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:	Summerhill House
Name of provider:	Health Service Executive
Address of centre:	Wexford
Type of inspection:	Announced
Date of inspection:	09 September 2025
Centre ID:	OSV-0004649
Fieldwork ID:	MON-0039111

About the designated centre

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

Summerhill House is a designated centre operated by the Health Service Executive (HSE). It provides a residential service to a maximum of nine adults with a disability. The centre comprises of two units located within a short distance of another in County Wexford. The first unit is a large two story house set on its own grounds. The unit consists of a kitchen, sitting room, dining room, office, six individual resident bedrooms and a number of shared bathrooms. The second unit is located on a campus based setting and consists of a dining room/sitting room, three individual resident bedrooms, staff office, laundry room, multi-sensory room and a number of shared bathrooms. There is a large secure garden area to the side and rear of the unit with activity equipment and two central enclosed courtyard areas with activity equipment which the residents can access. The centre is located close to local amenities. The staff team consists of a person in charge, clinical nurse manager 2, nurses and multi-task workers.

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
Tuesday 9 September 2025	09:00hrs to 16:45hrs	Marie Byrne	Lead
Tuesday 9 September 2025	09:00hrs to 16:45hrs	Sinead Whitely	Support

What residents told us and what inspectors observed

This announced inspection was completed by two inspectors of social services over one day. It was carried out to assess the provider's regulatory compliance and to inform a recommendation to renew the registration of the designated centre. Inspectors found that action was required in a timely manner to support residents to transition to suitable accommodation and to ensure the provider could meet some residents' changing and evolving needs in this designated centre.

In Summerhill House, residential care is provided for up to nine adults with an intellectual disability. The designated centre comprises two premises a short drive from each other in a large town in County Wexford.

Both premises were found to be clean and well maintained during the inspection. However, three residents continued to reside in a campus based day service premises that had been reconfigured in late 2023 following flooding of a designated centre operated by the provider. While works had been completed to make this premises more suitable to meet residents' needs on an interim basis, it remained the case that it was not suitable to provide a long term residential care for the three residents currently living there.

During the inspection, the inspectors had the opportunity to meet and speak with a number of people about the quality and safety of care and support in the centre. This included meeting each of the nine residents living in the centre, seven staff, the person in charge and the Director of Nursing. Documentation was also reviewed throughout the inspection about how care and support is provided for residents, and relating to how the provider ensures oversight and monitoring in this centre.

Residents in the centre communicated using a variety of methods of communication including speech, eye contact, body language, vocalisations, gestures and behaviour. For some residents, it was of significant importance for them to have staff who knew them and their communication signals well to best interpret those communication attempts and to respond appropriately. Residents did not express their opinions to inspectors; however, throughout this inspection, they were observed to appear comfortable and content. Staff were observed by inspectors to be very familiar with residents' communication preferences and to pick up and respond to their verbal and non-verbal cues. Warm, kind, and caring interactions were observed between residents and staff.

On arrival to the first house, four residents were up and about and getting their day started and two residents were in the process of getting up and ready. Inspectors observed the environment to be busy. There were six residents living in this house and for the most part, they were supported by seven staff during the day and two staff at night. Staffing levels reduced to six staff during the day at the weekends.

The mealtime experience for two residents was observed in this house on the

morning of the inspection. Inspectors found that there was a calm and relaxed atmosphere during this mealtime. Residents were supported by staff in a sensitive manner, at a pace that appeared comfortable for them, and in line with their feeding, eating and drinking plans.

One inspector visited the second house on the morning of the inspection. They had the opportunity to meet with the three residents living in the premises and the four staff supporting them. On arrival the three residents were relaxing in the living room following their breakfast. One resident was playing a musical instrument and another resident was rearranging decorations on the windowsill. The third resident was observed relaxing watching the activity going on around them. Each of the residents appeared relaxed, comfortable and content. They were observed to smile when staff spoke with them and to seek staff support when it suited them. As the morning progressed they were observed moving around the premises to their favoured spaces.

Inspectors observed that residents had opportunities to leave the centre over the course of the inspection. In the first house, some residents were heading out to do some shopping and go for a coffee in a local shopping centre with support from staff. The service vehicle was used for this and residents appeared happy heading out together for this in the afternoon. Activation schedules noted that residents regularly accessed their community for various activities including meals out, walks around the town, meeting family and friends, trips to local parks and nature reserves and visiting a local sensory garden. One resident attended day services regularly. Residents all had social goals in place that they were working towards and some of these included developing picture scrapbooks, joining a gym, attending a fundraising event, spa days out and meeting friends and family.

In the second premises the three residents left the centre with staff to go out for lunch. The inspector spent some time with them while they were getting ready to go and they each appeared happy and well presented when leaving the centre. They were planning to go for a walk near the beach after lunch, weather dependent. One resident was due to be visited by their family member later that evening. Once the residents left for lunch the inspector returned to the first house.

In the afternoon, one resident presented as unwell and was assisted by staff to attend a local hospital. An inspector observed staff supporting them to prepare to go and to explain where and why they were going. One of their peers who staff reported they have a close relationship with accompanied them on the bus to drop them and staff to the hospital.

Residents experienced weekly house meetings together with staff and these were used as an opportunity to discuss plans for the week ahead and any ongoing issues or upcoming events in the centre. For example the upcoming registration inspection was a topic of discussion at some meetings. Non verbal methods were used to communicate and determine choices, for example pictures were used to communicate meal times options and shopping lists.

Residents and their representatives' opinions on the quality of care and support in

the centre were sought by the provider in a number of ways. These were captured in the provider's annual and six-monthly reviews. Feedback in the latest annual review was gathered from the nine residents and three residents' representatives. This feedback was positive with examples of comments included from residents' representatives such as, "we are happy with care....receives", "we express our thanks to all the staff", and "....is so well looked after by the staff". Resident feedback was mostly based on staff observations and a review of their plans. While feedback was overwhelmingly positive, it did identify that two resident were experiencing more falls and required a review of their environment.

In summary, residents were being supported to a engage in activities at home and in their local community. They were supported by a staff team who were familiar with their care and support needs. However, the provider needed to take action in a timely manner to ensure that residents' needs could be met in this centre and to ensure that three residents residing in a campus based day service building were supported to transition to alternative accommodation.

The next two sections of the report present the findings in relation to the governance and management arrangements in the centre and how these arrangements impacted on the quality and safety of residents' care and support.

Capacity and capability

This announced inspection found that the provider was identifying areas where improvements were required. However, work towards implementing the required actions was not progressing in a timely manner. This particularly related to residents' transitions to more suitable accommodation. The Chief Inspector was engaging with the provider to address this concern in a more timely manner.

Inspectors acknowledge that they had taken a number of actions to open a new designated centre and to support three residents from this centre to move there. In addition, as part of the registration renewal process they had also applied to reduce the registered beds from 12 to nine. However, it remained the case that the design and layout of one of the buildings was not suitable as a residential service.

There was a clear management structure in the centre which was outlined in the statement of purpose. The person in charge was present in this centre regularly. They reported to and received supervision and support from a Clinical Nurse Manager 3, the Assistant Director and Director of nursing. There was also an on-call service available out of hours.

The centre was not fully staffed in line with the statement of purpose but based on a review of documentation and discussions with staff, inspectors were assured that residents were in receipt of continuity of care and support.

Registration Regulation 5: Application for registration or renewal of registration

Inspectors reviewed information submitted by the provider to the Chief Inspector of Social Services with their application to renew the registration of the centre. They had submitted all of the required information in line with the required timeframes.

Judgment: Compliant

Regulation 14: Persons in charge

In advance of the inspection, the inspectors reviewed Schedule 2 documentation for the person in charge. They had the required qualifications and experience to meet the requirements for this regulation. During the inspection, inspectors found that they were present in this centre regularly. They had systems to ensure oversight and monitoring in this centre.

It was evident from their interactions with residents on the day of the inspection that residents were very comfortable in their presence and knew them well. Through discussions with them and a review of documentation, it was clear that they were motivated to ensure that each resident was in receipt of a good quality and safe service that was fully meeting their needs.

Judgment: Compliant

Regulation 15: Staffing

The provider had recruitment policies and procedures. A review of a sample of three staff files was completed. They each contained the information required under Schedule 2.

The centre was not fully staffed in line with the statement of purpose. There was one whole time equivalent vacancy and one staff on long-term unplanned leave. However, this was not found to be impacting on continuity of care and support for residents. A sample of eight weeks of rosters were reviewed. They were well-maintained and demonstrated that all of the required shifts were covered. Planned and unplanned leave was covered by regular staff completing additional hours or by regular relief or agency staff.

Judgment: Compliant

Regulation 16: Training and staff development

A review of the training matrix, and a sample of six training certificates for staff was completed. This demonstrated that staff had access to training identified as mandatory in the provider's policy such as safeguarding, first aid, fire safety, the safe administration of medicines, and manual handling. Staff had also completed additional training in relation to residents' specific care and support needs such as communication, positive behaviour support and managing eating and drinking. They had also completed training in areas such as open disclosure, the guiding principles of the Assisted Decision Making (Capacity) Act 2015, a human-rights based approach to health and social care and supporting decision making.

There was a supervision schedule in place to ensure that staff received supervision in line with the timeframes in the provider's policy. A sample supervision records for three staff were reviewed. Agendas were found to be focused on residents and staff roles and responsibilities. Staff had opportunities to discuss continuous professional development, wellbeing and any concerns they may have.

The sample of four staff meeting minutes reviewed for 2025 demonstrated that discussion were held around key areas such as, policies and procedures, infection prevention and control, risk, incident reviews and learning, complaints, safeguarding, residents' rights and staff training.

Judgment: Compliant

Regulation 22: Insurance

The contract of insurance was available for review in the centre. A copy was also submitted with the provider's application to renew the registration of the designated centre.

Judgment: Compliant

Regulation 23: Governance and management

Inspectors found that the provider was not taking action in a timely manner to ensure that residents were supported to move from the campus based day service building. In addition, they had identified that one premises was not fully meeting some residents' needs and action was required to address this in a timely manner.

Inspectors reviewed the actions outlined by the provider in their compliance plan following the last inspection in August 2024. While a number of actions had been

taken, the provider had not moved into compliance with Regulation 17: Premises by the end of April 2025, as planned. In the latest six-monthly and annual review, the provider had identified that they had not met these actions.

There was a clear management structure in place which outlined roles and responsibilities and lines of reporting. The provider's systems for oversight and monitoring included unannounced provider visits every six months, person in charge audits, area specific audits, and an annual review. Inspectors reviewed the latest annual review, the last two six-monthly reviews, three audits completed by CNM2 from another centre and 15 area specific audits. These demonstrated that the provider was developing actions plans and tracking the implementation of these actions. However, inspectors found that actions were carried over from the previous six-monthly and annual review. For example, those relating to resident compatibility, transport and the premises.

Judgment: Not compliant

Regulation 3: Statement of purpose

The statement of purpose was submitted with the provider's application to renew the registration of the centre and was available and reviewed in the centre. It contained the required information and had been updated in line with the time frame identified in the regulations.

Judgment: Compliant

Regulation 31: Notification of incidents

Inspectors reviewed a sample of incident reports and completed a walk around the premises. They found that the person in charge had ensured that the Chief Inspector of Social Services was notified of the required incidents in the centre in line with regulatory requirements.

Judgment: Compliant

Quality and safety

Overall, inspectors found that improvements were required to ensure that the environment was meeting some residents' needs and that restrictive practices were the least restrictive for the shortest duration. These areas will be discussed further

under the relevant regulations.

Inspectors reviewed a sample of residents' personal plans. These documents were found to positively describe their likes, dislikes and preferences. They had goals in place and were working towards achieving them. For some, their was limited evident of social goals. Some residents' assessments and plans indicated that their care and support needs could not be fully met in the centre and this will be discussed further under Regulation 5: Individualised Assessment and Personal Plan. Residents were being supported to enjoy best possible health. They were being supported to access health and social care professionals in line with their assessed needs.

Overall, residents, staff and visitors were protected by the fire safety and risk management policies, procedures and practices in the centre. There was a system for responding to emergencies and to ensure the vehicles were serviced and maintained.

Regulation 17: Premises

Inspectors acknowledge that a number of enhancements had been made to both premises to ensure they were as homely and comfortable as possible. However, in line with the findings of previous inspections and the provider's audits and reviews the environment in both houses was not fully meeting residents' needs.

As previously mentioned, one premises was added to the footprint of this centre as an interim arrangement (following an emergency in another centre) and the environment is not fully suitable as a long term residential service. For example, rooms were designed for day services, open plan, large in size and furniture did not fully fill the spaces. The industrial style kitchen was separate to the main living area and residents required support to access it through keypad locked doors. Within the building, there were management and administration offices and parts of the building were being utilised as a meeting point for day services.

Judgment: Not compliant

Regulation 20: Information for residents

Inspectors reviewed the residents' guide submitted prior to the inspection and it was also available and reviewed in the centre. It had been recently reviewed and contained all of the information required by the regulations including information on the service and facilities, arrangements for residents being involved in the centre, responding to complaints and arrangements for visits.

Judgment: Compliant

Regulation 26: Risk management procedures

The provider's risk management policy was found to meet regulatory requirements. The risk register and four residents' individual risk assessments were reviewed. These were found to be reflective of the presenting risks and incidents occurring in the centre. Based on a sample of 18 risk assessments reviewed, in the majority of these, there was evidence that risks had reduced following the implementation of additional control measures. They were up-to-date and regularly reviewed.

There were systems in place to record incidents, accidents and near misses. Inspectors reviewed a sample incident reports for 2025 and found that each incident had been reviewed and followed up on by the local management team. Trending of incidents was completed by the local management team, and learning as a result of reviewing incidents was used to update the required risk assessments. It was also shared with the staff team in the sample of staff meeting minutes reviewed.

One resident had experienced a recent increase in falls and a number of actions had been taken to review this to reduce the risk of further falls. A management meeting had taken place and actions had been agreed including, staff training, a review of the residents living environment, clinical reviews and an analysis of the residents service transport. It was identified that this resident may require a new living environment and this is discussed further under Regulation 5.

There were systems to respond to emergencies and to ensure the vehicles were roadworthy and suitably equipped. At the time of the inspection, the provider was in the process of reviewing the transport available in this centre to ensure it was fully meeting residents' needs.

Judgment: Compliant

Regulation 28: Fire precautions

During the walk around of the premises inspectors observed that emergency lighting, smoke alarms, fire-fighting equipment and alarm systems were in place. There were fire doors and swing closers, as deemed necessary.

Inspectors reviewed records for 2025 to demonstrate that quarterly and annual service and maintenance were completed on the above named fire systems and equipment. The evacuation plan was on display in each of the premises.

A sample of seven fire drill records for 2025 were reviewed. These demonstrated that the the provider was ensuring that evacuations could be completed in a safe

and timely manner taking into account each residents' support needs and a range of scenarios. A sample of four residents personal emergency evacuation plans were reviewed and contained sufficient detail to guide staff practice.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

Inspectors found that improvements were required to ensure that some residents needs could be met in this designated centre.

Inspectors found that residents had up-to-date assessments in place. Care plans were developed and reviewed as required. However, based on discussions with staff and a review of documentation it could not be demonstrated that some residents' needs could be met in the centre. This related to their changing and evolving needs. The provider had completed compatibility assessments for all residents in Summerhill House and these included a review of the residents living environment, peer group, mobility needs, communication needs and behavioural supports. These assessments indicated two residents required a change in residence in order to ensure their needs can be fully met. One resident was experiencing an increase in falls and the provider had identified that the environment was not ideal to meet their needs. This resident required a smaller home that was not as busy, where a low arousal environment could be supported. Furthermore, this resident presented with some behaviours that impacted their peers at times. A smaller, less busy environment was also identified as better suited to a second resident living in the centre through their compatibility assessment tool.

Each resident had an all about me document which highlighted their care and support needs. In the sample of residents;' goals reviewed, there was limited evidence of meaningful goals outside the centre. For example, for three residents inspectors found that there were four goals relating to accessing their community. The remaining goals related to their day-to-day lives such as decorating their bedroom or buying a new bed.

Judgment: Not compliant

Regulation 6: Health care

Inspectors found that residents were supported to manage their health in line with their changing needs. Residents all had full-time nursing support and their healthcare needs were regularly screened and reviewed. Residents were accessing a range of multi-disciplinary services including occupational therapy, speech and language services and mental health supports. Relevant referrals were made for

further multi-disciplinary supports when required.

Health support plans were in place for all identified healthcare needs. From the sample of nine healthcare plans reviewed, these had been regularly reviewed and updated in line with residents' changing needs. Residents were having their healthcare needs reviewed, at least annually, with their GP. A log was maintained in each residents' file of their appointments with health and social care professionals. An annual health check document and a hospital passport was developed and maintained for each resident.

Judgment: Compliant

Regulation 7: Positive behavioural support

Some residents presented with behaviours that challenge and supports and plans were in place to manage this. Residents all had access to support with a behaviour nurse specialist who regularly visited the centre and developed and reviewed behavioural support plans, when required. Some residents also accessed further mental health supports and this was reflected in their care plans and behavioural support plans.

Restrictive practices were in use, at times, and the provider had identified in their latest annual review that an environmental restriction used for one resident was having an impact for three other residents living in the centre. This was discussed further with staff and management during the inspection. Full time access to the centres kitchen posed a risk for one resident and therefore the door to the kitchen was locked at specific times. This in turn meant that other residents could not access their kitchen at these times during the day. Staff were removing this restriction when possible, for example when meal preparation was not taking place and when one resident was not present in the centre. However, this restriction did impact the residents' peers accessing their kitchen at times.

A system was in place for regularly reviewing any restrictive practices in use. The service had established a restrictive practice committee which comprised of the senior management team and the services behaviour nurse specialist. Residents all had individualised risk assessments in place with clear rationale for the use of any restrictive practice and these were subject to regular review with the committee.

Some behavioural support plans and compatibility assessments highlighted the need for a low arousal environment in the centre, particularly for two residents. This proved difficult at times in the house with six residents and seven staff present during weekdays. This is discussed further under Regulation 5.

Therapeutic interventions were available to residents and these were detailed in the residents behavioural support plans. Some residents regularly accessed massage therapy, sensory sessions, music sessions and aromatherapy. At the close of the inspection day inspectors observed residents relaxing in their living room with the

curtains drawn and low lighting, soft music and aromatherapy oils.

Inspectors reviewed a sample of three residents' positive behaviour support plans. These were being regularly reviewed and outlined some of the presenting behaviours, the potential triggers, the supportive actions and the proactive and reactive strategies to support residents. However, some improvements were required to ensure that what was meant by a "low arousal environment" was clearly detailed for each resident.

Judgment: Substantially compliant

Regulation 8: Protection

Overall, inspectors found that residents were safeguarded. All staff had completed up-to-date training in the Safeguarding and protection of Vulnerable Adults and all staff had up-to-date Garda Vetting in place. Staff spoken with were aware of what to do in the event of a safeguarding incident and who to report to with any safeguarding concerns

Inspectors noted appropriate engagement with the National Safeguarding Office following any safeguarding incidents in the centre, and thorough safeguarding plans and measures were in place to ensure the residents safety. All residents had intimate care plans on file, and these detailed measures in place to ensure residents privacy and dignity during personal care.

It was reported in the provider's annual review that some residents were experiencing difficulties sharing their living environment. This was also reflected in compatibility assessments reviewed during the inspection. The provider was aware of this and implementing a number of control measures to reduce presenting risks.

Inspectors reviewed a sample of three residents' intimate care plans and found that they were detailed in nature and guiding staff practice. They clearly indicated residents' support needs and their wishes and preferences. Inspectors also reviewed three residents' safeguarding risk assessments which detailed the control measures in place to keep them safe.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 5: Application for registration or renewal of registration	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 20: Information for residents	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Compliant

Compliance Plan for Summerhill House OSV-0004649

Inspection ID: MON-0039111

Date of inspection: 09/09/2025

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 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:

The contractor provided a plan of works for the new property and commenced work 23/10/2025, the completion date as per plan of works is 12/06/2026. HSE Capital and Estates will make every effort to meet the specified timeframe; however, as typical to all construction projects, this may be subject to change.
The Provider will submit an application for registration in Q2 2026. Based on the current plan of works, transitioning for the 3 Residents currently in temporary accommodation will also commence in Q2 2026.

In July 2025 three residents relocated from the campus-based day service to their permanent home, two remained and an additional resident who has very similar needs and requirements relocated to the campus day service. These three residents will relocate on completion of the newly acquired property.

All measures have been taken to ensure the temporary accommodation is homely in nature while respecting the risks presenting for individuals diagnosed with PICA

A service-wide review of compatibility assessments is scheduled for completion by Q4 2025. This review will take into account changes in residents' needs, and identify the possibility of internal transfers across the service to improve the Resident's needs.

There are 5 vehicles between the two locations, 2 of which accommodate wheelchair users. All vehicles are well maintained. As stated above a service-wide review of compatibility assessments is scheduled for Q4 2025 and this will also address the changing transport requirements for residents.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:

The contractor provided a plan of works for the new property and commenced work 23/10/2025, the completion date as per plan of works is 12/06/2026. HSE Capital and Estates will make every effort to meet the specified timeframe; however, as typical to all construction projects, this may be subject to change.
The Provider will submit an application for registration in Q2 2026. Based on the current plan of works, transitioning for the 3 Residents currently in temporary accommodation will also commence in Q2 2026.

The temporary accommodation will be reconfigured and will include free access for the residents to the following areas: a separate dining room, a smaller more homely sitting room, a multisensory room, a bathroom, a shower room, 2 separate toilet rooms, 3 bedrooms, a large activity area which has access to the garden area and provides a large space for mobilizing and activities during poor weather. Additional to this there are currently 3 internal courtyard areas. The kitchen will remain separate; however, the residents are supported to access this area with supervision for participation in food preparations or baking activities and can access the adjoining seating area for socializing with visitors/staff or friends.

A service-wide review of compatibility assessments is scheduled for completion by Q4 2025. This review will take into account changes in residents' needs, specifically the resident who is experiencing an increase in falls and whose behaviour is impacting on others and identify the possibility of internal transfers across the service.

Regulation 5: Individual assessment and personal plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:

A review of residents' goals is currently underway in collaboration with residents, the CNM2/PIC, and Keyworkers. This process includes the identification and development of meaningful and personal goals, which will be agreed upon with each resident and they will be supported to achieve same. Keyworkers will receive supervision from the PIC to ensure that documentation is enhanced and accurately reflects progress toward each resident's goals.

A service-wide review of compatibility assessments is scheduled for completion by Q4 2025. This review will take into account changes in residents' needs, specifically the resident who is experiencing an increase in falls and whose behaviour is impacting on others and identify the possibility of internal transfers across the service.

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive

behavioural support:
The Advanced Nurse Practitioner in Behaviour Support is currently reviewing the Resident's Positive Behaviour Support (PBS) plans and is collaborating with the Keyworks to enhance the PBS Plans ensuring the reference to Low stimulus environment and low arousal approach is achievable, person centered and specific.

A service-wide review of compatibility assessments is scheduled for completion by Q4 2025. This review will take into account changes in residents' needs, specifically the resident who is experiencing an increase in falls and whose behaviour is impacting on others and identify the possibility of internal transfers across the service.

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	31/07/2027
Regulation 17(6)	The registered provider shall ensure that the designated centre adheres to best practice in achieving and promoting accessibility. He. 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	Not Compliant	Orange	31/07/2027

	to ensure it is accessible to all.			
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	31/07/2027
Regulation 05(3)	The person in charge shall ensure that the designated centre is suitable for the purposes of meeting the needs of each resident, as assessed in accordance with paragraph (1).	Not Compliant	Orange	31/12/2025
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	31/12/2025