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:	Castlelodge
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Clare
Type of inspection:	Short Notice Announced
Date of inspection:	25 June 2025
Centre ID:	OSV-0008008
Fieldwork ID:	MON-0044005

About the designated centre

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

Castlelodge is a centre run by the Brothers of Charity Service Ireland CLG. Since April 2024 the provider has operated a respite service in this designated centre for a large catchment area with nineteen residents availing of a respite service on a planned and rotational basis. The centre can accommodate a maximum of three residents who are over the age of 18 years with an intellectual disability. The centre can support a broad range of needs including residents with a physical disability. The centre comprises of a bungalow dwelling on its own spacious site located in a residential area on the outskirts of a town. Residents are provided with their own bedroom, there is a shared en-suite facility, a main bathroom and a sitting room, kitchen and dining area provided. Additional facilities include a utility room and staff office-sleepover room. To the front and rear of the centre, provision is made for parking and a well-maintained garden is available for residents to use as they wish. The staffing levels are altered to meet the needs of the residents availing of respite and staff are on duty by day and by night to support the residents.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	2

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 25 June 2025	09:45hrs to 17:45hrs	Mary Moore	Lead
Wednesday 25 June 2025	09:45hrs to 17:45hrs	Maureen McMahon	Support

What residents told us and what inspectors observed

This inspection was completed by the Health Information and Quality Authority (HIQA) to assess the providers' compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with disabilities 2013. Some improvements were needed but overall inspectors found the centre was planned and managed well so that residents were provided with a good quality respite service.

The respite service is operated from a detached single-storey property located on a generous corner site in a populated residential area. This is a relatively new respite service having commenced in April 2024. It is a busy respite service with approximately 19 residents availing of the service on a planned rotational basis. The assessed support needs of the residents are broad with some residents requiring a low-level of support from staff members while other residents have higher needs and require a higher level of staff support and supervision.

Overall, inspectors found that the design and layout of the house was suited to this broad range of needs. For example, a ceiling track hoist had been fitted that serviced two of the three available bedrooms and the shower-room that was shared by these two bedrooms. Residents were provided with a safe and comfortable home for the duration of their respite stay and generally the house was well-maintained. However, there were some premises issues to be addressed. For example, inspectors saw that there was an evident issue with general storage that impacted on the provision of adequate personal storage space for residents. While the communal areas were spacious there was some evidence that accessibility for wheel-chair users was limited in the main hallway.

This inspection was facilitated by the person in charge. The inspectors also met with the social care worker who supported the person in charge in the management and oversight of the service.

The person in charge could clearly describe and demonstrate to inspectors how they planned, managed and maintained oversight of the respite service. For example, if residents had established friendships and similar needs the person in charge endeavoured to provide them with respite breaks together. The inspectors found that in terms of establishing those needs and preferences, the person in charge had good assessment procedures in place and different arrangements were put in place for residents. For example, the days on which the respite service opened altered in response to different needs, the occupancy of the centre fluctuated as did the number of staff on duty and their working arrangements such as whether staff were on waking duty or sleeping duty at night.

On the day of this inspection respite was scheduled for two residents. The inspectors had the opportunity to meet with these residents when they arrived in the evening. Both residents were in great form, literally skipped into the centre and

were evidently quite happy to be attending for respite. One resident laughed and said that they did not want to talk to the inspectors as they were waiting for their peer to arrive. The resident knelt on the couch and watched out the window for the arrival of their peer describing to the inspector the direction the service vehicle would come from. Both residents greeted each other by name and with a warm hug.

Both residents relaxed and chatted with the inspectors. Residents said that they liked coming to the respite house and said they used the same bedrooms on each respite stay. Residents discussed the person in charge and the social care worker by name. Residents said they would speak to the management team or to a family member if there was something worrying them. Residents discussed their general interests such as music and dance and friendships and relationships that were important to them. There was discussion of the relationship training they had attended facilitated by the social care worker.

While excited to be together each resident wanted to do something different for the evening. One resident expressed a desire to go to a particular shopping centre and was anxious to leave the centre so that it would still be open. There was easy laughter between the other resident and a staff member as they left the centre but had to return to retrieve an item. Inspectors noted that the staffing and transport arrangements supported these individual choices and preferences.

In addition to speaking with these two residents the inspectors also reviewed the feedback the person in charge had received from residents and their representatives as part of the annual quality and safety review. The feedback received was very positive. While all families had not returned a completed questionnaire those who had rated the respite service as excellent. Representatives mentioned the excellent communication they had with the person in charge and the staff team and the respect shown to them and residents. Residents with the support of staff reported that they loved coming to stay in the respite house, felt safe and had good choice and control over how they spent their time.

Inspectors were satisfied that concerns could be raised and if they were they were satisfactorily addressed through the provider's complaint management procedures.

In summary, based on what inspectors read, observed and discussed this respite service was planned, delivered, managed and overseen so that each resident received a good quality respite service that was suited to their specific needs. However, as discussed in the opening paragraph some improvements were needed such as general maintenance and storage issues.

The primary matter arising from the findings of this inspection was the improvement needed in the arrangements for ensuring each resident could be evacuated in the event of a fire emergency. There was evidence of good fire safety management systems but the provider was requested to review, as a matter of priority, and submit assurances to the Chief Inspector of Social Services that each resident could be evacuated from the centre in a safe and timely manner. The morning after this inspection, the provider submitted the actions it would take with immediate effect to address this.

The next two sections of this report will discuss the governance and management arrangements in the designated centre, how these ensured the quality and safety of the service provided to residents and, the areas were improvement was required.

Capacity and capability

Overall, as discussed in the opening section of this report inspectors found evidence of good management and oversight. The management structure was clear as were individual roles and responsibilities. The centre presented as adequately resourced. However, while the provider demonstrated a good level of compliance with the regulations there was some evidence of management capacity challenges. In addition, the provider had not used all of the information it gathered about the service to improve and better assure the quality and safety of the service.

The day-to-day management and oversight of the service was delegated to the person in charge. The person in charge worked full-time and was supported in their role by the social care worker and their line manager the community manager. Inspectors saw that the person in charge consistently implemented good local systems of management. For example, the person in charge ensured an assessment of needs was completed for each resident, the person in charge reviewed incidents and how they were managed and liaised with other relevant stakeholders such as the different day services that residents attended and with each family.

The person in charge delegated tasks and duties to the social care worker such as the planning and maintenance of the staff duty rota. The social care worker was able to show inspectors how these delegated duties were completed.

For example, the staffing arrangements for the centre were somewhat complex in that day service staff were part of the staffing complement for the centre. However, inspectors found that this arrangement was well managed and provided good continuity and consistency for the residents.

An inspector reviewed the staff training matrix and saw that good oversight was maintained of staff attendance at mandatory, required and desired training. There were no identified training gaps.

Systems of quality assurance included the review of incidents mentioned above, audits of medicines management practice and of residents personal plans. The annual review of the quality and safety of the service had been completed as were the quality and safety reviews required to be completed at least on a six-monthly basis. An inspector read the reports of these reviews, saw that these internal reviews found a high level of compliance and minimal quality improvement plans issued. However, there was one outstanding action in relation to a clinical referral. In addition while there were systems for reviewing risks and simulated evacuation drills this did not result in appropriate corrective actions being taken.

Regulation 14: Persons in charge

The person in charge worked full-time. The person in charge had the experience, skills and qualifications needed for the role. It was evident from these inspection findings that the person in charge was consistently engaged in the administration, management and oversight of the designated centre. The person in charge on speaking with had sound knowledge of each resident's needs, abilities and individual circumstances.

Judgment: Compliant

Regulation 15: Staffing

Inspectors found staffing levels, staff skill-mix and staffing arrangements were planned and managed so that they were suited to the number of and the needs of the residents availing of respite at any given time.

The staff team was comprised of staff affiliated to the respite service and staff affiliated to the day service. The person in change assured inspectors that there was clarity on reporting relationships and staff management systems. This staffing arrangement also meant that residents received continuity of support as staff supported residents in the day service and then came to the respite service with them.

An inspector reviewed the planned and actual staff duty rotas for June 2025. The rota showed how the staffing levels and staffing arrangements were matched to the number of and the needs of the residents availing of a respite service. There were two staff members on duty each evening up to 22:00hrs which meant, as inspectors saw, that residents could do different things if they wished. Additional staff were on duty by day and by night when residents with higher support needs such as physical care needs were in receipt of respite.

The staff rota format of matching occupancy and needs with the staffing levels and arrangement's was a good system that was clearly understood in the designated centre. However, inspectors recommended a minor format change so that staff members and residents were clearly differentiated for any other person reviewing the staff duty rota.

Judgment: Compliant

Regulation 16: Training and staff development

The person in charge maintained a record of the training requirements of each staff member working in the designated centre. This included the staff affiliated to the day services.

An inspector reviewed the training matrix and saw that good oversight was maintained of staff training requirements. No gaps were noted in the completion of baseline training including safeguarding adults from abuse, responding to behaviour that challenged, fire safety and the management of medicines. Refresher training was either booked or highlighted so that it would be booked.

The person in charge described appropriate staff reporting and supervision arrangements and told inspectors that formal staff supervisions were completed on schedule.

Judgment: Compliant

Regulation 19: Directory of residents

The registered provider had established and maintained a directory of residents in the designated centre. An inspector read the directory of residents and saw that the directory contained the information specified in paragraph three of schedule three of the regulations. For example, the residents name and date of birth and the contact details of their representative and their general practitioner (GP).

Judgment: Compliant

Regulation 21: Records

Any of the records requested by inspectors to inform and validate these inspection findings were in place. For example, a record of the charges paid by residents, a record of any restrictive practices in use, complaint records, staffing records and fire safety records. The records were well maintained.

Judgment: Compliant

Regulation 23: Governance and management

Overall, inspectors found a service that was well planned, managed and overseen: this was reflected in the good level of compliance found with the regulations. However, while compliance levels were good there were matters that were reported

to be impacting on the capacity of the management arrangements in place in the designated centre. There were some gaps in oversight and information gathered about the service was not always used to improve the appropriateness, quality and safety of the service.

Inspectors were not assured that the provider was robustly monitoring the capacity of the management arrangements in place. The person in charge had responsibility for another designated centre. The person in charge described to the inspectors challenges in that service including increased needs, increased risks and staffing deficits. This meant that the person in charge had been and was required to work as a frontline staff in that designated centre. For example, the person in charge told inspectors that they had worked a full shift the week prior to and the week of this HIQA inspection. This placed additional demands on the management arrangements in this designated centre while a busy respite service was also establishing and expanding.

The person in charge had escalated this to their line manager, who was described as receptive and supportive and additional administration support had been provided. At verbal feedback of the inspection findings the community manager accepted the recent demands on the designated centres management arrangements. The provider needed to review and assure itself as to the adequacy and sustainability of these management arrangements.

Inspectors found that there were some gaps in oversight particularly in relation to fire safety. While it was known by the provider that the time taken to evacuate a resident was lengthy, this did not result in actions being taken to improve the evacuation time. In addition, inspectors noted that an action from the most recent internal provider review in relation to an outstanding clinical referral was still not resolved.

Judgment: Substantially compliant

Regulation 24: Admissions and contract for the provision of services

An inspector saw that each resident attending the respite service had been provided with a contract for the provision of services. The inspector reviewed five contracts for the provision of services. The inspector also reviewed a similar sample of the available transition plans.

The contracts detailed the facilities and services that would be provided to the resident in the centre. It outlined the charges payable and what the resident would have to pay for themselves such as social events or activities. All contracts reviewed were signed by either the resident or a representative.

The transition plans reviewed detailed that the residents and their families if they wished, had opportunity to visit the centre prior to the resident's admission.

The person in charge described how they assessed and monitored resident compatibility so that residents were protected from any possible harm from their peers.

Judgment: Compliant

Regulation 34: Complaints procedure

The provider had and implemented effective systems to address any complaints raised by residents or their representatives.

Inspectors saw that the person in charge had ensured that the complaints' procedure and an easy to read version were prominently displayed and available to residents and representatives.

There were no open complaints on the day of inspection. On speaking to the person in charge and reviewing the complaints log, an inspector saw that two complaints had been received, progressed and dealt with in line with the complaints procedure. The inspector found that the person in charge had established and recorded that complainant's were satisfied with the response to their complaint and the outcome.

The provider had oversight of complaints received and this was evidenced in the report of the annual review of the service and the provider audit undertaken at least six-monthly in the centre.

Inspectors spoke to residents who were clear in relation to who they would raise a complaint with in the designated centre.

Judgment: Compliant

Quality and safety

Based on the findings of this HIQA inspection residents received a good quality respite service. Information was gathered about each resident's needs, abilities, choices and preferences. That information was used to inform the development of a personal plan and the arrangements put in place so that residents were safe and well and enjoyed their time spent in the respite service. Improvement was needed in relation to the centres fire evacuation procedures, in the management of risk and in relation to the premises.

Nineteen residents were regularly availing of the respite service on a planned and rotational basis. Respite breaks were planned in advance by the person in charge in consultation with residents and their families. Records of this planning and

consultation were on file.

Each resident had a personal plan specific to their respite care and support needs. The plan included a personal objectives tracker. The person in charge described to inspectors how keeping the plans updated was particularly challenging given that residents also had a plan and an overarching personal outcomes measures plan in the day service.

The inspectors reviewed a purposeful sample of three personal plans. There were some updating issues with one plan but overall the documentation was presented and maintained to a good standard and was sufficient to ensure that residents received a continuum of support and care between home, the day service and the respite service.

For example, the assessed needs of some residents included behaviour that could challenge or behaviours that posed a risk to resident wellbeing and safety such as abruptly leaving the company of staff or the designated centre without the knowledge of staff. Inspectors saw that staff had access to a positive behaviour support plan that outlined the behaviours that could present, why they might present and how they could managed and be responded to.

In response to some risk behaviours that did present there were controls in place that met the definition of a restrictive practice. For example, there were alarms to alert staff if the external doors were opened. The provider could justify why these controls were needed, how they were managed so that they were used only as needed and how their use was discussed with residents.

Overall, there were good systems in place for identifying such risks and for outlining their management. The inspector saw that the person in charge maintained a register of general risks and a log of the risks associated with each resident. Oversight was maintained by the person in charge and by the provider, for example during the internal provider reviews, of any incidents that had occurred and how these incidents were managed. However, this oversight had not assured the adequacy of some existing controls and the need for additional controls. For example, in relation to fire safety.

Inspectors saw that the premises was fitted with fire safety measures that included a fire detection and alarm system, emergency lighting and doors with self-closing devices designed to contain fire and its products. Regular evacuation drills were completed at a frequency that ensured each resident availing of the respite service participated in these drills. However, there was confusion in relation to one personal emergency evacuation plan (PEEP) and two drill records seen indicated that the resident was not evacuated in a timely manner.

Overall, the design and layout of the premises was suited to the stated purpose and function of the centre. However, there was an evident issue with storage that impacted on the personal storage available to residents and the homeliness of the service. There were other premises issues to be addressed such as possible limitations to accessibility in the main corridor.

Regulation 10: Communication

The provider had ensured that residents were supported and assisted to communicate in accordance with their needs and wishes.

The two residents the inspectors spoke with initiated and engaged in conversation and discussed a range of topics regarding their plans for the evening and their daily routines. Inspectors observed no communication barriers and the interactions between staff and residents were person centered and in line with the residents' communication needs and abilities.

Residents had access to televisions, radio, mobile phones, newspapers and the Internet. Inspectors viewed three residents' support plans and where they were required clear up-to-date communication passports were available. The communication passports outlined how each resident communicated and strategies for staff to use so as to best support effective communication. For example, using short sentences, allowing sufficient time for the resident to process what was said and not repeating requests or questions.

Inspectors noted in records seen that a resident in the centre was recently assessed by a speech and language therapist and a recommendation for assistive technology was made. The Person in charge was actively pursuing this recommendation at the time of this inspection.

Judgment: Compliant

Regulation 12: Personal possessions

The provider had arrangements in place that ensured resident's had access to and control of their personal property and were supported to manage and benefit from their finances in line with their assessed needs. However, improvement was required in relation to the space available to residents for the storage of their personal possessions.

Inspectors reviewed the providers arrangements and saw that a financial capacity assessment, a 'money management competency assessment' had been carried out for each resident. This established the level of support the resident required to safely manage their own money. This assessment was reviewed annually. The person in charge had ensured residents monies were securely stored and that clear and accurate financial management records were maintained. These records were viewed on the day of inspection.

There were suitable facilities in the centre for the laundry of residents' clothing. Wardrobes were available in each bedroom. However, the system for the storage of

personal possessions such as bedding required review. Bedding for residents was stored on an individual basis in a room off the utility and also in all of the bedroom wardrobes on the day of inspection. Inspectors observed that this meant that residents did not have adequate storage space for personal clothing and possessions during their respite stay. There was a possible risk of cross contamination due to the storage of personal bedding in many locations, along with some containers that were not sealed appropriately.

As this lack of personal storage was as a result of a general storage issue it is addressed in Regulation 17: Premises.

Judgment: Compliant

Regulation 17: Premises

Overall, residents were provided with safe and comfortable accommodation and the provider ensured that any equipment needed was provided and maintained in good order. For example, there was documentary evidence that the ceiling track hoist was periodically inspected and maintained as required. Shared communal spaces such as the sitting room and main bathroom were spacious. Resident's bedrooms presented as of a suitable size.

However, inspectors noted damage and scuffing to the kitchen door frame, a bedroom door frame and an area of the hallway that indicated possible limitations to accessibility and the turning space available for wheelchairs.

There were evident storage issues. The provider operated a system where each resident was provided with their own linen for their personal use. These items were stored in plastic boxes between each respite stay. This was a good system that supported individualised care but there were 19 residents accessing the service and some residents had two storage boxes. There was a specific storage room and it was full. When inspectors opened the wardrobes in the bedrooms they also contained boxes of items stored for different residents. This meant that while the duration of their stay was brief, residents did not really have space to store the personal items they brought with them. This practice did take from the personalisation of the facilities provided which was the opposite of what was intended.

Overall, there was scope to improve that personalisation. For example, there was acoustic padding affixed to a kitchen wall and the walls of one bedroom that the person in charge confirmed was no longer needed. It was drab, damaged and torn in some places. One ceiling light in one bedroom did not have a lampshade. Bedroom walls were bare in contrast to the shared areas that had pleasant pictures, a nice mural of all of the residents and wall hangings with happy slogans.

The house was visibly clean and a record was in place of the monitoring of the refrigerator temperature. However, there was an unpleasant odour from one

refrigerator when it was opened by inspectors.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

While they were good, the systems in place for identifying, assessing and reviewing risk on an ongoing basis, did not always identify the need for more suitable controls or additional controls.

For example, while there was a fire safety risk assessment the time taken to evacuate a resident had not resulted in a review and increase of the residual risk or the exploration of additional controls to reduce the risk such as the location of the residents bedroom.

As an alternative to the use of bedrails with a non-ambulant resident a height adjustable bed was provided and an item was placed on the floor outside the bed to reduce the risk of injury if the resident was to roll or fall from the bed. However, that item was a mattress for a bed rather than a proprietary lightweight, shallow, impact reducing floor mat. The mattress could present a manual-handling or trip risk to staff and could present an additional challenge to the resident's timely evacuation.

There was ramped access to the front and rear of the house. However, the guardrail to the front of the house did not extend to the level area in front of the door which was open with a step-drop down.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The provider did not demonstrate that all residents could be evacuated from the designated centre in a timely manner.

Inspectors found that there was confusion in relation to one resident's evacuation plan. Inspectors were told that the resident could assist in transferring to their wheelchair and that if in bed, the resident was transferred into and evacuated in their wheelchair. There was an evacuation device in the bedroom in the event that the resident could not be transferred to their wheelchair. However, when the inspector reviewed the residents PEEP it stated that the resident was to be physically evacuated by two staff members on the evacuation device.

The inspector then read the records of two night-time drills completed with the resident. Staff had used the ceiling track hoist to transfer the resident into their

wheelchair and evacuated the resident from the building in their wheelchair. While there was some improvement between both drills the evacuation times recorded for both drills were not timely. The first was recorded as taking six minutes, the most recent was four minutes. It was not evident that the first recorded evacuation time had been identified as requiring improvement. The second drill time was identified as requiring review and improvement but when the evacuation was repeated it was a day time drill with the resident already seated in their wheelchair. The repeat drill therefore did not re-test the night-time evacuation procedure.

A bedroom with an escape route door directly leading to the outside was available in the centre but the resident was not at the time of this inspection using this bedroom.

One door and designated escape route had a manual lock; the others were noted to have thumb-turn devices. There was no key-box in place to ensure a key was always available for this door if there was a ongoing requirement for a manual lock on this door.

A review was needed of the safe operation of domestic appliances. As everyone including the inspectors were leaving the centre inspectors noted that the tumble dryer was turned on and the fire resistant door to the utility was open. This was highlighted to the person in charge once noted by inspectors.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

There was robust systems in place to ensure safe medication management practices in the centre. An inspector reviewed these systems including records such as the relevant policy and procedures, a sample of prescriptions and discussed how medicines were managed in the designated centre.

Overall, inspectors found that the person in charge had appropriate and suitable practices relating to the receipt, prescription, storage and administration of medicines. Medication was appropriately prescribed and stored in the designated centre according to best practice on the day of inspection. The maximum dose was not stated for an as needed medicine on one record reviewed. This was highlighted to the person in charge who committed to have it amended.

The person in charge had appropriately responded to any medication related incidents in the service and had initiated quality improvement plans to support best practice regarding medication management. There was no concerning pattern of such incidents based on an inspectors review of incident records.

There was a system in place for the management of out-of-date or returned medicines including appropriate and lockable storage.

Each resident had a medicines management risk assessment that was reviewed at least annually to ensure safe medication practices were in place.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The person in charge confirmed that each resident participated in the process of personal planning. Inspectors saw that the person in charge in consultation with residents, representatives and other stakeholders such as the day services had completed a comprehensive assessment of each resident's social, personal and healthcare needs prior to admission.

The person in charge had prepared a 'respite care plan' for each resident based on the findings of their assessment. The plan detailed areas such as key information about the resident, person-centered planning, advocacy, consent forms, medication plans, daily support notes, goal tracking, risk assessments, financial information and multi-disciplinary input.

The person in charge confirmed that they were in contact with each family prior to each admission so as establish any changed needs and regular meetings were held with families and residents in the day service. The person in charge participated in these meetings.

Inspectors reviewed a purposeful sample of three personal plans. Each plan seen addressed the needs, abilities, likes and dislikes of the resident and the care and support to be provided during the respite stay. Each plan also included a tracker for monitoring the progress of the residents personal goals and objectives such as the development of their daily living skills, building and maintaining friendships and relationships. Each resident had a keyworker who supported the resident to explore goals and plans for their time in respite.

During their stay records seen indicated that residents enjoyed activities such as swimming, having meals out, trips to the cinema, meeting friends, shopping, going for a walk and having an ice-cream.

The person in charge told inspectors that ensuring the maintenance and updating of each plan was challenging. Overall however, inspectors found that the standard of personal planning documentation was good and adequate to guide the support and care needed. One file reviewed did require an update to ensure it was reflective of the residents changing needs. However, discussion with the person in charge established that the assessment (SLT) had been completed and the recommendations made were in progress.

Judgment: Compliant

Regulation 6: Health care

Residents ordinarily lived at home, therefore family were the primary caregivers in relation to each resident's health and wellbeing. However, inspectors saw that the person in charge collated information about each resident's health and wellbeing as part of the initial assessment of needs and on an ongoing basis. This ensured that residents would receive the care and support that they needed during their respite break. For example, the person in charge had identified residents with specific needs such as in relation to their meals and diet and any risk for seizure activity.

There was a reasonable expectation that residents were well when they attended for respite. The person in charge had procedures in place in the event a resident became unwell during a respite stay. This contingency plan was agreed upon admission to the designated centre.

The daily narrative notes created by staff confirmed that staff monitored resident wellbeing during the respite break and communicated any concerns or new needs. The respite service, the day service and families worked together in this regard. Residents could if needed access the provider's multi-disciplinary team.

Judgment: Compliant

Regulation 7: Positive behavioural support

The provider had suitable measures in place for the support and management of behaviour that challenged.

For example, inspectors saw that the risk for such behaviours was identified and assessed and procedures including positive behaviour support plans were put in place. Additional arrangements included consideration of resident compatibility when planning the respite service. These arrangements supported residents in managing behaviours of concern which contributed positively to their well-being.

Inspectors viewed three personal plans and saw that each of these plans included a positive behaviour support plan. The plans were clear and up-to-date and had been devised with input from the positive behaviour support specialist so as to inform their evidence base. The plans looked at non-verbal and expressive communication, likely behaviours, possible responses, therapeutic rapport, calming and tension reduction strategies and, reactive planning and crisis intervention if needed.

The centre was adequately staffed to ensure the residents had appropriate support at all times. Staff were trained in positive behaviour support including de-escalation and intervention techniques.

There were some interventions in place that met the definition of a restrictive practice. For example, enhanced supervision and alarms to alert staff. The provider could justify on the basis of risk why these restrictions were in place. Records were in place of staff discussions with residents as to their use but also of attempts to enhance resident understanding of risk and danger.

There were systems in place for reviewing and approving the ongoing use of the restrictions and evidence from the incident log that the risks being managed were active risks.

There was no evidence that the restrictions in place impacted on resident quality of life. Parameters were laid down for their use so that they were used only as needed. For example, they were only used at night and only when the relevant residents were availing of respite.

Judgment: Compliant

Regulation 8: Protection

The provider had measures in place to protect residents from abuse. For example, the provider had safeguarding policies and procedures. All staff had completed safeguarding training. The person in charge told inspectors that the training was a combination of on-line training and training provided in person by the designated officer.

As part of this inspection, inspectors followed a particular line of enquiry in relation to notifications that had been submitted to the Chief Inspector of Social Services. Inspectors found the provider had taken all measures to ensure the safety and protection of residents. These measures included referral to the designated safeguarding officer along with the relevant safeguarding teams.

Information posters for the designated officer were clearly displayed in the centre.

The social care worker told inspectors that they had completed a specific training programme with an external trainer so that they could facilitate training for residents. Some residents including the residents inspectors met had completed this training designed to develop resident understanding of what were good and safe relationships.

Inspectors also saw in the personal plans, plans for delivering personal and intimate care, social stories and accessible safeguarding materials used at regular intervals by staff when speaking with residents. Staff maintained a date of these discussions aimed at building resident understanding of harm and staying safe.

Judgment: Compliant

Regulation 9: Residents' rights

The respite service was planned and managed in a way that acknowledged and respected resident individuality. The person in charge in consultation with residents, their families and the day services collected information about the needs, abilities, choices and preferences of each resident. This information was then used to inform how the respite service was planned and delivered. This meant that residents could access respite with friends and peers that they got on well with and enjoyed being with. If the information gathered indicated that there may be an absence of compatibility between residents this also informed who residents shared their respite break with.

The residents met with evidently had good choice and control over how they wanted to spend their time in respite and their different choices were respected. The feedback provided by residents and seen by inspectors indicated that residents were happy with the choices that they had and could lead on these choices such as where they went, what activities they enjoyed, how they spent their money and how they could relax doing things that they enjoyed such as listening to their music in the privacy of their bedroom if this is what they wanted to do.

There was documentary evidence that residents were spoken with about their care and support needs. For example, the recorded discussions in relation to safeguarding and the use of restrictions.

Inspectors noted that any information in relation to residents such as their personal and intimate care needs was stored in the staff office and was not available in shared spaces.

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	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 19: Directory of residents	Compliant
Regulation 21: Records	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 24: Admissions and contract for the provision of services	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 12: Personal possessions	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Castlelodge OSV-0008008

Inspection ID: MON-0044005

Date of inspection: 25/06/2025

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 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: 1.Caseload for the Person in charge will be reduced from September 2025. 2.The centre is now at capacity, and the provider can confirm that the additional workload associated with setting up the service will reduce from September 2025. 3.Analysis of fire drills, by the Community manager and the P.I.C. has been added to the quarterly reviews template. 4. With reference to the "outstanding action in relation to a clinical referral", the Psychologist will carry out the requested assessment on 9/9/25.	
Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: 1.Residents will bring personal items to service as required and will not store belongings in the DC. 2.Acoustic padding removed from walls on 26/6/25. 3.Additional storage cupboards will be installed by Oct 2025. 4. Assessment of wheelchair accessibility within the home completed 26/6/25. The provider is assured there is adequate room to turn a wheelchair. Wear and tear in hallway on day of inspection was due to staff navigating new equipment. Training for all staff in the use of new equipment to be completed by October 2025. 5y. In order to ensure adequate hygiene standards are maintained, the P.I.C. has met with all staff, and highlighted the unpleasant odour coming from the fridge. An additional	

check of the fridge after breakfast, has also been added to the daily cleaning schedule. An unannounced I.P.C. audit will be completed by the Community manager in September 2025

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
1. Mattress on floor removed 26/6/25.
2. Impact reducing floor mat in situ 26/6/25.
3. Site specific fire training completed 10/7/25, issue of delayed fire evacuation resolved.
4. Guard rail at front of house to be extended Sept 2025.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
1. PEEPs plan updated.
2. Additional fire drill completed at night to retest efficacy and timing of evacuation procedure, 5/7/25. This drill addressed the findings identified at the inspection, and the evacuation time was significantly reduced.
3. Site specific fire training completed 10/7/25.
4. Bedroom for individual with reduced mobility changed, to facilitate safer/quicker evacuation in the event of fire/emergency, 26/6/25.
5. Key box to be installed at back door, August 2025.
6. A checklist for staff, to include ensuring all appliances have been turned off before leaving the house, has been added to the daily folder.

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 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Substantially Compliant	Yellow	31/10/2025
Regulation 17(6)	The registered provider shall ensure that the designated centre adheres to best practice in achieving and promoting accessibility. He. she, regularly reviews its accessibility with reference to the statement of purpose and carries out any required alterations to the premises of the designated centre to ensure it is accessible to all.	Substantially Compliant	Yellow	31/10/2025
Regulation 17(7)	The registered provider shall make provision for	Substantially Compliant	Yellow	31/10/2025

	the matters set out in Schedule 6.			
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.	Substantially Compliant	Yellow	30/09/2025
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.	Substantially Compliant	Yellow	30/09/2025
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.	Not Compliant	Orange	01/08/2025