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:	Dun Aoibhinn Services Cahir
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Tipperary
Type of inspection:	Announced
Date of inspection:	20 November 2025
Centre ID:	OSV-0005066
Fieldwork ID:	MON-0040069

About the designated centre

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

Dun Aoibhinn Services Cahir is a designated centre operated by Brothers of Charity Services Ireland CLG. The designated centre provides a community residential service for up to eight adults with a disability. The designated centre consists of two houses located within a close proximity to each other in a town in County Tipperary. The first house is a detached two storey house located on its own grounds. It comprised of a kitchen/dining room, living room, four individual bedrooms (two of which were en-suite), sensory room office and staff sleepover room. The second house is also a two storey house located in an estate which comprised of a living room, kitchen/dining room, office, four individual bedrooms (one of which was en-suite) and a staff sleep over room. There are gardens to the rear of both houses for the residents to avail of as they please. The centre is staffed by the person in charge, social care workers and care assistants. The staff team are supported by a person in charge.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	7

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Thursday 20 November 2025	09:30hrs to 17:30hrs	Conan O'Hara	Lead
Friday 21 November 2025	13:00hrs to 17:00hrs	Conan O'Hara	Lead

What residents told us and what inspectors observed

This was an announced inspection conducted to monitor on-going compliance with the regulations and to inform a decision regarding the renewal of registration.This inspection was carried out by one inspector over two days.

Previous inspections of the centre had identified that there were practices in place that did not adhere to a human rights' based approach to care and support and impacted on residents' choice and control across their daily routine. On foot of these findings a cautionary meeting was held with the provider in March 2024 and subsequent inspections noted that improved practices were in place. This inspection found that the provider had reviewed the practices and routines and made changes as required. This was having a positive impact on the lived experience of residents. However, at the time of inspection the provider had yet to complete a full review of the systems in place at that time to identify the failings that occurred in relation to addressing poor practices in a timely manner.

The designated centre comprises two separate units which provide a home to eight individuals. At the time of the inspection seven residents were availing of the residential service. The inspector had the opportunity to meet the five of the seven residents across two units over the course of this inspection. In addition, the inspector spoke with management and a number of staff members.

The inspection was facilitated by the service manager as the named person in charge had ceased in their role in October 2025. The inspector was informed that the provider had identified a new person in charge and was in the process of identifying a start date.

On the first day of the inspection, the inspector visited the first unit of the designated centre which was home to four adults. The inspector met with three of the four residents as one resident was staying with relatives in line with their routine and personal plan.

On the morning of the inspection, one resident was up while two residents chose to have a lie in. The inspector met with residents as they came to the kitchen and prepared for the day. Later in the morning one resident went out for a coffee in the community, one resident was supported to go for a walk and the third resident spent time in the home watching TV. In the afternoon, two residents were supported to go shopping and one resident went for a walk. The residents appeared comfortable in the presence of the staff team and management. The staff team were observed to interact and communicate appropriately with the residents throughout the inspection.

The inspector completed a walk around of this home. The house comprises of four individual resident bedrooms (two of which were en-suite), staff bedroom, office, shared bathroom, storage room, sitting room, utility room and an open plan living,

dining and kitchen area. In general, the house was observed to be well-maintained and decorated in a homely manner with residents' personal possessions and photographs throughout the centre. The inspector was informed of advanced plans to support the four residents to move to an alternative premises.

In the afternoon of the following day, the inspector visited the second unit of the designated centre which was located a short distance away. The inspector had the opportunity to met with two of the three residents as one resident was in hospital on the day of the inspection.

On arrival to the house, the residents were not present in the house as two residents were attending their day services. The inspector completed a walk around of the second unit which is a two storey house which comprised of a living room, kitchen/dining room, office, four individual bedrooms (one of which was en-suite) and a staff sleep over room. Similarly, the house was well maintained and decorated in a homely manner.

Later in the afternoon, the two residents returned home from their day service and greeted the inspector. The inspector sat down had a cup of tea and spoke about the days events and life in the house. Overall, the two residents appeared happy to be in the house and in the presence of the staff team.

Also, the inspector reviewed six questionnaires completed by residents with the support of staff. Overall, the questionnaires had positive feedback on many aspects of service in the centre such as activities, bedrooms, meals and the staff team.

Overall, the inspector found that the provider and staff team were striving to provide a person centred service. However, improvement was required in the governance and management of the centre. In addition, improvements were required in effectively implementing the provider's systems and training and development of the staff team.

The next two sections of the report present the findings of this inspection in relation to the the overall management of the centre and how the arrangements in place impacted on the quality and safety of the service being delivered.

Capacity and capability

The management systems in place to ensure the service provided was safe, consistent and appropriate to residents' needs required improvement.

At the time of the inspection, the governance and management of the centre required improvement. For example, the person in charge had ceased in their role in October 2025 and moved to another role in another centre. The provider did not notify the Office of the Chief Inspector in writing within 10 days of this.

In addition, the inspector found that the governance and management systems did not always ensure that the provider systems were effectively implemented.

On the day of the inspection, the inspector found that there were appropriate staffing arrangements in place in both homes. The roster demonstrated that there was an established staff team in place which ensured continuity of care and support. From a review of training records, the inspector found improvement was required to ensure a number of the staff team had up-to-date training.

Registration Regulation 5: Application for registration or renewal of registration

The application for the renewal of registration of this centre was received and contained all of the information as required by the regulations.

Judgment: Compliant

Registration Regulation 7: Changes to information supplied for registration purposes

The Office of the Chief Inspector was not notified within 10 days, in writing, when the person in charge ceased to be in charge of the designated centre.

Judgment: Not compliant

Regulation 15: Staffing

The registered provider ensured that the number, qualifications, skill mix and experience of staff was appropriate to the assessed needs of the residents. The provider maintained a planned and actual roster. From a review of the roster for October and November 2025, there was an established staff team in place. At the time of the inspection the centre was operating with one staff on long term leave which was managed by the staff team and a regular relief panel. This ensured continuity of care and support provided to residents.

In the first house, during the week the three residents were supported by five staff throughout the day. At night the three residents are supported by a sleepover and waking night staff at night. At the weekends when the fourth resident stayed in the house, the four residents were supported by seven staff during the day. At night the three residents are supported by a sleepover and waking night staff at night.

In relation to the second house, the three residents were supported by two staff in the afternoon and by one sleepover staff at night. At the time of the inspection, one

resident was receiving care in hospital and was supported on a 1:1 basis during the day.

Judgment: Compliant

Regulation 16: Training and staff development

The systems in place for the training and development of the staff team required improvement. From a review of the training records, the inspector identified a number of gaps in the training of the staff team in areas including fire safety, deescalation and intervention techniques, manual handling and safe administration of medication. This did not support the staff team to have up-to-date skills and knowledge to support residents with their identified support needs.

Judgment: Not compliant

Regulation 22: Insurance

The provider ensured that there was appropriate insurance in place in the centre. This policy ensured that the injury to residents, building, contents and property was insured.

Judgment: Compliant

Regulation 23: Governance and management

The governance and management structure and systems required improvement.

As previously stated, there was a prolonged period of time whereby certain practices were in place that did not promote a human right's based approach to care and support and at times practices met the threshold of a safeguarding concern. At the time of inspection it was found that the provider had taken a number of actions in relation to this, such as reviewing practices, commissioning external reviews of the service and informing the HSE safeguarding team. However, the provider had yet to complete a formal review of their own systems to identify how these practices continued and were not addressed in a more timely manner.

The person in charge had ceased in their role in October 2025 and moved to another role in another centre. The inspector was informed that a new person in charge had been identified and was in the process of identifying a start date. At the time of the inspection, the Service Manager was providing oversight and support to

the staff team.

There was evidence of quality assurance audits taking place to ensure the service provided was appropriate to the residents needs. The quality assurance audits included the annual review 2024 and six-monthly provider visits. The annual review demonstrated consultation with the residents as required by the regulations. However, improvement was required in the implementation of provider's systems. For example, this inspection found risk assessments not reviewed appropriately, gaps in personal plans, oversight of residents finances not in line with the provider's policy and a number of staff requiring up-to-date training.

Judgment: Not compliant

Regulation 3: Statement of purpose

The provider prepared a statement of purpose which included all the information as required in Schedule 1 of the regulations. This is an important governance document that details the service to be provided in the centre and details any charges that may be applied.

Judgment: Compliant

Quality and safety

Overall, the inspector found that the service was striving to provide person centred care. However, improvements were require in maintaining personal plans and the management of risk.

The inspector reviewed a sample of residents' personal files. Personal support plans reviewed were found to be up-to-date and to suitably guide the staff team in supporting the residents with their personal, social and health needs. However, improvement was required in the oversight and implementation of the plans.

Overall, there were appropriate systems in place to keep the residents safe. For example, a review incidents and accidents demonstrated that the were appropriately managed. However, the risk documentation required improvements to ensure it was up-to-date and reflected the control measures in place.

Regulation 17: Premises

Overall, the designated centre was designed and laid out to meet the needs of the residents. The inspector found that the two houses were decorated in a homely manner and well maintained. The designated centre consists of two houses located within a close proximity to
each other.

The first house is a two storey house which comprised of a kitchen/dining room, living room, four individual bedrooms (two of which were ensuite), sensory room office and staff sleepover room. The second house is also a two storey house which comprised of a living room, kitchen/dining room, office, four individual bedrooms (one of which was en-suite) and a staff sleep over room. There are gardens to the rear of both houses for the residents to avail of as they please.

The inspector was informed an alternative premises had been identified for the four residents in the first house and there were advanced plans in place to support the residents transition to these premises.

Judgment: Compliant

Regulation 26: Risk management procedures

The registered provider had a system in place for the assessment, management and ongoing review of risk. The inspector reviewed the risk register and found that general and individual risk assessments were in place. It was not evident that some risk assessments informing the risk register had been reviewed in line with the provider's system. The risk assessment in place for two residents identified as a high falls risk were not in line with the provider's new template and required updating. In addition, a number of risk assessments outlined the importance of staff training as a control measure. As noted under Regulation 16: Training and Development improvement was required to ensure all staff were suitably trained.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Each resident had a personal plan in place to guide the staff team in supporting the residents with their identified needs, supports and goals. The inspector reviewed a sample of residents' personal files and found that improvement was needed. For example, the implementation and recording of talk time for one resident was not in line with their personal plan and there were gaps in the recording of blood pressure measurements for another resident. In addition, a number of restrictive practices were in place were due review by the provider's human rights committee including

transport seating plans and safety intervention.

In relation to the residents finances, it was not evident that checks were happening in line with the provider's systems. For example, the staff team completed a monthly reconciliation of a resident's finances against their bank statement. It was not evident that this had been checked by management.

Judgment: Substantially compliant

Regulation 8: Protection

The registered provider had systems to keep the residents in the centre safe. The inspector reviewed incidents occurring in the centre for the period January 2025 to November 2025. There was evidence that incidents were appropriately managed and responded to. Staff were found to be knowledgeable in relation to keeping the residents safe and reporting allegations of abuse. All staff had received training in safeguarding vulnerable adults.

As noted at the time of the inspection, the provider was in advanced stages of responding identified governance issues and practices which at times impacted on residents. This had been identified to the HSE Safeguarding Team and safeguarding plans had been developed for identified safeguarding concerns as required.

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	
Registration Regulation 5: Application for registration or renewal of registration	Compliant
Registration Regulation 7: Changes to information supplied for registration purposes	Not compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Not compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Compliant
Quality and safety	
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 8: Protection	Compliant

Compliance Plan for Dun Aoibhinn Services Cahir OSV-0005066

Inspection ID: MON-0040069

Date of inspection: 21/11/2025

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
Registration Regulation 7: Changes to information supplied for registration purposes	Not Compliant
Outline how you are going to come into compliance with Registration Regulation 7: Changes to information supplied for registration purposes: The provider will ensure that PIC changes are notifed within the required timeframes going forward.	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: 1. Training Plan A structured training plan has been developed to identify staff members requiring mandatory training. These staff will be scheduled for training as soon as the January 2026 timetable becomes available. 2. Training Matrix Implementation Training records are being transferred to a newly designed matrix format. This matrix will enable the Person in Charge (PIC) to more efficiently identify training gaps and monitor staff compliance. 3. Attendance and Accountability Management will address instances of "No Show/No Call" for training sessions through staff supervision. Where appropriate, disciplinary procedures will be initiated to ensure accountability and adherence to mandatory training requirements	

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:

1. The service will conduct a comprehensive internal review to consolidate all previous shared learnings, recommendations and action plans, with time lines for completion. This review will result in a formal document that clearly outlines identified issues, corrective actions, and defined timelines for completion. This final document will be shared with all staff who have direct and indirect responsibility for the safety, health and wellbeing of all residents supported.
2. A Quality Improvement Plan will be drawn up to address updating of care plans, risk assessments and a systematic review of restrictive practices in line with policies. This will be reviewed and implemented by the Compliance Manager, Service Manager and new PIC alongside Staff Nurse, Social Care Workers and Keyworkers.
3. A new PIC monthly report will be in place from January 2026 that will ensure PIC oversight on internal and external audit action plans, training etc. This will be returned to the Service Manager monthly to ensure management oversight and accountability.
4. A guidance document will be developed to clearly define the responsibilities of the Person in Charge (PIC). This document will provide a structured framework that allows the PIC to record dates of completion for required tasks on a weekly, monthly, and quarterly basis. It will encompass essential checks such as the inspection of medication cabinets, verification and correction of financial records, monitoring of maintenance issues, review of medication recording charts, behavioral recording charts and updates to POMS (Positive Outcome Measures) and PCP (Person-Centred Plans). By formalising these responsibilities, the organisation will ensure accountability, consistency, and compliance with best practice standards.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:

1. The Service Manager, the Person in Charge (PIC), and designated senior staff members will take responsibility for reviewing existing risk assessments. Following these reviews, the risk register will be updated accordingly to ensure that risks are accurately recorded and monitored.
2. Risk management training to be providing to PIC and staff in the designated centre.
3. Falls risk assessments to be completed for all residents and Falls Management Care Plan to be drawn up where indicated, in line with BOC Falls Prevention & Management Policy.

Regulation 5: Individual assessment and personal plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:

1. Financial accounts have been reviewed by the Service Manager since the inspection. No concerns were noted. Service Manager will continue to do so until the new PIC is in place.
2. A guidance document will be developed to clearly define the responsibilities of the Person in Charge (PIC). It will encompass essential checks such as the inspection of medication cabinets, verification and correction of financial records, monitoring of maintenance issues, review of medication recording charts, behavioral recording charts and updates to POMS (Positive Outcome Measures) and PCP (Person-Centred Plans). By formalising these responsibilities, the organisation ensures accountability, consistency, and compliance with best practice standards.
3. Updates on restrictive practices will be formally communicated to both the Restrictive Practice Committee and the Human Rights Committees. This process will include the closure of certain restrictive practices where appropriate, as well as the identification and highlighting of chemical restraints within the new RPC protocol and referral form.

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
Registration Regulation 7(2)(a)	Notwithstanding paragraph (1) of this regulation, the registered provider shall in any event notify the chief inspector in writing, within 10 days of this occurring, where the person in charge of a designated centre has ceased to be in charge.	Not Compliant	Orange	01/01/2026
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Not Compliant	Orange	30/04/2026
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in	Not Compliant	Orange	28/02/2026

	place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.			
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	28/02/2026
Regulation 05(2)	The registered provider shall ensure, insofar as is reasonably practicable, that arrangements are in place to meet the needs of each resident, as assessed in accordance with paragraph (1).	Substantially Compliant	Yellow	30/04/2026