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:	15 October 2025
Centre ID:	OSV-0005082
Fieldwork ID:	MON-0047901

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:	4

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
Wednesday 15 October 2025	09:20hrs to 16:30hrs	Marie Byrne	Lead
Wednesday 15 October 2025	09:20hrs to 16:30hrs	Sarah Mockler	Support

What residents told us and what inspectors observed

In July 2025, the Chief Inspector of Social Services issued a notice of proposed decision to cancel the registration of this centre. This was due to the continuous failure of the provider to implement actions to come into compliance with key regulations, which was having a direct impact on the quality and safety of care provided for residents.

The provider responded to the notice with a written representation, outlining the actions that they would take to address the areas of concern.

The purpose of this inspection was to ensure that residents were safe and well cared for and that appropriate action was being taken by the provider to move back into compliance in this centre. The inspection was unannounced and completed by two inspectors of social services over one day.

Overall, the findings indicated that the provider had made progress in a number of areas and had achieved improved levels of regulatory compliance which was having a positive impact for residents. Examples of areas where improvements had occurred related to the quality and safety of care and support for residents, particularly relating to risk management and safeguarding. However, a number of key actions were still in progress and had not yet been completed. These actions related to governance and management, staffing and residents' assessments of need. These areas will be discussed further later in the report.

Comeragh High Support is a residential service providing full-time care and support for up to five residents with an intellectual disability. The centre comprises a bungalow and an apartment in Waterford City. There were four residents living in the centre at the time of the inspection. One resident had transitioned to another designated centre since the last inspection and the provider had committed to not admitting any further residents until levels of compliance improved in the centre. Inspectors visited one of the two premises during the inspection as the findings of previous inspections related primarily to this area.

During the inspection, inspectors had the opportunity to meet and speak with a number of people about the quality and safety of care and support in the centre. This included meeting the three residents living in the centre, two staff, a person participating in the management of the designated centre (PPIM) and the Director of Services. The person in charge was on unplanned leave. Inspectors also had an opportunity to speak two members of one residents' family and to meet the provider's compliance manager via video conference. Documentation was also reviewed throughout the inspection about how care and support is provided for residents, and relating to the actions detailed in the provider's compliance plan and representation.

Over the course of the inspection, inspectors had an opportunity to complete a walk

around of the bungalow and to speak to residents and staff. On arrival one resident greeted inspectors at the door. They were getting ready to go to an advocacy conference. They were staying in a hotel for two nights and spoke about how much they were looking forward to it. They had just gotten their nails and hair done and gone shopping for clothes for their trip.

Another resident were engaging in their morning routine and later showed inspectors their new double bed which had a remote control to change positions. They said they were very happy with their new bed. They left soon afterwards to attend a retirement group. The third resident had just gone back to bed after their breakfast. Inspectors had an opportunity to meet with them later in the morning as they got up for a hot drink and snack prior to getting ready to visit their family.

One residents was attending day services five days a week and another resident was attending a retirement group two days per week. Inspectors were informed that the third resident had a full-time day service placement but was choosing not to attend. At the time of the last inspection day service staff were attending the centre regularly to ensure this resident had opportunities to engage in activities outside the centre. However, inspectors were informed that in recent months this had not been occurring.

Inspectors found that the staff team was working hard to ensure that residents were safe, well cared for and accessing meaningful activities. Staff spoke about some of the improvements that had occurred since the last inspection. They said increased staffing in the evenings was providing opportunities for residents to engage in exercise in their local community. They also spoke about the positive impact of reduced resident numbers in the centre and a reduction in risks relating to falls and safeguarding. Over the course of the inspection, inspectors observed residents being supported in a kind and caring manner by the staff team.

Overall, while improvements had been made in relation to risk management and safeguarding, it remained the case that improvements were required in areas such as governance and management, staffing and residents' assessments of need.

The next two sections of the report present the findings in relation to the governance and management arrangements in the centre and how these arrangements impacted on the quality and safety of residents' care and support.

Capacity and capability

Inspectors found that while some improvements had been made since the last inspection, improvements were still required in relation to governance and management within the centre. This is an area where the provider has failed to achieve compliance since 2018.

As previously mentioned, in July 2025, the Chief Inspector of Social Services issued

a notice of proposed decision to cancel the registration of this centre and the provider responded to the notice with a written representation, outlining the actions that they would take to address the areas of concern. The provider's representation did not provide sufficient assurances so the Chief Inspector requested requested further assurances from the provider, which were provided. The actions from the representation, the further assurances letter and the provider's compliance plan response following an inspection in this centre on the 12 June 2025 were reviewed as part of the this inspection. While some improvements had been made, particularly relating to risk management and safeguarding, some key actions remained outstanding and these will be discussed further under Regulation 23: Governance and Management.

The person in charge was on unplanned leave on the day of the inspection and the inspection was facilitated by the PPIM.

The provider had recruited to fill the staffing vacancy in the centre and submitted an application to the funder for additional resources. In the interim they had committed to provide additional support hours in the evening; however, this was not being consistently implemented and this will be discussed further under Regulation 15: Staffing.

Regulation 15: Staffing

While inspectors found improvements in relation to staffing numbers and continuity of care and support for residents, further improvements were required to ensure that staffing numbers were fully meeting residents' needs.

The provider had recruited to fill the staffing vacancy in the centre since the last inspection and this was found to be having a positive impact on continuity of care and support for residents. In addition, one resident had transitioned from the centre since the last inspection which had increased staff availability to support residents.

The provider had submitted a disability supports application management tool to the funder in September 2025 to identify a need for additional staffing resources to meet one residents' needs. In addition, the provider had implemented additional staffing for a number of hours each evening to support residents to engage in meaningful activities and to mitigate risks relating to falls. However, based on a review of rosters and time sheets, this additional staffing was not being consistently implemented.

Inspectors reviewed a sample of three months of rosters. A review of July 2025 rosters indicated this evening shift had not been covered on 19 occasions and the August 2025 rosters indicated it had not been covered on 22 occasions. This was discussed with the PPIM who then reviewed staff time sheets and found that the rosters did not match the time sheets and that in July the majority of evening shifts were covered, but gaps were noted in August time sheets. Therefore, rosters were not reflective of staffing arrangements in place. In addition, the rosters for

September 2025 indicated that there were three day shifts where the centre was not fully staffed. They indicated that there was one staff on day duty.

Staff members were observed by inspectors to be caring, supporting residents well and very responsive to residents' needs. They were each found to be aware of their role and responsibilities for the quality and safety of care and support they are delivering. They were also aware of who to raise any concerns about residents' care and support, or the day-to-day running of the centre to.

Judgment: Substantially compliant

Regulation 23: Governance and management

Inspectors found that some improvements had been made in relation to governance and oversight in the centre. However, further improvements were required to ensure that the provider' systems were being fully utilised and proving effective in relation to oversight and monitoring in this centre.

Since the last inspection there had been an increased management presence in the centre For example, the service manager (PPIM) had been in the centre on 31 occasions, the regional service manager (PPIM) on three occasions and the compliance manager on six occasions. In addition, online meetings were occurring regularly to review the provider's quality improvement plan (QIP). However, the person in charge had been on unplanned leave on a number of occasions since the last inspection and inspectors found that the cover arrangements that were put in place, has not been fully effective. The PPIM covered their unplanned leave; however, due to competing demands they were present for limited times during this period.

In line with the findings of the last inspection, six-monthly reviews and the annual review by the provider were not available in the centre. Inspectors acknowledge that the PPIM sourced these documents for inspectors later in the day.

In addition, inspectors reviewed correspondence and documentation submitted to the provider by a residents' representatives which had not been followed up as a complaint in line with the provider's policy.

The documentation reviewed by inspectors included the provider's annual review for 2024, the last two six-monthly reviews by the provider, a sample of 10 daily handovers by staff, staff training and supervision records, two safety audits, a sample of two person in charge audits completed since the last inspection and a staff meetings since the last inspection.

Inspectors reviewed the 15 actions from the provider's representation and found that 73% of actions had been completed and 27% were in progress. Inspectors also reviewed the 21 actions outlined in the further letter of assurance submitted following the representation and found that 81% of actions had been completed and

19% were in progress. Inspectors acknowledge that some of these actions were not due to be fully completed until 30 October 2025.

Inspectors also reviewed the QIP which included the actions from previous inspections and the provider's six-monthly reviews. There were 22 actions relating to the inspection on the 12 June 2025. Of these 77% were marked complete and 33% were in progress. The QIP also included 57 actions relating to the provider's six-monthly review in July 2025. Of these actions 51% were marked in progress, 16% were marked not complete and 33% were marked complete. Inspectors reviewed the six-monthly review and QIP and found that there was no date identified for the majority of the actions to be completed by. Overall, the outstanding actions related to governance and management, staffing, residents' assessments and plans.

Overall following a review of documentation, while they showed that actions were being completed or were in progress, inspectors found that some actions marked as complete were not fully completed, or verified by the provider. For example, three actions relating to staffing were marked complete, but as detailed in Regulation 15, it could not be demonstrated that the additional evening shift was being consistently implemented.

Another example related to staff supervision. The QIP indicated that issues/concerns identified at staff supervision would be escalated to the PPIM, and it was recorded that one such issue was escalated to them. However, inspectors reviewed a sample of seven supervisions where five challenges/issues were highlighted by staff. These included issues related to resident safety, workload and time available to staff to complete documentation. There were no detailed actions identified or dates for completion in these individual supervision records.

The provider remained in breach of an additional restrictive condition which was added to the registration of this designated centre in December 2024. This condition required the provider to come into compliance with Regulation 23: Governance and Management, and Regulation 15: Staffing by the 31 May 2025.

As previously mentioned, while progress had been made, action areas relating to residents' assessments of need, staffing arrangements and the governance and management in the centre, all needed to be brought to a successful conclusion.

Judgment: Not compliant

Quality and safety

Overall inspectors found that progress had been made to the quality and safety of care and support for residents. These improvements particularly related to risk management and safeguarding. However, in line with the findings of previous inspections, it was identified that the provider had failed to effectively assess

residents' care and support needs in order to inform staffing supports.

Regulation 5: Individual assessment and personal plan

Although overall, improvements were noted in the assessment of need process and the reduction in resident numbers meant that residents' needs were overall well met. The assessment process to inform staffing requirements needed further improvements.

As part of the inspection process, the inspectors reviewed the residents' assessments of needs. As part of the provider's response to the Office of the Chief inspector they had committed to reviewing their assessment of need process to ensure the staffing supports were informed by residents' specific assessed needs. On the day of inspection, it was found that assessment of needs were in place, however, they did not inform the staffing supports in the centre. The inspectors reviewed three assessment of need documents. One assessment did not account for the staffing needs for the individual. While two other assessments briefly alluded to staffing it did not accurately reflect the staffing requirements in line with their specific needs.

It was discussed with inspectors that a new assessment of need process would be rolled out in the coming months to ensure staffing supports were assessed accordingly. This action remained outstanding on the day of inspection.

From a review of three assessment of needs and two personal plans. It was found that overall, residents' specific needs were well accounted for and there was good evidence of input from health and social care professional. All assessment of needs had been updated in October 2025. The assessment of need was informing care plans which were guiding staff practice. For example, the inspectors reviewed care plans in relation to epilepsy, falls, osteoporosis and feeding, eating, drinking and swallowing needs.

Judgment: Substantially compliant

Regulation 8: Protection

Inspectors found that the provider's systems for safeguarding residents had improved since the last inspection.

There had been no safeguarding incidents notified to the Chief Inspector since the last inspection. Any previous safeguarding concerns had been closed and the inspectors reviewed correspondence with the safeguarding and protection team that were in agreement with this recommendation. There was also evidence of Multi-disciplinary Team (MDT) discussion of safeguarding. For example, the inspectors

MDT notes dated July 2025, where two previous safeguarding concerns were discussed in detail including the measures in place to ensure the residents' safety.

Inspectors reviewed incident reports since the last inspection and found no incidents relating to safeguarding. Staff who spoke with inspectors were aware of their roles and responsibilities should there be an allegation or suspicion of abuse. They spoke about the reduction of risks relating to safeguarding since a resident transitioned from the centre.

All of staff had completed safeguarding training.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Substantially compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 8: Protection	Compliant

Compliance Plan for Comeragh High Support Residential Services OSV-0005082

Inspection ID: MON-0047901

Date of inspection: 15/10/2025

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • Additional support hours are being provided in the evenings to meet the assessed needs of the individuals. We will ensure that these hours are accurately reflected on the roster and the time sheet. • The support needs of the residents will be kept under review to ensure that appropriate staffing levels are in place to meet assessed needs. If the need for additional support hours is identified this will be escalated to to senior management.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • A Clinical Nurse Manager 2 has been appointed to the PIC role in the designated center. The PIC is currently completely supernumerary in the designated center to ensure appropriate oversight and compliance with the regulations. This will continue until the centre is at a sufficient level of compliance. • The PIC will ensure that the six-monthly audits and annual review are available in printed format at the centre for inspection. • Complaints received in relation any of the residents in the designated center will be managed in line with organisation policy and will be notified to the Complaints Officer.	

• The quality improvement plan has been updated to include dates for the actions to be completed where gaps were present.

• The PIC and the PPIM will work through the quality improvement plan ensuring that dates for completion of actions is met in so far as is possible. Regular meetings are scheduled with the Compliance Manager to ensure oversight of actions.

• A reporting mechanism is due to be put in place to ensure the escalation of information from PIC to Services Manager to Regional Services Manager. This will provide a more robust system of oversight

• Actions on the QIP relating to governance and management, staffing and residents assessments and plans will be prioritised for action

• Concerns raised at staff support meetings will, where possible, be addressed by the PIC or escalated to the Services Manager if required.

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:
• The assessment of need for each individual has been updated to reflect the staffing requirements based on the individuals specific needs.

• A new Assessment of Needs process is being developed which will enhance the process and provide a consistency of approach across the Services. This document will support the provider in ensuring that supports are provided to individuals in line with their assessed need and will include a clear indication of the staffing levels required.

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.	Substantially Compliant	Yellow	30/11/2025
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	30/11/2025
Regulation 15(4)	The person in charge shall ensure that there is a planned and actual staff rota,	Substantially Compliant	Yellow	30/11/2025

	showing staff on duty during the day and night and that it is properly maintained.			
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	31/01/2026
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.	Substantially Compliant	Yellow	31/01/2026