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:	Unannounced
Date of inspection:	09 September 2025
Centre ID:	OSV-0005449
Fieldwork ID:	MON-0047946

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 9 September 2025	07:45hrs to 17:42hrs	Raymond Lynch	Lead
Tuesday 9 September 2025	07:45hrs to 17:42hrs	Caroline Meehan	Support

What residents told us and what inspectors observed

This risk-based inspection took place as a follow up to an inspection of the centre on 08 and 09 July, 2025. The purpose of the inspection in July 2025 was to help inform a decision on the renewal of registration of the centre. However, that inspection found that the overall governance and management arrangements in place were not ensuring the service was at all times safe and adequate in providing for the assessed needs of the residents. Significant issues were also found with the staffing arrangements, training and staff development, risk management and fire safety precautions. The day after that inspection on 10 July 2025, urgent assurances were sought from the provider around staff training and risk management which the provider submitted to the Office of the Chief Inspector on 11 July 2025.

Following that inspection, the registered provider representative was requested to attend a provider warning meeting on 23 July, 2025 with the Office of Chief inspector. This was a formal meeting where the provider received a warning letter outlining specific areas of concern and non-compliance with regulations that were identified by the inspector on the inspection of the service on 08 and 09 of July 2025. At this meeting the provider was also informed that should the necessary improvements not be put in place the Chief Inspector would give consideration to cancelling the registration of the centre.

Because of the issues as found on the inspection in July 2025, the Office of Chief Inspector was not in a position to make a recommendation for the renewal of the registration of the centre. In turn, this risk-based inspection on 09 September, 2025 was undertaken to inform a decision on the renewal of registration. It was also to follow up on the assurances given by the provider (the day after the last inspection) and the compliance plan submitted to the Chief Inspector in August 2025 so as to ensure the issues as identified at that time, were being and or had been addressed effectively.

This inspection focused on specific key regulation that were actioned in the last inspection of the designated centre in July 2025 and was to ensure that the actions as detailed in the providers compliance plan submitted to the Office of the Chief Inspector after that inspection had been put in place and were effective. Additionally, as the inspector had concerns about the oversight and management of medicines in the centre (as identified and actioned under Regulation 23: governance and management in the last inspection), Regulation 29: medicines and pharmaceutical services, was also reviewed as part of this inspection.

While some improvements had been implemented in the centre since the last inspection, a number of issues remained ongoing and the provider had not taken necessary steps to ensure all concerns as found on the inspection of the centre on 08 and 09 July, 2025 had been adequately addressed. This inspection found non-compliance under the following: Regulation 6: healthcare, Regulation 15: staffing, Regulation 16: staff training and development, Regulation 23: governance and

management, Regulation 26: risk management procedures and Regulation 29: medicines and pharmaceutical services. Additionally, Regulation 28: fire precautions was found to be substantially compliant. The issues as found on this inspection are discussed in detail under the relevant Regulations later, in this report.

When the inspectors arrived to the centre at 07.45 am it was quiet as all residents were asleep in bed. They spoke with the shift lead manager for a short time until the person in charge arrived to the house. The inspectors spoke to the person in charge for some time over the course of this inspection and acknowledged this was their second week in the role of person in charge for this centre. Although new to the role of person in charge, they demonstrated an awareness of the role and responsibilities of the person in charge and were found to be responsive to the inspection process. When asked how they intended to address some of the issues as found on this inspection, they informed the inspectors that on floor mentoring and support for staff would be required, going forward all staff would be required to attend staff meetings and also stressed the importance of staff supervision.

Over the course of the day the inspectors met with three of the residents. Two of those residents spoke for some time with the inspectors. One was complimentary of the service provided saying that they were happy in the house and they much preferred it over their last placement. They had plans to go out shopping and go for a coffee and cake with staff support and said that they were looking forward to this trip. They also showed one inspector their bedroom which they said they were happy with. It was also observed to be decorated to their individual style and preference.

The other resident was more varied in their feedback. At times they appeared happy in the house and in the company and presence of the staff team and at other times they complained about things. For example, they raised a concern about a new glass panel that had been installed in the shower room downstairs (the previous panel had broken). However, the person in charge was attentive to the residents concerns and reassured them that they had their own shower room upstairs and reminded them they could use that one instead.

Overall however and as identified above, this inspection found non-compliance under: Regulation 6: healthcare, Regulation 15: staffing, Regulation 16: staff training and development, Regulation 23: governance and management, Regulation 26: risk management procedures and Regulation 29: medicines and pharmaceutical services. Additionally, Regulation 28: fire precautions was found to be substantially compliant.

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 care provided to the residents.

Capacity and capability

This risk-based inspection took place as a follow up to an inspection of the centre on 08 and 09 July, 2025. On that inspection issues were found that the overall governance and management arrangements which 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 day after that inspection on 10 July 2025, urgent assurances were sought from the provider around staff training and risk management which the provider submitted to the Chief Inspector on 11 July 2025. Additionally, the provider submitted a compliance plan on 12 August, 2025 providing assurances that all other issues as found on the inspection in July 2025, would be addressed in an acceptable time frame.

While some improvements had been implemented in the centre since the last inspection, a number of issues remained ongoing and the provider had not taken the necessary steps so as to ensure all concerns as found on the inspection of the centre on 08 and 09 July, 2025 had been adequately addressed.

The governance and management arrangements for this centre continued to require review and, improvements continued to be required in aspects of staffing, training and staff development, healthcare risk management and fire precautions. This inspection also identified issues with medicines and pharmaceutical services.

These issues are discussed in detail later, under the relevant Regulations as set out below.

Regulation 14: Persons in charge

The person in charge was a qualified and registered social care practitioner who also had a post graduate qualification in pharmaceutical business and technology.

This was only their second week in the role of person in charge and although new to the position, they demonstrated an awareness of the role and responsibilities of the person in charge. They were also found to be responsive to the inspection process.

For example, they were able to talk one inspector through some of the notifications as required to be submitted to the Chief Inspector (including the NF39s) and the requirements for updating the statement of purpose.

When asked how they intended to address some of the issues as found on this inspection (and discussed later in this report), they informed the inspectors that on floor mentoring and support for staff would be required, going forward all staff

would be required to attend staff meetings and also stressed the importance of staff supervision

Judgment: Compliant

Regulation 15: Staffing

On the inspection in July 2025, 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, aspects of the staffing arrangements and upkeep of rosters required review. This inspection found that the issues pertaining to the rosters had been addressed however, aspects of the staffing arrangements continued to require review.

In the compliance plan submitted after the last inspection in July 2025, the provider gave assurances that the assessed needs of the residents' would be reviewed in full and this review would determine whether there was a need for a full-time nurse on the team. This review was to be completed by 10 September 2025, the day after the last inspection.

However, when the director of operations was asked how this review had been carried out, they responded by saying one of the residents assessed needs were reviewed via a comprehensive needs assessment and this determined that there was no need for nursing staff to be employed in the centre. This was of concern to the inspectors as assurances were given that this review would be based on all residents residing in the house, not just one individual. Additionally, on review of the resident's comprehensive needs assessment that this staffing review was based on, there was no information pertaining to the actual review itself, or indeed if nursing personnel were required or not in the centre.

In turn, at the time of this inspection the inspectors could not determine if the skill mix of staff was appropriate to the assessed needs of the residents residing in this centre. This was of concern to the inspectors as residents living in this centre presented with significant health-related and behavioural issues.

One inspector spoke with two staff members about medicines prescribed for some of the residents living in this centre. The inspector found that staff had limited knowledge of medicines prescribed. This was of concern, due to the number and nature of medicines prescribed, the potential for adverse effects to be experienced by some residents, the current specific healthcare needs for residents, and the fact that medicines did form an integral part of the therapeutic response to support residents with their mental health needs. Of additional concern was that on the previous inspection of this service in July 2025, a serious concern was raised about the number of medication errors recorded in the service over the preceding twelve months.

Taking the above into account and the fact that the residents had significant health-related issues, the inspectors were not assured that the current skill mix of the staff team was at all times adequate, in meeting their assessed needs.

Judgment: Not compliant

Regulation 16: Training and staff development

The last inspection of this service on 08 and 09 July 2025 identified that not all staff working directly with the residents were required to have formal and or accredited qualifications. In turn, the inspector carefully reviewed the in-service training provided to staff. This was to be assured that they were provided with the necessary training to have the skill set and knowledge to support the residents in line with their significant assessed needs. That inspection found that of the 17 staff working in the centre:

- 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.

This training was important for staff to undertake taking into account the diagnosis and assessed needs of the residents. Because of the gaps found in training urgent assurances were sought from the provider on 10 July 2025, this this issue would be addressed in a reasonable time frame. The provider responded in writing to the Chief Inspector that these issues would be addressed over the months of July and August 2025.

The inspectors acknowledged that on this inspection staff had undertaken some of the additional training as identified above over the months of July and August 2025. However, as a number of certificates of this training were not available on staff files for review on the day of this inspection, the inspectors could not be assured that all staff had completed the required training. Additionally, the folder provided to the inspectors to review the training records required updating as some staff had ceased working in the centre since the last inspection, yet their records had not been removed from the system.

In the compliance plan received from the last inspection on 12 August, 2025, the provider gave assurances that a behaviour specialist would provide staff with support regarding behaviours of concern to include self-injurious behaviours. Clinical psychology was also to provide education to staff on bereavement inclusive of understanding depression, and emotional support. This was to be completed by 15 August, 2025. Additionally, the person in charge was to undertake tests of knowledge for all training completed within the training plan and this was to be

completed by 31 August 2025. However, on the day of this inspection 09 September, 2025 it could not be evidenced if all staff had undertaken this additional training in behavior or bereavement and, some tests of knowledge had not been completed for some staff.

This was of concern to the inspectors as it was identified in the report after the last inspection, that providing a high-quality service depended on high-quality training for all staff that was relevant to their role. In turn, because of the issues as found with training on this inspection, the inspectors continued to have concerns that the quality and safety of care provided to the residents could be potentially compromised. Additionally, the inspectors 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 as some of the evidence required to make this determination, was not available for review.

One inspector asked the person in charge how they intended to address the issue as identified above. They said that since the had started in their role the previous week, they had requested all staff to print of all of their certificates of training and place them in the training folder so as to ensure this folder (which was provided to the inspectors as evidence of compliance with this Regulation), was up-to-date. They also said that they would ensure this would be completed by staff going forward.

The inspectors were also concerned regarding the supervision systems in place for staff. This was because on review of the records of staff meetings for the month of June 2025, it was found that the person in charge and only two staff members out of a team of 17, attended this meeting. In July 2025, it was found that only the person in charge and three staff members out of a team of 17 attended this meeting. This was of concern to the inspectors as staff meetings are an important component to the supervision process as they provided a forum for the person in charge to provide feedback, guidance and support to their staff team.

Additionally, at these meetings important items were discussed and information disseminated to all staff as part of the standing agenda. For example, incidents and accidents were discussed as was risk management, safeguarding, medication errors, learning from adverse incidents and health and safety-related issues. One inspector discussed the process of how learning from incidents (as above) were communicated to staff if only two or three of them were attending staff meetings.

The director of operations outlined that staff were on the emailing list and all actions and learning from staff meetings was emailed to them. However, when one inspector asked, there was no staff available on the day of this inspection to allow for review of emails with learning. In turn, the inspectors were not assured that the current way in which staff meetings were being conducted, was effective in ensuring staff were aware of the ongoing issues in this service or the actions agreed, to help address those issues.

One inspector asked the director of operations and person in charge was attendance at staff meeting optional. They said that it was not and going forward, all staff

would be required to attend staff meetings and rosters would be updated to support this.

Notwithstanding, at the time of this inspection the process of staff training and supervision required review and the upkeep and maintenance of the records presented as evidence of compliance with this regulation required attention.

Judgment: Not compliant

Regulation 23: Governance and management

The last inspection of this service on 08 and 09 July 2025 found that the governance and management arrangements 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. Additionally, the day after that inspection on 10 July 2025, urgent assurances were sought from the provider around staff training and risk management which the provider submitted to the Chief Inspector on 11 July 2025. The provider also submitted a compliance plan on 12 August, 2025 providing assurances that all other issues as found on the inspection in July 2025, would be addressed in an acceptable time frame.

Some of the issues as found on the inspection of the service in July 2025 had been addressed in the agreed time frames as detailed in both the assurances and compliance plan submitted to the Chief Inspector after that inspection. However, a number of issues remained ongoing that required attention.

For example and as found on the last inspection of the centre:

- aspects of some residents healthcare-related plans continued to require review and this issue was identified in the last inspection
- risk management procedures and the overall review of individual risk management plans as identified in the last inspection, continued to require review
- issues related to the staffing arrangements and staff training also identified in the last inspection, continued to require review
- in the compliance plan submitted after the last inspection in July 2025, the provider gave a commitment that the assessed needs of the individuals' would be reviewed in full and this review would determine whether there was a need for a full-time nurse on the team. However, as identified under Regulation 15: staffing above, there was no information pertaining to this actual review available in the centre which meant the inspectors could not determine if the skill mix of staff was appropriate to the assessed needs of the residents residing in this service. This was of concern as residents living in this centre presented with significant health-related and behavioural issues
- one aspect of the fire safety precautions continued to require review.

The issues as identified above are discussed in detail in this report, under the relevant Regulations.

Additional issues were identified on this inspection. For example:

- the policy on escalation and staffs' understanding of this policy required review
- the inspectors were also concerned regarding the supervision systems in place for staff and how staff meetings were being conducted in the centre
- appropriate procedures were not in place for the administration of medicines in the centre, so to ensure that staff who took responsibility for administering medicines to residents were aware of the intended effects and potential side-effects of such medicines

Again, these issue as identified above are discussed in detail in this report, under the relevant Regulations.

Additionally, inspectors reviewed the minutes of two meetings held between the person in charge, director of operations and a member of the quality assurance team. The purpose of these meetings was to review the implementation of the compliance plan submitted to the Office of the Chief Inspector after the last inspection of the service on 08 and 09 July 2025. On one set of these minutes dated 25 August 2025, it was documented that some actions were outstanding but would be closed out by the weekend. However, those actions were not identified in the minutes. In the second set of minutes dated 01 September 2025, one action was identified and that was to review staff training certificates. However, a number of staff training certificates were not available for review on the day of this inspection. In turn, these meetings were not effective in ensuring the the actions as identified from the previous inspection of this service on 08 and 09 July 2025, were being implemented adequately or in the agreed time time frames.

The person in charge had changed since the last inspection of this service in July 2025 and a new person in charge had since been recruited to the centre. Because of this, the inspector sought assurances from the director of operations on 02 September 2025 that the actions as identified in the compliance plan arising from the last inspection had been implemented and or were being implemented within the agreed time frames. Assurances were provided in writing that the compliance plan from the inspection in July 2025 inspection would be completed within the agreed time frame. However, this inspection found that was not the case as a number of actions were not or could not be evidenced as being addressed adequately.

In turn, the auditing systems in place in the centre were ineffective as at the time of this inspection, they did not identify the issues as detailed above.

Taking into account the above issues and the cumulative findings on this inspection, the overall governance and management arrangements in place on this centre continued to require review so as to ensure the service provided was safe, appropriate to the needs of the residents, consistent and effectively monitored.

Judgment: Not compliant

Regulation 3: Statement of purpose

The statement of purpose had been reviewed since the last inspection and had been updated to reflect the recent changes to the person in charge role in the centre.

It contained the overall aim and objectives of the service and, the facilities to be provided to the residents.

The statement of purpose had also been updated to reflect the need that there was no requirement for nursing staff to work in this centre. However, the staffing review which determined this decision was inadequate and this issue was discussed and actioned under Regulation 15: staffing.

Judgment: Compliant

Quality and safety

As identified in in the last inspection of this service on 08 and 09 July 2025, some residents could present with mental health-related issues and behavioural concerns that could result in a risk of significant self harm and that inspection found a number issues with Regulation 26: risk management procedures. Issues were also identified with Regulation 6: healthcare and Regulation 28: fire precautions.

While some significant issues pertaining to risk had been addressed in the centre since the last inspection, this inspection found that the process of risk management continued to require review. Additionally, issues remained ongoing with regard to Regulation 6: healthcare and Regulation 28: fire precautions since the last inspection of the service in July 2025. This inspection also found Regulation 29: medicines and pharmaceutical services not-compliant.

The management and review of risk continued to require review as some of the issues as found on the last inspection had not been fully addressed.

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 with the last inspection, issues remained ongoing with some residents' healthcare-related plans.

Additionally, while most of the issues as found under in Regulation 28: fire precautions had been addressed since the last inspection, one issue remained outstanding.

This inspection also found that appropriate procedures were not in place for the administration of medicines in the centre, to ensure that staff who took responsibility for administering medicines to residents were aware of the intended effects and potential side-effects of such medicines.

These issues are discussed in more detail under the relevant Regulation as set out in the next section of this report.

Regulation 26: Risk management procedures

The last inspection on 08 and 09 July 2025 found issues with the management of risk and, some of those issues had been addressed by the time of this inspection. However, some issues had not been adequately addressed.

For example, at the last inspection in July 2025 it was identified that a control measure to manage a risk related to serious self-injurious behaviour exhibited by one resident required review. This control measure directed staff to make contact with another designated centre (about a 10 minute drive away) for support if there was no first aid responder on duty to provide immediate first aid assistance to this resident who was at risk of serious self-injurious behaviours. The inspectors expressed concerns about the appropriateness of this control measure as a first aid responder should be available to provide immediate assistance to this resident at all times when or if required. On 11 July 2025, the provider gave assurances to the Chief Inspector that there would be a first aid responder on shift at all times. Additionally, in their compliance plan received on 12 August 2025, it was noted that an additional eight staff members would complete first aid responder training by 23 July 2025. This increased the numbers of qualified first aid responders working in the centre from four to twelve and the provider assured that there would always be a qualified first aid responder on shift.

However, on review of a risk assessment for the resident at risk of serious self-injurious behaviour, the inspectors observed that the control measure of contacting a difference service a 10 minute drive away for first aid support if required, was still in place. This did not provide assurances that the management team had completed a full or effective review of all individual risk management plans as detailed in the compliance plan submitted to the Office of the Chief Inspector after the last inspection of the centre. This was concerning as this review was to ensure all risks pertaining to all individual residents were clearly documented with appropriate control measures recorded. These documents were also important as they were in place to guide staff practice.

Additionally, in the compliance plan received after the last inspection, the provider informed that all risks for the residents would be compiled in a summary document.

Risks would be rated, and controls would be reviewed to ensure that all appropriate controls were in place. This summary risk document was to be completed by 20 August 2025, and reviewed on a weekly basis to ensure that it was fully up to date and reflective of the needs of all residents.

However, in the risk summary document provided to the inspectors on the day of this inspection, some of the most significant risks in the centre were not identified. For example, some residents were at risk of serious self-injurious behaviour (as identified above) and could present with suicidal ideation. Additionally, there were risks of peer-to-peer related verbal abuse. None of these issues were identified in the risk summary document provided to the inspectors. The previous person in charge was also to complete competency assessments with staff on their application and knowledge of risk management practices by 29 August 2025. The inspectors asked to see evidence of these assessments on the day of this inspection however, they were not made available for review. Therefore inspectors could not evaluate if staff had been assessed or not.

The compliance plan submitted to the Office of the Chief Inspector after the last inspection of this service in July 2025 also committed to ensuring that the policy on escalation would be distributed to all staff working in the centre and that their signatures would be obtained so as to monitor adherence to this policy. On the day of this inspection, this policy had to be printed for the inspectors to review and there as no evidence provided that staff had actually read it as the signature sheet was not presented for review on the day of this inspection.

Additionally, and as detailed under Regulation 06: healthcare, one inspector noted a resident's blood pressure had not been recorded in their file since April 2025, and the personal plan specified that blood pressure was to be monitored every month. At the end of the inspection the director of operations told the inspectors that due to a risk related to this resident, their blood pressure was not to be taken by staff in the centre, and was only to be recorded at hospital appointments. The director of operations outlined this was documented in risk management plans. However, on review this residents individual risk management plan, it was stated their blood pressure was to be taken and recorded every month. Again, this did not provide assurances that the management team had completed a full or effective review of all individual risk management plans as detailed in the compliance plan submitted to the Office of the Chief Inspector after the last inspection of the centre in July 2025. It was also of concern to the inspectors as individual risk management plans were in place to guide staff practice, so it was important they were reviewed as required and contained accurate up-to-date information.

The inspectors also reviewed records of closed incidents since the last inspection in July 2025. While incidents forms had been completed, there was a lack of evidence that learning from incidents was identified or reviewed with the staff team, so as to implement actions to prevent a re-occurrence. In addition, where a debrief was identified as being required, this was not consistently recorded as completed.

For example, there was no learning identified for an incident involving a resident in August 2025, and the incident records had been signed off by the staff member. In

another instance where the incident records identified learning was identified, there was no record of what this learning was. The inspector discussed the process of how learning from incidents were communicated to staff, and the person charge outlined these were emailed to staff and were documented in the handover document within seven days for all staff to read. However, when asked, there was no staff available on the day of this inspection to allow for review of emails with learning.

Additionally, the handover notes reviewed for the period around these incidents did not refer to any learning from recent incidents, and consistently documented learning from one incident that had occurred in June 2025. The director of operations also confirmed that incidents should be discussed at handovers, emailed to staff and at staff meetings. This was of concern to the inspectors as learning from incidents helps improves the safety of the service and helps prevent further re-occurrences of adverse incidents.

Judgment: Not compliant

Regulation 28: Fire precautions

As found in the last inspection of this service on 08 and 09 July 2025, firefighting systems were in place to include a fire detection and alarm system, fire doors, fire extinguishers and emergency lighting and signage and equipment was being serviced as required. Additionally, most of the issues as identified under this regulation in the last inspection had been addressed.

For example, a schedule was completed for fire drills in the centre and a full review of all residents PEEPs had taken place with the most up to date information and supports required for residents that may refuse to engage in fire drills.

The compliance plan submitted after the last inspection provided assurances that all staff members would complete an additional on the job *'fire walk'* which was to ensure they were familiar with all fire arrangements within the designated centre. However, on this inspection it could not be evidenced that all staff had completed this additional '*fire walk'.*

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

Appropriate procedures were not in place for the administration of medicines in the centre, to ensure that staff who took responsibility for administering medicines to residents were aware of the intended effects and potential side-effects of such medicines.

Appropriate medicines management requires that the person (s) who administer medicines to residents are aware of the reasons a medicine is prescribed and the possible side effects. This is to ensure that staff can monitor if a medicine is improving symptoms for a resident, and to take action and seek medical advice if the resident is experiencing unwanted side effects. The inspector reviewed medicine management with two permanent staff on duty on the day of inspection, and found staff had limited knowledge of the reasons medicines were prescribed for residents. For example, one staff was not aware of why five of six medicines were prescribed for a resident, and had very limited knowledge of the purpose to the sixth medicine prescribed. The staff outlined how the doctor was responsible for prescribing the medicines, and they were only responsible for administering medicines, and they did not want to speak about this as they did not prescribe the medicines.

The inspector spoke to a second staff member and they stated they would know why some medicines were prescribed for two residents, however, on review with the inspector, the staff also had limited knowledge of medicines prescribed. This was of concern, due to the number and nature of medicines prescribed, the potential for adverse effects to be experienced by some residents, the current specific healthcare needs for residents, and the fact that medicines did form an integral part of the therapeutic response to support residents with their mental health needs.

The inspectors reviewed the medicine management policy in the centre, and this stated that all staff administering medicines must be educated and trained, and the provider ensures the provision of appropriate training and learning opportunities for staff to competently administer medicines. This was discussed with the director of operations who outlined all staff working in the centre should know why medicines were prescribed for residents, and the potential side effects of these medicines. The inspectors also discussed concerns regarding staff knowledge of medicines in use in the centre, and the director of operations outlined the person in charge had been working through staff competencies.

The inspectors reviewed records of recent medicine management competencies for the two staff, however, one staff had only commenced this the day before the inspection, and while the second staff member had completed three recent competency checks, this had not included checking staff knowledge of medicines uses and of potential side effects. Therefore, there was no arrangement in place for the provider to assure themselves that staff were competent in their knowledge of medicines used in the centre.

Medicines were supplied by a pharmacist in the community, and most medicines were packaged in monitored dosage systems. Medicines were stored in individual locked medicine cabinets for each resident, and the keys were securely stored in a coded locked press. Medicines cabinets were observed to be clean and organised.

The inspectors reviewed medicines prescription and administration records, and all medicines prescribed were appropriately documented, with the name of the medicine, time, dose, frequency, route and were signed by the prescriber. PRN (as needed) medicine prescription records also stated the circumstances for administration of these medicines, as well as specific instructions regarding timing

between doses for some medicines. The maximum dosage in 24 hours of each PRN medicine was clearly documented. The inspectors reviewed a sample of administration records over a two week period, and all medicines had been recorded to be administered as prescribed.

Overall the inspectors found the medicines management systems were not safe, and were not ensuring that staff could adequately monitor the effectiveness and potential side-effects of medicines administered to residents.

Judgment: Not compliant

Regulation 6: Health care

Residents did have timely access to healthcare professionals. However, recommended monitoring interventions were not adhered to in line with healthcare plans, and therefore the measures to ensure residents were receiving appropriate healthcare in the centre were not adequately completed.

Residents' healthcare needs had been assessed by healthcare professionals, and residents did attend regular reviews with these professionals as part of the ongoing monitoring of their identified healthcare needs. For example, residents had been reviewed by their general practitioner (GP), dietitian, psychiatrist, psychologist, dentist, and in general hospital services.

Healthcare plans were developed based on the identified needs of residents, and for the most part, plans did guide practice. However, one healthcare plan related to asthma was not individualised to the resident, was not dated, did not outline all aspects of care provision, and referred only to the first aid response in the event a resident had an asthma attack.

For another resident, the monitoring arrangements for hypoglycaemia (low blood sugar) were not achievable in the centre, as the resident did not routinely measures their blood glucose and a glucometer was not provided in the centre. Therefore, the recommended response in the healthcare plan was either not applicable to the resident, or not achievable.

Part of the healthcare support residents required was ongoing monitoring of their healthcare needs, for example, blood tests, electrocardiogram, weight monitoring, and these monitoring interventions were specified in plans. However, there were some inconsistencies completing these interventions.

For example, a resident was required to have their food intake monitored, however, duplicate documents for food intake were being used, with differing accounts of the dietary intake of the resident, for a number of days reviewed. This was of concern, as the resident had a significant health issue related to their dietary intake. In addition, it was noted in the resident's file they had been referred to specialised

services for this specific need, however, the person in charge was unable to confirm any details about this referral.

In addition one inspector noted a resident's blood pressure had not been recorded in their file since April 2025, and the personal plan specified that blood pressure was to be monitored every month. At the end of the inspection the director of operations told the inspectors that due to a risk of further injury, the resident's blood pressure was not to be taken by staff in the centre, and was only to be recorded at hospital appointments. The director of operations outlined this was documented in risk management plans, however, on review a risk management plan also outlined the blood pressure was to be recorded every month.

Healthcare was provided in the centre by the staff team, however, given the discrepancies in healthcare monitoring records, and in healthcare plans that were used to guide staff practice, residents were found not to be receiving appropriate healthcare.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Compliant
Quality and safety	
Regulation 26: Risk management procedures	Not compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 6: Health care	Not compliant

Compliance Plan for Rathdearg House OSV-0005449

Inspection ID: MON-0047946

Date of inspection: 09/09/2025

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant

Outline how you are going to come into compliance with Regulation 15: Staffing:
1. The assessed needs of the Individual's conducted by the Person in Charge via a Comprehensive Needs Assessment will be reviewed by the Admissions, Transitions and Discharges committee.

Due Date: 31 October 2025

2. Allied health professionals involved in the care and support to Individuals within the Centre who have regular access to, will also be consulted with. Following receipt of all relevant information, an informed decision will be made by Nua's Multi-Disciplinary Team regarding the need for direct nursing supports within the staffing arrangements.

Due Date: 31 October 2025

3. Following consultation with the Individuals' relevant allied health professionals, additional training may be scheduled to further upskill the Team Member's knowledge of the Individuals' health-related issues.

Due Date: 31 October 2025

4. As part of Continuous Professional Development, staff are to be provided with information regarding the medication prescribed for each Individual to increase their knowledge and understanding of same. In addition, Safe Administrations and Management of Medication (SAMM) training will be re-completed by the team.
Due Date: 31 October 2025

5. The Person in Charge (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 removed from administering medication and provided with practical training by the PIC. In addition, Team Members may be required

to complete classroom medication training.

Due Date: 31 October 2025

6. The PIC shall ensure that clear learnings from each incident are documented on the daily handover for a period of 7 days and in addition are discussed at the bi-monthly Team Meetings.

Due Date: 16 December 2025

7. Person in Charge to ensure supervision of Team Members is conducted in-line with policy and conduct further supervision where the need is required.

Due Date: 16 December 2025

8. To evaluate the progression and effectiveness of each action within the compliance plan, a weekly meeting with the PIC and/or Centre management will be conducted and chaired by the Senior Director of Operations (SDOO) and/or the Deputy Chief Operating Officer. Relevant members of the Multi-Disciplinary Team, a Quality Assurance Officer and/or the Quality and Safety Lead and other departmental functions will also be required to attend this weekly meeting until the final action of the compliance plan is completed.

Due Date: 19 December 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:
1. Following the Inspection on 08 and 09 July 2025, a comprehensive training plan was implemented for the entire team. Since the follow-up Inspection on 09 September 2025, a full review of the training plan has been completed to ensure that all certificates and Test of Knowledges (TOK's) are available within the designated Centre.

Date Completed: 29 September 2025

2. The Person in Charge (PIC) will completing regular on-the-job mentoring with the Team in relation to the training completed in line with the Statement of Purpose to ensure all Team Members have an understanding of the needs of the Individuals in the Centre and the support they require. Where any gaps in knowledge or practice are identified, additional training and/or mentoring will be completed with the relevant Team Member/s.

Due Date: 12 December 2025

3. There will be two separate Team Meetings scheduled in November and December 2025 and all Team Members will be rostered to attend a minimum of one of these meetings each month. If a Team Member is unable to attend due to unforeseen circumstances, they will be assigned time to review the meeting minutes, supporting documentation and sign an acknowledgement that they have read and understood all actions captured within the minutes.

Due Date: 16 December 2025

4. The PIC shall ensure that clear learnings from each incident are documented on the daily handover for a period of 7 days and in addition are discussed at the bi-monthly Team Meetings.

Due Date: 16 December 2025

5. Person in Charge to ensure supervision of Team Members is conducted in-line with policy and conduct further supervision where the need is required.

Due Date: 16 December 2025

6. To evaluate the progression and effectiveness of each action within the compliance plan, a weekly meeting with the PIC and/or Centre management will be conducted and chaired by the Senior Director of Operations (SDOO) and/or the Deputy Chief Operating Officer. Relevant members of the Multi-Disciplinary Team, a Quality Assurance Officer and/or the Quality and Safety Lead and other departmental functions will also be required to attend this weekly meeting until the final action of the compliance plan is completed.

Due Date: 19 December 2025

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
1. Following the Inspection on 08 and 09 July 2025, a comprehensive training plan was implemented for the entire team. Since the follow-up Inspection on 09 September 2025, a full review of the training plan has been completed to ensure that all certificates and Test of Knowledges (TOK's) are available within the designated Centre.
Date Completed: 29 September 2025

2. A Senior Director of Operations was appointed to oversee the Centre and directly

supervise the Person in Charge.

Date Completed: 12 September 2025

3. The Person in Charge (PIC) with support from a newly appointed Regional General Nurse to the Centre and 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. 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: 28 November 2025

4. The PIC in conjunction with the Senior Director of Operations (SDOO) will complete a full review of all Individual Risk Management Plans (IRMPs) to ensure all risks pertaining to the Individuals are clearly captured with appropriate control measures recorded.

Due Date: 31 October 2025

5. The PIC and Centre Management will clearly outline the escalation policy and procedure for Team Members and on-call roster via the bi-monthly Team Meetings and handovers each day.

Due Date: 16 December 2025

6. The assessed needs of the Individual's conducted by the Person in Charge via a Comprehensive Needs Assessment will be reviewed by the Admissions, Transitions and Discharges committee.

Due Date: 31 October 2025

7. Allied health professionals involved in the care and support to Individuals within the Centre who have regular access to, will also be consulted with. Following receipt of all relevant information, an informed decision will be made by Nua's Multi-Disciplinary Team regarding the need for direct nursing supports within the staffing arrangements.

Due Date: 31 October 2025

8. All Team Members will complete an additional on-the-job Fire Walk ensuring they are familiar with all fire arrangements with evidence of same available within the Centre.

Date Completed: 14 September 2025

9. There will be two separate Team Meetings scheduled in November and December 2025 and all Team Members will be rostered to attend a minimum of one of these

meetings each month. If a Team Member is unable to attend due to unforeseen circumstances, they will be assigned time to review the meeting minutes, supporting documentation and sign an acknowledgement that they have read and understood all actions captured within the minutes.

Due Date: 16 December 2025

10. The Person in Charge (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 removed from administering medication and provided with practical training by the PIC. In addition, Team Members may be required to complete classroom medication training.

Due Date: 31 October 2025

11. The PIC shall ensure that clear learnings from each incident are documented on the daily handover for a period of 7 days and in addition are discussed at the bi-monthly Team Meetings.

Due Date: 16 December 2025

12. Person in Charge to ensure supervision of Team Members is conducted in-line with policy and conduct further supervision where the need is required.

Due Date: 16 December 2025

13. To evaluate the progression and effectiveness of each action within the compliance plan, a weekly meeting with the PIC and/or Centre management will be conducted and chaired by the Senior Director of Operations (SDOO) and/or the Deputy Chief Operating Officer. Relevant members of the Multi-Disciplinary Team, a Quality Assurance Officer and/or the Quality and Safety Lead and other departmental functions will also be required to attend this weekly meeting until the final action of the compliance plan is completed.

Due Date: 19 December 2025

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
1. The Person in Charge (PIC) in conjunction with the Senior Director of Operations (SDOO) to complete a full review of all Individual Risk Management Plans (IRMPs) to ensure all risks pertaining to the Individuals are clearly captured with appropriate control

measures recorded.

Due Date: 31 October 2025

2. Following the review of all IRMPs, the PIC and SDOO will complete an additional review of the Risk Summary document to ensure all high risks within the designated Centre are captured. The Risk Summary document will also be discussed in the daily handover.

Due Date: 31 October 2025

3. The PIC and Centre management will clearly outline the escalation policy and procedure for Team Members and on-call roster via the bi-monthly Team Meetings and handovers each day.

Due Date: 16 December 2025

4. The PIC shall ensure that clear learnings from each incident are documented on the daily handover for a period of 7 days and in addition are discussed at the bi-monthly Team Meetings.

Due Date: 16 December 2025

5. The Person in Charge (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 removed from administering medication and provided with practical training by the PIC. In addition, Team Members may be required to complete classroom medication training.

Due Date: 31 October 2025

6. To evaluate the progression and effectiveness of each action within the compliance plan, a weekly meeting with the PIC and/or Centre management will be conducted and chaired by the Senior Director of Operations (SDOO) and/or the Deputy Chief Operating Officer. Relevant members of the Multi-Disciplinary Team, a Quality Assurance Officer and/or the Quality and Safety Lead and other departmental functions will also be required to attend this weekly meeting until the final action of the compliance plan is completed.

Due Date: 19 December 2025

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
1. All Team Members will complete an additional on-the-job Fire Walk ensuring they are familiar with all fire arrangements with evidence of same available within the Centre.

Date Completed: 14 September 2025

Regulation 29: Medicines and pharmaceutical services	Not Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
1. As part of Continuous Professional Development, staff are to be provided with information regarding the medication prescribed for each Individual to increase their knowledge and understanding of same.
Due Date: 31 October 2025

2. Safe Administration and Management of Medication (SAMM) training will be re-completed by the team.
Due Date: 31 October 2025

3. The Person in Charge (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 removed from administering medication and provided with practical training by the PIC. In addition, Team Members may be required to complete classroom medication training.

Due Date: 31 October 2025

4. To evaluate the progression and effectiveness of each action within the compliance plan, a weekly meeting with the PIC and/or Centre management will be conducted and chaired by the Senior Director of Operations (SDOO) and/or the Deputy Chief Operating Officer. Relevant members of the Multi-Disciplinary Team, a Quality Assurance Officer and/or the Quality and Safety Lead and other departmental functions will also be required to attend this weekly meeting until the final action of the compliance plan is completed.

Due Date: 19 December 2025

Regulation 6: Health care	Not Compliant

Outline how you are going to come into compliance with Regulation 6: Health care: 1. The Person in Charge (PIC) with support from the newly appointed Regional General Nurse to the Centre and 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. 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: 28 November 2025 2. There will be two separate Team Meetings scheduled in November and December 2025 and all Team Members will be rostered to attend a minimum of one of these meetings each month. If a Team Member is unable to attend due to unforeseen circumstances, they will be assigned time to review the meeting minutes, supporting documentation and sign an acknowledgement that they have read and understood all actions captured within the minutes. These meetings will also focus on Team Member knowledge of health-related monitoring for Individuals and relevant Specific Health Management Plans. Due Date: 16 December 2025 3. To evaluate the progression and effectiveness of each action within the compliance plan, a weekly meeting with the PIC and/or Centre management will be conducted and chaired by the Senior Director of Operations (SDOO) and/or the Deputy Chief Operating Officer. Relevant members of the Multi-Disciplinary Team, a Quality Assurance Officer and/or the Quality and Safety Lead and other departmental functions will also be required to attend this weekly meeting until the final action of the compliance plan is completed. Due Date: 19 December 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.	Not Compliant	Orange	19/12/2025
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Not Compliant	Orange	19/12/2025
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	19/12/2025

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.	Not Compliant	Orange	19/12/2025
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	19/12/2025
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	19/12/2025
Regulation 28(2)(b)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Substantially Compliant	Yellow	14/09/2025
Regulation 29(4)(b)	The person in charge shall ensure that the	Not Compliant	Orange	19/12/2025

	designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine which is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.			
Regulation 06(2)(b)	The person in charge shall ensure that where medical treatment is recommended and agreed by the resident, such treatment is facilitated.	Not Compliant	Orange	19/12/2025