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:	Springfield House
Name of provider:	Dundas Unlimited Company
Address of centre:	Meath
Type of inspection:	Unannounced
Date of inspection:	11 March 2026
Centre ID:	OSV-0005550
Fieldwork ID:	MON-0049934

About the designated centre

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

Springfield House is a designated centre operated by Dundas Unlimited Company. This centre provides residential services to adults with disabilities. The centre can accommodate up to six residents and is situated close to a large town in County Meath. The living accommodation for residents includes a five-bedroom two-storey house, and two one-bedroom stand-alone apartments on the grounds of the property. The main house consists of five bedrooms, two of which are en-suite, two communal bathrooms, a kitchen and utility room, and three living rooms. The apartments each contains a kitchen-come-living room, bedroom and separate bathroom. The centre is staffed on a 24/7 basis with a full-time person in charge, two team leads, two nursing staff and a team of direct 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
Wednesday 11 March 2026	09:00hrs to 17:00hrs	Brendan Kelly	Lead

What residents told us and what inspectors observed

This unannounced inspection was carried out in Springfield House following the receipt of solicited information of a serious peer-to-peer incident that occurred in the centre. The inspection reviewed the residents' wellbeing after the incident, the provider's risk management arrangements and their response and subsequent actions following the serious incident.

Overall, the findings of the inspection showed that the incident itself was as a result of circumstances that could not have been foreseen. The inspection showed the provider responded appropriately by implementing a serious incident review and numerous multi-disciplinary led strategies aimed at reducing the likelihood of a similar incident. However, concerns around the suitability of the centre and the risk management of incidents in the location required improvements.

Shortly after the inspection, the provider informed the Office of the Chief Inspector of Social Services that a resident had been moved to another stand alone single occupancy registered living arrangement which could better meet their assessed needs and would, in turn, mitigate the potential risks of peer-to-peer safeguarding incidents in this centre going forward.

Springfield House is a large two storey house that can accommodate up to six residents. The property also contained two single occupancy one bedroom apartments on the grounds of the main house. On the day of this inspection the provider had one resident vacancy which was in the main house. The provider had identified a resident for the vacancy and a transition plan was underway.

On the day of inspection the inspector had the opportunity to meet with and speak to the person in charge, two members of the providers senior management team, one staff member, three of the residents living in the centre and, two residents family members spoke to the inspector via phone calls. The inspector also observed the day-to-day operations of the centre, including interactions between staff and residents and the care and support provided to them.

The inspector completed a walk around shortly after arriving at the location firstly with a front line staff member and then the walk around was completed with the person in charge who arrived a short time later. The main house consisted of five bedrooms, two of which were en-suite, two additional bathrooms, a large kitchen, utility space and three sitting rooms. Residents each had their own bedrooms in the main house. Both of the residents in the single occupancy apartments required 2:1 staffing levels due to their assessed needs. Both apartments consisted of a single bedroom, bathroom and an open plan kitchen dining space.

During a walk around of the single occupancy apartments the inspector observed that one apartment was not suitable for one resident due to the lack of space the

resident had in the apartment for the staff team to safely meet the residents assessed needs. The inspector observed that the lack of space available to the resident was a contributing factor the serious incident that occurred.

The resident that resides in this apartment requires 2:1 staffing during the day and this also includes for personal care. The inspector observed that the bathroom space in this apartment was not big enough to safely accommodate the two staff assigned to the resident as well as the resident. The inspector observed that when the bathroom door in this apartment was opened the hallway that led from the sitting room to the residents' bedroom became blocked with no access to the residents bedroom, or, if the resident was in their bedroom while the bathroom door was opened they would have no access to the hallway leading to the sitting room.

The inspector had the opportunity to briefly meet with both residents who were involved in the incident reported to the Chief Inspector. Both residents appeared well to the inspector. The inspector met one resident in the main house and the resident proudly showed the inspector around their party room. The resident told the inspector they were happy in their home and the inspector observed the resident interacting with staff and the person in charge in a positive and engaging manner.

The inspector briefly met the second resident, they made it clear to the inspector that they did not wish to engage with the inspector and they went about their morning routine with their assigned staff. The provider had control measures in place that were designed to ensure the residents did not spend time around each other. However, while completing the walk around of the centre the inspector observed that both residents accidentally ended up in close proximity to each other while one resident was walking in the grounds of the premises and the second resident came over to see what the inspector and person in charge were talking about.

The inspector briefly met a third resident later in the day who had come back from an outing with staff. The resident appeared to the inspector to be happy and comfortable in their home. The appeared to be at ease with the staff team and the staff supporting the resident appeared to be comfortable in meeting the residents needs.

The inspector had a phone call in relation to the incident with the families of both residents. In the calls both families indicated their shock at the incident as no peer-to-peer incident of this nature had occurred before. Both families indicated they were, in the main satisfied with the providers response. Both families told the inspector they were informed immediately of the incident but that since the incident they had not been involved in the review while the provider was undertaking their own processes. One family member had, since the incident, met with a member of the providers multi-disciplinary team while visiting their loved one. Both families spoke positively of the centre, staff and management. One family member told the inspector they had regular contact with the staff team and person in charge, the inspector observed evidence of this through a series of emails. The inspector was also told of one residents happiness in the location and that in their opinion they

were happy with the care their loved one received but were concerned that an incident of a similar nature could happen again.

The inspector observed that staff interactions with all residents in the centre were warm, friendly and caring. The inspector observed that the staff team were knowledgeable of the residents care and support needs. Despite the serious nature of the incident that had occurred the inspector observed a calm and friendly atmosphere in the centre and staff appeared comfortable in supporting residents,

The next two sections of the report present the findings of the inspection in relation to the governance and management of the centre and how these systems have impacted on the quality and safety of the service provided to the residents.

Capacity and capability

This inspection was carried out in response to the provider notifying the Chief Inspector of a serious peer-to-peer incident. On the day of this inspection residents in the centre appeared to show no long term negative impacts of the incident that occurred. Residents in the centre appeared to happy and comfortable in their home and engaged with the inspector as they wished.

The centre had a clearly defined management structure with a person in charge, team leads and a person participating in management overseeing the day-to-day operations.

The provider had implemented a number of reviews and updates to key plans after the incident that involved various elements of the providers multi-disciplinary team.

The centre was appropriately resourced in terms of staffing at the time of the incident with the inspector also observing the staff team had been in receipt of adequate training.

Regulation 15: Staffing

The provider had ensured that the staffing levels and skills mix in the centre were adequate to support the residents with their assessed needs. The provider had actual and planned rosters in place that were maintained by the person in charge as part of their oversight responsibilities. On the day of inspection the inspector reviewed rosters from January and February 2026 and also on the day of a peer to peer incident reported to the Chief Inspector.

On review of the rosters the inspector was assured that the provider had an appropriate number of staff on shift each day. The roster review also showed that the provider had ensured that on all weeks reviewed staffing levels did not fall below the providers safe staffing levels. In addition to the person in charge who was present in the centre Monday to Friday, seven staff worked day shifts in the centre and four staff worked waking night duties.

The providers contingency plan in terms of cover for planned and unplanned leave centered around the use of familiar relief staff and staff from other centres nearby. The inspector was assured that staff, who were not familiar with resident's assessed needs, was not a factor in the peer to peer incident. However, it was possible that a domestic task undertaken by staff, which resulted for the resident in a short delay for a planned activity, may have contributed to the residents increased anxiety.

The inspector reviewed the staffing levels on the day of the reported incident, one resident required 2:1 supports during daytime hours. The required supports were in place for the resident and both staff were present with the resident.

The second residents' assessed needs were that they are supported by the core staff team with no staff specifically assigned. The inspector observed this to be proportionate and was also assured that the core staffing levels on the day were at the required level.

The inspector observed interactions between staff and residents on the day of inspection. Residents appeared to be comfortable and happy in the presence of staff. The staff team were knowledgeable of residents needs and the inspector observed staff to be following specific multi-disciplinary team guidance and strategies in relation to residents support needs.

Judgment: Compliant

Regulation 16: Training and staff development

In reviewing the training in place for the staff team, the inspector observed that in the main staff were provided with appropriate level of training to meet the assessed needs of the residents.

The staff team had been in receipt of the providers required mandatory training in areas such as:

- human rights
- managing of complex behaviours
- safeguarding
- fire safety
- autism awareness
- positive behavioural support
- medication theory and medication competency assessment

- communication effectively through open disclosure

The inspector reviewed the training records of the staff on duty on the day of the peer-to-peer incident that triggered this inspection. The inspector observed that the staff on duty had completed positive behaviour support and managing of complex behaviours training. However, the provider has acknowledged that the training provided to staff is not effective in managing the incident that did occur. The training provided to the staff team focused on the use of block techniques in the event of a behavioural incident. This level of training had been deemed by the provider as appropriate as there was no evidence of any similar peer-to-peer incidents in this centre or in the residents past.

Judgment: Compliant

Regulation 23: Governance and management

The provider had a clear governance structure in place in the centre with each level of management having clearly defined roles and accountability. The centre had an experienced person in charge who was on site Monday to Friday. There was also an experienced person participating in management who had regular contact with the person in charge.

The provider had in place systems that were aimed at service improvement such as an annual review, provider led unannounced six monthly audits, regular governance meetings and local team meetings. On the day of this inspection the inspector reviewed the providers response to a peer-to-peer incident that occurred in the centre. This included a serious incident review, multi-disciplinary team (MDT) reviews and updated guidance for the staff team post incident. Overall, the inspector was assured that the provider had taken appropriate steps to investigate and respond to the incident that had occurred. The provider had also put measures in place to support all residents and provided updated guidance for staff.

The providers serious incident review was carried out by members of the senior management team and in the main provided a comprehensive and reflective overview of the circumstances that led to the incident. However, some elements of the review required further examination from the provider. For example, one section of the review posed the question if staff had recognised and minimised threats and risk. The provider has answered 'yes', however, a decision made by staff had possibly led to the resident becoming heightened with increased anxiety. There was evidence that similar decisions had led to behavioural incidents in the past but none of those incidents had involved peers of the resident.

The provider's multi-disciplinary team (MDT) had significant input following the incident. An emergency MDT meeting had been called in the days after the incident. The inspector observed evidence of input from the providers behaviour specialist, occupational therapist, speech and language therapist, behaviour support trainer

and management team. The providers occupational therapist had conducted a review of one residents living environment and was preparing a report for the provider on the day of this inspection.

The providers speech and language therapist (SLT) was in the centre on the day of inspection. The SLT review aimed to inform and guide staff further on the goals and strategies contained in resident's communication profiles.

The provider had ensured that the staff team were provided with updated guidance for the staff team that ensured impacts on residents were minimised. For example. residents were not restricted in terms of accessing areas of the house or gardens. Staff were guided on additional vigilance rather than restrictions being added. Additional and reinforced guidance was provided in terms of most likely times of incidents and the importance of behaviour support guidance was reiterated to staff. The importance of consistency was also discussed with staff, for example, the inspector observed guidance on the importance of the service vehicle being food free for one resident.

As outlined earlier in this report, since the inspection the provider has transitioned one resident to a more suitable premises. As part of the residents transition, the inspector had requested updates on the residents presentation since they have moved to their new home. The provider has informed the inspector that the resident had responded well to their new environment. To date there had been no recorded incidents with the resident. Additional measures the provider had in place was for staff from Springfield House to continue to work with the resident in their new home and adaptations to the environment would continue to be made to meet the residents needs

Judgment: Compliant

Quality and safety

Risk management systems in the centre required review to ensure residents were in receipt of a quality and safe service. The provider had gathered information in the form of incident reports that could have informed earlier that a residents environment was not suitable to meet their needs. Control measures that were added since a serious incident also required review to ensure they were both practical and feasible.

The provider had robust systems in place in terms of behaviour support and had committed to and implemented reviews and updated guidance to residents behaviour support needs.

While the serious incident that occurred could not have been predicted and the provider had implemented a swift and detailed response, the provider was not in a

position to assure themselves a similar incident could not occur again. With this in mind, to ensure all residents assessed needs could be met, the provider had planned for one resident to transition to a new home.

The provider had also notified all relevant internal and external stakeholders of a serious incident and implemented a detailed interim safeguarding plan.

Regulation 26: Risk management procedures

The provider had systems in place to identify, manage, mitigate and, review risk in the centre. However, these systems required some improvements

The front line staff team completed incident reports as incidents occurred in the centre. The inspector reviewed one resident's incident reports from 2025. The inspector observed that the provider had evidence in these reports to suggest that the resident's environment was not fully meeting their needs prior to a peer-to-peer incident. In an assessment of needs completed, staff had identified concerns with the resident's environment, in particular with personal care.

Multiple incidents occurred in the centre that required staff to leave one resident's immediate environment for their own safety. Staff could not engage with the resident to attempt any reactive behaviour support strategies due to the lack of space in the residents environment.

A number of incidents also occurred at night time when the resident was supported in their apartment by one waking night duty. The provider had a risk assessment in place for lone working. However, on review, the inspector observed that the assessment was generic in nature. Control measures were based on staff slips, trips and falls, intruders and sickness. The assessment was last reviewed in October 2025 and between January and October 2025 there had been four significant incidents at night.

Since the peer-to-peer incident reported to the Chief Inspector, the provider had reviewed the risk assessment in place in regard to aggression for one resident. One additional control measure specifically related to supporting this resident at night. The additional control measure stated that one waking night duty in the main house must be situated in the kitchen for the duration of a night duty to have a visual line of sight on the residents apartment at all times. The inspector observed that this was not a realistic control measure given there were only two waking night duties in the main house and one resident in the main house required 1:1 supports.

The inspector observed that the providers behaviour support team had identified on three separate occasions incidents that had occurred with the resident as a result of staff informing the resident they were going out but then the resident being required to wait for the agreed activity. This is despite clear guidance that the

resident expects a specific response to a specific request. Risk assessments also stressed the importance of a predictable and consistent routine for the resident.

Judgment: Not compliant

Regulation 7: Positive behavioural support

The provider had detailed behaviour support guidance in place where required for residents. Behaviour support plans were complied by the providers behaviour support team and plans then implemented by the front line staff team. The inspector reviewed the behaviour support plan of one resident on the day of inspection.

The residents behaviour support plan guides staff on the behaviours the resident may engage in. Known triggers for the resident were also discussed such as as noise, busy environments and, too many people in their environment. The residents behaviour support plan also tracked incident data. The inspector observed that incident numbers in the centre were low and that behaviours could increase around the time of the resident's birthday. This coincided with the pattern observed in 2025 and in 2026. In speaking with the resident's family member this was also confirmed as a known time of year for the resident when behaviours could increase.

There was clear guidance in place regarding proactive and reactive strategies. Proactive strategies outlined were aimed at structure and a calm environment for the resident. Reactive strategies showed the importance of remaining calm and not engaging with the resident. The inspector observed that the guidance for staff could not have included supports for the peer-to-peer incident in the centre as the provider had no evidence of any residents presentation or behaviours towards peers.

Since the peer-to-peer incident the provider's behaviour support team had reviewed behaviour support plans in the centre and provided staff with updated guidance. Updates had been made in relation to personal space for residents, a new communication system in one residents apartment and staff to be aware of residents whereabouts when they are outside, in particular if any peers are showing signs of anxiety. The provider had also made it clear on staff allocation sheets who on the team would respond in the event of an incident.

Judgment: Compliant

Regulation 8: Protection

The provider had systems and plans in place to safeguard residents and support their safety. A serious incident occurred in the centre, the provider had reported the incident in line with their statutory requirements and updated guidance for staff in supporting residents.

The provider had implemented an interim safeguarding plan that was reviewed by the inspector on the day of inspection. The safeguarding plan outlined details of the incident that had occurred and also outlined the measures implemented to protect all residents. Measures observed and verified by the inspector on the day of inspection included referrals for residents to members of the providers MDT teams. meeting with residents, enhanced communications methods between stand alone apartments and the main house and, the consideration of environmental adaptations.

The provider had ensured all staff in the centre had completed safeguarding and managing complex behaviour training and this was also verified by the inspector on the day of inspection. Safeguarding was discussed at team meetings and specific guidance was distributed to the staff team in relation ot keeping all residents safe in the days post a serious incident.

While the inspector was assured that the provider had responded to an incident in a timely and appropriate manner, the provider was not in a position to assure themselves or the Chief Inspector that a similar incident could not occur in the future. For example, on the day of inspection the inspector observed that residents involved in a serious incident were again by coincidence in close proximity to each other in the garden of the centre.

On the day of inspection, the provider had planned an emergency meeting where the level of risk and safeguarding implications were discussed. The inspector spoke to a member of the providers senior management team following this meeting. The provider informed the inspector that a transition plan would commence immediately with one resident with a view to them moving to a more suitable environment.

As outlined earlier in this report, the provider has given regular updates to the Chief Inspector outlining how the resident has transitioned to their new home.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Compliant
Quality and safety	
Regulation 26: Risk management procedures	Not compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Springfield House OSV-0005550

Inspection ID: MON-0049934

Date of inspection: 11/03/2026

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 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:

Following a serious incident within the designated centre, a emergency review of the resident's needs and review of risk was undertaken. As a result, and in consultation with the resident and their nominated representatives, the resident transitioned to a single-occupancy residence that more appropriately meets their assessed needs. The residents staffing supports were increased and is currently supported on a 2:1 staffing ratio on a 24-hour basis and is demonstrating positive outcomes and improved wellbeing in their new living environment. The new residence is located near to two other designated centres to provide support if required. Risk assessments and emergency plans have been updated to reflect the new accommodation, environment and emergency staffing plan should this be required. There have been no similar incidents reported since transition.

The resident is on the agenda for weekly review with the senior management team at the transitions meeting, for as long as is required, but no less than 4 weeks.

The supporting unsafe behaviour plan for this resident was reviewed by a professional management of complex behaviour practitioner, in the context of their new residence, and training was provided to the staff team in the implementation of same, with particular emphasis on the residents' lack of tolerance to waiting.

Incidents continue to be documented if they occur by the front-line staff team and are reviewed prior to closure by both the Person in charge and the Assistant Director of service, to determine any learning or further action to be taken..The Assistant Director of service is also a professional management of complex behaviour practitioner.

The registered provider has ensured that robust systems are in place within the designated centre for assessment, management, and ongoing review of risk. Trending of incidents is discussed during the monthly governance meeting with a clear escalation

pathway for any concerns noted. These systems include clear procedures for responding to emergencies, thereby promoting the safety and welfare of all residents.

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 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	20/04/2026