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:	Stewarts Care Adult Services Designated Centre 4
Name of provider:	Stewarts Care DAC
Address of centre:	Dublin 20
Type of inspection:	Announced
Date of inspection:	08 July 2025
Centre ID:	OSV-0005835
Fieldwork ID:	MON-0038753

About the designated centre

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

Stewarts Care Adult Services Designated Centre 4 is operated by Stewarts Care DAC. The centre aims to support and empower people with an intellectual disability to live meaningful and fulfilling lives by delivering quality, person-centred services, provided by a competent, skilled and caring workforce, in partnership with the person, their advocate, their family, the community, allied healthcare professional and statutory authorities. The centre consists of two separate detached houses in County Kildare. The centre can accommodate a maximum of nine male or female adult residents. The centre is staffed by staff nurses, social care workers, care staff and a person in charge.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	9

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Tuesday 8 July 2025	09:00hrs to 18:20hrs	Michael Muldowney	Lead

What residents told us and what inspectors observed

This announced inspection was carried out as part of the regulatory monitoring of the centre and to help inform a decision on the provider's application to renew the centre's registration. The inspector used observations, conversations with residents and staff, and a review of documentation to form judgments on the quality and safety of the care and support provided to residents in the centre.

Residents gave good feedback on what it is like to live in the centre, and indicated that were happy and felt safe there. However, the inspector found that the oversight and management of the service provided to residents required improvement to ensure that it was safe, consistently, effectively monitored, and appropriate to their assessed needs. While compliance was found under some regulations such as communication, improvements were required under most regulations including staffing, training, governance and management, positive behaviour support, and in particular, health care.

The centre comprises two two-storey houses in separate housing estates and towns. The houses are within a short driving distance of each other, and close to many services and amenities, including shops, cafés and public transport. The inspector walked around both houses. Overall, they were found to be homely, bright, comfortable, and nicely decorated and furnished. Residents had their own bedrooms (some had en-suite facilities) which were decorated to their tastes and provided sufficient storage. The communal facilities included sitting rooms, dining space, kitchens, bathrooms, laundry equipment, and nice gardens for residents to use. Some minor upkeep and cleaning was required in areas.

The inspector also observed some good fire safety precautions, such as fire detection and fighting equipment. However, other precautions were found to require improvement, including the maintenance of important documents such as residents' evacuation plans. The premises and fire safety are discussed further in the quality and safety section of the report.

The centre accommodated nine residents. The inspector met eight residents during the inspection; however, not all of them communicated their views. The residents communicated in different ways including speech, making gestures and signs, and using visual aids.

In the first house, one resident told the inspector that they liked living in the centre, but that they did not get on with all of their housemates. They said that staff helped them to 'sort it out'. They knew the staff working in the centre, said that there were enough staff on duty and that they listened to them if they ever had any concerns. They said that the new person in charge was settling in well, but that there are different persons in charge 'all the time'. They said that their bedroom was comfortable, and they were familiar with fire evacuation procedure.

The resident attended a day service, but was actively looking for a paid job. They described their day service as being boring at times. The resident told the inspector about their interests, including reading, music, cinema, eating out, shopping and style. They also liked to cook, and had their favourite meals often. They were also learning new life skills, such as using public transport independently. They received support to manage their finances, and were satisfied with these arrangements.

Another resident, with support from a staff member, told the inspector about their interests and plans for the day using manual signs, pictures and some words. They also showed the inspector their smart device that they used to stream music. The staff member communicated with the resident in a kind manner, and it was clear that they understood each other well.

In the other house, a resident told the inspector that they liked living in the centre and with their friends. They also got on well with the staff. They said that they enjoyed gardening, and spent time during the inspection tending to plants in the garden. They also told the inspector that enjoyed spending time with their family and going out for coffee. Other residents did not express their views, but engaged with the inspector through gestures such as putting their thumbs up and smiling.

In advance of the inspection, staff supported residents to complete surveys on what it is like to live in the centre. Overall, the feedback was positive, and indicated that residents felt safe, liked the staff, were satisfied with the premises, and received good care. Residents said that they had choice in their life, liked their bedrooms, and described the staff team as being kind and fun.

The inspector did not have the opportunity to meet any of the residents' representatives, but did read a recent compliment from a resident's family. The compliment said that the family were very happy that the resident was living in the centre and with the care they received, and described the staff as being kind and welcoming.

The inspector also spoke with different members of staff including the person in charge, social care workers and care assistants. The person in charge had commenced in the centre in June 2025, and was getting to know the residents. They had identified some areas that required improvement. For example, they said that while there were no staff vacancies, the skill-mix required review. They also spoke about compatibility issues in one house, and said that compatibility assessments were planned to determine if the centre was suitable for all residents. One resident's needs had also recently changed, and a multidisciplinary professional report noted that some environmental adaptations were needed (some of which were underway).

A staff member told the inspector that residents are happy, but shared the person in charge's concerns regarding the compatibility of some residents due to their varying needs. This staff member was familiar with the residents' health, communication and social care plans. They also told the inspector about residents' hobbies, interests and personal goals, such as swimming, sensory activities, eating out, farming, and learning new life skills. They said that staffing levels had recently improved, but that

when the centre was short staffed it impacted on the maintenance of documentation and records. Some residents also showed signs that they did not like changes in staffing by engaging in behaviours of concern. Behaviour support plans were in place, but the staff member told the inspector that the strategies were not always effective.

Another staff member told the inspector that residents could express their wishes and that they were facilitated by staff. They said that the residents in one house got on well and had no concerns for their safety. The inspector found from speaking with the staff member that they required more guidance on residents' health care and positive behaviour support plans.

While the inspector found good examples of compliance under some of the regulations inspected, improvements were required to the governance and management of the centre, and the quality and safety of the service provided to residents to ensure that it is consistent, effectively monitored, and appropriate to their needs.

The next two sections of this report present the inspection findings in relation to the governance and management in the centre, and how governance and management affects the quality and safety of the service being delivered.

Capacity and capability

The inspector found that the governance and management arrangements were not fully effective in ensuring that the service provided to residents was safe and appropriately resourced to their needs.

There was a clearly defined management structure, including a full-time person in charge, programme manager, and Director of Care. The management team were experienced, skilled and possessed qualifications relevant to their roles. However, there had been frequent changes of person in charge in the previous twelve months, and this was seen to be contributing to poor compliance findings. For example, audits and supervision meetings had not been carried out as per the provider's policies.

There were no staff vacancies, but the inspector found from reviewing staff rotas that the centre was often short staffed. Staff tried to minimise the impact on residents, but told the inspector that when they were short staffed it was difficult to complete all tasks such as maintaining documentation. From speaking with the management team, it was also clear that the skill-mix required review to determine if it was still appropriate.

Staff were required to complete training as part of their professional development. However, training logs showed that not all staff had completed necessary training to inform their practices. Furthermore, not all staff had received supervision in line with

the provider's policies, and scheduled staff team meetings were inconsistent which limited their opportunities to raise concerns. For example, in one house, there had only been two monthly team meetings in 2025.

The provider had systems to monitor the quality and safety of the care and support provided to residents. Comprehensive annual reviews, unannounced visit reports, and infection prevention and control audits had been carried out by which identified areas for improvement. Additional audits were also carried out by staff and the management team. However, the findings of this inspection show that the oversight systems require enhancement.

Regulation 14: Persons in charge

The person in charge commenced working in the centre in June 2025. They had previously worked in other centres operated by the provider. They were suitably experienced and skilled for the role, and posed relevant qualifications in nursing and management.

Judgment: Compliant

Regulation 15: Staffing

The staffing arrangements in the centre required improvement to ensure that appropriate staffing levels were in place and that the skill-mix was meeting the residents' needs.

The skill-mix comprised two social care worker whole-time equivalent, one nurse (primarily working night shifts) whole-time equivalent, and 11.4 health care assistant whole-time equivalents. There were no vacancies. However, the person in charge and programme manager told the inspector that a review of the skill-mix would be useful to determine if it is still appropriate to residents' needs.

Staff and the person in charge told the inspector that three were to be on duty in each house during the day time from Monday to Saturday. The inspector reviewed staff rotas in both houses and found that appropriate staffing levels were not maintained. In the first house, from 6 April to 30 June 2025, there were at least 31 days when there were only two staff on duty. In the other house, from 1 May to to 30 June 2025, there were seven days when there were only two staff on duty. The unannounced visit report in January 2025 also noted significant concerns over the staffing levels in the centre.

Staff told the inspector that the staffing issues had improved from previous months, and that they tried to minimise any impact on residents' quality of services. However, staff said that when they were short staffed, it impacted other duties such

as completing documentation.

Additionally, the rotas reviewed by the inspector required improvement to better indicate the exact hours worked by staff during sleep over shifts.

The inspector did not review staff Schedule 2 files as part of this inspection.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Staff were required to complete training as part of their professional development and to support them in delivering safe and appropriate care to residents. The inspector reviewed the staff training logs, and found deficits that posed a risk to residents. During the inspection, the inspector reviewed the log for one house with the person in charge, and the log for the other house was submitted the following day. The logs showed that all staff had completed human rights training. However, discrepancies were found under other areas where staff required full and or refresher training; for example:

- Fire safety: four staff required training, one is booked to attend upcoming training.
- Managing behaviours of concern: four staff require training, three are booked to attend upcoming training.
- Infection prevention and control: three staff require training.
- Manual handling: two staff require training, one is booked to attend upcoming training.
- Supporting residents with their meals (FEDS): three staff require training.
- Epilepsy (responding to seizures): five staff require training.
- Safeguarding of residents from abuse: one staff requires (refresher) training.
- Positive behaviour support: one staff requires training.

Additionally, not all staff working with residents that used manual signs to communicate had completed associated communication training.

There were systems for the supervision and support of staff. Staff were to receive formal supervision every three months as per the provider's policy. The person in charge had commenced in early June 2025, and had completed formal supervision with all of the staff team. However, records shown to the inspector in one house indicated that only three had received supervision in the first three months of the year.

Judgment: Substantially compliant

Regulation 23: Governance and management

The provider had implemented systems to ensure that the centre was resourced to meet residents' needs, monitored, and that appropriate governance and management structures were in place. The inspector found that these systems were not fully effective and required improvement.

The management structure included a person in charge and a programme manager. However, both had only recently commenced working in the centre, following two previous changes of the person in charge in the previous twelve months. The changes were seen to impact on the management of the centre. For example, finance audits, and supervision of all staff were not been carried out in line with the provider's policies. Additional to the supervision discrepancies, staff meetings were inconsistent in frequency which impinged on opportunities for staff to raise any potential concerns.

Aspects of the centre were well resourced. However, as reported under other regulations, some areas required more consideration from the provider, such as staffing arrangements, to ensure that they were meeting the residents' needs. Additionally, one resident's needs had recently changed, and it was identified that their current environment was not suitable, and compatibility assessments were outstanding for other residents to determine their needs. The recent unannounced visit report also noted that the vehicle assigned to one house required assessment to ensure that it was suitable; and during the inspection, staff told the inspector that this matter was outstanding.

The provider had systems to monitor the consistency and quality of care and support provided to residents in the centre. Comprehensive annual reviews were carried out and consulted with residents, along with detailed unannounced visit reports that identified areas for improvement. Many of the issues identified in this inspection had also been noted in those audits.

There were also audits on medication, meetings, infection prevention and control, fire safety, residents' finances, and health and safety. However, the findings of this inspection demonstrate that enhanced monitoring is required. For example, documentation was poorly maintained, fire safety precautions required improvement, and health care plans were not fully implemented.

Furthermore, as part of the annual review, dated February 2025, some residents expressed that they were not fully satisfied with the service they received in centre. It was not demonstrated to the inspector during the inspection how actions related to this feedback had been implemented and if they were to the residents' satisfaction.

Judgment: Not compliant

Quality and safety

The residents spoken with told the inspector that they liked living in the centre, and they also provided some good feedback in the annual review and HIQA surveys. However, the inspector found that the provider had not ensured that residents were in receipt of quality and safe care and support in the centre. While compliance was found in relation to the safeguarding of residents and communication, improvements were required in relation to the premises, positive behaviour support, healthcare, risk management, and fire precautions.

The inspector reviewed a sample of the residents' assessments and care plans in both houses. The inspector found that communication plans were in place to support residents to communicate their needs and wishes and to be understood. Staff were observed to have a good understanding of the plans.

However, some of the health care records were poorly maintained and did not demonstrate if residents' health care plans were being implemented. Some staff were also found to require more guidance on the residents' health care needs and the associated strategies. These issues posed a serious risk to their health and wellbeing.

Behaviour support plans had been prepared for residents where required. Some of the staff spoken with were unclear about some of the strategies outlined in the plans, and the inspector found that not all of the strategies were implemented. This posed a risk to the effectiveness of the plans. Furthermore, potential restrictive practices had not been recognised as such.

The provider had implemented arrangements to safeguard residents from abuse, and the inspector found that safeguarding concerns were reported and managed to protect residents from potential abuse.

Risk assessments were in place, and were being updated by the newly appointed person in charge. However, on the day of the inspection, not all relevant risk assessments were readily available. The inspector also found that improvements were needed to the recording of the implementation of control measures.

The premises comprises two separate houses. They were found to be homely, comfortable, and nice decorated. Some minor upkeep and cleaning was required in areas.

The inspector observed good fire safety precautions, such as fire detection and fighting equipment; however, improvements were required. Some of the evacuation plans were inaccurate or insufficiently detailed, and this posed a risk to the effectiveness of the plans. There was also an absence of clear guidance on using the fire panels, and the tumble dryer in one house required cleaning of a potential fire hazard.

Regulation 10: Communication

The inspector found that residents received good person-centred support to communicate their wishes and needs, and to express themselves in accordance with their individual means.

The inspector reviewed two residents' communication care plans. The plans were up to date and provided sufficient detail to guide staff on communicating effectively with residents, such as pictures of manual signs and information on cues that residents commonly used.

The inspector observed that staff understood the residents' communication means. For example, the inspector sat with a resident with complex communication and a staff member. The resident used a mix of manual signs, words and visual aids, and the staff member helped them to plan their day using these means. It was clear that the resident was understood, and that their wishes were being facilitated by the staff member.

Within the centre, residents could access different forms of media including the Internet, and some residents used their smart devices to stream entertainment and keep in touch with their family through video calls.

Judgment: Compliant

Regulation 17: Premises

The premises comprises two separate two-storey houses in different housing estates. The houses were close to many services and amenities including shops, cafés and public transport.

The residents had their own bedrooms which were personalised to their tastes, and the communal facilities included sitting rooms, kitchens, utility facilities, and nice gardens. The houses were bright, comfortable, nicely decorated, and homely. However, some upkeep was required. For example, the carpet on the stairs in one house was worn, and some paint work in both houses, such as around doors, was chipped. Some high dusting was also required in one house; for example, to clean thick dust of a bathroom fan.

Generally, the premises was suitable to accommodate the residents and their needs. However, one resident's health care needs had recently changed, and a multidisciplinary team report noted that the current environment was not fully suitable. The provider had implemented some of the report's recommendations such as installing additional hand rails. The provider was still determining the best

approach to meet the other recommendations.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

The provider had prepared a written risk management policy which outlined the arrangements for the identification, assessment and management of risks. The policy was last revised in May 2022, and was due review.

The inspector reviewed the centre's risk register and a sample of the residents' individual risk assessments. The recent unannounced visit report in June 2025 had highlighted area for improvement, and the the inspector found similar issues. For example, on the day of the inspection, there was no risk assessment on the impact of staff shortages or the impact of specific behaviours on residents. The person in charge was aware that some improvements were needed, and had begun reviewing and updating the risk register and risk assessments to ensure that they were comprehensive and accurate.

The inspector found that actions were identified to reduce the likelihood of risks and incidents occurring. However, the recording of the consistent implementation of actions required improvement. For example, staff were to carry out a specific weekly check as part of a resident's safety plan. The inspector found that the checks were not always recorded to indicate that they had been carried out.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The provider has implemented some good fire safety precautions, such as installing fire detection, fighting and containment equipment, and emergency lights in both houses. However, improvements were required to the precautions in both houses to ensure that they were fully implemented, monitored and effective.

The inspector found that the equipment was regularly serviced, and staff also completed daily checks of the equipment and general precautions. The social care workers did more comprehensive checks every six months, where they checked the fire drill and evacuation plan records. The inspector found that two resident's individual evacuation plans were poorly detailed. For example, they noted that residents required assistance, but did not specify the exact type of assistance. Furthermore, it was noted in a recent fire drill record, that one residents required physical assistance, but this was not documented in their plan. The lack of clear guidance for staff to follow posed a risk that residents would not receive sufficient

and appropriate support to evacuate the centre safely.

There was also inaccurate information regarding staffing levels in the evacuation plan for one of the houses. This did not demonstrate that the plans were subject to robust review. Furthermore, the evacuation plans noted that staff should check the fire panel to identify the location of a potential fire, and while both panels could list the 'zones' in the houses, there was no information for staff to refer to indicate where exactly each zone covered. Staff told the inspector they were not sure of the zone locations. This oversight compromised the effectiveness of the panels, and while noted in other recent inspections of the provider's centres had not been fully addressed.

The inspector also observed that one fire door did not close fully when released, and the lint filter in a tumble dryer was full of lint which posed a hazard and risk of combustion.

Judgment: Substantially compliant

Regulation 6: Health care

The inspector found that residents' health care plans were not been fully implemented, and that the associated records were very poorly maintained.

The inspector reviewed residents' health care assessments, plans and records in both houses, and found discrepancies in the documentation, and in particular, in one house. For example:

- A resident's health care plan (prepared by a nurse) outlined how much fluid they should take throughout the day due to a specific health need, and stated that the intake should be recorded in their records. The inspector reviewed the records with the person in charge and found only one record dated 27 May 2025.
- A resident had been prescribed a knee support in December 2024. Staff told the inspector that the resident stopped using it following a phone call conversation in January 2025 with a multidisciplinary team member. However, there was no record of the phone call or correspondence from the multidisciplinary team member to verify this.
- Another care plan outlined clear instructions on a specific intervention. Staff spoken with could not describe the intervention, and it was not recorded in the resident's records if it was been carried out.
- A resident was overdue a National Screening Service check. It was not demonstrated in the resident's health care records if this matter had been identified and escalated prior to the inspection .
- A resident's dental care plan outlined that they required deep cleaning of their teeth every four months. However, records were not available to

demonstrate if they had attended such appointments.

Overall, there was poor oversight and monitoring of the implementation of residents' health care plans, and the discrepancies posed a risk to their health and wellbeing.

Judgment: Not compliant

Regulation 7: Positive behavioural support

The provider had systems to ensure that residents received support to manage their behaviours of concern, and that the use of restrictive practices were appropriately managed. However, the inspector found that the implementation of these systems required improvement to ensure that they were effectively monitored.

The inspector reviewed two resident's behaviour support plans. The plans had been prepared by a multidisciplinary professional, and had been reviewed within the previous twelve months. One plan outlined different strategies to help the resident manage their behaviours. However, the inspector found from speaking with staff that they could not clearly describe how some of the strategies were to be implemented, such as the use of 'timers', and also told the inspector that other strategies were not in place such as a 'reward scheme'.

This compromised the effectiveness of the overall plan, and did not demonstrate that residents were receiving all recommended supports. One of the behaviours of concern listed was also a symptom of a health care need, and this matter needed to be better indicated to ensure that staff were aware to respond to the health care need. Additionally, four staff working in the centre had not received positive behaviour support training.

Furthermore, the plan referred to strategies such as limiting fluids and ensuring that the resident does not stay in bed 'too long'. There was insufficient detail on these strategies, and presented as potential restrictive practices that required consideration from the provider.

Judgment: Not compliant

Regulation 8: Protection

The registered provider and person in charge had implemented good systems to safeguard residents from abuse. The systems were underpinned by its written policy.

Staff had completed safeguarding training to support them in the prevention, detection, and response to safeguarding concerns, and there was guidance for them

in the centre to refer to. The inspector reviewed a sample of the safeguarding concerns from October 2024 to June 2025 and found that they had been appropriately reported and managed to protect residents from potential abuse; for example, investigations were carried out where deemed necessary, and safeguarding plans were put in place with associated actions.

Intimate care plans had been prepared to guide staff on delivery care to residents in a manner that respected their dignity and bodily integrity. The inspector reviewed two plans. The plans had been recently updated; however, the inspector found that one plan contained outdated information as it referred to measures that were only relevant during the early stages of the COVID-19 pandemic. This further demonstrated poor oversight of important documentation as noted elsewhere in the report.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 6: Health care	Not compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Compliant

Compliance Plan for Stewarts Care Adult Services Designated Centre 4 OSV-0005835

Inspection ID: MON-0038753

Date of inspection: 08/07/2025

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: The register Provider has arranged on 18th of August 2025, for a scoping review of the residents' nursing needs to determine if nursing compliment is sufficient. The Register Provider has also recruited a nursing staff member to cover auditing in the designated centers which will commence in October 2025. The new Person in Charge has since ensured that any deficits in the roster are filled and that there is a full oversight on the planned and actual roster of the centers. This started on August 25, 2025 and will be completed by September 31, 2025. The Register Provider will arrange for the Workforce and Time Management Department to review the improvement required to better indicate the exact hours worked by staff during sleep over shifts. This is due to be completed by December 31, 2025	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: The Person in Charge has ensured that the discrepancies found in other areas where staff required full and or refresher training is action and has ensured that - Four staff identified that require Fire Safety training during the inspection have completed their training on July 31, 2025. - Four staff identified that require Managing behaviors of concerns training during the	

inspection have completed their training on August 22, 2025.
- Three staff require training Infection prevention and control identified during inspection has booked their training and will complete this by September 30, 2025.
- Two staff that require Manual handling training during the inspection completed their training on August 22, 2025.
- Three staff that require Supporting residents with their meals (FEDS) training has booked their training and will complete this by September 30, 2025.
- Five staff that require Epilepsy (responding to seizures) training is due to complete this by September 30, 2025
- One staff that requires Safeguarding of residents from abuse (refresher) training has completed this training on July 31, 2025.
- One staff that requires Positive Behaviour support training is due to complete the training by September 30, 2025.

- The Person in charge has arranged with the Learning and Development Team to ensure that all staff working with residents that used manual signs to communicate are booked to complete LAMH Training Module 1 by December 31, 2025.

- The Person in Charge has ensured that all staff are receiving Quarterly Supervisions, Q2 2025 were completed in June 2025, Q3 2025 are due to be completed by September 2025, Q4 2025 are scheduled to be completed by December 31, 2025.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The new Person in Charge has ensured that better governance and oversight is in place in the centre to ensure that internal audits are in place and actions are completed timely. The Person in Charge ensures that staff meetings are held regularly and staff are supported with quarterly supervision.

The register Provider has arranged on 18th of August 2025, for a scoping review of the residents' nursing needs to determine if nursing compliment is sufficient and to ensure that the residents' needs are met.

The Director of Care has arranged on August 25, 2025 for the multidisciplinary team to review and assess changing needs of one resident, where it was identified that their current environment was not suitable. The Director of Care has arranged for the Technical Services team to develop a plan on how to reconfigure the centre and convert one area into an accessible bedroom.

The Person in Charge has arranged for the Behaviour Support Specialist to complete a compatibility assessment of the residents to determine their needs. This was completed

on August 21, 2025.

The person in Charge has ensured that the vehicle was assigned to one house and that is suitable to meet their needs considering that it is wheelchair accessible, serviced and road worthy. August 15, 2025

The Person in Charge has ensured that there is an enhanced monitoring in the centre. Focusing on improvement in maintaining documentation and that there is an oversight in ensuring that fire safety precautions, and health care plans were fully implemented. This commenced on July 31, 2025.

The Person in Charge supported by the social care workers ensures that Complaints procedure are discussed on the weekly service users' meeting and that complaints form are offered to ensure that the residents' are bale to express if they are not fully satisfied with the service they received in centre and offer support on how to address and resolve this. This is due to be completed in September 30, 2025.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
The Person in Charge has addressed the premises issues identified during this inspection to Technical Services to ensure that the following are actioned by December 31, 2025:
- carpet on the stairs in one house requires replacement.
- Painting work in both houses, such as around doors that were chipped are to be completed.
- High dusting required in one house is completed.

The Director of Care has arranged for the multidisciplinary team to review and assess changing needs of one resident, where it was identified that their current environment was not suitable. The Director of Care has arranged for the Technical Services team to develop a plan on how to reconfigure the centre and convert one area into an accessible bedroom. The is due to be completed by December 31, 2025.

Regulation 26: Risk management procedures	Substantially Compliant

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

The Person in Charge will ensure that improved Risk management is in place, and that risk assessment on the impact of staff shortages is developed. The Person in Charge has updated the Behaviour of Concern risk assessment of one resident and highlighted the impact of specific Behaviour on residents in the centre. The person in charge will ensure there is a comprehensive and accurate risk register and risk assessments in place. This is due to be completed by October 31, 2025.

The Person in Charge has ensured that improvements in recording of the consistent implementation of actions are in place and is aligned to the resident's safety plan.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions: The Person in Charge will ensure that improvements required to the precautions in both houses were fully implemented, monitored and effective. August 31, 2025

The Person in Charge has updated the two residents' individual evacuation plans to ensure that they were detailed and provides clear guidance to staff and that required assistance is specified the exact type of assistance is clear. August 31, 2025

The Person in Charge will ensure that fire drills are completed and that staff are adhering to the residents Personal Emergency Evacuation Plans and that the residents are supported appropriately to evacuate the centre safely. August 31, 2025

The person in Charge has ensured that accurate information regarding staffing levels in the evacuation plan is in place that the plans are reviewed and monitored.

The Person in Charge has reviewed the evacuation plans and ensured that all staff are trained during fire drills to check the fire panel to identify the location of a potential fire. This is completed on July 31, 2025

The Person in Charge has liaised with Fire Safety Officer in July 2025, to follow up on further action plans to provide information for staff to indicate where exactly each zone covered. The Fire Safety officer has ensured that the panels are addressable systems, and the concept of traditional hardware "zone" charts is superseded, as the system can pinpoint each device individually. This exceeds the requirements of conventional zoning and is fully compliant with I.S. 3218 and relevant best practice and has met the requirement as per HIQA Fire Safety Handbook: A Guide for Providers and Staff of Designated Centers (section: "Category of alarm system used") and the Code of Practice for Fire Safety in New and Existing Community Dwelling Houses (section: "3.3.14 Fire detection and alarm system")The inspector also observed that one fire door did not close fully when released, and the lint filter in a tumble dryer was full of lint which posed a hazard and risk of combustion. July 31, 2025.

The Person in Charge has addressed the fire door that was not fully closed when released to the Fire Safety Officer and Tech Services to ensure that this action is completed by August 31, 2025

The Person in Charge has ensured that lint filter checks are completed daily and that additional monitoring is in place through internal audits. Commenced on July 31, 2025.

Regulation 6: Health care	Not Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
The Person in Charge will ensure that residents' health care plans are fully implemented, and that the associated records are maintained to ensure that serious risk to residents' health and wellbeing are mitigated.

The Person in Charge ensures that health care assessments, plans and records in both houses that were found with discrepancies in the documentation as follows are actioned by August 31, 2025:
- The Person in Charge has ensured that improvement is in place in staff recording of the resident's daily recommended fluid intake by ensuring that this is checked daily.
- The Person in Charge has arranged for the multidisciplinary team member to review the resident's prescribed knee support in December 2024 to get clarification regards discontinue of use of the said knee support in January 2025.

- The Person in Charge has commenced updating Health Care Plans addressed during inspection to ensure that interventions are implemented and this is due to be completed by August 31, 2025.

- The Person in Charge in collaboration with the Community Liaison Nurse team will ensure that service users are regularly observed for any new or unusual signs and symptoms and to ensure that they are checked to provide necessary medical attention
The person in Charge will ensure that Annual Medical review are in place.

- The Person in Charge has arranged for the residents to attend their dental appointments in July 28, 2025 for deep clean and future appointments were scheduled.

The Person in Charge in collaboration with the Community Liaison Nurse provided an educational and awareness discussion with the staff team on July 24 and 27, 2025 to ensure that staff are supported in implementing the health care plans.

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
The Person in Charge will ensure that there is an oversight in the implementation of the residents' Behaviour support plans by monitoring the behaviour recording forms, and incident trends. The Person in Charge will arrange for the Behaviour Specialist to discuss the strategies with the staff team and to ensure that they are fully aware of the plans in place. This is due to be completed by August 31, 2025.

The Person in Charge will ensure that implementation of Behaviour Support Plans is addressed on staff supervision and staff meeting.

The person in Charge has ensured that four staff identified that require Managing behaviors of concerns training during the inspection have completed their training on August 22, 2025.

The Person in Charge has arranged for the Psychologist who prescribed the Behaviour Support Plans to review the strategies referred to as limiting fluids and ensuring that the resident does not stay in bed 'too long' and to consider that the plan does not pose to potential restrictive practice. The review is due to be completed by September 30, 2025.

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Substantially Compliant	Yellow	31/12/2025
Regulation 15(2)	The registered provider shall ensure that where nursing care is required, subject to the statement of purpose and the assessed needs of residents, it is provided.	Substantially Compliant	Yellow	31/12/2025
Regulation 15(4)	The person in charge shall ensure that there is a planned and actual staff rota, showing staff on duty during the	Substantially Compliant	Yellow	31/12/2025

	day and night and that it is properly maintained.			
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.	Substantially Compliant	Yellow	31/10/2025
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	30/09/2025
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Substantially Compliant	Yellow	31/12/2025
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Substantially Compliant	Yellow	31/12/2025
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	Substantially Compliant	Yellow	31/12/2025

	purpose.			
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	30/09/2025
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.	Substantially Compliant	Yellow	31/12/2025
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and	Substantially Compliant	Yellow	31/10/2025

	ongoing review of risk, including a system for responding to emergencies.			
Regulation 28(1)	The registered provider shall ensure that effective fire safety management systems are in place.	Substantially Compliant	Yellow	31/10/2025
Regulation 28(2)(b)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Substantially Compliant	Yellow	31/10/2025
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	31/10/2025
Regulation 06(1)	The registered provider shall provide appropriate health care for each resident, having regard to that resident's personal plan.	Not Compliant	Orange	31/08/2025
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.	Substantially Compliant	Yellow	31/07/2025
Regulation 06(2)(d)	The person in charge shall ensure that when a resident requires services provided by allied health	Substantially Compliant	Yellow	31/07/2025

	professionals, access to such services is provided by the registered provider or by arrangement with the Executive.			
Regulation 07(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.	Not Compliant	Orange	30/09/2025
Regulation 07(2)	The person in charge shall ensure that staff receive training in the management of behaviour that is challenging including de-escalation and intervention techniques.	Substantially Compliant	Yellow	30/09/2025
Regulation 07(3)	The registered provider shall ensure that where required, therapeutic interventions are implemented with the informed consent of each resident, or his or her representative, and are reviewed as part of the personal planning process.	Substantially Compliant	Yellow	30/09/2025