Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Disabilities (Adults).

Issued by the Chief Inspector

Name of designated centre:	Centre 1 - Cheeverstown House Residential Services
Name of provider:	Cheeverstown House CLG
Address of centre:	Dublin 6w
Type of inspection:	Unannounced
Date of inspection:	15 August 2025
Centre ID:	OSV-0004924
Fieldwork ID:	MON-0047134

About the designated centre

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

Designated Centre 1 provides 24-hour support for adults with an intellectual disability in two houses on a campus in South County Dublin. The purpose of this service is to provide temporary accommodation, enabling necessary fire remediation works to be completed in the resident's current home. It is not intended that this location will be used as a permanent accommodation.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	5

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Friday 15 August 2025	10:45hrs to 17:50hrs	Erin Clarke	Lead

What residents told us and what inspectors observed

This inspection was initiated following receipt of information submitted by the provider via the notifications process over a six-month period, which indicated that the same residents had been living in the centre for a prolonged period. The purpose of the inspection was to determine whether the centre was continuing to operate within the conditions of its registration.

Overall, the inspection found that the centre was operating in breach of the conditions of its registration. Inspectors also identified poor adherence to key regulatory requirements intended to uphold residents' rights and ensure their welfare during admission to a designated centre. For example, assessments of need were not consistently completed or updated to reflect each resident and the specific environment of the centre, and residents were not consistently supported to access and manage their personal finances.

Centre 1- Cheeverstown House Residential Services comprises two buildings located within a larger congregated setting that includes several designated centres, a school, an administration building, a restaurant, and a number of unused buildings. In early 2024, the centre function was reconfigured from providing full-time, long-term residential services to operating solely as a temporary residence for individuals whose homes were undergoing fire remedial works.

The centre consists of two separate buildings. The first is a single-storey residence that can accommodate up to five residents and is situated around a shared courtyard alongside five other similar residential units. The second building is a two-storey terraced house located on the same campus, which was unoccupied at the time of inspection and was being used to store office equipment for staff.

When the inspector arrived at the centre, no residents were present as they were attending day services or engaged in activities outside of the centre. The inspector completed a walkaround of the premises accompanied by a member of the administration team. During the visit, the inspector also met the incoming person in charge, who was due to take up their role the following week and was currently working in another part of the organisation.

During the walkaround, the inspector observed that one resident's bedroom did not align with the registered bedroom and floor plans for the centre. A room designated as a storage space was being used as a bedroom, while another registered bedroom was being used for storage. This discrepancy required review to ensure compliance with registration conditions.

The inspector was informed that three residents had moved from their community home in September 2024 into the first house while premises works were being completed in their original accommodation. At the time of inspection, there was no confirmed timeline for the completion of these works. The inspector also found that

two further residents had transitioned into the centre directly from their family homes. These admissions were not in line with the centre statement of purpose, which does not provide for emergency or unplanned admissions, nor with the overall admissions policy for the campus. That policy aligns with the national strategy *Time to Move on from Congregated Settings – A Strategy for Community Inclusion*, which seeks to support people with disabilities to transition from institutional settings to their own homes in the community, with appropriate supports in place.

The inspector met with the five residents when they returned from day services. One resident chose to spend time in a separate sitting room and staff reported that they were looking forward to returning to their home in the community, as they missed their garden. Another resident showed the inspector items they had purchased while out and shared pictures on their mobile phone. The atmosphere in the house became busy as all residents arrived back, with one permanent staff member supported by two agency staff. Some residents gathered around the dining room table for tea and biscuits, later followed by dinner.

The inspector was informed that adaptations had been identified for a resident admitted in June, and these had been implemented the day before the inspection to better support the resident to eat comfortably at the dining table. From observation of the physical environment, further adjustments were required; for example, one resident's chair appeared too high, leaving their feet unsupported, and requiring staff to push the chair in and out to assist them.

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

Capacity and capability

The inspector learned that the centre was undergoing a change in governance, with a new person in charge scheduled to take up the role the following week. The inspector found that some elements of the governance structure were operating effectively, such as the provider's six-monthly unannounced audits. These visits, which are a mandatory internal process, are designed to assess compliance with national standards and regulations. However, while issues were being identified through these audits, the processes for tracking and reviewing actions between audits required improvement. This was evident from the recurrence of similar findings in subsequent audit reports and inspection activity, as well as gaps noted in centre operations, including resident meetings, fire drills, and the timely completion of personal plans.

The inspector reviewed the two emergency placements into the centre and identified significant gaps in the admissions process, notwithstanding the finding that the centre and campus were not open for admissions at the time. For example, comprehensive assessments of need were not completed prior to admission, and

there was evidence that the centre was not suitable for all residents living there. In addition, the centre's admissions policy did not clearly set out the roles and responsibilities of the governance structure in upholding residents' rights during the admission process.

As a result of the non-compliant findings, a regulatory decision was taken following the inspection to convene a cautionary meeting with the provider.

Regulation 23: Governance and management

The roles and responsibilities of management, the person in charge, and the Admission, Discharge and Transfer (ADT) Committee were not clearly defined within the admissions policy, resulting in gaps in the admissions process. There was insufficient oversight of transition arrangements to ensure that comprehensive assessments of need were completed prior to admission to the centre. Contracts of care for some residents were either incomplete or referred to previous or future residences rather than the centre in which the residents were currently living. Documentation maintained during the admissions process was of poor quality. Although this issue had been identified through the provider's six-monthly unannounced audit, the documentation reviewed by the inspector did not demonstrate evidence of residents' will and preference being sought or consultation being undertaken as part of the admission process. Furthermore, while the centre was intended to be used solely for temporary accommodation during fire remedial works, the provider had not applied to vary the conditions of registration to operate outside the existing scope of registration.

Judgment: Not compliant

Regulation 24: Admissions and contract for the provision of services

There was an admission, discharge, and transition policy in place dated March 2025. On review, the inspector found that the policy required revision to ensure that it accurately guided and reflected practice. For example, there were discrepancies between the stated admission criteria for the campus, the designated centre, and the actual admissions taking place, meaning admissions were not being managed through a formalised process. In addition, the policy did not provide sufficient detail on the protection of residents' finances and personal income at the point of admission to the centre.

Judgment: Not compliant

Regulation 3: Statement of purpose

The inspector reviewed the centre's statement of purpose and found that it did not fully reflect the actual operation of the service. For example, the statement of purpose outlined that the centre was only to be used as temporary accommodation for residents whose homes were undergoing fire remedial works; however, the inspector found that two residents had transitioned into the centre from their family homes, which was not in line with the stated purpose.

In addition, the inspector found that the centre was operating outside the conditions of its registration, as emergency admissions had occurred despite the centre not being registered to accept such admissions.

During the walkaround of the premises, inspectors noted that one resident's bedroom did not align with the registered floor plans. A bedroom designated as storage was being used as a resident's bedroom, while a different room was being used for storage instead of its registered purpose. This required review to ensure the floor plans submitted for registration accurately reflected the current use of rooms in the centre.

Judgment: Not compliant

Regulation 31: Notification of incidents

The inspector reviewed notifications submitted by the centre prior to the inspection and found that not all notifications were made within the required three working days. For example, notifications relating to allegations of abuse or misconduct, which are required to be submitted promptly under Regulation 31, had instead been included in the six-monthly notification of minor events. This practice delayed the timely escalation of serious issues to the Chief Inspector and limited regulatory oversight.

In addition, the inspector found that bedrails had been used in June 2025; however, this restrictive practice was not included in the most recent quarterly notifications submitted to the Chief Inspector, as required by the regulations.

Judgment: Not compliant

Quality and safety

Due to concerns regarding the temporary nature of the centre, alongside poor admission and assessment of need processes, the inspector found that there was limited assurance that the centre was suitable to meet residents' needs in a safe and appropriate manner.

The inspector found that residents' rights to have control over and access to their personal finances were not fully upheld. Some residents' funds had not transferred with them into the centre and remained managed by third parties, and bank statements were not available for review. This limited transparency and assurance that residents' monies were being managed in line with regulatory requirements.

In addition, comprehensive assessments of need had not been completed for all residents. Where information was available, it was not always reflective of the residents currently living in the centre or the environment in which they were placed. This impacted the provider's ability to plan effectively for residents' care and support needs and ensure that suitable living arrangements were in place.

Regulation 12: Personal possessions

Not all residents had access to their own bank accounts or social welfare payments at the time of inspection. Regulation 12 requires that residents have easy access to, and control over, their personal finances in line with their wishes. While the provider had completed financial capacity assessments to determine the level of support required for each resident, the outcomes had not been fully implemented. In some cases, residents' funds had not been transferred following their move into the centre and remained under the control of a third party. Furthermore, records of residents' finances were not fully transparent, as bank statements were not available for some residents this limited oversight and assurance that their monies were being managed in line with best practice, their wishes and the provider's policy.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

An assessment of need was not available in the files of two residents. While some information was submitted by the provider after the inspection, it did not constitute a comprehensive assessment of needs and was not accessible to staff. During the inspection, staff confirmed that they did not have access to the online system where care plans were stored. Furthermore, the information provided post-inspection referred to a different designated centre and contained contradictions regarding the residents' current living arrangements.

For example, one resident's assessment indicated that they required a low-arousal environment and would be most suitably placed to live with one other person.

However, this resident was living with four others at the time of inspection. Staff meeting records also stated that the resident was to have their own living room within the centre, but this was not possible due to all available rooms being occupied. The inspector also found that another resident had been awaiting a mobility aid since their admission in June 2025 and, as a result, had experienced a two-month delay in the implementation of appropriate mealtime supports.

The inspector identified that several behavioural and emotional support needs were referenced in the information reviewed; however, there were no corresponding support plans in place to guide staff in consistently supporting residents with these needs.

Judgment: Not 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 23: Governance and management	Not compliant
Regulation 24: Admissions and contract for the provision of services	Not compliant
Regulation 3: Statement of purpose	Not compliant
Regulation 31: Notification of incidents	Not compliant
Quality and safety	
Regulation 12: Personal possessions	Not compliant
Regulation 5: Individual assessment and personal plan	Not compliant

Compliance Plan for Centre 1 - Cheeverstown House Residential Services OSV-0004924

Inspection ID: MON-0047134

Date of inspection: 15/08/2025

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 Admission, Discharge and Transfer Policy will be reviewed and updated to ensure that it accurately refelcts the roles and responsibilities of all relevant stakeholders, will clearly guide practice, will set out admission criteria to the service and outline the steps in the Admissions process. This Policy will also ensure to demonstrate the evidence of the residents will and preference and consultation with the resident about their admission. A comprehensive needs assessment will be completed for the residents who transitioned in to the Centre and all plans of care will be updated reflective of their needs. All residents contracts of care for residents will be reviewed and upated to accurately reflect the relevant information and supports for the residents within the centre. The Provider will review and update the centre's statement of purpose and and function to ensure it clearly outlines and reflects the operation of the service.	
Regulation 24: Admissions and contract for the provision of services	Not Compliant
Outline how you are going to come into compliance with Regulation 24: Admissions and contract for the provision of services:	

The Admission, Discharge and Transfer Policy will be reviewed and updated to ensure that it accurately refelcts the roles and responsibilities of all relevant stakeholders, will clearly guide practice, will set out admission criteria to the service and outline the steps in the Admissions process. This Policy will also ensure to demonstrate the evidence of the residents will and preference and consultation with the resident about their admission.

Regulation 3: Statement of purpose	Not Compliant
Outline how you are going to come into compliance with Regulation 3: Statement of purpose: The Provider will review and update the centre's statement of purpose and and function to ensure it clearly outlines and reflects the operation of the service.	
Regulation 31: Notification of incidents	Not Compliant
Outline how you are going to come into compliance with Regulation 31: Notification of incidents: The PIC will ensure that all notifications will be submitted in line Regulation 31 to ensure effective governance and oversight of incidents and risk.	
Regulation 12: Personal possessions	Not Compliant
Outline how you are going to come into compliance with Regulation 12: Personal possessions: In line with Reg 12. The PIC will support and engage with the residents and their circle of support to ensure that the resident has access to their own financial affairs inclusive of their own bank account and social welfare payments. All outcomes and goals following the completion of the residents financial 'My Money Management Plan' will be implemented and support to ensure that resident's personal finances are in line with the will and preference.	

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 comprehensive needs assessment will be completed for the residents who transitioned in to the Centre and all plans of care will be updated reflective of their needs.

The PIC will ensure that all staff will have access to the online system where residents care plans are stored to ensure ease of access and prompt updates of plans reflective of their needs and supports.

The prescribed mobility aid for the resident in this centre that had been identified during the inspection has been obtained.

Since the inspection the provider has identified an alternative accommodation for one resident in the interim whilst awaiting on the registration of their new home. This home will best provide the supports for this resident's based on their assessment and will promote quality of life.

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 12(1)	The person in charge shall ensure that, as far as reasonably practicable, each resident has access to and retains control of personal property and possessions and, where necessary, support is provided to manage their financial affairs.	Not Compliant	Orange	30/11/2025
Regulation 23(1)(b)	The registered provider shall ensure that there is a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.	Not Compliant	Orange	30/11/2025
Regulation 23(1)(c)	The registered provider shall	Not Compliant	Orange	30/11/2025

	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.			
Regulation 24(1)(a)	The registered provider shall ensure that each application for admission to the designated centre is determined on the basis of transparent criteria in accordance with the statement of purpose.	Not Compliant	Orange	30/11/2025
Regulation 24(3)	The registered provider shall, on admission, agree in writing with each resident, their representative where the resident is not capable of giving consent, the terms on which that resident shall reside in the designated centre.	Not Compliant	Orange	30/10/2025
Regulation 24(4)(b)	The agreement referred to in paragraph (3) shall provide for, and be consistent with, the resident's needs as assessed in accordance with Regulation 5(1) and the statement of purpose.	Not Compliant	Orange	30/10/2025

Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose containing the information set out in Schedule 1.	Not Compliant	Orange	30/10/2025
Regulation 31(1)(f)	The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: any allegation, suspected or confirmed, of abuse of any resident.	Not Compliant	Orange	17/10/2025
Regulation 31(1)(g)	The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: any allegation of misconduct by the registered provider or by staff.	Not Compliant	Orange	17/10/2025
Regulation 31(3)(a)	The person in charge shall ensure that a written report is provided to the chief inspector at the end of each quarter of each calendar year in relation to and of the following incidents occurring in the designated	Not Compliant	Orange	17/10/2025

	centre: any occasion on which a restrictive procedure including physical, chemical or environmental restraint was used.			
Regulation 05(1)(a)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out prior to admission to the designated centre.	Not Compliant	Orange	30/11/2025
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	30/10/2025
Regulation 05(4)(a)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which reflects the resident's needs, as assessed in accordance with paragraph (1).	Not Compliant	Orange	30/10/2025