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:	Cairdeas Services Belmont
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Waterford
Type of inspection:	Unannounced
Date of inspection:	20 November 2025
Centre ID:	OSV-0005077
Fieldwork ID:	MON-0048014

About the designated centre

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

Cairdeas Services Belmont consists of two single storey houses based on a campus that is located on the outskirts of a city. The centre provides full-time residential support for a maximum of 11 residents, of both genders between the ages of 40 and 80, with intellectual disabilities including those with additional needs. One house can support six residents while the other can support five residents. All residents have their own individual bedrooms and other rooms throughout the two houses that make up this centre include kitchens, living or sitting rooms, bathrooms and staff offices. Residents are supported by the person in charge, clinical nurse managers, staff nurses and care assistants.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	11

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	09:00hrs to 17:30hrs	Linda Dowling	Lead

What residents told us and what inspectors observed

This inspection was unannounced and carried out with a specific focus on safeguarding, to ensure residents felt safe in the centre they were living in and were empowered to make decisions on their care and how they wished to spend their time.

Overall, this inspection found good levels of compliance across the regulations reviewed, it was evident that residents were in receipt of good care and support in the centre. Improvements were required in governance and management and residents' communication plans, which will be discussed in more detail later in the report.

This centre comprises of two single story properties located a short distance from each other on a campus setting. The centre was home to eleven residents, six in one property and five in the other. The most recent admission to the centre was July 2025.

On arrival to the first property, the inspector was welcomed by the person in charge and was introduced to one resident who was at the kitchen table having their breakfast, also at the table were two members of staff and an student nurse. The remaining five residents in this property were either still asleep or being supported to get up and dressed. The inspector completed a walk around of the centre. The centre was warm, clean and in good state of repair. The person in charge and the inspector completed a brief opening meeting and then went to the second property.

On arrival to the second property residents were seen to be up and going about their day. The first resident the inspector met was sitting in the sun room having their breakfast,they were in good from and smiling. Another resident was at the kitchen table relaxing and another was being supported to have a hot drink while sitting on the couch in the living room. The residents did not interact much with the inspector but they were seen to be well dressed and content. One resident in this property had their own living area at the end of the house this included a en-suite bedroom and sitting room. While they had access to the rest of the house they enjoyed spending time in this area. The inspector asked if it was ok to come in and they agreed. The room was bright and spacious, the resident was observed to be looking out the window and interacted with the person in charge seeking reassurance. The resident agreed when the inspector when asked if they liked where they lived. The remaining resident in this centre was in bed resting, the person in charge informed the inspector they like to go back to bed after their breakfast. When the person in charge knocked on the door and requested we come in the resident declined. The inspector viewed the rest of the second property and found a number of rooms that were identified as relaxing or sensory rooms along with a storage room and an office.

The inspector returned to the first property and based themselves in the visitors

room near the main hub of the house, throughout the day the inspector met with the other residents as they got up. The inspector sat with three residents as they were relaxing in the sitting room listening to music. Residents spoke about trips away and concerts they have recently attended. One resident was seen to lean out their hand to another resident sitting in the chair next to them, the other resident responded and they connected with hand touch. The resident who had moved into the centre during the summer was observed to move around the centre with ease, they listened to music with other residents and then moved to sit in the front sun room.

Overall, residents were seen to approach staff to express their needs and wishes. Staff were observed to be respectful to residents and offer choice and reassurance where required. Residents were also advised of their right to make a complaint and advocacy services available to them through their weekly residents meeting.

The next two sections of the report presents the findings of this inspection in relation to governance and management of this centre and, how the governance and management arrangements impacted on the quality and safety of the service being provided.

Capacity and capability

Overall, the findings from this inspection were positive. The inspector found that there was a clearly defined management structure in place and regular management presence in the designated centre, with a full time person in charge and two clinical nurse managers who were rostered on day and night shifts. However, some improvements were required in quality of the provider audits.

There was a consistent staff team in place and while the centre had some vacant positions the provider was actively engaging in recruitment to fill the positions. The number and skill mix of staff were appropriate to meet the needs of the residents and in line with the statement of purpose. Staff were knowledgeable about the care and support needs of each resident and were seen to support them in line with their will and preference.

Regulation 14: Persons in charge

The provider had appointed a full-time person in charge of the designated centre who was suitably qualified and experienced. The person in charge was responsible for this designated centre only. There were suitable support arrangements in place to ensure effective management of the centre. The person in charge had the support of two clinical nurse managers who covered shifts across both day and night, they also received support from, and reported to the residential service

manager.

The person in charge demonstrated a very good knowledge of the residents including their support needs, wishes and preferences. It was evident the person in charge was spending time in the centre. On the day of inspection positive and respectful interactions and conversations were observed between the residents and the person in charge.

Judgment: Compliant

Regulation 15: Staffing

There was a core and consistent staff team supporting the residents in this centre.

The inspector reviewed rosters from the previous six weeks and found them to be reflective of the staff on duty. Between the two locations seven staff were on duty during the day and three waking staff at night. While some shifts were being completed by agency and relief these were monitored and a focus on consistency was evident.

From review of four staff personnel files the inspector found they were reflective of the necessary documents required under Schedule 2 of the regulations. For example, they all had up -to -date photo identification, complete employee history inclusive of two references and in date Garda Vetting all stored on file.

Team meetings were being held in each location every quarter, the last meeting was held in October 2025. The inspector reviewed the minutes from these meetings for 2025, topics discussed included training, incident and accidents, safeguarding, health and safety and infection prevention and control. Minutes from each meeting were printed and available for staff to review and sign.

Judgment: Compliant

Regulation 16: Training and staff development

There were systems in place for the training and development of the staff team. The inspector reviewed the staff training matrix that was present in the centre.

The inspector found that for the most part staff were provided with the required training to ensure they had the necessary skills to respond to the needs of the residents and to promote their safety and well being. While there was a gap in communication training this is reflected under Regulation 10: Communication. Staff had up -to -date training in areas including safeguarding, fire safety and management of behaviours. They also received specific support needs training in

areas such as dementia and feeding ,eating, drinking and swallowing supports.

The person in charge was ensuring all staff received supervision in line with the provider's policy of once per year. From review of supervision minutes detailed discussions were held on topics such as what is going well, what are the current challenges, any training or additional supports required and follow up on actions from previous meeting.

Judgment: Compliant

Regulation 23: Governance and management

There were clear lines of authority and accountability in this service. The centre had a clearly defined management structure in place which was led by a person in charge. They were supported in their role by the residential services manager.

There was a number of local audits taking place in the centre to a good standard including, medication audits and financial checks on residents' personal finance. These audits were seen to identify areas for improvement and action plans were present and followed up.

Although the designated centre was being audited as required by the regulations, an annual review of the service had been complete for 2024 along with a six monthly unannounced visit to the centre carried out in June 2025. The quality of these audits required review.

The purpose of these audits were to ensure the service was meeting the requirements of the regulations and was safe and appropriate in meeting the needs of the residents. The 2024 annual review of the quality and safety of care and support in the centre had been completed in March 2025. This did not always capture areas in need of improvement and lacked a comprehensive improvement plan with clear time lines for achievement and persons responsible. For example, outstanding staff training at the time of the report was not identified in the audit and therefore lacked a measurable action. This did not promote the completion of outstanding quality and safety issues in a timely manner.

On review of the six-monthly audit completed in June 2025 some areas lacked detail. For example, in the section that reviewed the safeguarding measures in the centre, this part did not reflect the detail associated with the open safeguarding plans in the centre, actions taken by the provider, support given to residents effected or if reports were made to relevant authorities.

Judgment: Substantially compliant

Quality and safety

The inspector found that the quality and safety of care provided for residents, was of a good standard. The inspector observed that the residents had opportunities to take part in activities and to be involved in their local community. Residents were also supported to maintain connections with their families and friends. Some improvements were required in the residents' communication plans to ensure they were reflective of their changing needs.

The premises was spacious and suitable for the needs of the residents living there. Both properties were well maintained and had sufficient communal space for the residents to spend time. The management and staff team were striving to provide a person centred care to the residents in the centre.

Safeguarding concerns were being identified, reported to the relevant authorities and managed well within the centre.

Regulation 10: Communication

The inspector reviewed the processes in place to assist residents' with their communication. It was found that while some supports, in the form of support plans, were in place to help residents' communicate, the inspector found these were not reflective of the changing needs of residents.

On review of two residents' files, the inspector could see that while local management developed communication support plans for the residents, the plans had not been updated to reflect their changing communication needs. For example due to two residents recent decline in health their communication needs and supports had increased. This had not been reflected in their plans or reviewed by a clinical professional and therefore guidance was not in place to guide the staff team to ensure residents could effectively communicate their needs and wishes.

Some residents support plans identified that Lámh signs could be used to help aid their communication. On review of training records Lámh training was not listed, the person in charge informed the inspector that three staff had completed Lámh training and three were booked to attend the next available session in November, this left three staff outstanding this training with no planned date to attend.

Residents were seen to have access to appropriate media such as televisions, radio and the Internet. Some residents daily notes referred to regular phone contact they had with family members.

Judgment: Substantially compliant

Regulation 17: Premises

As mentioned previously the centre comprised of two single story properties located a short distance from each other on a campus setting. The centre was home to eleven residents, six in one property and five in the other. Both locations were reviewed as part of the inspection process. The floor plans outlined in the statement of purpose were reflective of what was seen on the day of inspection.

Both locations were in good state of repair. While their was minor work to be completed, the local management had reported these and a member of the maintenance team was present on the day of inspection to completed some outstanding work. The person in charge was seen to advocate on behalf of the residents for funding to improve and enhance aspects of the centre.

Residents were seen to move around the centre with ease, those who required the use of a wheelchair had bedrooms and en-suites with appropriate space.

On review of the bedrooms in both locations they were seen to be personalised in line with residents' wishes and preferences. Residents had photographs and items of importance on display in their bedrooms.

Judgment: Compliant

Regulation 26: Risk management procedures

Systems were in place to manage and mitigate risk and keep the residents safe in the centre.

There was a policy on risk management and residents had a number of individual risk assessments on file so as to support their overall safety and well being.

The inspector reviewed individual risk assessments for five residents in the centre and found they suitability address the risk, the provider had appropriate controls in place to minimise the risk. The identified controls were also aliening with guidance available in other supporting documents such as behaviour support plans. The person in charge was seen to review all risk assessments regularly.

Additionally, the person in charge was completing quarterly trending of incidents and accidents and sharing learning from this at staff team meeting.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

Not withstanding the need for improvement in Regulation 10: Communication, residents needs had been identified and support plans were in place to guide staff in meeting these needs.

Local management were seen to use universal assessment tools to identify residents' needs. On review of five residents files they had up -to -date personal plans and support plans in place for their identified needs.

Residents were seen to have support plans in place in areas such as, swallow care, diet and nutrition, medication and medical related needs such as bowel management and health failure. These plans were seen to be detailed and reflective of the supports in place to ensure residents were kept safe. For example, one resident who had a diagnoses of heart failure had a support plan in place that detailed the requirement for them to have their weight and blood pressure checked every morning. Evidence of these recordings were reviewed on the day of inspection.

One resident had a specific night time support plan and on review of these the inspector could clearly see how it interlinked with the resident's behaviour support plan and was guided by the behaviour support specialist.

Residents were supported to have circle of support meetings with the families and representatives in attendance, these meetings were seen to review the previous year of the residents' life and plan for the year ahead. Residents had set goals including traveling on a train, attending musical sessions or concerns, and spending more time with family.

Judgment: Compliant

Regulation 7: Positive behavioural support

Residents who required it had behaviour support plans in place. These plans were reviewed by the inspector and found to be in date and appropriately guided staff in the management of behaviours of concern.

From review of the plans in place they identified the behaviours, triggers and early indicators. The plans also guided staff in their responses to the behaviours. and For example, one behaviour support plan has a section on how to manage behaviours when they present in transport. The plans also referred to skill teaching for the resident and de-escalation strategies.

From review of one resident's file and clinical support notes the inspector could see the involvement of clinical supports throughout the first half of 2025, this resident

had been presenting with a number of behaviours of concern that were having a negative safeguarding impact on other residents in the centre. With regular reviews and clinical supports ,including behaviour support and guidance available to staff these behaviours are no longer presenting and the resident appears to be more settled.

There was a number of restrictions in use in the centre including lap belts, bed rails, motion sensors and alarms, to name a few, all of these had been reviewed by the provider's human rights committee and were seen to be appropriate to the needs of the residents. These restrictive practices had also been returned on a quarterly basis to the Chief Inspector of Social Services.

Judgment: Compliant

Regulation 8: Protection

The inspection found that, safeguarding concerns were being identified, reported to the relevant authorities and managed with appropriate control measures in place within the centre. There was ongoing review of the safeguarding plan to sure it was effective.

From review of the documentation it was evident that there was consistent guidance for staff across all documentation such as safeguarding plans, risk assessments, personal plans and positive behaviour support plans and ongoing discussions at supervision and team meetings on the topic of safeguarding. This ensured staff were aware of their role in keeping the residents safe. All staff had received training in the safeguarding of residents, and were aware of the various types of abuse, the signs of abuse that might alert them to any issues, and their role in reporting and responding to those concerns.

The residents were also kept informed about their right to raise a concern and how to make a complaint to the staff team or the person in charge at weekly residents meetings.

Each resident had detailed intimate care plans in place. This plans guided staff in the areas the resident required support and their preferences around these supports.

Judgment: Compliant

Regulation 9: Residents' rights

From review of documentation, discussion with staff members on duty on the day of the inspection and the person in charge and from the inspector's observations,

residents were supported to exercise their rights.

There was a culture of openness in the centre, residents and staff had regular residents meetings where conversations were held on specific topic. For example, restrictive practices within the centre, advocacy, staying safe and I'm not happy.

Residents were also given the opportunity to attend an I'm not happy training session with the provider's social worker. Residents' certificates of attendance were seen to be on file.

Residents were also supported in celebrate milestones such as birthdays, this was discussed at residents meetings, they were supported to purchase sweet treats and sign happy birthday with other peers. Some residents who had significant milestone birthdays also enjoyed planning parties in local community venues and invited their extended family and friends.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Substantially compliant
Quality and safety	
Regulation 10: Communication	Substantially compliant
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Cairdeas Services Belmont OSV-0005077

Inspection ID: MON-0048014

Date of inspection: 20/11/2025

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
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • The 2025 Annual review and provider audits will include a comprehensive improvement plan with clear timelines and persons responsible • The provider will continue to provide training and feedback to auditors around the quality of six monthly audits completed with a view to improving the overall standard of six monthly audits across the region.	
Regulation 10: Communication	Substantially Compliant
Outline how you are going to come into compliance with Regulation 10: Communication: • The remaining three staff have been booked in to attend Lámh training in January 2026. • The SLT department has been contacted requesting a review of communication support plans	

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 10(2)	The person in charge shall ensure that staff are aware of any particular or individual communication supports required by each resident as outlined in his or her personal plan.	Substantially Compliant	Yellow	31/03/2026
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.	Substantially Compliant	Yellow	31/03/2026