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:	The Ash
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Clare
Type of inspection:	Unannounced
Date of inspection:	11 September 2025
Centre ID:	OSV-0004759
Fieldwork ID:	MON-0044538

About the designated centre

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

This centre is located in a residential area on the outskirts of the busy town. The location of the centre facilitates access to a range of services, shops and recreational opportunities. The premises is a bungalow type residence divided into two separate units. A residential service is provided to a maximum of two residents with one resident residing in each unit. Each unit is self-contained and provides each resident with their own bedroom, bathroom, living room, kitchen and laundry facilities. An administration office for staff is also provided in each unit. The centre operates fifty-two weeks of the year providing wraparound residential and day supports for both residents. Residents are assessed a having medium to high support needs in the context of their disability and other needs such as physical and health needs. Residents are supported by a staff team comprised of social care workers and support workers. The person in charge manages and oversees the day-to-day operation of the centre supported by a social care worker.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	2

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Thursday 11 September 2025	10:00hrs to 19:00hrs	Mary Moore	Lead

What residents told us and what inspectors observed

This inspection was undertaken by the Health Information and Quality Authority (HIQA) to follow up on the findings of the last inspection undertaken in April 2024. Those inspection findings were not satisfactory. Following that inspection there was regulatory engagement with the provider and a decision was made by the Chief Inspector to renew the registration of the centre with a condition attached that the provider address the identified non-compliance with the regulations.

The inspector found that the provider had taken the actions it said it would to improve its compliance with the regulations. For example, while it had taken sometime to achieve, staffing levels were increased and each resident now had one-to-one staff support for twelve hours each day. Additional social care worker support was in place to assist in the management and oversight of the service. The multi-disciplinary team (MDT) had inputted into the assessment of residents' needs and their support requirements. The MDT had provided site specific sessions for staff on safeguarding residents from abuse and supporting residents to eat and drink safely. There was an evident governance structure and evident systems of management and oversight. However, based on these inspection findings these arrangements did not provide robust assurance that the quality and safety of the service was consistently and effectively monitored. For example, in relation to the management of risk including the reporting and management of incidents involving residents.

The inspector arrived unannounced at the designated centre. The inspector was greeted by the social care worker who advised the inspector that the person in charge was on planned leave. The social care worker was providing direct support for a resident in response to a staff absence. There was a second staff member on duty in the apartment that adjoins the main house. Both residents were in the designated centre. In the context of these staffing arrangements the community manager who is a person participating in the management of the centre was contacted and came to the designated centre to support the inspection process. A staff member also kindly came on duty for a period of time so that the social care worker could meet with the inspector.

In 2023-2024 the provider completed a major refurbishment of this property and each resident is provided with a high standard of accommodation and their own self-contained area of the house. Each resident has their own bedroom, bathroom, living, and kitchen and dining areas and there is a staff office in each section of the house. The inspector found the centre was tidy and organised but homely and welcoming and all areas of the house were noted to be visibly clean. The inspector saw that the provider had completed the external remedial work that was needed at the time of the last inspection. The inspector was advised that further work to enhance the external spaces was planned.

One resident was still in bed when the inspector arrived, an alarm activated and alerted the social care worker to the fact that the resident was getting up. The social

care worker attended to the resident while the inspector went to see the other resident. The first resident had however heard the inspector and was very anxious for the inspector to return to the main house which the inspector did. The resident smiled, took the inspectors hand and guided the inspector to sit at the kitchen table with them. The resident was recovering from a recent hospitalisation, looked well but was a little tired. The resident smiled and nodded their head when the inspector discussed the recent hospital stay and asked the resident how they were feeling. The resident was content once the inspector sat for a while with them and was happy for the inspector to go and visit the other resident.

That resident was up and ready for the day and was relaxing in their sitting room. The assessed needs of both residents include communication differences and residents communicate using a variety of methods including words, gestures, manual signing and at times, behaviour. It was evident from what the resident signed that the resident recognised the inspector. The inspector saw how the resident signed to communicate with the staff member on duty that they wished to go for a drive, to establish if it was going to rain and if they would need to take a coat with them. The resident had sustained a recent injury, pointed to their leg and give the inspector the thumbs-up sign when the inspector asked the resident how they were feeling.

The staff member described how the resident would lead the routine for the day. For example, the staff member described how the resident had a planned activity but might arrive at the destination and decide they wanted to remain in the car. The staff member described how there were locations and activities that the resident did like such as having a coffee, doing their shopping and going to the pharmacy where they were well known to the staff. Both residents had access to a service vehicle and left at intervals during the day to access the community with their supporting staff member.

The inspector discussed with this staff member, another staff member and with the social care worker how both residents expressed their preferences and how their choices were respected, for example, where there were challenges and protocols were in place such as for the delivery of personal care. All staff spoken with said that residents' choices were always respected and both residents could clearly communicate what it was they wanted and did not want to do.

The inspector saw that the annual quality and safety review for 2024 had been completed. It was clearly recorded how feedback from residents was sought and established as part of the review. For example, it was reported that a resident signed a thumbs-up in response to some questions and residents listed the things that they liked about living in the centre such as certain recreational activities and treats. Feedback from representatives had been actively sought. For example, when one family had not returned the formal questionnaire their verbal feedback was sought. Both families were reported to have rated the service as excellent. Records seen confirmed that both residents were supported to have ongoing contact with their families including regular visits made to the designated centre.

In summary, the inspector did find improved systems of governance and

management. For example, the community manager told the inspector that they met weekly with the person in charge to discuss the general management and oversight of the service. Staff meetings were held and staff supervisions were being completed. Staff spoken with were happy with the new duty rota and were happy with the access they had to and the support they received from the social care worker, the person in charge and the community manager. However, based on these inspection findings the inspector was not assured that the management systems in place ensured the service provided to residents on a daily basis was safe, appropriate to their needs, consistent and effectively monitored. The findings of this inspection indicated a gap between the formal systems of management and oversight and the formal and informal systems for guiding, supporting and overseeing the day-to-day operation of the service.

Further to the findings of this inspection, the provider was requested to review the circumstances of a recent incident and submit assurances to the Chief Inspector of Social Services in relation to the systems in place for managing risk including the reporting and management of incidents such as falls. This assurance was needed to assure the safe functioning of these systems and hence to assure the safety of residents.

The requested assurance was received within the timeframe specified. The provider did identify a number of actions to be taken such as enhanced risk mitigating controls and ensuring there were thorough recording and reporting systems in place.

The next two sections of this report will discuss the systems of governance and management in place and how these did or did not assure the appropriateness, quality and safety of the care and support provided to residents.

Capacity and capability

Many of the indicators of good governance were in place. However, as discussed broadly in the first section of this report this did not always ensure consistent day-to-day oversight that effectively monitored and assured the appropriateness, quality and safety of the service.

The local and wider governance structures were clear as were individual roles and responsibilities. For example, the community manager line managed and met weekly with the person in charge to discuss the general management and oversight of the service. They discussed matters such as the supervision of staff, the findings of internal reviews and the progression of internal quality improvement plans.

The social care worker supported the person in charge in the day-to-day management and oversight of the centre and had delegated duties such as the preparation of the staff duty rota and the completion of some staff supervisions. The social care worker worked a mixture of shifts including evenings and alternate

weekends and did not ordinarily work as part of the frontline staff team. While the social care worker had worked two shifts as a direct support for residents the week of this inspection, the social care worker told the inspector that this was not a regular occurrence and therefore it did not impact on their core administration and supervisory duties.

Staff spoken with confirmed they had good access to and support from the person in charge and the social care worker. There were no reported barriers to staff raising concerns.

It was evident from records seen that the provider sought to improve the quality and safety of the service. For example, the senior management team had met at regular intervals for an extended period of time after the last HIQA inspection to monitor the progress of and the effectiveness of it's HIQA compliance plan response. The provider had also commissioned an external review of the service.

The inspector was advised that there were no staff vacancies, additional staff had been recruited since the last HIQA inspection and each resident had one-to-one staff support each day from 08:00hrs to 20:00hrs. A new staff duty rota was in place following discussion and agreement with the staff team.

A record was in place of the training completed by each staff member listed on the staff duty rota. The inspector reviewed this training record and was satisfied oversight was maintained of staff training requirements.

There were systems for formally and informally monitoring and overseeing the centre. The inspector reviewed the audit folder and saw that formal systems of quality assurance included relatively recent audits of the medication management systems in place and audits of the completeness of both residents' personal plans. The inspector saw that the annual review of the quality and safety of the service had also been completed and as mentioned in the opening section of this report feedback from residents and their representatives had been actively sought.

The provider had also ensured that the quality and safety reviews required to be completed at least on a six-monthly basis were completed on schedule and most recently in July 2025. The inspector read that report and saw that the auditor was satisfied that satisfactory progress was being made on the progression of internal quality improvement plans. However, the internal auditor did note that further improvement was needed in daily record keeping and in the reporting of reportable events.

While all of the above was very positive, there was, based on these inspection findings a shortfall in the effectiveness of these systems as to how they guided, monitored and assured the care, support and services provided to residents on a daily basis. For example, based on the observations of this inspection the inspector was not assured adequate arrangements were in place for communicating to staff, details of resident care and support needs particularly where there was a change in needs. Based on records seen there was a possible gap in communication between change of shifts, poor correlation of records and deficits in the systems for managing risk and reporting incidents. How the systems of governance and

management in place were failing to assure the appropriateness and safety of the service will be discussed in more detail below in Regulation 23: Governance and Management.

Regulation 15: Staffing

The provider had increased the level of staff support available to each resident. The improved staffing levels presented as adequate to provide the support that each resident needed.

The inspector reviewed the actual and planned staff duty rota from the 07.09.2025 to the 20.09.2025. The staff duty rota was well-maintained. The rota identified each staff member on duty during the day and night and the hours that they worked. The rota accurately reflected the staffing levels and arrangements described and observed. There was a regular pattern to the shifts worked by staff. The inspector saw that each resident had an increased level of individualised staff support each day from 08:00hrs to 20:00hrs.

There was flexibility to the staffing arrangements. For example, a change was made to the shift start and end times as a resident recovered from a recent injury. Where two staff members were needed, for example, to support swimming or attendance at medical appointments the social care worker confirmed that this was facilitated.

The social care worker said there were no particular challenges to maintaining the staff duty rota as the required staffing resources were in place. Additional staff had been recruited and existing staff had increased their contracted working hours. The feedback received by the inspector on the new staff duty rota was positive.

The social care worker described the arrangements in place for accessing nursing advice and care when it was needed. One resident was at the time of this inspection attending community based nursing services for wound care. The person in charge had also arranged for a nursing review to be completed of one resident's care and support plans.

Judgment: Compliant

Regulation 16: Training and staff development

There was a system in place for monitoring staff training needs and to ensure that adequate training levels were maintained.

The inspector reviewed the staff training matrix. A number of refresher trainings were due or overdue such as in the management of medicines, fire safety and

responding to behaviour that challenged, however, this training was booked.

Since the last HIQA inspection site-specific input and training had been provided by the wider multi-disciplinary team (MDT) such as in safeguarding residents from abuse, the use of restrictive practices and supporting residents to eat and drink safely.

Based on the inspector's review of the training matrix training in infection prevention and control that was outstanding at the time of the last HIQA inspection was completed.

There was a process for formally supporting and supervising all grades of staff. The community manager and the social care worker advised the inspector that formal staff supervisions were on schedule. The social care worker said they were supervised by the person in charge and the person in charge was completing probationary reviews with newly recruited staff. The social care worker confirmed they had, as outlined in the providers supervision policy, completed two formal supervisions with each support staff. The social care worker described the formal supervisions as positive with the staff team open and engaged with the process, responsive to change and to open discussion.

The inspector saw that since their appointment in April 2025 the person in charge had convened three staff team meetings most recently in August 2025. There was good staff attendance at these meetings and staff who were not in attendance were signing to confirm they had read the minutes. There was good discussion at these meetings including of each resident's needs and supports, MDT recommendations and, staff recording responsibilities.

Staff spoken with confirmed the regular presence of the person in charge and the social care worker in the centre. Records seen and staff spoken with confirmed there was a daily handover between staff on each charge of duty shift. Staff spoken with confirmed that as they could be providing support to both residents, they received a handover on each resident's support needs. The inspector saw that staff roles and responsibilities were also clearly displayed on the staff notice boards.

However, the inspector was not assured that these arrangements were always sufficient to ensure the guidance, support and supervision needed to underpin and assure the support and care provided to residents each day. This is addressed in Regulation 23: Governance and management

Judgment: Compliant

Regulation 23: Governance and management

Systems of governance, management and oversight were in place. However, based on the findings of this inspection this did not consistently assure the appropriateness, quality and safety of the support provided to residents. The

findings of this inspection did not reflect consistent, effective, pro-active management and oversight.

The inspector found there was a clear management structure and clarity on roles, responsibilities and reporting relationships. The provider maintained oversight of the local systems of management and oversight. However, based on the regulatory history of this designated centre there was much to be improved in this centre to ensure residents received a safe, quality service. That objective required consistent pro-active management, oversight, guidance and supervision that complemented the formal systems of management and oversight. The inspector was not assured this was in place. Based on the observations of this inspection, there was a lack of effectiveness and an apparent gap between the formal systems of governance and the day-to-day systems of management and oversight. This meant that the appropriateness, quality and safety of the care and support provided to residents was not robustly assured.

For example, based on the observations of this inspection and notifications that had been submitted to the Chief Inspector of Social Services the inspector was not assured that staff fully understood their roles and responsibilities, understood residents support plans, the risk that presented in the centre and the mitigation's in place to control those risks. For example, while the inspector saw that the provider had addressed a recent incident and had put clear out-of-hours guidance and protocols in place for staff, a more pro-active approach to staff support, guidance and supervision was needed based on these inspection findings. The incident itself reflected a lack of understanding of the resident's support and risk management plan and the out-of-hours on call support arrangements. The inspector was not assured that corrective actions notified to the Chief Inspector including enhanced supervision for lone working shifts were in place. For example, while a staff spoken with confirmed they had received a handover on resident care and support needs when coming on duty this handover was clearly not sufficient on the day of this inspection.

There were evident ongoing gaps in recording and reporting that did not provide assurance as to continuity of care and support and the effectiveness of day-to-day oversight. For example, the incident referred to above had not been recorded in the resident's daily narrative notes. Based on the findings of this inspection, the provider was required to submit additional assurances on the recording, reporting and management of a different incident that had also occurred prior to this inspection.

While the inspector saw that daily support notes were completed by day and by night those notes were not, based on these HIQA findings consistently read, reviewed and used as part of the quality assurance systems in the centre. For example, based on records seen there appeared to have been no formal reporting or follow-up of a fall self-reported by a resident. In addition, until the day of this inspection it had not been noted by the systems of management and oversight in place that a resident had not been weighed monthly as stipulated in their care plan in the two months prior to this inspection.

The providers own internal review of July 2025 had also found ongoing gaps in

record keeping and in the reporting of reportable events. The provider itself knew, based on the report of that review, that consistent day-to-day support, supervision and oversight was needed to address this. Based on these inspection findings the level of oversight and supervision required to assure this service was not in place.

Judgment: Not compliant

Regulation 31: Notification of incidents

Based on their review of the log of incidents and the risk register the inspector was not assured systems were in place that ensured clarity on the submission of notifications to the Chief Inspector of Social Services. For example, the inspector reviewed records of two incidents (falls) that had occurred in January and March 2025. On both occasions injury was suspected and medical review had been sought for the resident both at the local injury clinic and at an accident and emergency department. While it was recorded that serious injury had not occurred these incidents were not reported in any format such as the report to be submitted to the Chief Inspector at the end of each quarter.

Judgment: Substantially compliant

Quality and safety

As discussed in the previous section of this report the actions taken by the provider to improve the quality and safety of this service were evident. For example, the level of individualised staff support available to each resident had increased. However, based on the findings of this inspection the inspector was not assured of the consistent appropriateness, quality and safety of the support and care provided to residents. It was not consistently evident how systems of management and oversight informed, guided and assured day-to-day practice, support and care.

For example, it was evident from the reports of the analysis of incidents that had occurred that both residents could and did exhibit behaviour that challenged others. Patterns and triggers had been identified such as the role of communication. There was evidence of actions taken such as referral to the positive behaviour support team and the development of visual supports and social stories. The social care worker confirmed that a meeting with the positive behaviour support specialist was scheduled. However, the findings of this inspection indicated that interventions such as the social story were not effective and the positive behaviour support plan available to the inspector was dated as last reviewed in 2022.

Incrementally, the provided had refined and clarified the number of restrictive

practices in use in the centre. Generally, these were controls designed to manage risk to resident safety such as the risk for falls and the risk for leaving the centre without staff when it was not safe for either resident to do so. However, the inspector found there was a lack of clarity as to the restrictions in place, their purpose and their pro-active use.

The review and analysis of reported incidents was detailed. Actions for improvement were identified some of which were evidenced in practice. However, the inspector was not assured that the providers risk management procedures operated as intended so as to ensure their safe functioning and the safety of residents and staff.

Regulation 17: Premises

The provider had completed the actions it said it would and ensured the premises was well maintained internally and externally.

As referred to in the opening section of this report the provider had, in 2023-2024, completed a significant refurbishment of this property. At the time of the last HIQA inspection the internal works were completed to a high standard but much work was needed externally to ensure that external spaces were safe for the residents to access and use.

The inspector saw that these works were completed. The resident in the apartment section of the house had access to a pleasant outdoor seating area. A mural that represented the resident's interest in rugby had been painted on a wall facing the resident's bedroom.

The inspector was advised that it had not been possible to alter the stepped pathway between the main house and the apartment. This was not ideal in the context of both residents mobility needs and risks. A handrail had been fitted on both sides of the steps.

The resident in the main house did have to negotiate these steps to access their external area. That external area had been cleared and tidied and seating was provided.

The inspector saw that the height of the railing on the wall of the main access route into the apartment had been raised so as to offer better protection from the risk of falling from a height.

Judgment: Compliant

Regulation 26: Risk management procedures

There were systems in place for the identification and management of risk. This including systems for reviewing risk and for reporting incidents and adverse events that impacted on resident safety and well-being. However, based on the findings of this inspection those systems were not consistently implemented. This did not ensure these systems operated as intended and safely.

The inspector reviewed the risk register, the reports of the analysis of incidents that had occurred since January 2025, two specific incident reports and discussed how risk in the centre was identified, managed and reviewed.

While the inspector found that the review of risk and resident's individual risk management plans was linked to incidents and accidents that had been reported, the response to managing risk was not always timely so as to ensure the risk that presented was effectively controlled. For example, it was evident from records seen that interventions in response to a behaviour of concern were not effective and there was ongoing and possible increased risk to staff and resident safety while traveling in the service car. The inspector brought a recent incident recorded by staff to the attention of the community manager to address.

The inspector discussed the circumstances of an incident that had been notified to the Chief Inspector of Social Services prior to this inspection. The inspector was not assured, based on records seen, as to the systems in place for the reporting of and the management of incidents and injuries. That included the systems in place for the prevention of falls, for the reporting of falls and for the post-falls screening and assessment of residents.

While it was recorded that the resident had reported a fall, had visible injuries and reported pain there was no evidence that the fall had been formally reported through the providers incident reporting system or evidence of an assessment of the need for clinical review and care. Overall, the inspector found a concerning lack of documentation.

The inspector was advised that an occupational therapy assessment of the resident's post-falls needs had been completed. However, the inspector read the falls prevention and management plan and found that it lacked specific details to guide staff on the resident's abilities and required supports post their fall such as their moving and transfer needs. This lack of guidance for staff was evident on inspection. The associated manual handling assessment on file was not updated and did not reflect the resident's current circumstances such as their ability and any assistance they might need to safely transfer for example in and out of bed and, into their wheelchair.

Judgment: Not compliant

Regulation 7: Positive behavioural support

Based on the findings of this inspection better arrangements were needed for

assessing and supporting residents behaviour support needs and for ensuring effective evidence based guidance was in place for staff.

Incrementally there has been improvement and a commitment to provide residents with an environment with minimal restrictions. However, the provider needed to review and assure itself how this commitment and the way in which restrictions were used proactively promoted and ensured resident safety.

The inspector saw (from the findings that issued) that trends and patterns were identified from the analysis of behavioural incidents. For example, the inspector read that communication between a resident and staff had been identified as a trigger for responsive behaviours. For example, when the resident had been unsure of their plans and activities or requests such as going to the shop were not facilitated. The inspector saw that in response the resident had a daily visual schedule and staff spoken with confirmed that the resident led their daily routine and their wishes were respected. A staff member described for example, how the resident would agree to a particular activity or destination but may then decline to leave the service car when they arrived. The staff said that they always respected the resident's decision.

The most recent analysis of incidents identified a different pattern of behaviour towards staff that created risk such as when the resident and staff were in the service vehicle. An additional control from that analysis was the introduction of a social story and an education piece with the resident. The inspector saw that the resident had the social story. The resident took the social story from the glove-compartment of the car, showed it to the inspector and made a gesture signalling their understanding of the social story. However, the inspector reviewed a behaviour recording chart completed by a staff member in the days prior to this inspection. The staff member recorded their use of the social story but the resident had proceeded to exhibit the behaviour and additional unsafe behaviour that posed a risk to both the resident and the staff member. It was evident from this incident that additional, timely positive behaviour support input was needed.

With the exception of tools to support communication and resident understanding there was a deficit of updated information as to the assessment and support of behaviour support needs. The positive behaviour support plan in place was dated 2025 but throughout the plan it was recorded that it was last updated in 2022.

Generally the restrictions in place were devices designed to manage risk and to alert staff as an adjunct to the support provided by staff. For example, at night staff were based in the main house, they completed regular checks on the resident in the apartment while the resident used a falls-alert device. However, the inspector found that staff spoken with were unsure as to whether this device could be used by day if for example, they had to leave the apartment supervised so as to provide assistance in the main house.

It was not safe for either resident to leave the house without staff in the context of their risk for falls and their lack of road safety awareness. However, the main doors were generally unlocked and alarmed. The inspector reviewed an incident earlier this year where one resident had left via the front door of the house despite the

active presence of staff. The resident was described during the incident as not receptive to staff prompting to return to the house and had walked across the road to a neighbouring house. Another staff member confirmed that the resident would attempt to leave the house without staff, was not receptive to staff redirection and could display responsive behaviour when staff intervened. The inspector noted throughout the day that the alarms were somewhat intrusive as they chimed repeatedly when the main doors were opened by the inspector and by staff members. While they may have been the least restrictive option the provider needed to assure itself that having the doors unlocked was proportionate to the risk that presented to resident safety and the evidence available from the incidents that had occurred. The increased staffing levels meant that if the doors were locked, residents could and should have good opportunity to safely leave the house with staff who would have the time to prepare and support the resident to leave safely.

Judgment: Substantially compliant

Regulation 8: Protection

Based on the findings of this inspection the provider had arrangements for safeguarding residents from harm and abuse.

The inspector saw that the contact details of the designated safeguarding officer were prominently displayed. The designated safeguarding officer had provided training to the staff team following the last HIQA inspection and guidance from the safeguarding officer was sought as needed.

The training matrix indicated that the on-line and in-person safeguarding training requirements of all staff were up-to-date.

The inspector saw that the provider's safeguarding reporting procedures and staff reporting responsibilities were discussed at the most recent staff team meeting. Staff spoken with understood their responsibility to protect residents from harm and abuse and said there were no obstacles to reporting concerns.

The inspector saw that a social story had been developed for a resident as the person in charge sought to develop resident understanding of safeguarding.

The provider did invoke its safeguarding procedures as needed and also notified the Chief Inspector of Social Services of concerns that arose.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Substantially compliant
Quality and safety	
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Compliant

Compliance Plan for The Ash OSV-0004759

Inspection ID: MON-0044538

Date of inspection: 11/09/2025

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 registered provider will ensure the following actions are taken to achieve compliance with Regulation 23: Governance and Management:

• A schedule will be implemented which will ensure weekly sign off of support notes by the Social care worker – any issues with report writing will be addressed in a timely manner with the staff members. Issues requiring escalation to the PIC will be done so via the SCW. The PIC will then carry out an additional monthly review of all support notes. [Planned Completion:31/12/2025]

• The provider will liaise with the training department and schedule team specific report writing training to enhance the current report writing/record keeping so the level of information being recorded is accurate. [Planned completion:31/01/2026]

• The PIC – supported by the SCW and team will develop comprehensive guidance documents to guide staff's support of individuals on a day to day basis. This will enhance current documentation which is already developed and include more specific details for working with individuals daily. [Planned Completion: 31/11/2025]

• The PIC will ensure in cases that a relief staff/staff who has not been in the center for a period of time will be carrying out support hours there will be a comprehensive handover prior to them arriving on shift to ensure they are up to date with specific support needs. This will be completed by the PIC and/or SCW.

• Supervisions and Performance Appraisals will continue to be implemented and planned with staff team to ensure oversight and support to the staff team.

• The PIC and Community Manager will schedule Reflective Practice sessions for the team working in the centre. [Planned Completion: 31/01/2026]

Regulation 31: Notification of incidents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
The provider will ensure the following actions are implemented to ensure compliance with Regulation 31: Notification of incidents:

• The PIC will develop a specific protocol which outlines the process to follow with regard to one resident being unsupervised in the DC. [Completed:30/09/2025]

• The PIC will develop a protocol for responses to possible unwitnessed falls of a resident which will guide staff in actions to take following a self-reported/unwitnessed fall. [Completed: 30/09/2025]

• The PIC will continue to report incidents each Quarter through the systems in place and ensure all information is submitted with each notification. [Planned Completion: 31/10/2025]

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
The registered provider will ensure the following actions are implemented to ensure compliance with Regulation 26: Risk Management:

• The PIC will ensure the implementation of the protocol and guidelines for the reporting of unwitnessed falls for a resident by staff to ensure sufficient follow up and reporting same on the system in place. [Completed: 30/09/2025]

• The PIC will ensure a multidisciplinary lead approach to managing an identified risk in the work place transport. This will involve Positive Behavior Support and Social Work/Designated Officer. The required PBS plan will also be updated to ensure staff responses are thorough and comprehensive. [Planned Completion: 30/12/2025]

• The PIC will engage with the relevant professional to carry out a Manual Handling assessment for one individual. All recommendations will be implemented following the

assessment. [Planned Completion: 30/11/2025]

• The PIC will ensure that residents Falls management plans are updated to reflect changes to the National Policy. [Planned Completion: 30/12/2025]

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
The registered provider will ensure the following actions are implemented to ensure Compliance with Regulation 7: Positive Behavioral Support:

• A comprehensive review of the current Positive Behavior Support plan for one resident will be carried out. This will ensure that the most up to date information/behaviors of concern are captured and that the reactive strategies are documented to guide staff appropriately. [Planned Completion: 30/12/2025]

• The PIC will develop a specific protocol which outlines the process to follow with regard to one resident being unsupervised in the DC. [Planned Completion: 30/10/2025]

• The PIC will carry out a comprehensive review of all current restrictive practices in place and will alter as required to ensure they are proportion to the risk levels in the service. All restrictive practices will be reported on a quarterly basis to HIQA. [Planned completion: 31/10/2025]

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 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	31/01/2026
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Not Compliant	Orange	30/12/2025
Regulation 31(3)(d)	The person in charge shall ensure that a written report is	Substantially Compliant	Yellow	30/11/2025

	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).			
Regulation 07(3)	The registered provider shall ensure that where required, therapeutic interventions are implemented with the informed consent of each resident, or his or her representative, and are reviewed as part of the personal planning process.	Substantially Compliant	Yellow	30/12/2025
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.	Substantially Compliant	Yellow	30/12/2025