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:	Comeragh High Support Residential Services
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Waterford
Type of inspection:	Unannounced
Date of inspection:	12 June 2025
Centre ID:	OSV-0005082
Fieldwork ID:	MON-0046736

About the designated centre

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

Comeragh High Support Residential Services consists of one detached bungalow and a smaller terraced apartment both located in an urban area. The centre provides full-time residential support for up to five residents with intellectual disabilities. Some residents attend day services or active retirement groups and others take part in activities from their home. Each resident had their own bedroom. Other facilities in the detached bungalow include a kitchen, a sitting room, a dining room, a utility room and bathroom facilities while the apartment has a bathroom with a kitchen/living area also. The current staffing compliment is made up social care leaders, social care workers and care assistants.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	5

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 12 June 2025	09:10hrs to 17:35hrs	Marie Byrne	Lead
Thursday 12 June 2025	09:10hrs to 17:35hrs	Sarah Mockler	Support

What residents told us and what inspectors observed

This unannounced risk-based inspection was completed by two inspectors over one day. The centre's registration was renewed in December 2024 with an additional condition applied that required the centre to come into compliance with named Regulations by 31st May 2025. The additional condition was applied due to the provider's failure to demonstrate sufficient compliance in these areas in two previous inspections.

The purpose of the current inspection was to provide assurance that safe and good quality care was being provided to residents in this centre. In response to previous inspections and regulatory actions taken, the provider had submitted written assurances to the Chief Inspector of Social Services, that outlined the actions they would take to come back into compliance.

These compliance plans informed the lines of enquiry of the current inspection. Although the inspection found that the provider had implemented a number of actions as outlined in their compliance plan, the actions failed to address the ongoing issues within the centre. Continued improvement was required in the overall governance of the centre, safeguarding and protection, risk management and individualised assessment and personal planning. The issues in relation to these areas of care and support were continuing to negatively impact residents' lived experiences. This will be discussed further in the body of the report.

The designated centre provides a community residential service for up to five adults with an intellectual disability. The centre comprises of two premises in Waterford city. The findings of concern primarily relate to one of the homes associated within the designated centre.

The designated centre comprises a bungalow on its own grounds within a housing estate and one single occupancy apartment located approximately 10 minutes away in a separate location. In the bungalow there is living room, a kitchen come dining room, a utility room, a main bathroom, a shower room, a toilet, a storeroom, staff office and four resident bedrooms two of which have ensuite bathrooms. There is a parking area and small garden area to the front of the house and a garden with a shed to the back. The apartment has a kitchen come living area, a small self-contained garden with a seating area, a main bathroom, the residents' bedroom and a staff office/sleepover room. Overall, residents' bedrooms in each of the premises were personalised and their homes appeared homely and comfortable. One resident's bedroom had been reconfigured to reduce the risk of injuries if they had a fall.

There were five residents living in the centre and the inspectors had an opportunity to meet four of them over the course of the inspection. One resident was in hospital since April 2025 following a serious fall where they sustained significant injuries.

Residents in the centre communicated using a variety of methods of communication including speech, eye contact, body language, sign language vocalisations, gestures and behaviour. Inspectors were informed by staff that for some residents, it was of significant importance for them to have staff who knew them and their communication signals well to best interpret those communication attempts and to respond appropriately.

On arrival, inspectors found that residents living in the house were in the process of getting ready for their day. One resident was up and ready to go to day services and spoke with an inspector about their plans for the day, things they liked to do, their achievements and their goals. Another resident got up and dressed and then joined this resident, a staff member and the inspector in the sitting room. They spoke about their recent birthday celebrations, their plans for the week and about how much they enjoyed going to a retirement group twice per week. Before they left for the retirement group they sang one of their favourite songs for everyone.

The third resident living in the house had a long lie on and the inspectors then had an opportunity to engage with them a number of times in the afternoon. This resident was choosing not to engage in day services and instead day service staff were coming to the centre on average two days per week. On these days the resident was choosing where they wished to go and what activities they wished to engage in, if any. This resident had significant needs in terms of their mobility and was a significant falls risk. A number of protective factors were in place such as the use of rollator and the use of a protective helmet. The inspectors observed, on numerous occasions, the resident mobilising without the use of this equipment. This was a significant risk.

The resident living in the apartment was in the cinema on the morning of the inspection so arrangements were made for an inspector to meet them in their apartment before they went on to their next planned activity. They showed the inspector around their home and communicated with the inspector and staff about some of the favourite activities and their plans for the week. They also communicated their plans to visit and spend time with the important people in the life, and about the staff who would be supporting them this week. The resident was observed to be very comfortable in the presence of the staff supporting them. The staff member spoke about the residents strengths and talents and some recent holidays they had enjoyed. This included overnight stays in hotels and attending music events. They also spoke about the new activities they were exploring with the resident as some of their favorite activities were not occurring during the summer break. For example, they were planning to try golf the week after the inspection.

Inspectors were told and they reviewed documentation to indicate that one resident's care and support needs could no longer be met in the centre and this was being reviewed by the provider at the time of the inspection. In addition, inspectors reviewed documentation that indicated that due to one resident's complex needs and risks relating to safeguarding, they would benefit from an individualised 'wraparound' service. These areas will be discussed further under Regulation 5: Individualised Assessment and Personal Plan and Regulation 8: Protection.

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

Overall, inspectors found the systems for oversight and management of the centre were not effective in addressing ongoing identified issues within the centre, particularly those relating to the assessment and identification of residents' needs, safeguarding and resident compatibility and risk management.

Inspectors found that while there had been some increased management presence in the centre since the last inspection; the provider continued to fail to demonstrate effective governance with significant deficits found in the oversight and monitoring of the centre.

For example, the provider's stated action of assessment and identification of residents' assessed support needs to inform planning for resources/staffing remained incomplete. This did not provide assurance that the supports in place were as required for residents. This inconsistency or potential lack of knowledge regarding residents' needs remained an issue which was having a direct negative impact on the lived experience of residents.

Regulation 15: Staffing

Inspectors found that the provider was not clearly demonstrating that the centre was resourced to meet residents' care and support needs as their assessments and plans did not indicate what the required staffing supports were.

There were a high level of unsupervised falls, which did not assure inspectors that resident safety and quality of care was being appropriately managed at all times. For example, since March 2025 a resident had sustained six unwitnessed falls within the centre. Inspectors reviewed documentation to demonstrate that this resident had 41 incidents relating to falls between January 2024 and March 2025, with one document indicating at least half of these were not witnessed by staff.

Following two falls for a resident in March 2025 where they required medical treatment, the Chief Inspector required further assurances as to the providers ability to provide safe care in this centre. Following this, the provider implemented a number of additional control measures, however, as previously described, inspectors observed a resident mobilising without the required assistance/support equipment on a number of occasions during the inspection.

Although some improvements were noted, such as a change in working hours, reduction on the reliance of agency staff and the maintenance of a planned and actual roster, it remained the case that the provider had failed to assess the number of staff required in line with residents' assessed needs. In addition, the centre was not fully staffed in line with the statement of purpose at the time of the inspection. Inspectors were informed that efforts were being made to ensure continuity of care and support for residents through the used of regular relief or agency staff.

Inspectors reviewed some staff supervision records and recent staff meeting minutes which detailed concerns raised by staff in relation to low staffing numbers to meet residents' complex and changing needs, resident compatibility and difficulties implementing control measures in open safeguarding plans.

Judgment: Not compliant

Regulation 23: Governance and management

Overall, the inspectors found that the provider had not ensured that effective systems were in place for governance and management in this centre. This is an area that the provider had failed to meet compliance with since 2018.

Inspectors found that the provider's latest six-monthly and annual review were not available for review in the centre. These were sourced from the provider later in the inspection; however, following a review of these and a sample of area-specific audits completed in the centre, there was no evidence to show that the actions following these reviews were being completed or were leading to improvements in relation to residents' care and support and the day-to-day operation of the centre. In addition, the provider had failed to complete the latest six monthly review in line with the time-frame required by the regulations.

Inspectors were shown a quality improvement plan which combined the actions from the provider's compliance plan following the last inspection and a representation they submitted to the Chief Inspector. This showed that the majority of actions had been completed or were in action; however, over the course of the inspection inspectors found that sustained improvement had not occurred as evidenced in the levels of non compliance with regulations reviewed during this inspection.

In addition, the provider had not ensured that there were effective systems for the assessment, management and ongoing review of risk in the centre. Since the inspection in December 2024, the provider had submitted three statutory notifications in relation to a number of falls within the centre which resulted in two residents requiring medical attention in a hospital setting. Although a number of actions were completed, the provider had failed to complete a comprehensive incident review, particularly following a significant fall for one resident. This resident had sustained serious injuries and remained in hospital following an unwitnessed fall

in the centre that occurred in April 2025. Inspectors were informed that consideration of the current placement was now under review due to a change of need following the residents fall. Considering the serious nature of this incident, the completion of a serious incident review or other such measures is critical in ensuring sufficient oversight and identification of learning so as to proactively manage/prevent reoccurence of similar incidents. This had not taken place.

Judgment: Not compliant

Quality and safety

The findings of the current inspection did not provide assurances that residents in this centre were in receipt of a high quality safe services. Some improvements were noted which included, environmental enhancements, a review of restrictive practices, a decrease in the reliance on agency staff, changes to staffing rosters, and additional staff training. However, concerns remained in relation to safeguarding and the compatibility of residents in the centre. This will be discussed further under Regulation 8: Protection.

In addition, assessment of needs were not effective in identifying residents needs or the level of staffing supports required to deliver care in a safe and effective manner. This will be discussed further under Regulation 5: Individualised Assessment and Personal Plan.

Regulation 5: Individual assessment and personal plan

Overall, inspectors were not assured that residents' needs were being appropriately assessed and reviewed as required to reflect changing and emerging needs.

As previously mentioned, as part of the compliance plan response the provider had committed to completing assessment of needs for each of the residents within the home. Inspectors reviewed the documentation in place and were not assured that residents' needs had been appropriately assessed. For example, on review of one assessment of need on file it failed to identify that the resident had a diagnosis of Dementia. The inspector brought this to the attention of the person in charge and they later presented a copy that did account of this diagnosis. However, on further review of this resident's documentation it was found that previous recommendations in relation to his Dementia diagnosis had not been followed or accounted for. A Dementia support plan dated 1st October 2023 had recommended that a formal review of this diagnosis in a 12 month period. This had not occurred and this information was not present in the current assessment of need.

The assessment of needs completed failed to account for the level of staffing within

the centre. An inspector reviewed all falls accounted for in the accident and incident reports. As previously described, since March 2025 one resident had sustained six unwitnessed falls within the centre, and another resident remained in hospital following an unwitnessed fall. This lack of robust assessment was having a direct impact on resident's supervision and safety.

Additionally, the overview and assessment of falls from suitably qualified health and social care professionals was not occurring in line with best practice. One resident had 10 documented falls from March to June 2025. Two of these falls had resulted in medical care in a hospital setting. The inspector requested the assessments completed by relevant health and social care professionals in relation to this need. Although an environmental assessment had been completed no other review such as a physiotherapy assessment had occurred in relation to this need. The most recent physiotherapy report on file was dated in 2019. It was explained to inspectors that the resident attended a physiotherapist on a private basis however, there were no progress/clinical notes available in relation to these visits, or formal review of the resident's need within the centre.

As previously mentioned, the inspectors reviewed numerous documents completed by the provider that indicated that one resident required an individualised wrap around service. This included a review of a Disability Support Application Management Tool (DISMAT) that had been completed in relation to this resident in March 2025. Although this tool had been filled out, it had not been escalated through the appropriate management channels, was not submitted to the relevant funder and when the inspectors requested further information in relation to this improving the residents service, the management team were unable to provide any assurances that progress in this matter was underway.

Judgment: Not compliant

Regulation 8: Protection

Inspectors found that the provider had failed to recognise, respond to and address resident compatibility and safeguarding issues in this centre.

There were four safeguarding plans within one house. These related to the primary matters of resident incompatibility. The inspectors reviewed all four safeguarding plans and found that while there were some measures in place to try to keep residents safe, staff were continually raising concerns about resident compatibility and difficulties implementing control measures in safeguarding plans at supervision and at a recent staff meeting. Inspection findings indicated that the approach and the culture in relation to safeguarding was not in line with National Policy or the requirements of the regulations.

There were identified resident incompatibilities with the peer group in the centre. From March to June 2025 there were three documented occasions whereby a

number of residents were re-directed to their bedrooms due to behaviours of concern occurring in the centre.

An inspector completed a review of all incidents within the centre from March to June 2025 there were six documented incidents that fell under the threshold of a potential safeguarding concern that were not identified as such, investigated or reported to the relevant agencies as required. This included peer to peer allegations and allegations in relation to staff. This issue had previously been identified in inspection reports. However, the actions taken to date had been ineffective in ensuring safeguarding was been consistently identified.

On further discussion with the staff members present, it was stated that one resident had a history of making allegations that were deemed to have not occurred. However, there was no system in place to manage this care need. There was very limited guidance for staff and the provider had no evidence that they had consulted with the Safeguarding and Protection Team in relation to how this safeguarding risk was managed.

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	Not compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 8: Protection	Not compliant

Compliance Plan for Comeragh High Support Residential Services OSV-0005082

Inspection ID: MON-0046736

Date of inspection: 12/06/2025

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	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • The staffing complement in the centre is being reviewed in light of the assessment of needs of the individuals which is currently underway. Pending completion of the assessment of needs additional staffing has been put in place from 20.00 to 12.00 mid-night to provide increased oversight of the individual who is a falls risk. • Recruitment for one vacant position for reduced hours of permanent staff has been undertaken. • Issues/concerns identified from staff supervision meetings will be formally escalated by the PIC to the Services Manager for action.	
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 the governance and management arrangements of the centre is being undertaken to address the shortcomings found by the inspection. • A 6 monthly audit has been completed and the Quality Improvement Plan will be updated to reflect actions arising therefrom. Going forward we will ensure that the 6 monthly audits are completed within the required time frame and any actions identified are added to the Quality Improvement Plan and acted upon as promptly as possible. Additional oversight will be put in place to ensure actions are expedited within a timely manner. • Action has been taken to ensure that there is appropriate review of incidents/ accidents in line with our Policy on the Management and Reporting of Accidents, Incidents and	

Critical Incidents.
• Following the assessment of needs should additional staffing be required a DSAMT will be completed and forwarded to the HSE

Regulation 5: Individual assessment and personal plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
• A comprehensive assessment of needs for all individuals supported in the designated centre is being undertaken by the Multi-Disciplinary Team, this review will identify the staffing requirements to support the assessed needs of the individuals. These assessments will be subject to ongoing reviews in line with changing needs
• Additional staff resources have been introduced to mitigate additional risk of falls and provide additional supports.
• One resident who has poor posture and recurring falls has had a full medical review with his GP. He has been re-assessed by Neurology with a recommendation of changes to his medication in managing his seizure activity.
• The resident had a full OT assessment on 19/3/2025 however arising from an increase in falls he was re-referred. He was reviewed on 25/7/2025 and recommendations arising from this assessment will be actioned.
• A re-referral has been made for a physiotherapy assessment.
• A comprehensive risk assessment and falls care plan are in place for one individual
• The Health and Safety Manager has carried a review to assess the current environment in light of the falls risk. Recommendations following this assessment have been completed.
• The Person in Charge alongside the staff team of the designated centre will ensure that all support plans are reviewed within the identified timeframes.
• The MDT will ensure adequate oversight of risk assessments/ restrictive practices within the identified timeframe.
• The individual with a dementia diagnosis has transferred to a more appropriate residence

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
• One resident has transferred to an alternative residence due to changes in his physical and medical needs. This has significantly reduced the number of safeguarding concerns within the designated centre.

• Following the Inspection a MDT review was undertaken with the Designated Officer to review the safeguarding concerns identified and actions arising from this review are underway.
• Existing safeguarding plans were reviewed and amended to reflect the current position in the residence with the Multidisciplinary team and Designated officer on the 21.07.2025. These will be subject to ongoing review with the Management and Monitoring team
• All documented concerns or allegations of abuse will be addressed through the organisations safeguarding policy and will be notified via the portal to HIQA within the timeframe.
• Retrospective notifications have been submitted for the concerns identified during the inspection

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 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.	Not Compliant	Orange	30/10/2025
Regulation 15(3)	The registered provider shall ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.	Substantially Compliant	Yellow	30/10/2025
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to	Not Compliant	Orange	30/10/2025

	ensure the effective delivery of care and support in accordance with the statement of purpose.			
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	30/10/2025
Regulation 23(1)(d)	The registered provider shall ensure that there is an annual review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards.	Substantially Compliant	Yellow	12/06/2025
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on	Not Compliant	Orange	30/12/2025

	the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.			
Regulation 05(1)(b)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out subsequently as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.	Not Compliant	Orange	31/08/2025
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	31/07/2025
Regulation 08(3)	The person in charge shall initiate and put in place an Investigation in relation to any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.	Not Compliant	Orange	31/07/2025