were supported to engage in meaningful activities. Activities that one or more of the residents engaged in included visits to family, shopping trips, walks in parks, cooking and baking, coffee and meals out, swimming, arts and crafts,

bowling, swimming, golf, tennis and music sessions. Residents were supported to attend football and wrestling matches and support their favourite local sports teams. Each of the houses had their own dedicated vehicle for the use of staff supporting the residents to attend various activities and outings within the community. There were also a number of public transport links nearby that residents used on occasions. Two of the residents were in the process of getting their passport renewed as part of a plan to travel to a soccer games or theme parks abroad.

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

Capacity and capability

There were management systems and processes in place to promote the service provided to be safe, consistent and appropriate to the residents' needs. The provider had ensured that the centre was well resourced with sufficient staff, facilities and available supports to meet the needs of the residents.

The centre was managed by a suitably qualified and experienced person in charge. The person in charge held a degree in social care and a certificate in management. They were in a full time position and not responsible for any other centre. They were supported by an identified shift leader in each house. The person in charge reported that they felt supported in their role and had regular formal and informal contact with their manager.

There was a clearly defined management structure in place that identified lines of accountability and responsibility. This meant that all staff were aware of their responsibilities and who they were accountable to. The person in charge had protected management hours for their role. They reported to the area manager who in turn reported to the director of operations and service development. The inspectors reviewed meeting records which showed that the person in charge and area manager held formal meetings on a regular basis.

Regulation 15: Staffing

The staff team were found to have the skills and experience to meet the assessed needs of the residents. At the time of inspection, two new staff had recently been recruited and there was one whole time equivalent staff vacancy. A significant number of the staff team had been working in the centre for an extended period. This provided consistency of care for the residents. The inspectors reviewed the actual and planned duty rosters which demonstrated that there were an adequate

number of staff with the required skills to meet residents' assessed needs. The inspectors noted that the individual residents' needs and preferences were well known to the person in charge and the staff met with on the day of this inspection. The staff team comprised of social care workers, care staff and the person in charge.

Judgment: Compliant

Regulation 16: Training and staff development

Training had been provided to staff to support them in their role and to improve outcomes for residents. Training records reviewed by the inspectors showed that staff had attended all mandatory and refresher training. There was a staff training and development policy and a training programme was in place and coordinated centrally. A training needs analysis had been completed. There were no volunteers working in the centre at the time of inspection.

Suitable staff supervision arrangements were in place. The inspectors reviewed a sample of three staff supervision records for the preceding four month period and found that staff were receiving supportive supervision in line with the frequency proposed in the provider's supervision policy. A staff member spoken with told the inspectors that they felt supported in their role.

The inspectors reviewed the minutes of staff meetings. These were chaired by the person in charge and noted to provide an opportunity for staff to discuss residents' needs and any emerging issues, and to review policies and procedures. The meetings were considered to be supportive of staff member roles and promoted consistency in the operation of the centre.

Judgment: Compliant

Regulation 23: Governance and management

There were suitable governance and management arrangements in place. However, it had been identified over a significant period that the layout and facilities in one of the houses was not appropriate to meet the needs of the residents identified to live in that house. Although a new premises had been identified for these residents to move to, there had been a considerable delay and there remained no confirmed date for the move. This meant that the management systems had not been effective to ensure that the service provided was safe and appropriate to meet the identified residents needs.

The inspectors reviewed a defined management structure document, with clear lines of authority and accountability. Staff spoken with were clear on the management structures and supports in place. The provider had completed an annual review of the quality and safety of the service and unannounced visits on a six monthly basis as required by the Regulations. The last unannounced visit had been completed in October 2025. A number of audits and checks were completed in the centre in line with an audit schedule in place. These included health and safety, finance, personal files and infection prevention and control audits and fire safety checks. There was evidence that actions were taken to address issues identified in these audits and checks. Management were actively involved in overseeing the service and were visible within the centre, ensuring they were known to residents. Feedback mechanisms were in place which allowed residents, staff, and family members to share their views, which informed ongoing improvements in the service. There were regular staff team meetings and separately management meetings with evidence of communication of shared learning at these meetings.

Judgment: Substantially compliant

Regulation 24: Admissions and contract for the provision of services

There had been no new admissions to this centre since the previous inspection. Inspectors reviewed a sample of four contracts of care and support, which set out the terms and conditions of the residents residing in this centre, and outlined what services were and were not covered by residents' fees. These had been signed by the respective residents or their representatives and had been updated within the previous twelve months.

Judgment: Compliant

Regulation 4: Written policies and procedures

There was a suite of policies and procedures on the matters set out in schedule 5 of the Regulations. However, a number of the policies had not been reviewed in line with the timelines required by the regulations. These included, policies for : incidents where a resident goes missing, dated November 2022, Monitoring and documenting nutritional intake, dated April 2021, Visitors policy, dated March 2022, Provision of intimate care, dated April 2021 and Access to education, training and development policy, dated March 2022.

Judgment: Substantially compliant

Quality and safety

The residents appeared to receive care and support which was of a good quality, was person-centred and promoted their rights. Areas for improvement were identified in relation to the maintenance and repair in two of the houses. It had previously been identified that the design and layout of one of the houses was not suitable for the three residents living there. A new premises had been identified but there had been significant delays in facilitating the residents move to their new home.

The residents' wellbeing, protection and welfare was maintained by a good standard of evidence-based care and support. A personal support plan document reflected the assessed health, personal and social care needs of each resident and outlined the support required to maximise their personal development in accordance with their individual needs and choices. An annual review of residents' plans had been completed in line with the requirements of the regulations.

The health and safety of residents, visitors and staff were promoted and protected. The provider was found to have good systems in place to ensure that health and safety risks, including fire precautions were mitigated against in the centre. Adverse events were reported and actions were put in place where required, which were then shared with the staff team to ensure that they were implemented.

There were procedures in place for the prevention and control of infection. A cleaning schedule was in place which was overseen by the person in charge. Sufficient facilities for hand hygiene were observed. There were adequate arrangements in place for the disposal of waste. Specific training in relation to infection control arrangements had been provided for staff.

Regulation 17: Premises

The centre was found to be tastefully decorated in each of the areas with input from the residents. However, as previously identified at the time of the last inspection in 2022, the design and layout of one of the houses was not suitable to meet the needs of three residents living in that house. Principle among these issues was the requirement for residents to climb a flight of stairs to get to their bedrooms or to the bathroom. The provider had identified for a number of years that this house was not optimal for residents as they got older and their mobility support needs increased. Staff advised inspectors that the absence of ground-level bathroom facilities had resulted in residents often using the en-suite bathroom of one of their peers, which negatively impacted on the privacy of all residents.

Other areas observed around the designated centre included walls and ceilings requiring paint and plaster repair, and kitchen cabinetry and surfaces which were worn and damaged, and bathroom ware which required upgrading. While this was primarily cosmetic work it impacted on the homely and pleasant aesthetic of the centre, and also impacted on the ability to clean and sanitise some surfaces. One resident and their support staff highlighted to the inspectors that there was a cold draft in their bedroom caused by a gap in an external door seal, which the provider was aware of and had made unsuccessful attempts to address.

The inspectors observed that matters set out in Schedule 6 of the regulations had been put in place. The residents had personalised their own living areas and bedrooms according to their individual tastes and preferences. Pictures of loved ones and other memorabilia were on display in each of the areas. Some residents were due to have their bedrooms repainted and had picked out paint swatches and testers. Some residents had been supplied with new armchairs where previous furniture was found to be too low to the ground for them.

Judgment: Not compliant

Regulation 26: Risk management procedures

The health and safety of the residents, visitors and staff were promoted and protected. The inspectors reviewed environmental and individual risk assessments and safety assessments which had recently been reviewed. These indicated that where risk was identified, the provider had put appropriate measures in place to mitigate against the risks, including staff training. The inspectors reviewed a schedule of checklists relating to health and safety, fire safety and risk which were completed at regular intervals. There were arrangements in place for investigating and learning from incidents and adverse events involving the residents. This promoted opportunities for learning to improve services and prevent incidences. The inspectors reviewed records of incidents occurring in the centre in the preceding three month period. There were overall a low number of incidents and evidence that all incidents were reviewed by the person in charge, and where required learning was shared with the staff team and risk assessments updated to mitigate their re-occurrence.

Judgment: Compliant

Regulation 28: Fire precautions

The provider had composed a fire safety policy for the centre, and in the main, suitable precautions were in place against the risk of fire. However, on the morning

of inspection, it was identified that the magnetic hold-open devices were not working effectively on two separate doors in the centre.

A personal emergency evacuation plan was in place for each resident. The personal evacuation plans accounted for the mobility and cognitive understanding of the respective resident and explained where residents did or did not require support from staff to exit in a timely fashion, and the sample observed had been reviewed in recent months. These plans noted where residents' means of support may differ during night time hours.

The inspectors observed that there were adequate means of escape from each of the houses, including space through which a bed could be transported if necessary. A fire assembly point was identified in an area to the front of each of the houses. Records reviewed by the inspectors showed that fire drills involving the residents had been undertaken on a regular basis. These practice evacuations included scenarios reflective of night time circumstances, such as staff being at a minimum and residents being in bed, and provided assurance of how these affected the evacuation time with residents and staff still evacuating in a timely manner.

The inspectors reviewed documentary evidence that the fire fighting equipment, emergency lighting and the fire alarm system were serviced at regular intervals by an external company. Records reviewed by the inspectors showed that all fire fighting arrangements were checked regularly as part of internal checks in the centre. The inspectors tested the self-closing mechanism on fire doors which was operating correctly. For two of the doors in the centre, the magnetic hold-open devices were not working correctly, however inspectors were provided evidence that these had already been reported for correction by the facilities team.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

The inspectors reviewed the personal support plan for a sample of residents in each of the houses. The inspectors found that the plans reflected the assessed needs of the residents and outlined the support required to maximise their personal development in accordance with their individual health, personal and social care needs and choices. Each of the residents personal plans were subject to an annual review.

The inspectors found that the residents' healthcare needs appeared to be met by the care provided in the centre. The residents had their own General Practitioner (GP) who they visited as required. A healthy diet and lifestyle was being promoted for each resident with weekly menu planning. An emergency transfer sheet was available with pertinent information for each resident should they require emergency transfer to hospital.

Judgment: Compliant

Regulation 8: Protection

There were measures in place to protect the residents from being harmed or suffering from abuse. There had been a small number of safeguarding notifications to the Chief Inspector of Social Services in the preceding six month period. These had been appropriately responded to. The provider had a safeguarding policy in place. The person in charge and staff members met with on the day of inspection had a good knowledge of safeguarding procedures.

All current residents had financial accounts in their name, with statements provided to their respective houses, and the staff demonstrated how these were overseen to ensure residents were protected from potential financial exploitation. Where there had been a concern of this, prompt action was taken to safeguard the resident involved and amend risk controls to reduce the risk of future incident.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 24: Admissions and contract for the provision of services	Compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Centre 7 - Cheeverstown Community Services OSV-0004130

Inspection ID: MON-0048024

Date of inspection: 26/02/2026

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 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: A new premises has been identified for the residents in one of the locations in this centre to move to which will further enhance and meet their support needs. There has been a considerable delay with the construction of this property with initial targeted timeframes surpassed. A new revised timeframe has been identified with the provider and the construction team of the 30/06/26	
Regulation 4: Written policies and procedures	Substantially Compliant
Outline how you are going to come into compliance with Regulation 4: Written policies and procedures: A number of schedule 5 policy identified as being out of date recently and due for review will be updated and signed off by the PPPG and will be reviewed in line with the regulation to ensure compliance	
Regulation 17: Premises	Not Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: A new premises has been identified for the residents in one of the locations in this centre to move to which will further enhance and meet their support needs. There has been a considerable delay with the construction of this property with initial targeted timeframes surpassed. A new revised timeframe has been identified with the provider and the construction team, with a new timeframe of the 30/06/26	

Some residents that had identified and expressed a preference to upgrade their personal space/ bedrooms have had these works completed by the provider on 27/03/26.

A full costing review will be completed for other areas identified during the inspections which required upgrading by the provider and a schedule of these upgrades will be agreed and completed as follows;

• Walls and ceilings requiring paint and plaster repair – 30/06/26
• kitchen cabinetry and surfaces which were worn and damaged – 30/06/26
• Bathroom ware which required upgrading – 31/12/26
• Cold draft to bedroom caused by a gap in an external double fire door seal – 30/06/26

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:

Magnetic hold open devices that were identified as not operating as intended were immediately corrected by the provider on the day of the inspection to ensure that they functioned as intended and in line with the regulation.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 17(1)(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	30/06/2026
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.	Substantially Compliant	Yellow	31/12/2026
Regulation 17(6)	The registered provider shall ensure that the designated centre adheres to best practice in achieving and promoting accessibility. He.	Not Compliant	Orange	30/06/2026

	she, regularly reviews its accessibility with reference to the statement of purpose and carries out any required alterations to the premises of the designated centre to ensure it is accessible to all.			
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Substantially Compliant	Yellow	27/03/2026
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.	Substantially Compliant	Yellow	30/06/2026
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	26/02/2026
Regulation 04(3)	The registered provider shall review the policies and procedures referred to in paragraph (1) as often as the chief inspector may require but in any event at intervals	Substantially Compliant	Yellow	30/06/2026

	not exceeding 3 years and, where necessary, review and update them in accordance with best practice.			