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:	08 July 2025
Centre ID:	OSV-0004926
Fieldwork ID:	MON-0047206

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:	12

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 8 July 2025	10:30hrs to 18:30hrs	Karen Leen	Lead
Tuesday 8 July 2025	10:30hrs to 18:30hrs	Tanya Brady	Lead

What residents told us and what inspectors observed

This inspection was an unannounced risk-based inspection completed in July 2025. It was scheduled subsequent to high levels of non-compliance found on a previous inspection in the designated centre completed in January 2025.

The previous inspection found that improvement was required in the systems in place related to the monitoring and oversight of risk management procedures, protection, training and governance and management of the centre. This inspection was conducted to assess compliance with the regulations and to assess the implementation of the compliance plan submitted to the Office of The Chief Inspector following a warning meeting with the provider.

Overall, inspectors found that the provider had made significant improvements to the service and the systems in place and had brought about positive changes in the quality and safety of care provided to residents who used this service. However, some further improvements were required in relation to Regulation 26: Risk management procedures. These are outlined in the body of the report

The designated centre provides residential service for up to 14 adults with an intellectual disability, at the time of the inspection there was two vacancies. The centre comprises four premises situated on a campus setting in South Dublin. The provider was in the process of decongregation and since the previous inspection completed in January 2025 the provider had made significant progress towards transitioning four residents to community settings under the provider's remit. The provider had acquired new premises and recently completed a suite of works on the premises in order to comply with relevant measures to support each individual needs including accessibility for residents and meeting residents environmental needs.

During the course of the inspection, the inspectors had the opportunity to meet and speak with a number of people about the quality and safety of care and support in the centre. This included meeting nine of the 12 residents living in the centre, ten staff members, the person in charge, the director of operations and the Chief Executive Officer (CEO). The inspectors did not have the opportunity to meet with three residents t, two were gone out for the day with staff and a third resident was visiting family. Documentation was also reviewed throughout the inspection detailing how care and support is provided for residents, and relating to how the provider ensures oversight and monitors the quality of care and support in this centre

Residents in the centre communicated using a variety of methods of communication including speech, eye contact, body language, sign language vocalisations, gestures and behaviour. Residents were also supported by familiar staff who understood their communications styles and were able to assist some residents in detailing how they like to spend their day and activities they liked to avail of in their home and local

community.

On arrival to one house in the centre, inspectors found that residents were in the process of getting ready for their day. One resident was being supported by staff to have their breakfast in a quiet space in their home. One resident had left their home to attend their day service hub. Inspectors returned to the this house later in the evening, two residents were relaxing in their bedrooms after being supported to enjoy reflexology and massage. Inspectors spoke to another resident who was relaxing in a small sitting room in the house.

One resident spoke to one inspector while being assisted by staff to prepare their dinner. The resident informed the inspector that they had waited to say hello before they went out for an evening activity with their support staff. The resident discussed that they are very happy in their home. The inspector observed that the resident went to staff consistently throughout their chat with the inspector to seek support and encouragement. The resident discussed that they had planned to go for a drive, a walk in the park and then a visit a coffee shop.

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

Capacity and capability

This risk-based inspection was completed to determine progress by the provider towards completion of its stated actions as submitted to the Chief Inspector following an inspection in January 2025. In addition this inspection sought to verify if these actions had resulted in improvements for residents. Overall, inspectors found that the provider had made significant progress in addressing regulatory non-compliance as found on the previous inspection of this centre.

The inspectors found that the provider had completed stated actions in line with their submitted compliance plan and their warning letter response. Inspectors found that these actions had significantly enhanced their oversight and monitoring of the designated centre which resulted in a more person-centred and quality service for the residents who lived there.

The inspectors found that there were effective management systems in place to ensure that the service provided to residents living in the centre was safe, consistent, and appropriate to their needs. The provider had completed a review of staffing resources in the designated centre, which had allowed for greater oversight into residents chosen activities and community experience.

Regulation 15: Staffing

The provider had completed a review of the designated centre staffing resources. On the day of the inspection, inspectors found that this review had enhanced the skill mix of staff in the centre and that the number and qualifications of staff was appropriate to the assessed needs of residents.

At the time of the inspection the centre was operating on a 1.5 whole time equivalent staffing vacancy. Inspectors reviewed rosters from May and June 2025 and found that for the most part this vacancy was being covered by additional staff hours or members of the provider's relief staff. The person in charge had arranged cover for on average two shifts a week by regular agency staff who were supported in their role by core centre staff

During the course of the inspection, inspectors had the opportunity to speak to ten support staff, the person in charge, the CEO and the director of operations. Inspectors found that staff had clear knowledge of their roles and responsibilities and felt that they were supported in their role by the management team. One staff discussed with inspectors that there were a number of new systems in place in the centre which had helped to increase staff time with residents. Staff outlined that the initial set up and implementation of the systems which included changes to record keeping, residents social and community needs reviews and risk classification for the centre had taken a number of months to effectively complete. However, staff noted that this change had lead to positive changes such as more enhanced oversight of documentation and greater review of residents assessed needs.

The provider had appointed additional staff whose focus was on resident social experiences and inspectors were told of numerous examples where the additional staff support had ensured that even routine events such as a drive now had a stated purpose.

Judgment: Compliant

Regulation 16: Training and staff development

The provider had ensured that systems in place to record and regularly monitor staff training in the centre had been reviewed. The provider had identified that they needed to change their recording systems to enhance effective record keeping and monitoring of dates when refresher training was required. The previous inspection of this centre had identified that significant number of the staff team were overdue refresher training in key areas such as manual handling or safeguarding.

Inspectors found that the provider and person in charge had focused on actions which ensured they were now aware of what training staff had completed and that they scheduled refresher training in a timely manner.

The inspectors reviewed the staff training matrix and found that all staff had now completed the training courses identified as mandatory in the provider's policy. This ensured that staff had the appropriate levels of knowledge and skills to best support residents. Training in areas where gaps had been previously identified was now fully completed. In addition, training was provided in areas such as feeding, eating, drinking and swallowing (FEDS) and autism awareness which provided staff with bespoke skills to support individual residents' assessed needs.

There was a schedule of supervision in place by the person in charge, inspectors reviewed the schedule which identified that all staff had received supervision and support relevant to their roles. Supervision was being carried out with staff by the person in charge, clinical nurse manager 2 and clinical nurse manager 1. The inspectors reviewed the supervision records of eight staff and found that they contained content relevant to their roles such as, supporting residents to achieve their goals, training needs and any additional supports identified by either the staff member or the manager completing the supervision.

Judgment: Compliant

Regulation 21: Records

The person in charge had ensured that all records in relation to each resident as specified in Schedule 3 are maintained and were available for review on the day of the inspection. The inspectors found the information in residents files had information in relation to their assessed needs and that there were no duplication of information.

Inspectors found that information reviewed during the process of the inspection was accurate and up to date. The person in charge and support team had completed a review of the records system in all houses in the designated centre and had updated the storage systems of all records ensuring that they are securely kept but easily retrievable for all staff.

Judgment: Compliant

Regulation 23: Governance and management

Following the last inspection of this designated centre the provider had reviewed the monitoring and oversight systems in place and had developed further provider level

assurance systems. These changes were reviewed by inspectors including new audit structures, serious incident management review records, focused topic-based team meeting minutes, supervision records, and targeted action plans.

A suite of meetings and oversight mechanisms had been put in place including clinical governance review meetings on a monthly basis comprising the senior management team including the provider's Chief Executive Officer, director of operations, risk manager, quality manager, human resource manager, area manager and person in charge. Inspectors reviewed these meeting minutes which recorded the progress of a number of identified key areas in the centre. These key areas included, the providers' last compliance plan, risk management, safeguarding and staff training compliance.

The inspectors found that members of the senior management team had completed a number of centre walk around visits. These visits incorporated meeting with residents and support staff. Inspectors found examples where the completion of the walk around by senior staff members had led to actions being completed for the centre. For example, the risk manager had attended a walk through of the designated centre and identified that changes in internal premises layout were needed or that the oxygen cylinder in one house needed a new location.

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 statement of purpose sufficiently outlined 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. Since the last inspection the provider had made modifications to the centre statement of purpose to outline a number of quality enhancement initiatives in place in the centre. For example, the provider had changed the purpose of two of vacant rooms in two of the premises in the centre. The provider had refurbished rooms to create a family space for residents and visitors. The provider had also updated the services for residents to avail in the designated centre.

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

Judgment: Compliant

Quality and safety

Overall inspectors found that the provider had enhanced oversight and management of the everyday practices in the centre and this had resulted in a more person-centred and quality service for residents. However, the inspectors found that while the provider had made significant improvements in the area of risk management, further improvement was required in relation to risk identification through provider led audits and ensuring that identified risks within the centre are actioned with the appropriate control measures.

The provider had completed a review of residents' lived experiences in the community and in their home. From what the inspectors observed and through discussion with residents and support staff it was evident that residents were developing new connections to their community, leisure interests and maintaining meaningful connections with family and friends. The inspectors found that residents appeared to be demonstrating positive outcomes as a result of on-going review of each individuals' personal interests and goal plans by the provider

The inspectors reviewed the arrangements in place for the safeguarding of residents from abuse and found that the provider had good arrangements, underpinned by policies and procedures. The provider had clear lines of reporting for any potential safeguarding risk and staff spoken with were familiar with what to do in the event of a safeguarding concern. The inspectors also found that all staff had received training in safeguarding adults.

Regulation 13: General welfare and development

The inspectors found that residents had a "My life plan" which consisted of goals and wishes that residents would like to achieve or participate in. The aim of residents' "My life plan" was to identify activities and valued roles that residents would like to avail of in line with their personal interests and assessed needs. The provider had devised a new specific purpose role to assist with a comprehensive review of the process for residents and to complete relevant training with staff in supporting residents to achieve these identified goals. Examples of learning from this review included that *"sometimes goals were unclear and some goals which were clear were repetitions of things already achieved"* and *"goals achieved are contributing to a good life for the person".* As part of this review inspectors found that activity sheets were being reviewed to outline if residents enjoyed the activity, if they participated in the activity and details were given when a resident demonstrated or discussed with support staff that they did not enjoy an activity.

Inspectors reviewed "My life plans" for five residents in the centre and found that they had been reviewed with residents and support staff. Inspectors reviewed "brainstorming" sessions completed with support staff and residents to identify

possible goals and activities for the coming months. Support staff had made the distinction between long term goals for residents such as a holiday or reconnecting with old friends; compared to an activity that residents like to participate in during their week such as a coffee out in the local community.

Inspectors reviewed a sample of activities for residents from April, May and June 2025 and found that residents were availing of a number of meaningful social activities such as golf, gym visits, swimming, forest walks, botanic garden walks and visiting the zoo. A review of these activities demonstrated that residents were attending social activities throughout the week and that it was clearly reflected through documentation if a resident chose not to attend an activity or if a regular activity clashed with a hospital appointment or another commitment for the resident.

Inspectors also observed activities occurring within the designated centre for residents such as access to a massage therapist, sensory activities, visits to the coffee shop and relaxing watching movies.

Judgment: Compliant

Regulation 26: Risk management procedures

Inspectors found that the provider had made significant improvements to the systems in place for the assessment, management and review of risk in the designated centre. Inspectors found that these improvements were evident in both residents' individual assessed risks and wider centre based risks.

The provider had enhanced support systems in place for staff working in the designated centre which included the provider's risk manager and quality manager attending the centre at team meetings and for local site visits to support staff appropriately identifying risk in the environment. This support also included assisting staff to appropriately categorise accidents and incidents in the centre and ensuring that they are addressed and furthermore ensuring when required they were escalated through the appropriate systems to ensure senior management review when deemed necessary.

Inspectors reviewed some residents' files and found that the person in charge had completed individual risk profiles for each resident which incorporated identified areas of risk, support measures in place and a review of all accidents and incidents occurring in the centre for each individual resident. Risk management was a standing agenda at team meetings and as previously discussed both the risk manager and quality manager were in attendance at a number of staff meetings and walk through visits to the centre to support staff in risk management and identification.

However, during a walk through of one house in the designated centre inspectors found that a fire door to a storage area which contained a fridge and a freezer had been compromised and was no longer functioning as required in the event of a fire.

Inspectors found a lock had been removed from the fire door to remove a restrictive practice and ensure that residents could gain access to the storage area however, this had left two holes in the door. One inspector reviewed the inside of the door and found that there was also a large hole in the ceiling leading to the attic space further reducing fire containment of the area. This issue was brought to the attention of the provider and was actioned for immediate review by the relevant fire department in the organisation.

Judgment: Substantially compliant

Regulation 8: Protection

The provider had committed, following the findings of the previous inspection, that resident safeguarding plans would be reviewed and that following this a quarterly system of oversight and review would be implemented. In addition the provider had committed to reviewing and updating resident transition plans that were in place.

The inspectors found that stated actions had been completed and that the provider had additionally reviewed the risk controls in place to provide additional safeguards for residents. Inspectors reviewed the centre safeguarding overview matrix and found that clear records were maintained which guided local management in monitoring and updating information or in liaison with colleagues in the Health Service Executive safeguarding and protection teams.

Residents who required them, had safeguarding plans in place that identified supports required and gave guidance to staff in their practice. In areas such as the identification of bruising that had not a witnessed cause the provider had developed a clear pathway for staff to follow and was using information to trend patterns and to inform any additional onward health and social care referral.

Where incidents of concern were identified these had been appropriately reported and investigated and where staff practice was under review the provider had robust systems in place to protect residents while investigations were ongoing.

Staff had been in receipt of enhanced internal education on matters such as the recording of incidents accurately and reporting concerns. The use of person centred language had been a focus in the centre and safeguarding was a standing item in staff meetings and in resident meetings. Internal changes to the premises had been completed with resident compatibility considered in the decision making and new individual living areas had been created which was a positive change. Compatibility assessments had also been completed which had been used to inform and guide supports in place for residents and in some cases to initiate a discussion on potential transitions in a meaningful way.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 21: Records	Compliant
Regulation 23: Governance and management	Compliant
Regulation 3: Statement of purpose	Compliant
Quality and safety	
Regulation 13: General welfare and development	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 8: Protection	Compliant

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

Inspection ID: MON-0047206

Date of inspection: 08/07/2025

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 26: Risk management procedures	Substantially Compliant
Outline how you are going to come into compliance with Regulation 26: Risk management procedures: The fire door to the storage area, housing a fridge and freezer identified during the inspection as not functioning adequately in the event of a fire has been repaired to ensure it is effective in the event of a fire. A large hole in the ceiling leading to the attic space further reducing fire containment of the area was also identified during the inspection has been sealed and has had a smoke detection device installed to ensure the containment and detection in the event of a fire.	

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 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.	Substantially Compliant	Yellow	11/07/2025