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:	No.4 Fuchsia Drive
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Cork
Type of inspection:	Unannounced
Date of inspection:	05 September 2025
Centre ID:	OSV-0004478
Fieldwork ID:	MON-0048222

About the designated centre

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

No.4 Fuchsia Drive consistent of three detached houses located in a town that can provide full-time residential support for residents with intellectual disabilities and autism of both genders, over the age of 18 with the current resident being aged 35 and older. Two houses can support a capacity of five residents each while the third can support four residents so the maximum capacity of the centre is 14 residents. One house is a three-storey house with the other two being two-storey houses. Each resident has their own bedroom and other facilities in the houses include bathrooms, sitting rooms, kitchens and staff rooms. Support to residents is provided by the person in charge, social care leaders, social care workers, care assistants and a nurse.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	8

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 5 September 2025	09:00hrs to 17:00hrs	Conor Dennehy	Lead

What residents told us and what inspectors observed

Eight residents were met during this inspection. Most of these residents were seen to leave their homes during the day to go for walks, to go swimming or to go to day services. Staff members on duty interacted pleasantly with residents in both houses.

This centre was made up of three separate houses located within the same town. At the time of this inspection, one of these houses was vacant pending completion of premises works. The residents who had traditionally lived in that house were currently residing in another designated centre operated by the same provider. The other two houses of the centre were in use with four residents living in each at the time of this inspection. Both of these houses were visited during the course of the inspection with all eight residents present met by the inspector.

On arrival at the first house visited, the inspector was greeted by a staff member and a resident. The resident indicated that they been talking about the inspector and was expecting his arrival. The staff member present informed the inspector that two of the residents in this house were getting ready to go to day services while the other two residents would be going out with staff later in the day. At this time two residents were sat in the centre's sitting room while a third resident was in the staff office. A staff member indicated that this resident used the staff office as they liked their own space and did not like another resident talking a lot.

All of the three residents who had been in the sitting room and the staff office were greeted by the inspector but two of these residents did not interact with the inspector. After the inspector finished a discussion with a staff member, it was seen that the two residents who had been waiting to go to day services were collected by a bus. These two residents did not return to the house while the inspector was present and so were not met again by the inspector. One resident remained in the sitting room at this time while the remaining resident in the house was in their bedroom.

This resident came downstairs soon after and entered the kitchen area with a staff member present. The inspector greeted the resident but they did not respond despite some encouragement from the staff member. As the resident was preparing to have their breakfast, the inspector moved out of this room at the time. Staff were overheard to engage pleasantly with this resident during this time which included asking them what they wanted on their toast. A second staff member offered the other remaining resident a cup of coffee. This resident appeared to accept this offer by leaving the sitting room and also entering the kitchen.

Both residents were then seen to be present together in the kitchen area with staff when one of these residents was briefly heard to vocalise loudly. There was no obvious reaction noted from the other resident present. Discussion with a staff member and documentation highlighted that the resident who vocalised loudly could be loud at times in the house, including at night. The records reviewed related to

this resident indicated that the resident's loudness did not impact others although the staff member did highlight how two of the other residents could not tell staff if they were impacted or not due to their communication needs. It was further highlighted by the staff that neither of these residents showed any obvious signs of being impacted by the loudness.

As the morning of the inspection progressed, one resident was seen to move between the kitchen area and their bedroom while the other resident moved between the sitting room and kitchen. Things were mainly quiet during this time although one of the residents was again briefly heard making a loud vocalisation at one point. Both of these residents then left the house with staff on duty to go swimming. The inspector had departed the first house visited before these residents had returned so they were not met again. After leaving the first house, the inspector went directly to the second house visited during this inspection.

Four residents were living in this house which had recently had premises works completed. To facilitate these premises works, the four residents had been temporarily using the current vacant house of the centre for a period before returning to their home. The house where these residents were currently living had a capacity for five residents. A fifth resident had previously been living in this house but had to move to another designated centre owing to concerns around the suitably of the premises provided in this house. However, given the premises works that had since been completed in this house, it was hoped that the fifth resident would return there later in September 2025.

When the inspector entered this house, he immediately overheard one resident engage in a humorous way with staff present. The inspector was brought into the centre's sitting room where all four residents were seated with a staff member introducing the inspector to the residents. Such residents greeted the inspector at this time which included two residents shaking the inspector's hand. The inspector asked how residents were getting on in their newly refurbished home with positive responses indicated. The staff member present then asked residents if the inspector could view their bedroom with residents indicating yes to this.

The inspector then did a walk-through of the premises, the observations of which will be discussed further later in this report. After having a discussion with a member of the centre's management and reviewing some documentation, the inspector returned to communal areas of this house. At this time three residents were present in the sitting room watching television with one of these residents telling the inspector that they were just back from a walk. All three residents present appeared content at this time with a staff member indicating to the inspector that the fourth resident had gone for a walk with a second staff member.

A member of the centre's management and a staff member were overheard to interact pleasantly with the remaining three residents shortly after this which included talking about candidates for the upcoming Irish presidential election. The atmosphere at this time in the house was very relaxed and sociable. The inspector spent much of the remaining time in this house reviewing documentation in the staff office and speaking with a staff member. Upon leaving this house, it was observed

that the resident who had been earlier out for a walk had returned while a different resident had left the house to go for a walk with staff. The three residents that were present, remained in the sitting room. All three of these residents appeared happy at the time and said goodbye as the inspector departed.

In summary, it was observed and overheard that residents were supported by staff in a pleasant way. The atmosphere in both houses visited was generally quiet or relaxed but in one house a resident was heard to vocalise loudly briefly. Four residents were living in both houses visited during this inspection with a fifth resident intended to return to one of these houses during September 2025. As will be discussed further in this report, some regulatory actions were identified though in areas such as risk monument, notification of incidents and safeguarding.

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

Progress had been made with a premises plan for this centre which was positive for residents. Despite this, actions were found during this inspection related to areas such as notification of incidents and staff training.

This centre was registered until December 2026 and had last been inspected by the Chief Inspector of Social Services in February 2024. That inspection focused on one house of the centre and highlighted some areas for improvement in areas such as staff supervision and positive behaviour support. Given the length of time since that inspection taking place, the current inspection was conducted to assess compliance with the regulations in more recent times. As part of this inspection, two of the three houses that made up this centre were visited. While the inspection was initially intended to focus on the area of safeguarding, given the inspection findings the inspection type was changed to a risk based inspection to include an additional regulation. Overall, the inspection did find that the provider had made progress with a premises plan for the centre which was a positive development. However, regularity actions were identified relating to staff training, safeguarding, and notifications of incidents amongst others. The nature of some of these findings raised concerns around oversight and the management and monitoring systems for this centre.

Regulation 16: Training and staff development

Under this regulation, staff working in a centre must be appropriately supervised.

During the July 2023 and February 2024 inspections of this centre, it was highlighted that staff were not receiving formal supervision in a timely manner. On the current inspection, it was indicated verbally to the inspector and read in some documents that staff were to receive two supervisions every 12 months. The inspector was also informed that the current person in charge, who had only recently started working in the centre, was due to commence staff supervision in the house where they were based on the day that this inspection occurred.

A supervision log for 2025 was provided for staff working in this house. These indicated that none of the staffing working in the house had received supervision before this inspection in 2025 but that all were due to receive such supervision between 5 September 2025 and 7 September 2025. A further supervision log for the same house indicated that staff had received two formal supervisions during 2024. However, when comparing the 2024 and 2025 supervision logs it was observed that two staff had not received formal supervision in nearly 12 months while another staff member had not received formal supervision for just over 12 months.

In the other house visited during this inspection, a folder reviewed on the inspection day contained a supervision log for 2025 but not 2024. The supervision log for 2025 listed five staff and indicated that three of these of these have undergone one formal supervision each between February and June 2025. At the feedback meeting for the inspection the inspector specifically requested details of the supervision that all staff working in this house had received since the February 2024 inspection. This was requested to be provided on 8 September 2025 but was not submitted then.

After a further request from the inspector, the requested information was submitted on 9 September 2025. This include a supervision log for 2024 which indicated that staff working in this house had completed two formal supervisions during that year. A supervision log for 2025 was also provided which was now noted to list eight different staff members, all of whom were indicted as having had one formal supervision completed between February and September 2025.

Aside from staff supervision, training records for the houses visited were provided following the inspection after the inspector was informed on the day of inspection that a training matrix for the centre was in the process of being updated. The training records provided following the inspection indicated that most staff had completed relevant trainings to support the needs of residents. However, the following gaps were noted in trainings which were indicated as being mandatory:

- Two staff were overdue refresher training in fire safety while four staff members had not completed this training.
- Two staff members had not completed training in manual handling.
- Two staff members had not completed training in safeguarding.
- Two staff members had not completed training in infection control.
- Three staff members had not completed training in personal protective equipment.
- Three staff members had not completed training in hand hygiene.

In addition to the above mandatory training, risk assessments related to one house

indicated that staff were to receive particular training in de-escalation and intervention. The training records provided following this inspection indicated that four staff working in that house had not received this training while another four staff were overdue refresher training in this area. Another risk assessment related to the same house indicated that staff were to have first aid training but the training records reviewed indicated that seven staff members did not have this training done.

Judgment: Not compliant

Regulation 23: Governance and management

Under this regulation, the registered provider has responsibilities to ensure that staff are appropriately supported, developed and performance managed to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering. During the inspection documentary and verbal information given to the inspection indicated that staff were to undergo annual appraisals. As such during the feedback meeting for this inspection, management of the centre were requested to provide dates of when staff had such appraisals completed. Communication received on 8 September 2025 indicated that the provider was using staff supervision to support and develop staff. After a further query raised, it was confirmed on 9 September 2025 that no annual appraisals for staff had taken place in 2024 or 2025.

Aside from this, there was evidence of some monitoring systems in operation for this centre during this inspection based on documentation reviewed. These included an annual review and three provider unannounced visits that had been conducted since the previous inspection of this centre in February 2024. Conducting such annual reviews and provider unannounced visits are required under this regulation. Reports of these were viewed during this inspection and it was seen that they such monitoring systems did consider matters relevant to quality and safety of care and support provided to residents. For example, restrictive practices and complaints were considered during provider unannounced visits.

Despite this, the findings of the current inspection raised some concerns as to whether the monitoring and management systems for the centre were operating effectively to ensure that all relevant matters were identified and addressed in a timely manner. For example, it was found that not all incidents occurring in one house were being reported appropriately nor that all required notifications had been submitted to the Chief Inspector. Such matters are discussed further in this report under relevant regulations. It was also noted during the inspection process that some requested documents were not provided or not provided in a timely manner following the inspection. Again these matters are referenced elsewhere in this report.

While such matters required further review and consideration from the provider, it

was noted that the provider had made progress with a wider premises plan for this centre. This is discussed further Regulation 17 Premises with the provider having submitted an application to vary a condition of registration for the centre to reflect premises works completed for one house. This application was still under consideration at the time of this inspection. However, during the inspection the inspector did observe a notice outside the house in question which raised a query around planning compliance for this house. This was highlighted to management of the centre and appropriate assurances in this regard were provided following the inspection.

Judgment: Not compliant

Regulation 3: Statement of purpose

A statement of purpose is an important governance document that describes the services and supports to be provided to residents while living in a designated centre such as No.4 Fuchsia. While in one of the houses visited, a statement of purpose was seen which had been reviewed during June 2025. This was found to contain required information such as details of the admission criteria for the centre and the fire precautions of the centre. The statement of purpose also took account of premises works that had been recently completed in one house of the centre.

Judgment: Compliant

Regulation 31: Notification of incidents

Under this regulation the Chief Inspector must be notified of certain types of injuries on a quarterly basis. Three such notifications were submitted from this centre in April 2025 and July 2025 which covered the first and second quarters of 2025. However, when reviewing incident reports in one house, the inspector noted two incidents from January 2025 and April 2025 where residents were recorded as having suffered a minor injury neither of which had been included in the notifications received in April 2025 and July 2025. When queried during the inspection, it was indicated that both of these should have been notified to the Chief Inspector.

Aside from this when reviewing daily records for one resident, the inspector saw reference to a resident suffering a scratch on 30 June 2025. This had not been recorded in the provider's incident recording system nor had it been notified in the quarterly notification submitted for the second quarter of 2025. Issues relating to some daily record entries not being recorded in the provider's incident recording system is discussed further under Regulation 26 Risk management procedures.

Judgment: Not compliant

Quality and safety

Premises works completed in one house meant that this house was now better suited to meet the needs of residents living there. Some actions were found during this inspection relating to the living environment for one resident in another house and incident reporting.

Residents were found to have a good standard of personal plans in place that contained guidance on how to support their needs. Works that had been completed in one house of the centre which helped to ensure that the residents now living there were provided with a premises that was better suited to their needs. In another house, a recommendation had been made that a resident living there needed a different living environment than the one that their current home provided for them. In the same house, it was noted that not all incidents occurring there were being appropriately reported. Some safeguarding incidents had occurred in both houses visited during this inspection since the previous inspection. Documentation was provided indicating that some of these incidents had been subject to a preliminary screening in keeping with relevant safeguarding policies. However, it was not provided for others. Staff members spoken demonstrated a reasonable knowledge around safeguarding and strategies to support residents engage in positive behaviour.

Regulation 17: Premises

Previous inspections of this centre had raised concerns around the suitability of two of the three houses which made up this centre. Following the July 2023 inspection of the centre, the provider outlined a plan which involved residents of one house temporarily moving to another designated centre and residents of another house moving into the vacated house. While some initially stated time frames for this plan had not been met, this plan progressed in 2024 and enabled works to be completed in one house of the centre with such works being completed by May 2025 when the provider submitted an application to vary one of the centre's conditions of registration to reflect this.

Completion of the works in this house resulted in the size of that house being increased and more residents' bedrooms being added to the ground floor of that house. Residents who had traditionally lived in this house returned to this house before this inspection and it was found that the current layout of the house was better suited to their needs particularly for some residents who no longer had to use a stairs to access their bedrooms. It was observed though that two of the bedrooms on the ground floor were noticeably smaller compared to other rooms. As a result,

not all of one resident's clothes could be stored in their bedroom with some of their clothes stored in a vacant bedroom on the first floor. The inspector was informed that this resident was happy this arrangement.

Aside from this, the house that had recently had premises works completed was seen, in general, to be presented in a clean, homelike and well-furnished manner on the day of inspection. It was highlighted to the inspector though that there were some markings on a bathroom floor plan that had been left from the premises work done while another bathroom was not in use on the day of inspection having had some re-grouting recently done. This latter bathroom was on the first floor of the centre and so was not used by residents with other bathrooms available. The inspector was also informed that some practical issues had been encountered with doors in the house since the premises works done. These meant that a door from the house's lobby could block a door to a toilet. The inspector was informed that this matter was being reviewed by the provider.

While premises works had been completed in this house, the house in the centre that was currently vacant, which had been highlighted as an area for improvement on previous inspections, had no works completed. While this house was not visited on the day of inspection, the inspector queried the status of premises works for this house but it was unclear when premises works would commence there nor how long they would take. In addition, while it had initially been the intention of the provider for residents who had transitioned to another designated centre to return to this vacant house, it was unknown at the time of this inspection if this would occur. In particular, it was indicated that some of the residents who had transitioned to this other designated centre were now expressing a wish to remain in that centre.

The third house of No.4 Fuchsia Drive, had not had premises concerns raised on previous inspections. This house was visited during this inspection and, overall was seen to be reasonably presented, homely and clean on the inspection. However, documentation provided related to one resident, including a profile piece for the resident that had been conducted by a multidisciplinary team in October 2024 indicated that the resident's current residential environment was impacting their presentation. As a result, a recommendation was made for the resident to have a solo occupancy residential environment to meet their needs. The premises layout of the resident's current home did not provide this and as such was not suited to their needs. It was indicated to the inspector that providing the resident with the recommended living environment was related to completing premises works in the house that was currently vacant.

Judgment: Not compliant

Regulation 26: Risk management procedures

The risk register and risk assessments for one house were reviewed during this inspection with the risk assessments in place noted to have been reviewed on 31

July 2025. The risk assessments in place had been reviewed on 31 July 2025 and described the risks in question and outlined control measures for each risk to mitigate against these risks. However, when reviewing a risk assessment for one resident related to falls, the risk assessment indicated that the resident used crutches and wore a leg boot. When queried it was confirmed that the resident had not used these in some time. When reviewing other risk assessments, it was noted that a number of risk assessments were in place related to the impact that the presentation of one resident could have on others. Some of these risk assessments indicated a higher likelihood of this resident's presentation impacting others while such risk assessments also indicated as a control measures that all incidents were to be recorded in the incident recording system used by the provider.

However, despite the higher likelihood indicted in some relevant risk assessments, when reviewing incident records for the relevant house, it was seen that only three incidents had been recorded in the house since April 2025. The inspector subsequently reviewed a daily record book related to one resident living in this house. From this it was noted that not all relevant incidents occurring in the house were being recorded in the incident recording system used by the provider. For example, one recent daily record entry described a resident being vocal and grabbing the wrists of a staff member but this had not been recorded as an incident. Some minor injuries sustained by the same resident were also being recorded in the daily records but not being logged as incidents. As such, the documentation reviewed did not assure that all incidents occurring in this house were being appropriately recorded and reviewed from a risk perspective. This was particularly notable given that during 2024, notifications received indicated that some safeguarding matters occurring in the same house were recorded in daily records but had not been not appropriately reported as incidents at the time they occurred.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Under this regulations, residents are required to have individualised personal plans in place that set out the needs of the residents and provide guidance for staff in meeting such needs. This regulation also outlines specific requirements in how such personal plans are to be reviewed. When in one of the houses visited, the inspector reviewed the personal plans of two residents. From these two personal plans the following was noted:

- The contents of the personal plans had been reviewed within the previous 12 months.
- Guidance on supporting residents with various needs was outlined in these plans. This included guidance on how to support residents with their assessed health needs.
- Residents' personal plans were subject to multidisciplinary review.

Such findings were in keeping with the requirements of this regulation.

Judgment: Compliant

Regulation 7: Positive behavioural support

The February 2024 inspection of this centre highlighted that the strategies in place to support one resident to engage in positive behaviour needed updating. On the current inspection, documentation reviewed indicated that these strategies had been reviewed in September 2024 while a staff member spoken with demonstrated a broad awareness of the outlined strategies. Some staff training gaps were noted though related to de-escalation and intervention which is addressed under Regulation 16 Training and staff development.

Some restrictive practices were in use in both houses visited during this inspection. Records reviewed relating to one house indicated that such restrictions were subject to review. However, when reading such documents, the inspector noted that a referral had been made in March 2025 for use of child locks on a vehicle used by one resident. When queried it was indicated that this referral had been sent but that this restriction had never been used so the referral was to be cancelled.

Judgment: Compliant

Regulation 8: Protection

During the February 2024 inspection it was identified that there had been an increase in safeguarding incidents occurring in one house with of most of them involving negative resident interactions. It was further indicated during the February 2024 inspection that a compatibility assessment for residents in the house was being pursued. The compliance plan response submitted for the February 2024 inspection indicated that the provider's multidisciplinary team was involved in assessing the needs and the compatibility of the residents in this house. After receipt of further safeguarding notifications from this house and queries raised with the provider, it was indicated in August 2024 that after multidisciplinary review it was agreed that a compatibility assessment was required. The Chief Inspector requested the outcome of this assessment in October 2024.

Communication received from the centre since then, most recently in July 2025, suggested that this compatibility assessment process was ongoing with no definitive outcome or recommendations communicated. However, during the current inspection the inspector was informed that a specific compatibility assessment had not been done. It was indicated though that that a profile piece for one resident of this house had been conducted by the multidisciplinary team in October 2024 which

informed a risk assessment that had been completed in March 2025. Both of these documents were provided which appeared to focus more on the living environment for one resident but they did make some reference to resident compatibility. Matters related to the resident's living environment are discussed further in the context of Regulation 17 Premises.

As referenced earlier in this section, there had been some safeguarding incidents that had been notified from the same house since the previous inspection with some safeguarding notifications received involving residents from the other house visited. In total 22 safeguarding matters had been submitted to the Chief Inspector since the February 2024 inspection. In accordance with relevant safeguarding policies such safeguarding matters must be subject to a preliminary screening with a safeguarding plan put in place where required. As part of this inspection, the inspection specifically requested copies of the preliminary screening documents for all 22 of the safeguarding matters notified since the February 2024 inspection to be provided by 8 September 2025. Communication was subsequent received on 8 September 2025, 9 September 2025 and 10 September 2025 but this only provided the preliminary screening documents for 13 of the 22 safeguarding maters requested. This did not provide assurances that all safeguarding matters that had occurred since the February 2024 inspection were being subject to preliminary screenings.

It was noted though that no immediate safeguarding concerns were found on this inspection and that the number of safeguarding matters notified from this centre had decreased from 2024 into 2025. A staff member spoken with in one of the houses visited indicated that there had been no recent safeguarding incidents that had occurred between residents in this house. However, this staff member did make reference to a recent incident that had occurred between two residents of the house in their day services. Aside from this staff members spoken with during this inspection did demonstrate a reasonable knowledge around safeguarding and how to report any concerns. Training records provided following the inspection indicated that most staff had completed safeguarding training but that two had not. This is addressed under Regulation 16 Training and staff development.

Judgment: Not compliant

Regulation 9: Residents' rights

From documentation reviewed, observations and discussions during this inspection, examples were these seen where residents were treated in a respectful manner or where their rights were promoted. These included:

- Residents being asked if they wanted coffee.
- The personal plans of two residents reviewed contained information sheets on how residents consented or did not consent. Such sheets were noted to have been signed by the residents.

- A resident being risk assessed to determine if they could remain in their own home without staff support.
- Residents being supported to go advocacy meetings or advocacy conferences away from the designated centre.
- Residents who were temporarily living in another house of the centre while premises works were ongoing, being brought on a weekly basis to see progress with these works before they returned living there.

In one of the houses visited, it was also indicated by the provider that residents' meetings were taking place on a weekly basis. The inspector reviewed notes of such meetings and noted that matters such as meal planning, safety, social plans and rights were recorded as being discussed and consulted with residents. However, based on the notes seen, these residents' meetings were not taking place weekly as suggested. For example, there was only notes of one residents' meetings from July 2025 and none since then.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Not compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for No.4 Fuchsia Drive OSV-0004478

Inspection ID: MON-0048222

Date of inspection: 05/09/2025

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 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: The Person in Charge will ensure that all staff have been booked on and completed relevant training on an ongoing basis and that the Training Matrix is kept updated. The Person in Charge will ensure that training is a standing item on the agenda for team meetings and that the staff training matrix will be reviewed at all team meetings any required training booked in line with training periods Following the inspection all staff have been booked on relevant training and will be completed by 31.12.2025. The Person in Charge will ensure that staff supervision is scheduled in line with policy i.e. twice yearly and that the supervision schedule is followed. Supervision received in other areas by some relief staff will be noted on supervision schedules. 31.12.2025. The Provider will arrange training for managers and staff guidance on staff appraisal process in 2026 [See Regulation 23 below].	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The Provider is currently reviewing its staff appraisal rollout to ensure separate from the Supervision process in 2026. The Provider will arrange training for managers on the Appraisal System and the PIC will schedule appraisal for the year and ensure this is	

completed as planned.
The Provider has reviewed weaknesses in the operation of its incident management system and has advised all Persons in Charge to ensure that staff complete the Incident Log (Green Book) in the first instance to ensure completeness of recording and in tracking notifications to the Authority.
The Person in Charge will ensure that the procedure of reporting of incidents, completion of appropriate incident forms etc. is discussed at the November 2025 team meeting. The Person in Charge will also ensure that all staff are made aware to the regulatory requirement to notify specific incidents.
The Person in Charge will ensure that a look back exercise is undertaken for the period since the 2024 inspection to ensure the appropriate reporting of incidents and that incidents are retrospectively reported as required.
The Provider will ensure that the Incident Log is used to identify and appropriately score the frequency and impact of risks in the Centre especially for vocalisations, minor injury and falls risks.
The Provider will ensure that the Sector Manager and Person in Charge are kept updated in relation to the timelines for renovations of one house in the Centre.
The Provider and Person in Charge will ensure that all documentation requested by the Inspector following Inspection is tracked for completeness of submission, especially where there are known email delivery difficulties due to size of attachments being submitted. The required timelines for such submissions will be monitored to ensure compliance in this respect.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
The Person in charge will ensure that
• the notification of incidents is in line with required notification periods [31/10/2025]
• staff are reminded of the responsibilities of reporting all notifiable events to the PIC and for all incidents to be logged in the Incident Log in the first instance to ensure completeness of notification to the Authority. This will be discussed at October Team meeting. [31.10.2025]
• The Team Leader on reading daily reports tracks issues of concern to the incident log and onwards for notification purposes. The PIC audits also spot check the completeness of these reviews.
• The PIC tracks the completeness of notifications from issues logged in the incident report book
The Provider will ensure that its unannounced visits review the effectiveness of the above process

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
The Provider will
• continue to work with the Facilities manager to finalise the schedule of works for the vacant house in the Centre. The initial schedule went to tender but was priced far in excess of original budget due to escalated materials costs. A number of meetings have been held with the design team to progress this and final meeting is scheduled for w/e 10 October. There is a 6-8-month timeline for the works and the house renovation should be complete in Q/4 2026.
• The identified maintenance to bathroom floor and door opening issues in the lobby will be addressed by 31.12.2025
• The recommended single occupancy apartment for one resident will be addressed when the third property in the Centre is renovated. The exact location of this will be determined once the residents of the house under renovation are supported in their choice to return or remain in their current location. Q/4 2026

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
The Provider will ensure that
- The PIC regularly reviews the Risk Register with the staff Team.
- The Person in Charge will also ensure that risk assessments will be reviewed/ closed as appropriate where the risks to resident's presentation are outdated/ changed. (30.09.2025)
- Ensure all incidents (e.g. falls, vocalisations, minor injury) are recorded in the Incident Log to guide risk rating on frequency and impact (31.10.2025)

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
• The Provider will ensure all residents are free from abuse, and that all safeguarding concerns are reported by insisting that the staff team members complete the incident log for all incidents. This will support monitoring and management of issues in the Centre. (31.10.2025)

• The Provider will clarify with all PIC/PPIM personnel that compatibility assessments are commissioned by the Provider when there is a defined proposed destination and that referral for MDT Assessment of needs will be undertaken where guidance of suture supports and profile of possible co-residents/neighbours is requested for future planning processes.
• The Provider has a plan in place to ensure the single occupancy living area is available to one resident once the third house in the Centre is renovated (see Regulation 17 above)
• The Provider will arrange a meeting with the Designated Safeguarding Officer (DO) in relation to streamlining the current system of recordkeeping to ensure (a) the completeness of information held by the Person in Charge in the Centre (including evidence of screening and HSE oversight) and (b) the Safeguarding Plans to be followed by the Team which should include recommendations from HSE Safeguarding oversight team when necessary. [7.11.2025]
• The Person in Charge will ensure that all safeguarding incidents which occur in the designated centre are notified appropriately. This will include a a look back exercise for the period since the 2024 Inspection is undertaken to ensure the appropriate reporting of incidents and that as appropriate incidents will be notified and referred through safeguarding processes as appropriate. 7.11.2025
• The Provider and Person in Charge will ensure the timely and complete submission of all documentation requested by the Authority as outlined under Regulation 23 above.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
The Person in Charge will ensure that
• Residents rights awareness and training is supported in the Centre via their person centred planning system and resident forum meetings
• resident forums are held weekly and that there is a standard agenda with scope for additional items as residents may require and that the notes of the meetings are available in the Centre.
• Residents are supported to have individual meetings with Key workers, Team Leader or PIC as they may require and
• Staff support ad hoc consultations as may be requested by residents outside of the scheduled meetings above.

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 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	31/12/2025
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	31/12/2025
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	31/12/2026
Regulation 17(1)(b)	The registered provider shall ensure the	Substantially Compliant	Yellow	31/12/2025

	premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.			
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	31/10/2025
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 personal and professional responsibility for the quality and safety of the services that they are delivering.	Substantially Compliant	Yellow	30/06/2026
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment,	Substantially Compliant	Yellow	30/09/2025

	management and ongoing review of risk, including a system for responding to emergencies.			
Regulation 31(3)(d)	The person in charge shall ensure that a written report is provided to the chief inspector at the end of each quarter of each calendar year in relation to and of the following incidents occurring in the designated centre: any injury to a resident not required to be notified under paragraph (1)(d).	Not Compliant	Orange	31/10/2025
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	31/10/2025
Regulation 08(3)	The person in charge shall initiate and put in place an Investigation in relation to any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.	Not Compliant	Orange	07/11/2025
Regulation 09(2)(e)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature	Substantially Compliant	Yellow	31/10/2025

	of his or her disability is consulted and participates in the organisation of the designated centre.			