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 2 - Cheeverstown House Residential Services
Name of provider:	Cheeverstown House CLG
Address of centre:	Dublin 6w
Type of inspection:	Unannounced
Date of inspection:	07 May 2025
Centre ID:	OSV-0004925
Fieldwork ID:	MON-0046328

About the designated centre

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

This designated centre comprises of three houses located on the residential campus in South Dublin. The centre provides 24 hour residential care and support for adults both male and female. The capacity of the service is for up to 14 adults with intellectual disabilities including some adults with physical and sensory disabilities. Residents all have their own bedrooms and each house while configured differently, contains a kitchen, laundry room, two sitting rooms and adequate numbers of bathrooms. Each house had a garden area to the rear of the house and residents had access to a number of communal garden areas. The centre's staff team consisted of a person in charge, clinical nurse managers, staff nurses, care assistants and housekeeping staff.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	14

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
Wednesday 7 May 2025	10:30hrs to 17:00hrs	Erin Clarke	Lead
Wednesday 7 May 2025	10:30hrs to 17:00hrs	Karen Leen	Lead

What residents told us and what inspectors observed

Overall, the inspectors found that the centre demonstrated effective leadership systems that ensured residents received safe, high-quality care. This was evidenced by the levels of compliance observed during this focused, risk-based inspection. The provider had identified that residents would benefit from increased access to community-based activities and more meaningful engagement opportunities. Inspectors found that this was an area of active focus for the centre, with efforts underway to enhance residents' social participation and community integration.

The centre is part of a large, mixed-use campus comprising three main residential buildings alongside ten other residential buildings, office facilities, a school, a protected heritage building, annexes, four day service units, and a central mall that includes a restaurant and a disused swimming pool. The provider has committed to the *Time to Move On from Congregated Settings* (2011) policy, reflecting an organisational aim of transitioning residents from institutional settings to smaller, community-based accommodations. At the time of the inspection, two of 14 residents living in this centre were identified for transition to a community house.

The inspectors visited all three houses to meet with residents and staff before holding a meeting with the person in charge and reviewing relevant documentation. Following this, the inspectors returned to the houses to engage with additional residents and staff as they arrived back from their activities.

The first house visited by the inspectors is home to four residents. This house, similar in design to other buildings in the centre and campus, is a single-storey structure arranged around an atrium. The atrium featured a glass roof, which created a warm environment on sunny days. Staff informed the inspectors that during the summer months, residents preferred to spend time outdoors due to the heat in the atrium.

The house accommodated four residents who required significant mobility support. This included the use of various mobility and postural aids such as wheelchairs, ceiling hoists, and specialised shower equipment. Staff demonstrated a clear understanding of residents' mobility needs and were observed supporting residents in moving safely and comfortably within the house.

Residents communicated primarily through non-verbal means, including body language, facial expressions, and other individualised methods. Staff were observed interacting with residents in a respectful and supportive manner, adapting their communication styles to meet each resident’s needs. Staff were knowledgeable about each resident’s communication preferences and could describe how they recognised when a resident was expressing discomfort, displeasure, or satisfaction.

Two empty bedrooms in the house had been re-purposed for storage and as additional space to support residents' needs. Staff explained that these adjustments

were made to ensure that residents had access to the necessary equipment and that space was available for safe use of mobility aids.

The second house visited by the inspectors was home to four residents with varying needs, abilities, and individual requirements. During the inspection, two residents were observed relaxing, with one sleeping comfortably while a movie played in the background. Residents had access to personal comfort items, contributing to a homely environment. Inspectors were informed that the kitchen was undergoing renovations, which were identified as necessary to enhance the living space. One resident was seen preparing to go out for coffee, with staff providing attentive support to ensure their needs were met. Later, this resident was observed sitting outside in the sun, under shade, an activity they clearly enjoyed.

The inspectors visited the third house and met with three of the six residents living in the house. Two of the residents were observed relaxing comfortably in each others company, engaging with items of particular personal importance to them. A third resident was seen spending time alone in a separate living area. When approached by the inspectors, the resident indicated that they did not wish to engage with them, and this preference was respected. Staff were observed supporting the resident's choice for privacy.

Inspectors received mixed feedback regarding staffing levels in the centre. Some staff felt that the current staffing levels were sufficient, while others indicated that improvements could be made. During the inspection, the inspectors observed that adequate staffing levels appeared to be in place, with staff visible in all areas of the houses and actively supporting residents. However, it was acknowledged that in previous months, due to staff leave, the centre had experienced some staffing challenges that had since resolved.

Staff also spoke with inspectors about the transition of two residents from the centre to smaller, two-bed community houses. Staff shared that they had raised concerns regarding limited bathrooms and communal space in the proposed new houses, citing residents' preferences for accessible and comfortable spaces. Inspectors were informed that these concerns were considered as part of the transition planning, and that environmental works were being carried out to ensure the new homes would meet residents' needs.

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

This risk-based inspection was undertaken to assess ongoing compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013. The inspection was

prompted by areas of concern identified during a previous inspection of another designated centre within the same campus in January 2025. The purpose of this inspection was to review the effectiveness of governance structures, quality of care, and the provider's commitment to regulatory compliance. Overall, the centre demonstrated strong governance and management practices, with clear accountability structures in place.

The management structure in the centre was clearly defined with associated responsibilities and lines of authority.There was a person in charge employed in a full-time capacity, who had the necessary experience and qualifications to effectively manage the service. Inspectors found that the person in charge had a suite of audits in place to ensure effective oversight of systems in the centre. Furthermore, inspectors found evidence of formal and informal supervision and staff support in 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 inspectors 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. Inspectors found that support staff were actively advocating for the rights of each individual resident in relation to their individual goals and their home.

Regulation 14: Persons in charge

The provider had appointed a person in charge for the centre that met the requirements of Regulation 14 in relation to management experience and qualifications. The person in charge was full-time in their role and had oversight solely of this designated centre which in turn ensured good operational oversight and management of the centre.

The person in charge demonstrated a comprehensive understanding of the service needs and of the residents' needs and preferences. There were adequate arrangements for the oversight and operational management of the designated centre at times when the person in charge was or off-duty or absent.

Judgment: Compliant

Regulation 15: Staffing

The inspectors reviewed the planned and actual staff rosters for February, March, and April 2025, as well as the current roster for May 2025. The person in charge maintained a clearly documented roster, which accurately reflected the staffing levels and skill mix in the centre. Staffing levels were consistent with the centre's

statement of purpose and the assessed needs of residents.

Residents benefited from a stable and consistent staff team, with some staff working on the campus for many years, which contributed to continuity of care. During the inspection, inspectors spoke with the person in charge, a clinical nurse manager (CNM1), and eight support staff. Staff demonstrated a clear understanding of residents' assessed needs and were observed advocating for individuals within the designated centre.

Overall, staff reported that they were supported to maintain safe staffing levels, with arrangements in place to access additional support if required. The inspectors observed staff interacting with residents in a warm, respectful manner, demonstrating a strong rapport and understanding of each resident's preferences and communication styles.

Judgment: Compliant

Regulation 16: Training and staff development

The inspection found that there was a clear and effective system in place to evaluate staff training needs and to ensure that adequate training levels were consistently maintained within the centre. A review of training records indicated that all staff were up-to-date with their training requirements. New staff were provided with induction training as part of their on-boarding process to ensure that they were familiar with the centre's policies, procedures, and the specific needs of residents.

Supervision records reviewed by the inspectors were in line with the organisation's policy, and staff were receiving regular supervision sessions appropriate to their roles. All staff were up-to-date in mandatory training areas, including safeguarding vulnerable adults, infection prevention and control, manual handling, and fire safety. In addition, staff had received training in risk assessment in order to support safe and effective care.

Judgment: Compliant

Regulation 23: Governance and management

The centre demonstrated a clear and effective management structure, with all staff aware of their roles, responsibilities, and reporting relationships. The person in charge was supported by two Clinical Nurse Managers (CNMs) who had recently joined the management team. One of the CNMs commenced their role in January 2025, while the second CNM began their position a week prior to the inspection. This addition to the management structure provided enhanced clinical oversight and

support for the staff team, strengthening the leadership capacity within the centre.

Quality assurance was actively maintained through a structured schedule of audits, which included reviews of person-centred plans, restrictive practices, and medicine management. These audits were designed to identify areas for improvement and ensured that care was delivered in line with best practice standards. For example, a recent infection, prevention and control audit had resulted in several actions, all of which were documented and monitored.

The provider also maintained robust processes for the reporting, recording, and monitoring of accidents and incidents. All incidents were documented in a clear and consistent manner, and any required actions were tracked until they were fully resolved.

Inspectors also found that staff meetings were held weekly in the centre, with management in attendance at each meeting. This provided an opportunity for staff to discuss any issues, receive updates, and share feedback. Where staff were unable to attend a meeting, detailed minutes were recorded, and staff were required to review and sign these upon their return to work. This ensured that all staff were kept informed of key discussions and any decisions made.

Judgment: Compliant

Regulation 31: Notification of incidents

The person in charge had ensured that incidents, as detailed under this regulation, which had occurred in the centre were notified to the Chief Inspector of Social Services. For example, the inspectors reviewed a sample of the records of incidents that had occurred in the centre in the previous 12 months, such as serious injuries, allegations of abuse, and use of restrictive practices, and found that they had been notified in accordance with the requirements of this regulation.

Judgment: Compliant

Quality and safety

The inspectors found that the centre demonstrated a commitment to maintaining quality and safety under the regulations reviewed. Ongoing efforts were observed to enhance residents' access to meaningful activities.

The centre maintained established systems for risk management, safeguarding and positive behavioural support. Staff were knowledgeable and confident in implementing these practices, promoting resident safety, dignity, and personal

choice. Further improvements were identified to ensure that residents consistently experienced meaningful engagement and activities tailored to their interests. These systems included clear procedures for identifying, assessing, and managing risks, with a focus on maintaining a safe environment for residents. Safeguarding measures were robust, with staff trained in recognising and responding to potential concerns, ensuring that residents were protected from harm.

In the area of positive behavioural support, staff were knowledgeable about the individual needs of residents and were confident in implementing personalised strategies to support positive interactions and reduce behaviours of concern. Behaviour support plans were regularly reviewed, and restrictive practices, where used, were subject to oversight and review to ensure they remained the least restrictive option.

Regulation 13: General welfare and development

The provider had ensured that residents were receiving appropriate care and support in line with their needs and preferences. The provider had identified that resident activities could be improved upon and recognised the need to increase opportunities for community-based social activities and outings. This area for improvement had been highlighted in the previous two six-monthly unannounced provider audits.
Inspectors observed that there was evidence of community involvement in residents' goal-setting. These included planning for hotel breaks, attending fitness classes, visiting family grave sites, visiting a charity for animals, and enjoying trips to the seaside. These activities were guided by residents' interests and preferences.

Logs of resident activities were not one off and were maintained, with a target of achieving at least two off-campus activities per week for each resident. One resident also attended a formal day service, providing them with an additional structured social programme. The inspectors noted that further improvements were needed to enhance community integration for residents, given the centre’s campus-based setting.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

The centre maintained a comprehensive risk register for each house, which accurately captured all risks associated with the service. The risk register had been recently reviewed and contained clear, relevant information to support staff in their duties. This included guidance on safety, health, and welfare at work, as well as protocols for managing areas such as needlestick injuries or ergonomic risks.

There was clear evidence that the person in charge regularly reviewed all incidents and brought these to team meetings for shared learning. For example, an unexplained injury resulting in a fracture was identified as an incident requiring further review. This incident was escalated through the internal risk management processes, prompting the involvement of the safeguarding officer and the risk management department. The case was reviewed in follow-up meetings where staff discussed the circumstances of the injury, identified potential contributing factors, and implemented corrective measures to prevent recurrence.

Following a previous campus inspection, inspectors found that learning had been shared with fluid thickeners now stored securely, with clear safety alerts in place. These safety measures were reinforced by the addition of fluid thickeners to the centre risk register, ensuring that their storage and use were subject to ongoing risk assessment and management.

Judgment: Compliant

Regulation 7: Positive behavioural support

The provider had ensured that where residents required behavioural support, suitable arrangements were in place to provide them with appropriate and individualised support. The inspectors reviewed three residents' support plans and found that these plans were tailored to each resident's assessed needs and were subject to regular review. Each plan contained clear, well-documented strategies that guided staff in effectively supporting residents.

The support plans were detailed and person-centred, providing staff with practical techniques to support each individual. For example, one resident's support plan outlined the importance of providing self-soothing items, including laces, Lego, puzzles, and small handheld objects. During the inspection, the inspectors observed that these items were readily available and easily accessible to the resident in their home, demonstrating that the support plan was actively implemented in practice.

Staff demonstrated up-to-date knowledge and skills in supporting residents who may present with behaviours of concern. They were confident in using positive behaviour support strategies and were aware of the specific needs of each resident they supported. Staff described how they recognised triggers for behaviours of concern and used de-escalation techniques tailored to each resident's preferences.

The use of restrictive practices within the centre was regularly reviewed, with clinical guidance ensuring that any such practices were risk-assessed and applied using the least restrictive approach possible. Inspectors reviewed several examples where restrictive practices had been successfully reduced, leading to positive outcomes for residents.

Judgment: Compliant

Regulation 8: Protection

The inspectors reviewed the processes for investigating and reporting incidents of bruising and found that all incidents and concerns were reported and addressed in line with the provider's policy. Safety 'pauses' were in place to ensure that staff were alerted to any safety risks within the centre, and these 'pauses' were also used to share learning from incidents.

The inspectors noted that appropriate actions were taken following incidents of bruising, including medical referrals where necessary. These measures ensured that the cause of bruising was identified, whether it resulted from a personal or medical issue. Staff were aware of the procedures for reporting, documenting, and responding to such incidents.

A compatibility assessment was also undertaken by a designated safeguarding officer to ensure that the residents moving to the new community house would be appropriately supported and that their individual needs and preferences were respected. This assessment aimed to ensure a safe, positive transition experience for the residents.

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 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 13: General welfare and development	Substantially compliant
Regulation 26: Risk management procedures	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Centre 2 - Cheeverstown House Residential Services OSV-0004925

Inspection ID: MON-0046328

Date of inspection: 07/05/2025

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 13: General welfare and development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 13: General welfare and development:
All residents' current 'My Life Plan' and associated goals will be reviewed and updated to ensure they reflect opportunities for meaningful participation in community-based activities aligned with each individual's interests, abilities, and preferences.
As part of this process, a new structured 'My Life' planning framework will be introduced. This will include: A dedicated 'My Life' folder that captures broader life aspirations and community engagement goals.
The review will document the supports required to help residents develop and maintain personal relationships and connections within the wider community, in line with their expressed wishes.
Progress will be monitored quarterly, with measurable outcomes including the number of residents actively participating in community activities and the number of new or sustained personal/community connections facilitated. In order to achieve this, the Person in Charge (PIC) will continue using a weekly social experience record sheet, which will be reviewed and discussed during weekly staff meetings to ensure all residents are supported in their community involvement.

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 13(2)(b)	The registered provider shall provide the following for residents; opportunities to participate in activities in accordance with their interests, capacities and developmental needs.	Substantially Compliant	Yellow	08/07/2025