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 3 - Cheeverstown House Residential Services
Name of provider:	Cheeverstown House CLG
Address of centre:	Dublin 6w
Type of inspection:	Unannounced
Date of inspection:	21 January 2025
Centre ID:	OSV-0004926
Fieldwork ID:	MON-0045952

About the designated centre

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

This designated centre is currently registered to provide 24-hour care, seven days per week, for up to 14 male and female adult residents. The centre is located on a residential campus in South Dublin. The centre consists of four residential houses primarily caring for people with an intellectual disability. The range of intellectual disability in this group covers all ranges from mild, moderate to severe/profound in nature. Some individuals have physical and sensory disabilities also. There is a full-time person in charge and the front-line staff are primarily made up of clinical nurse managers, staff nurses, care assistants and housekeepers. The service has access to a number of accessible vehicles to facilitate transport to appointments, social outings and activities in the community.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	13

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Tuesday 21 January 2025	10:30hrs to 16:30hrs	Karen Leen	Lead
Wednesday 22 January 2025	10:30hrs to 17:30hrs	Karen Leen	Lead
Tuesday 21 January 2025	10:30hrs to 16:30hrs	Erin Clarke	Support
Wednesday 22 January 2025	10:30hrs to 17:30hrs	Erin Clarke	Support

What residents told us and what inspectors observed

This report outlines the findings of an unannounced risk inspection of this designated centre. The inspection was carried out following the receipt of solicited information submitted by the provider to the Office of the Chief Inspector of Social Services. This information concerned two notifications of serious injury to a resident and 31 separate incidents of unexplained bruising to three residents, raising significant concerns about the safety and well-being of individuals living in the centre.

In addition, inspectors followed up on findings from a previous inspection carried out in April of 2023 which demonstrated high levels of non compliance with the regulations and standards, resulting in a cautionary meeting with the provider. Following inspection findings carried out in April of 2023 and August of 2023, the provider had submitted a compliance plan stating that for one resident their transition would be completed to their new home by quarter four of 2023. However, the inspectors found that this planned move had not occurred for the resident and no time line had been set.

During this inspection, inspectors used observations, conversations with residents and staff, and a review of documentation to form judgments on the quality and safety of care and support provided to residents in the centre. While elements of good practice were observed, significant systemic issues and risks remain unaddressed in relation to unexplained injuries, risk management and oversight mechanisms.

Inspectors found that residents received good care and support under some of the areas inspected and residents were supported by a staff team who had a strong understanding of their current assessed needs, interests and likes. However, the incompatibility of some residents posed a serious ongoing risk to their safety and wellbeing, and the provider had not yet ensured that all residents were in receipt of services that were appropriate to their needs.

The centre was in the process of decongregation, with four residents awaiting a move to their new homes in a community setting. However, delays in this transition had prolonged their exposure to an unsuitable living environment. The lack of clear timeframes and contingency planning presented a barrier to improving the quality of life for these residents who would benefit from a more appropriate setting.

Furthermore, the inspectors found that despite the transition plans in place for residents, risks remained in the current environment due to resident incompatibility and delays in securing appropriate placements.

The inspection was carried out by two inspectors over two days. On the first day of inspection, inspectors completed a walk around of all four houses, both inspectors visited three of the houses with one inspector visiting the last with the person in

charge. Following on from the walk around the inspectors completed an introductory meeting with the person in charge. The person in charge was a clinical nurse manager grade two (CNM2), and their reporting manager was a clinical nurse manager grade three (CNM3) who was also the nominated person participating in the management (PPIM). The inspectors highlighted discrepancies between the centre's statement of purpose (SOP), floor plans, and actual operations following the walk around requiring amendment to the registration documents. Risks were also identified and brought to the attention of the management team.

Inspectors met with 11 residents over the course of the two day inspection. One resident told the inspector that they liked living in their home and that the 'staff were the best'. The resident communicated in short burst of sentences taking time to consider their conversation. Staff discussed with the inspectors that the resident would take some time to communicate and to not rush with another question before the first was answered. Inspectors observed staff attentively listening and waiting for resident to discuss things they liked to do in their home and what plans they had made for the day.

One inspector had the opportunity to meet with one resident who resided in a single occupancy house within the designated centre. Support staff informed the inspector that they had informed the resident that there would be one inspector visiting the house in preparation prior to the visit. The resident was relaxing watching television and enjoying a light snack. The resident told the inspector that they were happy in their home and continue to watch their show. On day two of the inspection, the inspector met with the resident and their support staff. The support staff discussed with the inspector that they were making some plans for the afternoon. Support staff demonstrated a strong knowledge of the residents likes and interests and discussed the importance of being prepared for chosen activities. While the resident appeared content and comfortable, the inspector noted the importance of predictability and preparedness in daily routines to minimise anxiety. Staff were well attuned to the resident's preferences, reinforcing the significance of individualised support in reducing distress and promoting stability. Support staff discussed that once the resident had decided a course of action for the day staff would need to be ready to go in order to reduce anxiety. The inspector observed kind and friendly interactions between both the resident and their support staff.

Inspectors met with one resident who was relaxing in the sitting room area of their home. The resident had warm blankets placed around them while they enjoyed a cup of tea. The resident told the inspectors that they were very happy and very comfortable relaxing in their home. Support staff informed the inspector that the resident had been going through a period where they had not wanted to go out on activities. From a review of the residents information, inspectors found that the resident had previously attended a day service, however, since the COVID 19 pandemic they had not returned to a day service. On review of the residents file inspectors found that the need for day service review was identified in 2022. At the time of inspection, no alternative day service had been secured, impacting their social engagement and overall quality of life.

In conclusion, while staff demonstrated strong knowledge of residents' needs and

engaged in kind and supportive interactions, the findings of this inspection highlighted serious shortcomings in resident safety, compatibility, and access to essential services.

The next two sections of this report will present 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 the service being provided.

Capacity and capability

This risk-based inspection was conducted following the receipt of solicited information from the provider to the Chief Inspector of Social Services. Inspectors were not assured on the day of inspection that appropriate governance systems were in place to ensure that the service provided was safe, consistent, and responsive to residents' needs. Significant gaps in governance and oversight were identified, particularly in relation to risk identification and management, staff training and supervision, provider response to risks, and record-keeping practices.

During the inspection, it was found that several documents required for the inspection were not provided in a timely manner. Documentation requests were sent to senior management at 12:50 on day one, and further requests were made on day two for outstanding information, including incident reviews, accident and incident reports, audit schedules, and staff supervision records. There were also gaps in staff supervision and training records, with some staff not completing mandatory training and refresher courses in safeguarding and manual handling. Inspectors also observed that senior management and the person in charge had not attended all staff meetings, leading to a lack of escalation for some concerns raised by staff. Furthermore, documentation supporting the governance process, including the annual review of quality and safety, six-monthly unannounced visits, and senior management meeting minutes, were missing or delayed.

The staffing structure comprised staff nurses and healthcare assistants, with regular on-call staff covering vacancies and planned/unplanned leave. However, inspectors found that staffing levels and skill mix were inadequate to meet the changing needs of residents, particularly in relation to supporting access to community engagement and meaningful activities. The current deployment of staff prioritised essential personal care but did not sufficiently support residents' broader well-being and social inclusion. This shortfall had a direct and negative impact on residents' opportunities to engage in activities both inside and outside of the centre, limiting their ability to lead self-directed, fulfilling lives.

Inspectors found significant deficiencies in the oversight and audit of documentation within the centre. Key records were not readily available for review, raising concerns about the transparency and accuracy of governance practices. Furthermore, documentation that was available was not always accurate or up to date. For

example; safeguarding plans did not reflect recent updates or indicate whether cases had been closed by the national safeguarding team, creating a lack of clarity around active safeguarding measures. Inspectors also found that risk assessments and provider responses lacked clear evidence of timely action, leaving gaps in how emerging risks were identified, tracked, and mitigated. The failure to maintain accurate and up-to-date records compromised accountability and hindered the ability of staff and management to make informed decisions that directly affect the safety, welfare, and rights of residents.

Regulation 15: Staffing

The inspectors found that adequate staffing resources were not in place to meet the needs of residents. The lack of staffing resources was also having an impact on residents access to meaningful activities and goals within the local community.

The provider had identified changing needs in residents which required support of staff in a number of key areas for residents. For example, in one house within the designated centre, one resident had a decline in their health with an increase in seizure activity which was also presenting in unusual or previously unwitnessed pre-seizure activity. Staff spoken with during the course of the two day inspection discussed that the resident required one to one staff support to monitor seizure activity. Furthermore, a number of residents required the assistance of two staff for personal care.

Inspectors had the opportunity to speak to 16 staff over the course of the two day inspection and found that staff spoken with had a good understanding of residents' individual personalities and needs, and supported them in a kind and respectful manner.

Inspectors reviewed the training record for the staff team that formulated the current worked rosters in the centre. The inspectors found that staff were provided with training in safeguarding vulnerable adults and patient manual handling, however, a number of staff required refresher training in both areas.

The designated centre had a number of open safeguarding plans in place for residents, with three safeguarding plans reviewed requiring all staff to have patient manual handling training completed. Inspectors found that the training matrix was not reviewed appropriately in order to highlight the lapse in training for staff and action refresher training for 11 staff in the centre.

Judgment: Substantially compliant

Regulation 16: Training and staff development

The provider had submitted 31 notifications to the Office of the Chief Inspector concerning allegations, suspected, or confirmed incidents of abuse in relation to three residents in the designated centre in line with the providers safeguarding processes. These notifications reported instances of unexplained bruising on residents, with the provider suggesting that poor patient or manual handling practices might be the possible cause. During the inspection, management explained that upon reviewing the bruising incidents, it appeared that poor manual handling during personal care or assistance with dressing might have contributed to the injuries. Although staff had completed manual handling training, additional training was also provided, and manual handling was discussed with the staff team. However, when reviewing manual handling training records, inspectors found that 11 out of 33 staff were overdue for mandatory training. According to the centre's risk assessments, staff were not permitted to work in the designated centre without having completed this training.

Additionally, inspectors found that staff meetings across the four houses in the centre from January 2024 to January 2025 did not consistently address concerns regarding the unexplained bruising or poor manual handling practices. Although 27 staff meetings had been held in two houses, only one meeting on September 22, 2024, mentioned safeguarding and manual handling in relation to bruising. Three of the four houses had monthly team meetings, but the prepopulated agendas did not address specific issues such as manual handling concerns or guided the practice of staff who had not attended the meetings. On review of staff meetings inspectors found that staff had highlighted concerns in relation to supports in place for residents. However, there was no management in attendance of the staff meetings in order for concerns to be escalated.

Inspectors also reviewed supervision records for the 37.5 full-time equivalent staff, including nurses and healthcare assistants, within the centre. Records were provided for only 21 staff, all of whom had received one supervision meeting from January to December 2024. The provider's supervision policy indicated that staff should have formal supervision meetings quarterly, with additional availability from line managers when needed.

Finally, when reviewing training records for Safeguarding Vulnerable Adults, inspectors found that 18 out of 33 staff had not completed the mandatory refresher training for safeguarding.

Judgment: Not compliant

Regulation 21: Records

The inspection highlighted gaps and inconsistencies in the records, which could negatively impact residents. For example, a bed rail risk assessment for one resident was reviewed, and although it had been in place since July 2021 and reviewed in July 2023, the risk assessment advised that bed rails should not be used due to the

high risk of injury. The assessment recommended using a crash mat and sensory alarm instead. However, during the inspection, it was noted that the resident's bed had bed rails and bumpers in place.

Furthermore, significant resident information, such as documentation regarding bed rail use, was not readily accessible to staff. The relevant documents were stored in the night manager's office, making it difficult for staff to review and follow proper guidance.

Judgment: Not compliant

Regulation 23: Governance and management

Inspectors found that while the provider had established systems for overseeing the care and support of residents, these systems were not fully effective in practice. For example, the provider completed six-monthly reviews, as required by the regulations. However, the latest review, completed in September 2024, identified several actions to be addressed in the designated centre. Upon reviewing the action plan, inspectors noted that the provider had allowed up to six months for the completion of all actions, including those concerning residents' rights, safety updates, and procedures. One action from the six-monthly review was to ensure that all actions from meetings were placed in the action section for follow-up, with a completion timeline of four months.

Furthermore, inspectors found that residents' opportunities to access community activities were limited. The provider acknowledged this in their review and set an action to "further develop and explore community participation and opportunities" and to "encourage and promote more community-focused goals" by the next review in the second quarter of 2025.

Inspectors also found that the provider's systems for monitoring and reviewing ongoing risks within the centre were inadequate. Key issues, such as the compatibility concerns of residents, had been identified, but the provider had not ensured that appropriate arrangements were in place to meet the individual needs of each resident. One resident's living arrangements were not suitable, and there were concerns about their incompatibility with other residents. While the provider had transition plans in place for four residents, these plans, which began in 2021, had not progressed as expected. During the inspection, the provider could not provide an update on when these transitions would occur. The transition plan for one resident was part of a broader safeguarding plan, but no updates were available on the planned move.

Additionally, the minutes from meetings between the person in charge and senior management showed that the template used for these meetings only allowed brief summaries and did not adequately capture the concerns or action plans arising from these discussions. Inspectors found that while staff raised concerns about quality

and safety in team meetings, the provider had not ensured effective arrangements were in place to support and manage the performance of the workforce in relation to service quality and safety. Staff meetings had poor attendance from senior management, with only four out of 35 meetings reviewed attended by senior management, including the person in charge. As a result, concerns raised during staff meetings were not properly escalated due to the absence of management.

Judgment: Not compliant

Regulation 3: Statement of purpose

The statement of purpose (SOP) is one of the most important documents that a provider is required to have in relation to its services. It is where the provider clearly sets out what the services does, who the services is for and information about how and where the service is delivered.

The inspectors found that the statement of purpose did not accurately reflect the operations of the centre or the services being provided. For example, the statement outlined the admissions process, but when management was asked about admissions to the centre, it was clarified that the centre was not open to new admissions, in alignment with the 'decongregation', of the campus.

In the section outlining arrangements for residents to engage in education, training, and employment, the statement mentioned external instructors providing activities such as arts and crafts, literacy classes, and music. However, inspectors found that this service had not been in place since before the pandemic restrictions.

The floor plans also required review. One house listed a room as a multisensory room, but upon inspection, the room contained several chairs and a mattress propped against the wall, with no indication that it was a functioning multisensory room, apart from a single water light.

Additionally, renovations had been carried out, such as a bathroom being adapted for accessibility, but these changes were not reflected in the floor plans. This discrepancy between the statement of purpose and the actual service and facilities provided indicates a need for a review and update of the document to ensure it accurately represents the current operations and facilities at the centre.

Judgment: Not compliant

Regulation 31: Notification of incidents

The inspectors reviewed a record of incidents that occurred in the centre over the last year and found that the person in charge had notified the Health Information

and Quality Authority (HIQA) of adverse events as required under the regulations.

Judgment: Compliant

Quality and safety

Overall, inspectors found that residents appeared happy and comfortable in their homes, and their immediate needs were being met by staff. However, inspectors were not assured that residents were receiving a consistently high-quality and safe service. The governance and oversight structures in place required strengthening to ensure that incidents, risks, and safeguarding concerns were proactively managed. Significant improvements were required in key areas, including Regulation 13: General Welfare and Development, Regulation 26: Risk Management Procedures, and Regulation 8: Protection.

Risk management policies and procedures were in place at the designated centre, but significant improvements were required. While the risk register recorded several hazards and reflected their level of risk, it did not comprehensively capture all risks present in the centre, particularly in relation to delays in residents' transitions to the community. This lack of oversight meant that risks were not being appropriately monitored or escalated, increasing the potential for harm.

Upon reviewing incident documentation, inspectors found that serious incidents had not been initially reported through the appropriate system, nor had they been categorised correctly under the appropriate risk level. This misclassification impacted the effectiveness of the response and follow-up actions, meaning that critical incidents may not have received the level of review or intervention required under the provider’s own risk management framework.

Inspectors identified a risk to a resident and brought it to the attention of the person in charge on the morning of the first inspection day. Despite requesting a verbal update, no details were provided, and the issue remained unknown during the feedback session, raising further concerns about the centre’s responsiveness to risk and incident management.

Safeguarding concerns were identified due to unexplained bruising incidents and serious injuries to residents, with inadequate risk mitigation measures in place. Resident placement incompatibilities were an ongoing issue. Delays in resident transitions since 2021 further heightened risks, despite properties being identified and tenancy agreements signed. The failure to provide a safe and appropriate living environment represents a potential breach of residents' rights. Additionally, no alternative internal solutions were explored to mitigate these risks within the campus.

Additionally, as previously highlighted, inspectors found that residents had limited opportunities to engage in activities outside of their home or off the campus, further

impacting their overall quality of life.

Regulation 13: General welfare and development

From a review of a sample of residents' assessments, meaningful activities, and daily records, inspectors found that some residents did not have regular opportunities to engage in meaningful activities outside their home or off the campus. Inspectors identified that several residents required the support of two staff members to engage in community activities. For instance, one resident required two staff members to attend an appointment on day one of the inspection, and the same resident needed two staff members to attend a social activity. Staff informed inspectors that two staff members remained in the house to support four residents, two of whom needed assistance with personal care. As a result, resources were limited to provide activities for residents within the local community.

Inspectors also reviewed the residents' meaningful activities support plans within the designated centre. For one resident, the planned meaningful activities included walking in the park, paying for meals, setting the table, putting clothes from the laundry away, using the dishwasher, bottle return, hand washing, and driving. However, inspectors found that the resident did not have the opportunity to participate in these activities, particularly those outside the centre.

For example, from December 11, 2024, to January 9, 2025, the resident attended a restaurant five times, two of which were in the provider's canteen on campus, rather than in the local community. For another resident, meaningful activities carried out from October 2024 to December 2024 showed that the resident had gone on fifteen drives within the local community. This indicates that while some activities were planned, the opportunities for residents to engage in meaningful community participation were limited, and the available resources did not adequately support the delivery of these activities. This impacted residents' general wellbeing and development, as it restricted their ability to fully participate in and benefit from community-based experiences.

One resident had previously attended day services five days a week but could no longer do so due to an injury. The resident had reported enjoying their day programme, and an email was sent on their behalf in 2022 seeking a new community placement. The email stated that the resident had been without a day service for four years at that point. However, upon reviewing the resident’s file, inspectors found no updates on the progress of securing a new placement for them.

Judgment: Not compliant

Regulation 26: Risk management procedures

A risk register was maintained in the centre, however, this risk register did not accurately capture all risks pertaining to the centre in particular in relation to the length of time for progressing transition plans for residents to new identified community houses and the patient manual handling risk identified by the provider as a possible cause of unexplained bruising to residents. The storage of critical risk-related documents in the night manager's office further hindered the effective management of risk and oversight of resident safety.

The inspectors reviewed the management of two serious injuries sustained by one resident over a three-month period. As part of this review, the provider's risk management policy, dated November 2022, was examined to assess the required actions in response to serious incidents. Inspectors found that both injuries had been incorrectly categorised as involving no injury and, therefore, classified as minor/negligible. While contributing factors were identified for the first injury, the cause of the second injury remained unclear. Due to the severity of the second injury and unknown cause, it should have been categorised appropriately. Had this been done, the system would have triggered an alert notifying the provider that a serious risk incident had occurred, necessitating the establishment of a Serious Incident Management Team (SIMT) meeting. According to policy, decisions regarding the SIMT meeting should have been made within 72 hours and, at a minimum, within one working week.

Inspectors found that this process did not occur. The incident occurred on 03 December and was reported on the incident management system on 06 December, yet a serious incident review meeting was not convened. Instead, an "After Action Review Learning" (AAR) meeting took place on December 15. Membership of the SIMT should include nominated members of the executive management team. However, due to the misclassification of the incident, the review was conducted solely through a multidisciplinary team approach rather than the required SIMT process. Inspectors were, therefore, not assured that incidents involving residents were effectively reported and risk-rated to flag serious incidents to the provider. Additionally, it was unclear why, when the severity and unknown cause of the incident had been established, it had not been escalated to the appropriate personnel in accordance with the provider’s policy.

Inspectors observed tubs of fluid thickeners openly stored in kitchen areas within the houses. Fluid thickener is a prescribed medicine and there are safety alerts regarding the risk of asphyxiation which means these products should be securely stored out of residents' reach. Inspectors raised the issue with management on the first day of the inspection, despite this, on the second day of the inspection, the thickeners were still stored in accessible locations, and no risk assessment had been conducted to address the potential hazard.

Judgment: Not compliant

Regulation 8: Protection

The occurrence of 31 separate incidents of unexplained bruising to three residents, along with reports of serious injuries, raised significant safeguarding concerns. The lack of conclusive explanations for these injuries and the absence of timely and effective risk mitigation measures highlighted issues with the centre's oversight, monitoring, and protective mechanisms. The inadequate response to these incidents posed the potential risk of further harm to residents and required more robust protective measures and a review of the centre’s approach to identifying and addressing safeguarding risks.

Additionally, the unsuitability of some resident placements was identified as an ongoing risk, yet no immediate or effective actions had been taken to address these incompatibilities. This failure to resolve the issues promptly resulted in heightened safeguarding concerns, as it compromised the safety and well-being of residents.

The ongoing placement of residents in unsuitable environments represents a potential breach of their rights to a safe and appropriate living arrangement. While transition plans had been developed for some residents, with properties identified and tenancy agreements signed, the significant delay in progressing these moves since 2021 has exacerbated risks for the residents. The delay has created uncertainty and continued exposure to incompatible living arrangements.

Furthermore, during the course of the inspection the inspectors were not presented with documentation evidence of alternative internal solutions being explored within the campus to mitigate or reduce the impact of these compatibility issues.

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 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Not compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Not compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 13: General welfare and development	Not compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 8: Protection	Not compliant

Compliance Plan for Centre 3 - Cheeverstown House Residential Services OSV-0004926

Inspection ID: MON-0045952

Date of inspection: 22/01/2025

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 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: A review of all residents assessment of needs will be completed for this designated centre by the 16/03/25 A review of this designated centre's current resources will be completed to ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: All staff within this centre will have completed all mandatory training, including refresher training, as part of a continuous professional development programme. A training review will be completed per house to identify additional training needs to support the residents. There will be a training schedule and staff participation. The PIC will ensure that there is a schedule for staff supervisions in this designated centre which will ensure 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. All staff within this centre will have had one supervision completed by the end of the 31/03/25	

and will receive 2 further supervisions and 1 performance developments by the end of the year.

Regulation 21: Records	Not Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
The PIC will ensure that all records in relation to each resident as specified in Schedule 3 are maintained and are available for inspection by the chief inspector.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
A review of this designated centre's current resources will be completed to ensure that it is resourced appropriately to ensure effective delivery of care and support in accordance with the statement of purpose. Any vacancies highlighted during this review will be actively recruited against.

A review of the designated centre's governance structure has been completed. An additional manager has been provided to this centre's governance structure to bring it into compliance.

Clinical Governance Review Meetings (with Senior Management) will be conducted monthly in this designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.

The PIC will receive fortnightly supervision from the PPIM. These meetings commenced 16/02/25

The person in charge will ensure that there is a schedule of PIC (or delegated manager)/Staff Team meetings which will be held fortnightly. These meetings commenced on the 08/02/25.
Manager to staff supervisions have commenced for this quarter

All staff meetings will have a clear and set agenda to include Safeguarding, Risk and Training

The PIC will ensure that there is a schedule for staff supervisions in this designated

centre which will ensure 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. All staff within this centre will have had one supervision completed by the end of the 31/03/25

Regulation 3: Statement of purpose	Not Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
The registered provider will conduct a review of this designated centre statement of purpose and will ensure it is revised at intervals of not less than one year.

Regulation 13: General welfare and development	Not Compliant

Outline how you are going to come into compliance with Regulation 13: General welfare and development:
A review of all residents' assessment of needs will be completed for this designated centre.

All residents My Life Plan's and Goals will be reviewed to ensure all residents have opportunities to participate in activities in accordance with their interests, capacities and developmental needs and will identify access to facilities for occupation, recreation. This review will identify supports to develop and maintain personal relationships and links with the wider community for all residents in accordance with their wishes.

This My Life and Goals review will ensure that residents are supported to access opportunities for education, training and employment in line with their preference.

The PIC will complete a weekly social experience review and discuss at staff meetings to ensure that residents are developing and maintaining personal relationships and links in their wider community.

My Life Audits will be completed to ensure My Life Plans are reviewed and updated in line with the person's wishes.

A new specified purpose post has been agreed for the organisation to help look at the universal good things in life for a person that is more person centred and meaningful. This role will support all staff in this designated centre by delivering training on social

valued roles and meaningful opportunities.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
The provider will ensure that the service and care provision and health & safety risk registers and supporting risk assessments within this Centre will be updated to reflect all risk areas highlighted in the Inspection Report.

A clear guidance will be provided to direct all staff and managers on how to escalate any risk that may have been initially incorrectly categorised on NIMS.

All serious incidents will be escalated to the SIMT for review and this will be reflected in our Integrated Incident Risk Management Policy.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
The person in charge will ensure that all staff receive appropriate training in relation to safeguarding residents and the prevention, detection and response to abuses or allegations of abuse.

The risk controls in effect to safeguard residents in their home will be monitored and discussed at monthly clinical governance meetings inclusive of training records, safeguarding trend reports, open and closed cases with the Adult Safeguarding Team in the HSE and Time to Move On/ Decongregation.

The Provider will review the transition plans for the residents and ensure all information is up to date and reflect all engagement, discussions and expected timeframe for the resident and their family.

The Provider has reviewed its capacity to transition some residents from their current home internally however, no suitable alternative home was assessed as appropriate.

All safeguarding plans will be reviewed and a quarterly Safeguarding report will be furbished to the PIC from the Designated Officer. Outcomes and actions from these

safeguarding plans will be shared at team meetings and implemented and followed. All safeguarding plan and reports will be held in their location.

The provider aims to register future homes for some of the residents in this centre for submission to HIQA by 16/05/25

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(1)	The registered provider shall provide each resident with appropriate care and support in accordance with evidence-based practice, having regard to the nature and extent of the resident's disability and assessed needs and his or her wishes.	Not Compliant	Orange	30/04/2025
Regulation 13(2)(a)	The registered provider shall provide the following for residents; access to facilities for occupation and recreation.	Not Compliant	Orange	30/04/2025
Regulation 13(2)(b)	The registered provider shall provide the following for residents; opportunities to participate in activities in	Not Compliant	Orange	16/03/2025

	accordance with their interests, capacities and developmental needs.			
Regulation 13(2)(c)	The registered provider shall provide the following for residents; supports to develop and maintain personal relationships and links with the wider community in accordance with their wishes.	Not Compliant	Orange	31/03/2025
Regulation 13(4)(a)	The person in charge shall ensure that residents are supported to access opportunities for education, training and employment.	Not Compliant	Orange	30/04/2025
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Substantially Compliant	Orange	30/04/2025
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a	Not Compliant	Orange	31/03/2025

	continuous professional development programme.			
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	31/03/2025
Regulation 21(1)(b)	The registered provider shall ensure that records in relation to each resident as specified in Schedule 3 are maintained and are available for inspection by the chief inspector.	Not Compliant	Orange	31/03/2025
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.	Not Compliant	Orange	30/04/2025
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	16/03/2025
Regulation 23(3)(a)	The registered provider shall ensure that	Not Compliant	Orange	31/03/2025

	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.			
Regulation 23(3)(b)	The registered provider shall 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.	Not Compliant	Orange	28/02/2025
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	30/04/2025
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose containing the information set	Not Compliant	Orange	10/03/2025

	out in Schedule 1.			
Regulation 03(2)	The registered provider shall review and, where necessary, revise the statement of purpose at intervals of not less than one year.	Not Compliant	Orange	10/03/2025
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	16/05/2025
Regulation 08(7)	The person in charge shall ensure that all staff receive appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse.	Not Compliant	Orange	31/03/2025