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:	Rathdearg House
Name of provider:	Nua Healthcare Services Limited
Address of centre:	Louth
Type of inspection:	Announced
Date of inspection:	08 July 2025
Centre ID:	OSV-0005449
Fieldwork ID:	MON-0038527

About the designated centre

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

This is a service that provides full-time residential care and support for up to 5 adults with disabilities. The centre comprises of a large detached house and a stand alone apartment on their own grounds in Co. Louth and is in close proximity to a number of large towns and villages. Transport is provided for residents so that they have ease of access to community-based facilities such as hotels, shops, shopping centres, restaurants, cinema, bingo and health clubs. The house is a two-storey dwelling and each resident has their own private spacious bedroom which is decorated to their individual style and preference. Communal facilities include a large state of the art and well equipped kitchen (with two dining areas), three spacious fully furnished sitting rooms/TV rooms (one upstairs), separate utility facilities, adequate storage space and well maintained gardens to the rear and front of the property. The apartment (which is to the rear of the property) comprises of a living/kitchen area and an ensuite bedroom. There is also adequate private parking available to the front and side of the house. The service is staffed on a 24/7 basis and the staff team includes an experienced, qualified person in charge, a team leader, a deputy team leader and a team of assistant support workers.

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
Tuesday 8 July 2025	09:45hrs to 17:45hrs	Raymond Lynch	Lead
Wednesday 9 July 2025	09:30hrs to 15:00hrs	Raymond Lynch	Lead

What residents told us and what inspectors observed

This inspection took place over the course of two days and was to monitor the designated centre's level of compliance with S.I. No. 367/2013 - Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (the Regulations). It was also to help inform a decision on the continued registration of the centre.

On the days of the inspection the inspector found that the overall governance and management arrangements for this centre required review so as to ensure the service was at all times safe and adequate in providing for the assessed needs of the residents. Issues were also found with the staffing arrangements, training and staff development, risk management and fire safety precautions. The provider was required to provide urgent assurances the day following the inspection to address the issues found under training and risk management as detailed later in this report. The provider's response provided assurance that the issues as found on the inspection were being adequately addressed.

These matters will be discussed further, later in the report. Notwithstanding, feedback from one family representative on the service provided was positive and complimentary and on the day of this inspection, staff were observed to support the residents in a patient, caring and person-centred manner.

At the time of this inspection, there were five residents living in the centre and the inspector met with all of them at different times, over the course of the inspection process. Written feedback on the quality and safety of care from all five residents living in the house was also viewed by the inspector as part of this inspection process. Additionally, the inspector spoke with one family representative over the phone so as to get their feedback on the quality and safety of care provided in the centre.

The house was found to be warm, welcoming, clean and generally well maintained on the days of this inspection. The main house comprised of four individual bedrooms (2 ensuite). Communal facilities included a large well equipped kitchen, two dining areas, two furnished sitting rooms/one sun room, separate utility facilities, adequate storage space and well maintained gardens to the rear and front of the property. One of the residents living in the main house had their own private apartment area which was attached to the house. There was also a separate ensuite one bedroom apartment on the grounds of the property which accommodated another resident. There were spacious well maintained garden areas around the property with the provision of adequate private parking to the front and side of the house.

On review of a sample of documentation the inspector observed that some residents living in the centre presented with significant mental health support needs and behavioural issues to include serious self-injurious behaviours. The inspector

observed over the course of this two-day inspection that for some of the residents, their mood and how they were feeling could fluctuate at times during the day because of their mental health needs. For example, some residents seemed in good form and happy in the house (playing music and or singing and or chatting with staff) and seemed to get along together. At other times they were more vocal expressing things that they were not happy about (for example, a resident expressed dissatisfaction to the inspector about another resident after visiting them in their apartment).

One resident asked to speak with the inspector early in the inspection. The resident said that while they had everything they needed, they didn't like the centre and wanted to move closer to home. They were working on a plan to realise this goal and said to the inspector that this was going well for them. They also said that they did not like some staff but liked others, including their key worker. However, in their written feedback on the quality and safety of care which they handed to the inspector, they reported that they made their own choices and decisions, people were kind to them, they had their own money to spend and went on social outings. They also reported that staff knew what was important to them (to include their likes and dislikes), staff provided help when needed, they were included in decisions made about their home and had friends and advocates to support them with decisions. In this feedback they said that they would like to have their own home as the centre was too far from their family and as their family did not drive, it was hard for them to visit. Notwithstanding they said they got to visit family at the weekends and on the second day of the inspection they told the inspector they were going to visit relatives later in the day and were looking forward to this. The inspector also observed that at times the resident appeared to get on well with their housemates and at other times could complain about them. However, they did report in their written feedback that they had made friends living in the centre and while they got along with the people they lived with, it was hard as everyone had different needs. The resident also acknowledged that they had their own issues and could get stressed but did their best to cope and get along with everyone. Over the two days of this inspection, the inspector observed the person in charge and staff interacting with this resident in a professional, person centred and patient manner at all times.

Another resident invited the inspector to see their room. Over the course of this two day inspection, the inspector observed that this resident spent most of their time in their room and or in bed with the support of a staff member on a 24/7 basis. Their room was decorated to their individual style and preference to include things they liked such as pictures of wildlife and sun catchers. They said that they were happy in the house and had everything that they needed. They also introduced the inspector to the staff member supporting them and said that they got on well with staff. They reported that they had everything they needed and could talk to staff if they had any issues. Due to their complex assessed needs, this resident was on 1:1 staffing support on a 24/7 basis. The person in charge said that at night time, the resident's bedroom door was kept ajar and staff were situated outside their bedroom door to monitor them. This 1:1 24/7 staffing support was put in place after the resident engaged in a significant incident of self-injurious behaviour causing serious injury to their arm in December 2024.

The inspector met with two other residents on the first day of the inspection for a short time. One lived in an apartment area within the main house and the other lived in a separate stand-alone apartment to the rear of the house. The resident who lived in the apartment area said that they were happy there and could talk to staff if they needed anything. They also said that they had some pain in their leg. The person in charge explained to the inspector that the resident had arthritis and was being treated for this.

The other resident in the stand alone apartment only spoke to the inspector very briefly and said that they were not happy living in the house. This resident had their own bespoke apartment to the rear of the property decorated to their individual style and preference. The director of operations informed the inspector that this resident would prefer to live closer to their home and plans were in the early stages to support the resident with this move.

The fifth resident spoke to the inspector on and off over the two days of the inspection. They reported that they were happy living in the house and that they got on well with staff. They also said that they were happy with their room. The resident liked to go out and about and on the first day of this inspection, they went shopping to Dublin with staff support and on the second day they went to visit a relative, again with staff support. This resident appeared happy and settled in the house.

Written feedback from these four residents on the quality and safety of care provided in the centre was generally positive but one resident reported that aspects of the service could be better. For example, when asked was the centre a nice place to live and did they make their own choices, one resident answered it could be better. When asked did they choose what to do every day, could they make a phone call in private and did they get on with the people they lived with, again one reported this could be better. However, all reported that staff knew their likes and dislikes and provided support when required. They also said they felt listened to and staff kept them informed about new things happening in their home.

The inspector observed that at times, compatibility issues (which could sometimes result in safeguarding concerns and where required, had been notified to the Chief Inspector) could occur between the residents and they could complain about each other. However, each resident had allocated 1:1 staffing support each day and two had their own separate living facilities so residents could spend time apart if they wanted to. Additionally, staff working in this centre had training in safeguarding and three of them spoken with said that if they had any concerns about the welfare of the residents, they would report them to the person in charge.

While the inspector observed that the staff were very attentive to the needs of the residents over the course of this two-day inspection, it was difficult at times to talk to them at times, as the residents required intensive supports on a 1:1 basis.

One family member also spoke over the phone to the inspector on the morning of the inspection. They reported that they were 100% happy with the quality and safety of care and that staff were responsive, very nice, supportive and easy to deal with. They also said that their relative was doing very well since moving into this

service and that they were happy and content there. They said that their relative was well looked after and they were happy with the care and support provided (to include healthcare-related supports). The service also put in a brand new bathroom for this resident so as to better suit their assessed needs which the family member was complimentary about saying if anything was needed, it was provided for. When asked had they any complaints they said no and that all was good.

Notwithstanding, the feedback from residents and one relative, this inspection found issues with the governance and management of the centre, the staffing arrangements, training and staff development, risk management procedures, fire safety precautions and the statement of purpose.

The next two sections of the report outline the findings of this inspection in relation to the governance and management arrangements in place in the centre and how these arrangements impacted on the quality and safety of the residents lives.

Capacity and capability

The governance and management arrangements for this centre required review so as to ensure the service was at all times safe and adequate in providing for the assessed needs of the residents. Additionally improvements were required in staffing, training and staff development and the statement of purpose.

Following review of the findings from the inspection, in response to concerns raised, the registered provider was contacted the following day to seek urgent assurances regarding staff training and development and risk management.

The centre was led by a qualified person in charge who was only appointed to the centre on 01 June, 2025. Despite their short time frame in this role, they demonstrated a good knowledge of the residents' assessed needs. They were also aware of the their legal remit under S.I. No. 367/2013 - Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (the regulations).

A review of a sample of rosters from June 2025 informed that the staffing arrangements required some level of review and the maintenance and upkeep of the rosters required attention.

Additionally, it could not be evidenced on the day of the inspection that all staff had the necessary training as required taking into account the assessed needs of the residents. Due to the gaps found in staff training, urgent assurances were sought from the provider the day after this inspection 10 July, 2025 that this training would be provided to all staff in a timely manner.

The statement of purpose also required review as it informed that a staff nurse formed part of the staff team and this was not the case at the time of this inspection.

The provider had systems in place to monitor and audit the service. An annual review of the quality and safety of care had been completed for 2024 and a six-monthly unannounced visit to the centre had been carried out in October 2024 and April 2025. However, some actions identified in these audits were not bringing about effective change as one issue to do with medication management kept reoccurring in the centre. This did not provide assurances to the inspector that the auditing process was always effective in addressing some of the issues identified on this inspection in a timely manner.

Regulation 14: Persons in charge

The person in charge was a qualified professional who also had an additional qualification in management.

They were aware of the their legal remit under S.I. No. 367/2013 - Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (the regulations).

For example, the person in charge was aware that the statement of purpose required review on an annual basis or sooner as required by the regulations and aware of their legal remit to notify the Office of Chief Inspector of any adverse incident occurring in this centre in line with the regulations.

Throughout the inspection, the person in charge also demonstrated their knowledge of the residents' assessed needs.

They worked on a full-time basis with the organisation and overall demonstrated that they had the appropriate qualifications, skills and experience required to manage the day-to-day operations of the designated centre.

Judgment: Compliant

Regulation 15: Staffing

A review of a sample of rosters from June 2025 informed that there were staff members on duty each day and night as described by the person in charge on the day of the inspection. However, the staffing arrangements and upkeep of rosters required review.

The statement of purpose clearly indicated that one full-time staff nurse should form the make up of the staff team. While the director of operations said that the centre had access to community nursing support, there was no staff nurse employed in the centre on a full-time basis. The person in charge also informed the inspector that the centre was operating with a shortfall of two staff members however, these shifts were being covered by the current staff team and or staff working in another nearby centre. Taking into account the significant support needs of the residents, this required review.

The risk assessment for safe staffing levels also required review particularly at night time. The rosters presented to the inspector for review for the month of June 2025 showed that the centre had operated with a shortfall of one waking-night staff member on seven occasions. This issue is discussed further under Regulation 26: risk management procedures.

It was also observed that the upkeep of rosters required review so as to ensure they included all staff members full names that worked on all shifts in the centre. For example, when the inspector enquired as to why their was a shortfall of staff on seven particular nights in June 2025, the person in charge reported that some of those shifts had been covered by staff who worked in another centre nearby.

However, those names were not inputted into the actual roster and the inspector could not determine the exact staffing levels for these particular shifts from the roster provided on the day of the inspection. Neither could the management in the centre categorically state the number of times the centre operated with a shortfall.

Notwithstanding, over the course of this inspection staff were observed to support the residents in a kind, caring and person centred manner. They were also observed to be attentive to the needs of the residents. Additionally, a family member spoken with over the phone was also complimentary of the staff team.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Not all staff working directly with the residents were required to have formal and or accredited qualifications so the inspector carefully reviewed the in-service training provided to them. This was to be assured that staff were provided with the necessary training to have the skill set and knowledge to support the residents in line with their assessed needs.

Given the specific support needs and presentation of the residents in this centre, the inspector found that the provision of staff training required review as a number of staff did not have adequate training to support the residents in line with their assessed needs as detailed in the centres' own statement of purpose.

Some residents living in the centre presented with significant mental health and behavioural issues. Their diagnoses included schizophrenia, borderline personality disorder, suicidal ideation, serious behavioural issues (to include serious self-injurious behaviours) depression and anxiety.

However, of the 17 staff working directly with the residents, the evidence as provided to the inspector on the day of this inspection informed the following:

- 9 staff had no training in mental health
- 12 staff had no training in schizophrenia
- 9 staff had no training in borderline personality disorder
- 11 staff were due training in challenging behaviour
- a number of staff had no training in depression and anxiety
- only three staff had first aid responder training.

Qualified first aid responder training was very important in this centre due to risks presented and was an identified control measure in a risk assessment for a resident who could present with self harm resulting in significant injuries that had previously required urgent medical attention. This issue is actioned and further discussed under Regulation 26: risk management procedures.

Providing a high-quality service depends on high-quality training for all staff that is relevant to their role. In turn, because of these significant gaps in training, the inspector had concerns that the quality and safety of care provided to the residents could be potentially compromised. Additionally, the inspector could not determine if all staff working in this service had the adequate skill set and knowledge to meet the assessed needs of the residents in a safe or effective manner.

Given the concerns identified, the day after this inspection on 10 July, 2025, the provider was required to submit urgent assurances that this training would be provided to all staff working in the centre in a timely manner. The provider's response provided assurance that this issue would be adequately addressed in a reasonable time frame. For example, there would always be a qualified first aid responder on duty in the centre from 11 July, 2025 onwards and, by the 23 July, 2025 there would be a total of 12 qualified first aid responders working in the centre. Additionally, all outstanding training regarding mental health and challenging behaviour would be provided to staff that required it, over the next three weeks.

Notwithstanding the issues as identified above, from a review of the training matrix staff had completed the following training:

- safeguarding
- safe administration of medication
- manual handling
- safety interventions
- basic first aid
- protection and welfare
- food hygiene
- hand hygiene

- infection prevention and control
- providing intimate care
- blood pressure
- risk assessment

The inspector asked the person in charge to see hard copies/certificates of the safeguarding training for the nine staff working on day one of the inspection and all nine certificates were presented for review prior to the end of the inspection.

Judgment: Not compliant

Regulation 23: Governance and management

The governance and management arrangements for this centre required review so as the provider could be assured the service provided was at all times safe, effectively monitored and appropriate to the assessed needs of the residents. This was of particular concern as the day after the inspection, the provider had to be contacted to seek urgent assurances around staff training and risk management.

The inspector reviewed the governance matrix for the centre and observed that a significant amount of issues regarding medication management practices were recorded for 2024 and 2025. An internal audit of the centre found medicines and pharmaceutical services non compliant as far back as October 2024. The director of operations informed the inspector that a route cause analysis had been completed post that audit however, the inspector was not assured that the actions arising from this analysis had been effective. This was because a subsequent audit of medicine management practices on 07 April 2025 found that the centre was again not compliant in this area.

Additionally, while the inspector acknowledged that additional training in medication management had been provided to all staff, it was not provided in a timely manner. This was because the second audit found medicines and pharmaceutical services non compliant on 07 April, 2025 however, staff were not provided with that additional training until the first week of May 2025.

Taking into account that the auditing process highlighted this issue twice over a period of six months and the fact that the issue was ongoing from July 2024 to May 2025, the governance systems in place in the centre required review. This was to ensure that the provider could be assured that the service delivered was at all times safe and actions being identified through internal audits, were effective in addressing issues in a timely manner.

The inspector also found that the management of records in the centre required significant review. Good record keeping is a fundamental part of good practice and an integral part of safe and effective care and support. It also guides staff practice, provides evidence for making the right decisions and helps to safeguard the

residents. However, a number of concerning issues with records which could impact on the quality and safety of care provided to residents was identified on this inspection. For example:

- the inspector requested to view the daily monitoring of fluid intake for the month of June 2025 that was required for one resident with polydipsia (a medical definition of excessive thirst which could compromise a persons health). However, most of these records could not be located in the centre (for June 2025) and were not presented for review. This meant that the inspector could not determine if staff were recording this important health-related information on a daily basis as required by the resident's care plans and this did not ensure effective monitoring of the residents daily intake of fluids. This could potentially cause risk to the resident.
- a personal emergency evacuation plan (PEEPS) presented as evidence to the inspector contained conflicting information that was not in line with the practices in the centre. One identified that one resident was not on any identified 1:1 staff support. However, all residents in this centre were on 1:1 staffing support at various times throughout the day. It was also observed that a number of PEEPS required review as they were not updated adequately after a number of fire drills in June 2025 (This issue was discussed in more detail and actioned under Regulation 28: fire precautions)
- the inspector queried when one resident was last reviewed by an optician. This was because their care plans noted that they had refused to attend their appointment in 2024 and another appointment was to be made. Additionally, this was an important check up for the resident as an eye test can detect vision problems and other health issues early on. However, there was no documentation available on the first day of this inspection to inform if this appointment had been made or if the resident had attended an optician on a different date. The person in charge had to contact the optician directly on the day of this inspection to get this information. This did not provide assurances that records stored in the centre were up to date and correct at the time of this inspection or that the resident's care plans were updated accordingly.
- as already identified under Regulation 15: staffing, the upkeep of the actual rosters required review so as to ensure they included all staff members names that worked all shifts in the centre
- the statement of purpose required review as it explicitly stated that that one staff nurse formed part of the staff team when this was found not to be the case on the day of this inspection
- some risk assessment required review. For example, a risk assessment for one resident who could engage in serious self-injurious behaviours stated that there were two qualified first aid responders working in the centre to manage an emergency situation. This was of concern as it meant that there was not a first aid responder on every day. When the inspector enquired about this on the day of the inspection, they were informed that there were actually three staff who were qualified in first aid responder. Additionally, a subsequent phone call with the provider noted that there were four first aid responders working in the centre. This did not provide assurances about the oversight of training, some of which was a critical component to managing

risk in the centre. As well as this, the inspector was not assured that a resident who presented with significant risks causing injury to themselves, could be responded to in a timely manner by a qualified first aid responder. This issue is further discussed under Regulation 26: risk management procedures.

The governance systems in place in this centre did not pick up on some of these specific issues. This was of concern to the inspector as these systems should be in place to ensure that the service delivered was safe and appropriate to the assessed needs of the residents through the ongoing and effective auditing and monitoring process.

Judgment: Not compliant

Regulation 3: Statement of purpose

The statement of purpose is one of the most important documents that the provider was required to have in relation to its services. It is also required to be submitted to the Chief Inspector as part of the provider's application to renew the registration of the centre.

This document should provide accurate details on the staffing arrangements required to meet the assessed needs of the residents. The document submitted for the purpose of renewing of the registration of the centre indicated that one whole time nurse was employed in the centre.

However, this was not the case on the day of the inspection and the centre did not have access to a whole-time nurse as part of the staff team.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

The person in charge was aware of their legal remit to notify the Office of Chief Inspector of any adverse incident occurring in this centre in line with the regulations.

Judgment: Compliant

Quality and safety

The residents living in this service were supported to live their lives based on their day-to-day preferences however, while some reported that they were happy with the centre, one said that they wanted to move nearer to their family as discussed in section one of this report, *'What residents told us and what inspectors observed'*. As already identified, some of the residents could present with mental health-related and behavioural concerns that could result in the risk of significant self harm and this inspection found issues with Regulation 26: risk management procedures. Issues were also identified with Regulation 6: healthcare and Regulation 28: fire precautions.

The management and review of risk required significant review and the day after this inspection on 10 July, 2025, urgent assurances were sought from the the provider that the issues as found under risk management, would be addressed as a priority. The provider's response provided assurance that this issue would be addressed as a priority.

Residents were being supported with their healthcare-related needs and had access, as required, to a range of allied healthcare professionals and multi-disciplinary support. However as discussed under governance and management, the inspector was not assured from the records viewed on the day of the inspection that one resident fluid intake was being recorded correctly. This was a concern and is discussed further under Regulation 6: healthcare.

Systems were in place to safeguard the residents and where required, allegations of abuse and or adverse incidents were being reported to the designated officer, the Chief Inspector and the national safeguarding team.

In terms of the fire evacuation procedures in the centre, the learning from previous fire drills had not been adequately reviewed. This was of concern as some residents had refused to evacuate the centre on two recent fire drills. This did not provide assurances around the ongoing management and review of fire safety measures in centre.

The house was found to be clean, warm and welcoming on the day of this inspection and generally, in a good state of repair.

Regulation 17: Premises

The house was found to be warm, welcoming, clean and generally well maintained on the day of this inspection.

In the main house residents had their own individual bedrooms (2 ensuite). One resident invited the inspector to see their bedroom and it was observed to be decorated to their individual style and preference. One of the resident's living in the

main house had their own private apartment area (which was attached to the house).

There was also a separate ensuite one bedroom apartment to the rear of the property which was housed another resident.

Communal facilities included a large well equipped kitchen, two dining areas, two furnished sitting rooms/one sun room, separate utility facilities, adequate storage space and well maintained gardens to the rear and front of the property.

There were spacious well maintained garden areas around the property with the provision of adequate private parking to the front and side of the house.

Judgment: Compliant

Regulation 26: Risk management procedures

The systems in place to manage and mitigate risk in this service required review.

As identified earlier in this report, some residents living in the centre could present with significant risks related to their mental-health and behavioural-related issues. Some residents were also presenting with significant physical health-related issues due to lifestyle choices they made. It was also observed that one resident presented with a ligature risk and their risk assessment informed that one control measure to mitigate this risk was for staff to have ligature release training. However, it could not be evidenced on the day of this inspection that four staff members had this training.

Overall, this inspection found that a number of staff had inadequate training related to the residents' assessed needs. As identified under Regulation 16: training and staff development, one aspect of providing a high-quality safe service depends upon appropriate training for all staff relevant to the role they carry out. This issue was of concern to the inspector as it was not possible to ascertain if all staff had the required knowledge and or skill set to respond adequately to the the serious risks that residents could present with (for example, suicidal ideation and serious self-injurious behaviour).

Additionally, it could only be evidenced on the day of this inspection that three staff had first aid responder training. A risk assessment for a resident who could present with serious and significant self-harm stated that if the resident caused injury to themselves the first aid responder was to be alerted immediately to attend to the wound. It also stated that if no first aid responder was available, staff were to ring another designated centre (which was a ten minute drive away) to get support from a first aid responder from that centre.

On the night of 16 December, 2024 the resident engaged in a serious and significant episode of self-injurious behaviour by biting into their arm. This resulted in four

wounds two inches in length to their arm, with no skin remaining around the affected area. While an ambulance was called to attend the centre, there was no first aid responder on duty on the night this incident occurred.

The resident re-opened the wound through an episode of self-injurious behaviour on 29 December, 2024 and again, an ambulance had to be called to the centre. There was also no first aid responder on duty when this incident occurred.

This inspector expressed concerns about this issue to the director of operations as staff trained in first aid responder training would have the ability and skill set to manage a medical emergency and could provide immediate and important initial care to the resident, while waiting on an ambulance to arrive to the centre.

Additionally, the risk assessment for safe staffing levels in the centre required review. Information reviewed for one resident outlined that this resident was on 1:1 staffing during the day however, the waking-night staff compliment had increased from two to three in December 2024 to provide direct 1:1 staffing support to this resident on a 24/7 basis. This resident was at risk of self-injurious behavior and had caused significant injury to themselves at that time and this additional 1:1 staff support was a control measure to minimise the risk. This left the other two waking night staff available to care for the other four residents (two residents lived in their own self contained apartments and two in the main house). They also had (if required), the support of one sleep over staff.

However, on the seven occasions over the month of June 2025, the roster informed that only two staff were available to work waking-night duty. When this was the case one of these staff had to provide the 1:1 support to the resident that required it, leaving only one waking-night staff member to provide cover to the residents in the rest of the centre and two apartments when the sleepover staff retired to bed. Taking into account that some residents presented with significant risks (to include serious incidents of self-injurious behaviour and suicidal ideation), this arrangement required review. This was so the provider could be assured the service was adequately resourced at all times to meet the assessed needs of the residents and safely manage the risks that residents could present with in the centre.

The day after this inspection 10 July, 2025 urgent assurances were sought from the provider that there was an adequately trained first aid responder available at all times in the centre to deal with a first aid emergency. The provider responded on 11 July, 2025 to report that four staff on the team had trained as first aid responders and that they had identified a further eight staff to complete this training by 23 July, 2025. This would increase the number of first aid responders in the centre to twelve, which would ensure there was always a first aid responder on shift.

The provider also assured that until the completion of this training, the person in charge would ensure the currently trained first aid responders were rostered on shift until the additional staff were qualified.

Judgment: Not compliant

Regulation 28: Fire precautions

Firefighting systems were in place to include a fire detection and alarm system, fire doors, fire extinguishers and emergency lighting and signage. However, the centre's fire risk assessment, fire drills and a number of personal emergency evacuation plans (PEEPs) required review.

Equipment was being serviced as required by the regulations.

For example:

- the fire detection and alarm system was serviced on 17 February, 2025 and again on 29 May, 2025
- the emergency lighting had also been serviced on 17 February, 2025 and on 29 May, 2025
- and the fire extinguishers had last been serviced in March 2025.

Staff also completed as required checks on all fire equipment in the centre, and from reviewing the training matrix it was noted that they had training in fire safety.

Fire drills were being conducted as required however. For example:

- a drill carried out on 10 June 2025 informed that two residents refused to leave the centre
- two other drills carried out on 17 June 2025 and 22 June 2025 also informed that on both occasions, one resident refused to leave the centre.

However, on review of these residents' PEEPs, and the centre fire risk assessment, the inspector observed that they had not been adequately updated to reflect these issues and did not provide sufficient guidance to staff as to how they should manage a situation were a resident refused to leave the centre in the event of a fire.

As an example; there was no evidence available to inform if the provider had reviewed or considered, if a resident would not leave the centre in the event of a fire, what staff should do or how they should manage such a situation.

This was of concern to the inspector as incidents where residents had refused to evacuate the centre during fire drills was not a once off occurrence. In turn, it was important that risk posed by fire should be subject to ongoing assessment and where required adjusted, based on the needs and behaviours of the residents.

Judgment: Not compliant

Regulation 6: Health care

The residents were being supported with their healthcare-related needs and had as required access to a range of allied healthcare professionals and multi-disciplinary support.

However, as discussed under Regulation 23: governance and management, health interventions for one resident with polydypsia could not be evidenced as consistently recorded on the day of this inspection even though it was included in the management plan for this resident.

The inspector reviewed this residents' personal plans regarding this healthcare need and cross-checked with observations being completed in relation to the implementation of practices in this plan and found that observations in terms of the residents daily fluid intake were not recorded every day for the month of June 2025.

In another plan the inspector crosschecked to see if the resident had attended an optician's appointment and this information was not available in the centre on the day of this inspection. This required review.

Notwithstanding this, from reviewing one residents' file, the inspector observed that they had access to the following services:

- general practitioner (GP)
- optician
- audiology
- dietitian
- psychiatry
- psychology
- behavioural support.

One resident had also been recently reviewed by a plastic surgeon due to the severity of a wound they caused to their arm during an incident of serious and significant self-injurious behaviour (as detailed under Regulation 26: risk management procedures). At the time of this inspection, they also had a wound management care plan in place and their wound was being reviewed and the dressing changed by their GP and/or a nursing professional on a weekly basis.

Judgment: Substantially compliant

Regulation 8: Protection

Policies, procedures and systems were in place to support the residents' safety in this centre.

There were some ongoing safeguarding issues in the centre at the time of this inspection however, these were being recorded, investigated, reported to the designated officer, reported to the national safeguarding team and safeguarding

plans were in place. The person in charge was also aware of their legal remit to notify the Chief Inspector of any adverse incident occurring in this centre in line with the regulations.

The inspector observed over the course of the inspection that at times the residents got on with each other and at times, they could complain about each other. However, they were all on 1:1 staffing support over the course of the day and staff could monitor residents' interactions and intervene where or if required.

The director of operations also informed the inspector that down the line, there were plans to support two residents to move closer to their families.

The inspector also noted the following:

- easy read information on safeguarding was available in the centre/on residents files
- the person in charge said that advocacy was available to the residents
- three staff spoken with said they would raise any concerns with the person in charge if they had any
- one family member spoken with said that they were happy with the quality and safety of care provided in the centre.

Additionally, the inspector noted that staff had training in the following areas:

- safeguarding
- Children First (training in relation to the Children First National Guidance for the Protection and Welfare of Children 2017 and the Children First Act 2015)
- protection and welfare.

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	Substantially compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 6: Health care	Substantially compliant
Regulation 8: Protection	Compliant

Compliance Plan for Rathdearg House OSV-0005449

Inspection ID: MON-0038527

Date of inspection: 09/07/2025

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Substantially Compliant

Outline how you are going to come into compliance with Regulation 15: Staffing:
1. The Person in Charge (PIC) will complete a full review of the rosters and ensure that all rosters clearly identify the shifts rostered and include the full names of all Team Members who have worked or are rostered to work in the designated Centre.

Due Date: 29 August 2025

2. The Centre-specific Risk Register will be reviewed to ensure there is clear guidance on the minimum staffing levels the Centre in the event there are any unfilled shifts, either planned or unplanned.

Due Date: 18 August 2025

3. The assessed needs of the Individual's will be reviewed in full. This will determine whether the need for a full-time nurse on the team is appropriate. The Statement of Purpose may be updated depending on the outcome of this review.

Due Date: 10 September 2025

4. A review of the current Team will be completed; any open vacancies will be actioned with the recruitment team to support with filling the vacancies in line with the Policy and Procedure on Recruitment and Selection.

Due Date: 31 August 2025

Regulation 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
Regulation 16: Training and staff development
Not Compliant

1. A Training Plan to be developed and submitted to the Authority to ensure Team Members are provided with the necessary training to have the skill set and knowledge to support the Individuals in Rathdearg House in line with their assessed needs.

Date Completed: 11 July 2025

2. The Multi-Disciplinary Team will provide additional support to the team to further enhance the team's knowledge and understanding of the Individuals in the Centre and their assessed needs.

a. Behaviour Specialist will provide support with challenging behaviour, section four of the Personal Plan; proactive and reactive strategies, while also advising reaction to Self-Injurious Behaviours and managing of same, a well-being plan and setting events.
b. Clinical Psychology will provide education on understanding of bereavement and impact on everyday life, this will be inclusive of understanding depression, and emotional support.

3. The Person in Charge (PIC) to complete a full review of the Centre Training Matrix to ensure all Team Members have completed all mandatory training.

Due Date: 15 August 2025

4. The PIC will complete Test of Knowledge (TOK)'s for all training completed within the Training Plan.

Due Date: 31 August 2025

5. As part of Continuous professional development all Team Members to complete eight (8) Social Care Modules. These are:
Module 1 – Understanding Intellectual Disability and impact on everyday Life.
Module 2 – Understanding Autism Spectrum Disorder and impact on everyday life.
Module 3 – Understanding Acquired Brain Injury and impact on everyday life.
Module 4 – Understanding Mental Illness and impact on everyday life.
Module 5 – Effective Communication and Active Listening with Individuals with Intellectual Disabilities.
Module 6 – Supporting Individuals with Anxiety.
Module 7 – An Introduction to the role of the professional.
Module 8 – An Introduction to Positive Behaviour Support.

Due Date: 15 September 2025

Regulation 23: Governance and management	Not Compliant

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

1. A Governance Improvement Plan shall be implemented in the Centre and will be overseen by the PIC and Director of Operations.
Due Date: 11 August 2025

2. A Key Event Schedule (KES) linked to the Governance Improvement Plan will be implemented to monitor all actions, assigning responsibilities.

Due Date: 15 August 2025

3. A meeting is to be held with the Centre's Management Team by the Director of Operations about Centre Management's Key Task List, Roles, and Responsibilities and Governance Driven Improvement Plan.
Due Date: 15 August 2025

4. ID360 will be discussed at Nua's weekly Admission, Transition & Discharge (AT&D) meeting. They have been added to the Transition list, and it is planned that they will move to a bespoke standalone environment to meet their current assessed needs which have changed over recent months and to minimize any potential impact on their peers in Rathdearg House linked to ID360's increase in risk behaviors.
Due Date: 31 October 2025

5. The PIC will complete a weekly medication audit which will be submitted to the DOO for review to identify corrective actions and ensure effective measures are taken to address any non-conformances.

Due Date: 12 September 2025

6. The PIC will complete a reassessment of each Team Member's competency in administrating medication. Where non-conformance or significant gaps are identified Team Members will be reassigned to complete classroom medication training.

Due Date: 19 September 2025

7. All Team Members will be reassigned to complete their SAMMS e-training.

Due Date: 12 September 2025

8. The PIC with support from the Administration Manager will complete a review of all Specific Health Management Plan's and supporting monitoring documentation. In

addition, any health-related appointments will be reviewed, scheduled where required and updated in the Centre communication book as well as the Individual's Personal Plan.

Due Date: 29 August 2025

9. The PIC will complete a full review of the rosters and ensure that all rosters clearly identify the shifts rostered and include the full names of all Team Members who have worked or are rostered to work in the designated Centre.

Due Date: 29 August 2025

10. The PIC in conjunction with the DOO will complete a full review of the Statement of Purpose (SOP) and ensure all information is accurate and up to date. Following this review the updated SOP will be submitted to the authority.

Due Date: 10 September 2025

11. On the Floor Mentoring will be completed by Centre Management with all Team Members. In addition, supervision will be conducted by Centre Management with all Team Members as per Supervision Policy.

Due Date: 30 September 2025

12. Administration Manager to attend biweekly, complete supervisor review of paperwork, and provide feedback to PIC and DOO.
Due Date: 05 September 2025

13. A member of the Quality Assurance Team to complete a review on the above actions. The findings from the report to be sent to the Director of Operations (DOO) and Senior Director of Operations (SDOO).
Due Date: 07 November 2025

14. Person in Charge and Director of Operations will meet weekly to review the Governance Improvement Plan progress and identify areas for further improvement.

Due Date: 30 September 2025

15. There will be Twice daily check-in with the Director of Operations by Centre Management to report progress of the action plan.

Due Date: 30 September 2025

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
1. The Person in Charge (PIC) in conjunction with the Director of Operations (DOO) will complete a full review of the Statement of Purpose (SOP) and ensure all information is accurate and up to date.

Due Date: 10 September 2025

2. The assessed needs of the Individual's will be reviewed in full. This will determine whether the need for a full-time nurse on the team is appropriate. The Statement of Purpose may be updated depending on the outcome of this review.

Due Date: 10 September 2025

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
1. Immediate action was taken to ensure there was a First Aid Responder on shift at all times.

Date Completed: 11 July 2025

2. An additional eight (8) Team Members to complete First Aid Responders (FAR) course by 23 July 2025. This will increase the numbers of Team Members who are trained in FAR from four (4) to Twelve (12) and ensuring there is always a FAR on shift. The PIC has ensured there is a trained FAR on shift.

Completed: 07 August 2025

3. The Person in Charge (PIC) and Director of Operations (DOO) to review Individual Risk Management Plans ensuring risks are accurately documented and consistent approach is adhered to through on-the-floor supervision, handovers, and supervisions.

Due Date: 31 August 2025

3. The PIC to distribute and obtain team member signatures on Policy [PL-013 Escalation] and monitor adherence.
Due Date: 31 August 2025

4. The PIC to complete a full review of planned rosters to ensure all shifts are filled. In

the event of any unfilled shifts, roster gaps or sick leave, this is escalated to the DOO and the Relief Coordinator to identify support staff to cover these gaps. Note: If the event any new staff complete a shift in the designated Centre, they have an opportunity to read the relevant plans of the Individual they are supporting.

Due Date:31 August 2025

5. The PIC in conjunction with DOO to complete a full review of all Individual Risk Management Plans (IRMP's) to ensure all risks pertaining to the Individuals are clearly captured with appropriate control measures recorded.

Due Date: 18 August 2025

6. Key risks for the Individuals will be compiled in a summary document. Risks will be rated, and controls will be reviewed to ensure that all appropriate controls are in place. The summary risk document shall be reviewed on a weekly basis by the Acting PIC to ensure that it is fully up to date and reflective of the needs of everyone.
Due Date: 20 August 2025

7. The PIC will complete competency assessments with Team Members on their application and knowledge of risk management practices.

Due Date: 29 August 2025

8. A member of the Quality Assurance Team to complete a review on the above actions. The findings from the report to be sent to the Director of Operations (DOO) and Senior Director of Operations (SDOO).
Due Date: 07 November 2025

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
1. A Schedule will be completed for Fire Drills ensuring a minimum of two (2) fire drills occur in the month of August with one (1) fire drill with minimum staffing levels. In the event of any Individuals refusing to partake in the Centre fire drill an action plan will be developed to support with Individuals with engaging in these drills.
Due Date: 31 August 2025

2. The Person in Charge (PIC) will conduct a full review of all Individuals Personal Emergency Evacuation Plans (PEEPS) ensuring all PEEP's have the most up to date information and outline additional supports where an Individual has refused to engage with a Centre fire drill.

Due Date: 15 August 2025

3. The PIC shall ensure all Individuals Comprehensive Needs Assessments (CNA's) are updated in line with their Peep's.
Due Date: 22 August 2025

4. All Team Members will complete an additional on the Job Fire Walk ensuring they are familiar with all fire arrangements within the designated Centre.
Due Date: 31 August 2025

5. A member of the Quality Assurance Team to complete a review on the above actions. The findings from the report to be sent to the Director of Operations (DOO) and Senior Director of Operations (SDOO).
Due Date: 07 November 2025

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
1. The Person in Charge with support from the Administration Manager will complete a review of all Specific Health Management Plan's and supporting monitoring documentation. In addition, any health-related appointments will be reviewed, scheduled where required and updated in the Centre communication book as well as the Individual's Personal Plan to ensure that:
a. All information reflects current assessed needs.
b. Historical gaps in documentation are rectified with up-to-date clinical information.
c. Ensure all discipline-specific professionals' recommendations are actioned and recorded in agreement with the PIC and Individuals' Keyworker.
d. The most up-to-date and relevant information regarding Individuals' health status or needs are reflected in their Comprehensive Needs Assessments, Personal Plans and consistent across all relevant Care Planning documents.

Due Date: 23 August 2025

2. A member of the Quality Assurance Team to complete a review on the above actions. The findings from the report to be sent to the Director of Operations (DOO) and Senior Director of Operations (SDOO).

Due Date: 07 November 2025

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	10/09/2025
Regulation 15(4)	The person in charge shall ensure that there is a planned and actual staff rota, showing staff on duty during the day and night and that it is properly maintained.	Substantially Compliant	Yellow	10/09/2025
Regulation 16(1)(a)	The person in charge shall ensure that staff	Not Compliant	Orange	15/08/2025

	have access to appropriate training, including refresher training, as part of a continuous professional development programme.			
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.	Substantially Compliant	Yellow	31/10/2025
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	31/10/2025
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Not Compliant	Orange	11/07/2025

Regulation 28(2)(b)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Substantially Compliant	Yellow	31/08/2025
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.	Not Compliant	Orange	31/08/2025
Regulation 03(2)	The registered provider shall review and, where necessary, revise the statement of purpose at intervals of not less than one year.	Substantially Compliant	Yellow	10/09/2025
Regulation 06(1)	The registered provider shall provide appropriate health care for each resident, having regard to that resident's personal plan.	Substantially Compliant	Yellow	26/08/2025