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:	26 February 2026
Centre ID:	OSV-0004924
Fieldwork ID:	MON-0049442

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
Thursday 26 February 2026	10:00hrs to 18:00hrs	Karen Leen	Lead

What residents told us and what inspectors observed

This report presents the findings of an unannounced risk-based inspection undertaken in February 2026. This was scheduled subsequent to findings of high levels of non-compliance on a previous inspection in the designated centre in August 2025. This inspection was conducted to assess compliance with the regulations and to assess the implementation of the action plan submitted to the Chief Inspector of Social Services following a cautionary meeting held with the provider. The inspection found that the provider had strengthened a number of governance and management systems and conducted reviews which had increased regulatory compliance in the centre. These changes had improved the quality of care and support for each resident. However, the inspection found that greater improvements were required in relation to local governance and management systems and to the premises.

The inspector found that the provider had implemented systems to improve provider level governance. The provider was conducting bi-weekly compliance meetings which included the person in charge and senior management. These meetings were being utilised to drive compliance at provider level for residents in the designated centre. The inspector found improvements in the monitoring and auditing of care and support for residents in the centre, which was in turn promoting best practice amongst staff.

Centre 1 Cheeverstown House Residential Services comprises two buildings located on the provider's campus setting in South Dublin. The centre has the capacity for seven residents and at the time of the inspection there were two vacancies. Residents transitioned to the centre in 2024 as a result of required fire remedial works in residents' previous home. During this time, the provider identified changing needs of residents and completed a proposal for a number of adaptations to be included to the original house, including extending the ground floor to ensure the house was accessible to residents' needs. The funding process had significantly extended the residents' transition to Centre 1 on the campus setting.

The inspector spoke to three residents who had transitioned to the designated centre as a result of the required works to their home. Residents told the inspector that they are looking forward to moving home when the works there are completed. Residents told the inspector that they are happy in Centre 1 as all of their staff and peer members moved with them. One resident told the inspector that they like their room, they had taken all of their belongings with them and that the staff are all very helpful. The resident went through each staff by name and what they like to do when each staff is in the centre.

During the course of the inspection, the inspector had the opportunity to met with four residents, five staff, the person in charge, area manager and the director of operations. Through these interactions the inspector was given an insight into the

activities that residents liked to participate in, and the people and places that were most important to each individual resident. Residents discussed their on-going personal plans and their achievements from 2025. The inspector found that each resident had personal plans in place which were subject to regular review.

On arrival to one house in the designated centre, the inspector was greeted by a staff member who introduced them to one resident who was relaxing watching television. The resident said hello to the inspector and asked the staff for some tea. The staff discussed with the inspector and the resident that they usually attend their local day service, however, they had an appointment on campus in the morning and they prefer not to fill their day with activities before medical appointments. The resident and staff discussed that they would go for a walk and coffee out in the afternoon.

The inspector was greeted by another resident on their return from an exercise class in the community with staff. The resident went to the dining area where staff had made them lunch. The resident told staff they were having a short rest after their class. After lunch, the resident offered to show the inspector around their home. The resident gave the inspector a tour of their home and told the inspector that they like living in the designated centre. The resident showed the inspector some water damage to the bathroom and pointed out additional areas of the house that required repair. The inspector found that the person in charge had highlighted these areas to the provider's maintenance department and completed a walk through with the facilities manager in February 2026. This will be discussed further under Regulation 17:premises.

Later in the afternoon, the inspector visited the second house in the designated centre which is home to one resident. The resident had attended their local day service during the day and had returned home for dinner. The inspector was introduced to the resident by their staff, the resident took the inspector's hand and gestured for them to sit beside them while they were finishing a snack. The inspector observed the resident to be listening to music. While the resident was listening to their music and enjoying their food the staff member was giving them a foot massage. The staff told the inspector that in the evening the resident might go out for a walk. The staff informed the inspector that family is very important to the resident and that they visit regularly.

During the course of the inspection, the inspector observed residents coming to and from activities in the local community. The inspector found that the residents were busy attending exercise classes, shopping trips, meals out, appointments and visiting family and friends. Residents were also observed enjoying massage, completing puzzles, taking part in arts and crafts and relaxing watching television.

The next two sections of the report outline the findings of this inspection in relation to the governance and management arrangements in place in the centre and how these arrangements impacted on the quality and safety of care provided to the residents.

Capacity and capability

This section of the report sets out the findings of the inspection in relation to the leadership and management of the service, and how effective it was in ensuring that a good quality and safe service was being provided. The inspection found that while the provider had implemented systems and procedures which had strengthened provider governance in the centre, further improvements were required in relation to the local governance and management in place.

Six-monthly unannounced visits of the centre were taking place to review the quality and safety of care and support provided to residents. The reviews included an action plan to address any concerns regarding the standard of care and support provided. In addition, the person in charge had completed an annual review for 2025 of the centre.

From a review of the rosters there were sufficient staff with the required skills and experience to meet the assessed needs of residents available. The inspector spoke with staff members on duty throughout the course of the inspection. The staff members were knowledgeable on the needs of each resident, and supported their communication styles in a respectful manner.

Regulation 15: Staffing

The designated centre was staffed by suitably qualified and experienced staff to meet the assessed needs of residents. Planned and actual rosters were maintained in the centre which demonstrated that staffing levels were consistent with the statement of purpose. The inspector reviewed planned and actual rosters at the centre for December 2025, January and February 2026. These reflected the names and grade of staff working in the centre during the day and night. The rosters clearly identified the shift lead and in the absence of the person in charge staff the roster reverted staff to manager on call log.

At the time of the inspection there was three whole time equivalent vacancies in the roster. However, the inspector reviewed evidence for two newly recruited staff who were in the final stages of the recruitment process. The inspector found that the vacancies in the roster were being covered by regular staff completing additional hours, the provider's relief panel and familiar agency. The inspector had the opportunity to speak to one agency staff who had been working in the designated centre for over a one year period. The inspector found that the agency staff was knowledgeable of the assessed needs of residents in the centre and was aware of appropriate reporting structures such as the person in charge, senior management and the designated officer for the centre.

In addition, the inspector spoke to three staff in the designated centre. Staff discussed the changing needs of residents in the centre and their identified goals for 2026. The inspector found that staff were advocating on behalf of residents needs and were promoting a safe and homely environment.

Judgment: Compliant

Regulation 23: Governance and management

The inspection found that improvements were required in a number of local level management systems. For example, for one house in the designated centre, the inspector found that staff meetings were not occurring regularly. Those that were held did not follow a set agenda where concerns could be escalated through to the appropriate channels. The inspector found that there was no responsibility placed on staff to attend the house meetings and that only one meeting in the previous six months had been attended by the person in charge.

Furthermore, the inspector found that staff supervision had not been implemented in line with the provider's policy and procedures. The inspector acknowledges that the provider had increased senior management support and that individual supervision and team meetings had been set for the coming year. The provider and human resources department had also set a date for an in-person staff meeting to address non-resident related concerns from the staff team.

As previously discussed, residents have been residing in the designated centre since early 2024 while awaiting the commencement of work in the residents' original home. On the day of the inspection the provider gave an updated to the inspector on planning applications, house floor plans and pricing for tender of the works in the house. However, the inspector found that this information had not been provided to residents in an accessible format or to their representatives. The inspector reviewed documentation which identified that residents were waiting to return to their previous home but with no information on the progress of their home.

The inspection found that the provider had sufficiently addressed a number of non-compliant regulations identified in the previous inspection through a variety of systems including internal auditing, bi-weekly compliance meetings, greater senior management presence and improved resources for the designated centre.

In addition, to increasing auditing tools in the centre, the provider had completed a review of the auditing tool used by the provider in the six-monthly unannounced visit to the designated centre. The inspector found that the newly devised tool was identifying core regulations which required review at each six-monthly audit such as residents assessments of needs, rights, risk management procedures and protection.

The person in charge had completed an annual review of quality and care for the designated centre for 2025 which included consultation with residents and their representatives. The annual review was readily available in the centre. The annual

review had identified a number of gaols and action plans for completion throughout 2026 including residents' individual goals, premises refurbishment plans and health initiatives.

Judgment: Substantially compliant

Regulation 24: Admissions and contract for the provision of services

There had been no new admissions to the designated centre since the previous inspection. The inspector reviewed the contracts of care and support for five residents, which had been updated in August 2025 to set out the terms and conditions of the residents residing in this centre, and outlined what services were not covered by residents' fees. The updated copies of the contract of care and support had been reviewed and signed by residents and their representatives.

The inspector found that while there had been no admission or discharges in the centre since the previous inspection, the person in charge, staff team and provider had reviewed the assessed needs of residents to ensure that the environment was meeting the needs for each resident. This review identified that for one resident, the environment was at times very busy with residents coming and going to activities and this was increasing anxiety responses for one resident. Through support of the multidisciplinary team, staff, the resident and their family a transition plan was completed for the resident to transition internally within the designated centre to the second premises comprising the centre. The inspector found that a clear internal transition plan had been implemented for the resident and was having a positive effect on the individuals lived experience in the designated centre

Judgment: Compliant

Regulation 3: Statement of purpose

The registered provider had prepared a written statement of purpose containing the information set out in Schedule 1 of the regulations.

The inspector found that the statement of purpose had been reviewed to reflect the services and facilities provided in the designated centre, its staffing complement and the organisational structure of the centre and clearly outlined information pertaining to the residents' well-being and safety.

A copy of the statement of purpose was readily available to the inspector on the day of inspection. It was also available to residents and their representatives.

Judgment: Compliant

Quality and safety

This section of the report details the quality and safety of service for the residents living in the designated centre. Overall, the inspection found that the provider had implemented a series of audits and reviews to ensure that the centre increased regulatory compliance. The provider had reviewed compatibility concerns and through resident consultation had implemented internal transitions in the designated centre. These transitions had reduced safeguarding concerns and were having a positive impact on the lived experience of residents in the centre.

The provider had self identified a number of pieces of maintenance work which were outstanding in one premises in the designated centre. The inspector found that while the provider had self identified the required works no time frame for completion had been implemented. This will be further discussed under Regulation 17: premises.

There were arrangements in place to manage risk, including an organisational policy and associated procedures. The inspector found that risk was well managed. All identified risks were subject to a risk assessment, with control measures in place to support residents and minimise risks to their safety or well being. Risk control measures were found to be proportionate, and supported residents to safely take positive risks.

Regulation 17: Premises

The inspector completed a walkthrough of all houses that made up the designated centre. The inspector found that while the provider had identified a number of maintenance issues which required completion, the inspector found some of these issues had not been addressed despite being identified in December 2025 by the provider's facilities team and through the provider's six monthly unannounced audit completed in September 2025.

On the day of the inspection outstanding maintenance work included:

- A large hole in the ceiling of one bathroom ceiling
- ·A hole in the staff office ceiling
- ·Televisions to be mounted to the wall of the main sitting room
- ·Picture to be hung in one resident's bedroom
- ·Kitchen floor de-laminating

The inspector found that residents' bedrooms had been decorated to their personal tastes. Residents noted that in the previous months more storage and interior decorations had been added to their home and bedrooms.

The inspector found that both premises had ample communal and living space. In one house in the centre, residents' had access to a second sitting room if they wished to watch television alone or listen to music. Staff discussed that most residents' like to watch shows together, however, one resident if their day has been busy with multiple activities will avail of the second sitting room.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

The provider had ensured consistent implementation of risk management systems which were in place in the centre. For example, the person in charge was maintaining a risk register for the designated centre that was reflective of the assessed needs of each resident, environmental concerns and residents lived experience and was subject to regular review.

Adverse incidents were found to be documented and reported in a timely manner. These were trended on a monthly basis by management to ensure that any trends of concern were identified and actioned. The inspector found that the person in charge was reviewing each accident and incident in relation to residents to ensure that safeguarding or changing needs concern increase were immediately identified and actioned with additional supports or control measures put in place.

The provider also had risk management assessments in place to assist in addressing any known or potential safety concerns. These risk assessments were found to be robust in nature and they were reviewed on a regular basis. As previously discussed the provider was completing bi-weekly compliance meetings with the person in charge, senior management and clinical team. The inspector found that these meetings were informing risk management and escalating risk procedures when necessary

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The inspector reviewed five residents' files and found that an up-to-date and comprehensive assessment of need was in place for each resident. The inspector found that residents had been consulted with and that plans in place reflected the assessed needs of the residents and outlined the support required to maximise their

personal development in accordance with their individual health, personal and social care needs.

Each resident in the centre had a "my life" plan in place, the inspector reviewed three plans and found that residents were being supported with monthly keyworker meetings. These meetings were being used to identify what stage of a goal each resident was currently at and what additional supports if any were required to meet goals.

Judgment: Compliant

Regulation 8: Protection

The provider had completed a review of residents living in the designated centre and had identified that for one resident the environment was proving to be too busy for their assessed needs. Through discussion and consultation with the resident, family and staff an internal transfer was completed to another house within the designated centre. The inspector found that this move had a positive impact for the resident who required a low arousal environment. The move had also led to a reduction in incidents in the centre as residents' environmental support needs were being met.

The inspector spoke to support staff and the person in charge and they discussed that while the move was positive for the individual resident there was a vacancy in the centre for an additional resident. The support staff and person in charge discussed that the resident would benefit from living with a peer and that while at present no resident had been identified future placements would be subject to robust compatibility assessments.

The inspector had the opportunity to speak to five staff during the course of the inspection and found that they were knowledgeable of safeguarding plans in place and previous safeguarding concerns in the centre. Staff were aware of control measures in place to support residents in their home and all staff were aware of the reporting structure in relation to safeguarding residents. In addition, all staff had up-to-date safeguarding training.

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 23: Governance and management	Substantially compliant
Regulation 24: Admissions and contract for the provision of services	Compliant
Regulation 3: Statement of purpose	Compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 8: Protection	Compliant

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

Inspection ID: MON-0049442

Date of inspection: 26/02/2026

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • A structured staff meeting schedule will be developed by 10/04/26, and all scheduled meetings will be held in line with this schedule over the following 3 months, with attendance and minutes recorded for each meeting. • The PIC will review and revise the staff team meeting template to ensure it is agenda-driven, action-focused, includes assigned action owners, and clear timeframes. This will be completed by 10/04/26, and the updated template will be implemented at all subsequent staff meetings. • The PIC will complete two documented staff supervision sessions with team members in the centre, with at least one supervision completed by 17/05/26, in line with the supervision schedule and organisational policy. Records of supervision will be maintained by the PIC. • The provider will issue a written update to all residents and their families outlining the progress on home improvements and estimated completion timelines by 24/04/26.	
Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: A full costing review will be completed for areas identified during the inspections which required upgrading by the provider and a schedule of these upgrades will be agreed and completed as follows • A large hole in the ceiling of one bathroom ceiling – 17/05/2026 • A hole in the staff office ceiling – completed 23/03/26 • Televisions to be mounted to the wall of the main sitting room – completed 30/03/26 • Picture to be hung in one resident's bedroom – Completed 30/03/26 • Kitchen floor de-laminating – 17/04/26	

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)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Substantially Compliant	Yellow	17/05/2026
Regulation 23(3)(a)	The registered provider shall ensure that effective arrangements are in place to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.	Substantially Compliant	Yellow	17/05/2026
Regulation 23(3)(b)	The registered provider shall	Substantially Compliant	Yellow	17/05/2026

	ensure that effective arrangements are in place to facilitate staff to raise concerns about the quality and safety of the care and support provided to residents.			