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:	Crossroads
Name of provider:	St Aidans Services
Address of centre:	Wexford
Type of inspection:	Announced
Date of inspection:	10 June 2025
Centre ID:	OSV-0008304
Fieldwork ID:	MON-0038407

About the designated centre

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

Crossroads provides long term residential care for up to five residents in a purpose built single storey house close to a town in County Wexford. The centre provides care for both male and female residents who have a primary diagnosis of mild to severe intellectual disability, and possible secondary diagnoses of mental health, autism, epilepsy and behaviours that challenge. The staff team consists of a social care leader, social care workers and support workers. The residents all have their own individual bedrooms. Rooms are decorated to reflect the personal choices and needs of the residents. The centre is homely and comfortable. The centre is located on the grounds of a busy garden centre and day services managed by the provider. The day-services offer varied levels of support, training and age appropriate activities for the residents. It is within easy access of all local facilities and services.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	5

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Tuesday 10 June 2025	08:40hrs to 17:15hrs	Sarah Mockler	Lead

What residents told us and what inspectors observed

This was an announced inspection, completed to monitor the provider's compliance with the regulations and to inform decision making in relation to renewing the registration of the designated centre. Overall, the inspection findings indicated that the residents that lived in the centre were well cared for, safe and had a good quality of life. Some minor improvements were required in relation to staffing supports, staff training and ensuring a resident had access to their own finances.

The inspector used observations, conversations with staff, conversations with residents, and a review of documentation to form judgments on the quality and safety of the care and support provided to residents in the centre.

The centre had capacity to accommodate five residents. On the day of inspection five residents were living in the centre. The inspector had the opportunity to meet or see all residents that lived in the centre.

On arrival at the centre, the inspector was welcomed in by the team leader, the person in charge was present and one staff was finishing up their shift. Two residents were in the sitting room. All other residents had left for the day.

The two residents present were up and ready for the day. They were both heading out to their day service. Both residents were in the sitting room and were seen to help to get items ready for their day service. For example, one resident was given a letter to post in the day service as they particularly liked this job. With the support of staff, a resident told the inspector that they had completed a fire drill early in the morning. This had been an unplanned drill and all residents had responded very well. Both residents were eager to leave and staff supported them to accordingly.

The inspector completed a walk around of the premises with the person in charge. The residents lived in a bungalow building on a campus type setting. In close proximity of the centre was another separate designated centre and other services operated by the registered provider.

The residents all had their own individual bedrooms, two bathrooms, a large sitting room, and kitchen area. Additionally, there was a room allocated as a staff office and sleepover room, a visitor's room, and a laundry room. The home was well kept and very clean. Maintenance staff were present on the day of inspection to touch up painting in resident's bedrooms. All parts of the home were nicely decorated with personalised items such as photographs, paintings, personalised cushions, personalised blankets, and music equipment. Some residents had televisions and smart music players in their bedrooms.

Later in the morning, one resident returned to their home for a brief period of time. They had a one-to-one staff allocated to them and their day service was adapted to meet their individual needs. They went into their home to get an item and soon left

to go back to the day service which was located on the same site.

Later in the afternoon the inspector got to meet with a resident and have a short conversation with them. They were sitting in their room after returning from day service. They were happy to speak with the inspector and expressed that their long term goal was to move out of the home and live with less people. The provider was aware of this and had accounted for this in the annual review and six-monthly unannounced provider led audits. There was a long term plan to work on this goal with the resident. The resident spoke briefly about this gaol and was able to tell the inspector about some of the different people involved in this process.

The final resident returned in the late afternoon and was observed to be in the garden area. They declined to meet with the inspector and this was respected.

From speaking with the staff team, reviewing documentation and observations on the day of inspection, residents were encouraged and facilitated to engage in activities of their preference and choosing. Residents enjoyed attending day service, helping in animal charities, day trips, going out to coffee shops and restaurants and family visits. Two residents had planned a holiday to Wales for the coming weeks and were looking forward to travelling on the ferry. The inspector saw that one resident had recently purchased a suitcase for this holiday and had it ready in their bedroom.

In advance of the inspection, residents had been sent Health Information and Quality Authority (HIQA) surveys. These surveys sought information and residents' feedback about what it was like to live in this designated centre and were presented to inspectors on the day of the inspection. Five surveys were returned to the inspector. The feedback in general was very positive, and indicated satisfaction with the service provided to them in the centre, including; the staff, activities, people they live with, food and the premises.

The next two sections of the report present the findings of this inspection in relation to the governance and management arrangements in place in the centre and how these arrangements impacted on the quality and safety of the service being delivered to each resident living in the centre.

Capacity and capability

This section of the report sets out the findings of the inspection in relation to the leadership and management of the service, and how effective it was in ensuring that a good quality and safe service was being provided.

Overall, it was found that the service was very well managed with suitable systems in place to ensure comprehensive oversight of the care and support being delivered. As previously mentioned some improvements were required in relation to ensuring the staffing arrangements were sufficient to meet the needs of residents and that

staff received adequate training in all areas of care and support needs.

Although there was a regular core staff in place, the centre was operating at a staff deficit which meant the minimum number of staff were not always present in the centre. For the most part, measures had been put in place to mitigate against the risk of low staffing numbers. However, further enhancement of the number of staff employed was required.

Although there was a number of core training courses completed to enable the staff to deliver care and support in line with residents' specific assessed needs. A small number of staff required training in specific areas to ensure care was in line with evidence based practices.

Registration Regulation 5: Application for registration or renewal of registration

The registered provider had submitted an application seeking to renew the registration of the designated centre to the Chief Inspector of Social Services. The provider had ensured information and documentation on matters set out in Schedule 2 and Schedule 3 were included in the application. For example, as part of the application process the provider submitted floor plans which accurately represented the layout of the designated centre.

Judgment: Compliant

Regulation 15: Staffing

The provider was striving to ensure there were enough staff with the right skills, qualifications and experience to meet the assessed needs of residents at all times. On the day of inspection there were four staff available to meet the needs of the residents during the day time hours and two staff rostered for the evening shift.

On the day of inspection the centre was operating with three whole time equivalent vacancy posts. The inspector and person in charge reviewed the staff rosters across a three month period from April to June 2025. Although the provider strived to use agency or relief staff to cover the identified gaps on the roster, on 10 occasions the centre was not operating with the required number of staff. The provider had taken a number of measures in relation this, such as completing comprehensive risk assessments. The inspector reviewed the 10 risk assessments that had been completed. In the risk assessment the control measures included ensuring the staff on duty had sufficient training, the use of the team leader and person in charge to cover the floor (if required) and on call available at all times. However, further measures were required to ensure that the centre had sufficient staffing at all times.

The rosters reviewed were well maintained with the staff members full name and

role clearly represented. Although it was evident that agency and relief staff were utilised for the most part the provider was ensuring this was with same named staff as much as possible. Regular staff were always rostered with agency staff to ensure continuity of care.

The Inspector reviewed three staff records and found that they contained all the required information in line with Schedule 2, including evidence of professional references and vetting by An Garda Síochána.

Judgment: Substantially compliant

Regulation 16: Training and staff development

The inspector reviewed the staff training matrix that was in place to track the completion of staff training within the designated centre. It was found that all staff had training in key areas such as safeguarding, fire safety, safe administration of medicines (including the management of epilepsy), and managing behaviour that is challenging. Staff also were up-to-date in all training areas related to infection prevention and control (IPC) measures.

Additionally, although a number of staff had training completed in relation to residents' specific needs there were training gaps in this area. For example, not all staff had training in relation to feeding, eating drinking and swallowing needs or first aid. There were a number of residents with swallow care plans in place and one resident who engaged in behaviours of eating non-edible items. Although this was not a lone working home and therefore there was usually a minimum of one member of staff trained in this area on shift. This required review to ensure all staff had up-to-date knowledge and skill in this area.

Staff were in receipt of regular support and supervision through supervision and staff appraisals. Staff appraisals were in place for new staff or existing staff that were promoted to new roles. The inspector reviewed one staff members supervision records and two staff members appraisals. This documentation indicated that staff were supported to complete their role effectively.

Judgment: Substantially compliant

Regulation 22: Insurance

The service was adequately insured in the event of an accident or incident. The required documentation in relation to insurance was submitted as part of the application to renew the registration of the centre. The inspector reviewed the insurance document and found that it covered against risks in the centre, including

injury to residents.

Judgment: Compliant

Regulation 23: Governance and management

Overall the systems in place were effective in ensuring the service was safe and was promoting a good quality of life for all residents that lived in the centre.

There was a clearly defined management structure in place with the staff team reporting to the person in charge, who in turn reported to the residential manager. The person in charge has remit over two designated centres operated by the registered provider. The person in charge had the support of a team leader which enabled them to effectively provide sufficient oversight across their managerial remit. The person in charge and team leader were both supernumerary to the staff team.

The provider had in place a series of comprehensive audits both at local and provider level. For example, at local level, regular Infection Prevention and Control (IPC), medication management, finance and health and safety audits were completed. Action plans were implemented where risks were identified on these audits. For example, finance audits had identified potential fraudulent transactions on a resident's bank account. As this was identified in a timely manner this issue was rectified and the residents were reimbursed.

As part of the audit process, staff knowledge around aspects of care and support was also audited to ensure that staff had sufficient information and skills to deliver care appropriately. The inspector reviewed staff knowledge audits around IPC, managing finances, safeguarding and positive behaviour support. Supportive actions were identified though these audits such as having further discussions around specific topics in individual supervision sessions.

The provider had systems in place to complete annual and six-monthly reviews for the designated centre. The inspector reviewed the most recent annual review and the six-monthly provider unannounced audit. Again, these were comprehensive and identifying areas of improvement. For example, in the six monthly unannounced audit on dated January 2025 accounts for the resident's will and preference to move out of the designated centre and live with a smaller cohort of residents.

Judgment: Compliant

Regulation 3: Statement of purpose

The provider had submitted a statement of purpose which accurately outlined the

service provided and met the requirements of the regulations.

The inspector reviewed the statement of purpose and found that it described the model of care and support delivered to residents in the service and the day-to-day operation of the designated centre. It included all the required information as set out in the associated schedule. For example, the criteria of admissions was clearly described in the document.

Judgment: Compliant

Regulation 31: Notification of incidents

Documentation in relation to notifications which the provider must submit to the Office of the Chief Inspector under the regulations were reviewed during this inspection. Such notifications are important in order to provide information around the running of a designated centre and matters which could impact residents. It was noted that all required notifications had been submitted as required in line with the statutory time frames. For example, the provider submitted all notifications in relation to minor injuries within the designated centre.

Judgment: Compliant

Quality and safety

Overall, the inspector found that the centre presented as a comfortable home and provided person centred care to the residents. A number of key areas were reviewed to determine if the care and support provided to residents was safe and effective. These included meeting residents and staff, a review of personal healthcare plans, risk documentation, fire safety documentation, and documentation in relation to finances. The inspector found good evidence of residents being well supported in the majority of areas of care and support. One area of improvement was required in relation to the oversight and management of one resident's finance.

The inspector noted that the provider had put in significant measures to ensure residents' finances were accounted for and kept safe. This included the completion of assessments, care plans risk assessments and ensuring staff were equipped with the right knowledge in this area. Safeguarding residents finances were regularly discussed with both residents and staff. However, the provider had limited oversight of one resident's finances.

Regulation 12: Personal possessions

There were a number of good practices around the management of residents' personal possessions. All residents had good storage facilities in their bedroom to store and display there personal belongings. The inspector observed large wardrobes, bedside lockers and shelving units in place. There were facilities for residents to launder their clothes.

Four of the five residents had control over their own finances which included, bank accounts in their own name, finance assessments and robust systems in place to effectively maintain oversight and safeguard their monies. However, the same practices were not in place for one resident within the centre. This required review to ensure that it was in line with the requirements of the regulation and that support was in place for the resident to take part in managing their own finances.

Judgment: Substantially compliant

Regulation 17: Premises

The centre comprises a large bungalow building on a campus type setting in Co. Wexford. The premises was in walking distance to the day service operated by the same registered provider. There was a corridor interlinking this designated centre with another designated centre.

The centre appeared very clean, well maintained and homely in presentation. The communal areas were large and spacious with plenty of room for residents to relax. A smaller room within the centre had been recently reconfigured with new furniture purchased to provide additional space for residents to relax in.

All residents had their own bedrooms, all individually decorated and personalised to each resident's specific preference. There were lots of personal items on display in bedrooms and through out the home. For example, in the kitchen area there was a smart picture frame device that displayed different photographs of the residents on rotation.

Member of the maintenance team were present on the day of inspection to complete some minor works within the home, such as touch up painting in some residents bedroom.

Judgment: Compliant

Regulation 20: Information for residents

The residents' guide had been reviewed as part of the registration of this centre. It was found to contain all information as required by the Regulation. For example, the residents guide outlined how to make complaints if a resident was unhappy with any aspect of the care and support provided.

Judgment: Compliant

Regulation 26: Risk management procedures

The provider's risk management policy contained all information as required by the Regulation. The provider and person in charge were identifying safety issues and putting risk assessments and appropriate control measures in place. Risk assessments considered each individuals needs and specific preferences. The inspector reviewed individual risk assessments in place for slips, trips and falls, road safety, seizure activity, self injurious behaviour and specific medical needs. Control measures listed on the risk assessments were found to be in place.

Arrangements were also in place for identifying, recording, investigating and learning from incidents, and there were systems for responding to emergencies. The inspector reviewed all incidents that had occurred in 2025. The inspector saw that appropriate measures had been taken in relation to the incidents reviewed. For example, the inspector reviewed an incident in relation to a seizure. The risk assessment had been updated following a review by neurology and this accounted for the increase in medication prescribed to the resident. Risk ratings were proportionate to the identified risks.

Judgment: Compliant

Regulation 28: Fire precautions

There was suitable fire equipment in place and systems to ensure it was serviced as required. On the walk around of the premises the inspector saw fire extinguishers, emergency lighting, smoke detectors and the fire alarm. Fire containment measures were in place and effective.There was automatic door closures in place to ensure that doors would close in the event of an emergency. There were adequate means of escape. All fire equipment was being regularly serviced. For example, the inspector saw records that the emergency lighting and fire alarm panel were serviced in April 2025. There was a procedure for the safe evacuation of residents and staff, which was prominently displayed.

Each resident had a personal emergency evacuation plan (PEEP) which was clear in relation to any supports they may require. Fire drills were occurring regularly in the

centre and being completed at different times. The inspector reviewed six fire drills that occurred in 2025. The fire drills evidenced that all residents could evacuate in a timely manner with minimal supervision. The staff team also practiced evacuating the car in an event of a fire breaking out. This was important as one resident had a specific safety belt in place to ensure they were safe when travelling. The purpose of the drill was for staff to practice removing the specific safety belt in a timely manner.

Judgment: Compliant

Regulation 6: Health care

The registered provider took measures to ensure the residents' healthcare needs were met. Healthcare assessments were in place and reviewed regularly with appropriate healthcare plans developed from these assessments.

The inspector reviewed the individual healthcare plans in place for three residents. The residents had detailed plans in place to describe the support they required in the management of a range of assessed needs. For example, there were care plans in relation to managing infections, epilepsy, swallow care plans and pain management. In addition, there was guidance in place on how to support residents during healthcare appointments to ensure they felt comfortable during appointments and that they were successful. One plan detailed how a resident should bring a preferred item to each appointment.

Residents had up-to-date hospital passports in place to ensure that the correct information was available if a resident was transferred to a hospital setting. The inspector reviewed two of these plans and found them reflective of residents' current needs. For example, the hospital passport stated if the resident had a specific assessed need such as epilepsy.

Judgment: Compliant

Regulation 7: Positive behavioural support

The inspector found that there were arrangements in place to provide positive behaviour support to residents with an assessed need in this area. Not all residents in the home required support in this area. One positive behaviour support plan was reviewed by the inspector. It was detailed, comprehensive and developed by an appropriately qualified person. In addition, each plan included antecedent and setting events, proactive and reactive strategies in order to reduce the risk of behaviours that challenge from occurring.

The provider had ensured that staff received training in the management of behaviour that is challenging and received regular refresher training in line with best practice. Staff spoken with were knowledgeable of support plans in place and the inspector observed positive communications and interactions during the inspection between residents and staff.

There were a very small number of restrictive practices used in the designated centre which had been been notified to the Chief Inspector of Social Services in line with regulations. The inspector reviewed the systems in place in relation to the review and oversight of restrictive practice. It was found that a least restrictive approach to care and support was in place. For example, the inspector reviewed documentation whereby a the reduction of a restrictive practice evidenced.

Judgment: Compliant

Regulation 8: Protection

The registered provider had implemented systems to safeguard residents from abuse, which were underpinned by a written policy. The policy was available in the centre for staff to refer to. Staff had also completed safeguarding training to support them in the prevention, detection, and response to safeguarding concerns. Staff spoken with were aware of the procedure for responding to and reporting safeguarding concerns.

The inspector found that safeguarding concerns had been appropriately reported and notified to the relevant parties. Safeguarding plans had also been prepared, as required, which outlined the measures to protect residents from abuse. The plans were discussed at staff team meetings to remind staff of the measures to be in place.

All residents had safeguarding passports in place which ensured staff had up-to-date information on how to keep residents safe.

Intimate care plans had also been prepared to support staff in delivering care to residents in a manner that respected their dignity and bodily integrity.

Judgment: Compliant

Regulation 9: Residents' rights

Overall, the centre promoted a rights' based approach to care and support. The residents who lived in this centre were supported to take part in the day-to-day running of their home and to be aware of their rights through residents' meetings

and discussions with staff and their keyworkers.

All residents had right's assessments completed as part of their assessment of needs. This ensured that the residents care plans were considered from a right's based approach. The charter of rights was also discussed with residents on a regular basis.

Residents were consulted in relation to the implementation of restrictive practices, behaviour support plans and a range of other support plans. The inspector reviewed consent forms, signed and explained to residents which indicated how they were involved in the process.

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	
Registration Regulation 5: Application for registration or renewal of registration	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 12: Personal possessions	Substantially compliant
Regulation 17: Premises	Compliant
Regulation 20: Information for residents	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Crossroads OSV-0008304

Inspection ID: MON-0038407

Date of inspection: 10/06/2025

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 15: Staffing	Substantially Compliant

Outline how you are going to come into compliance with Regulation 15: Staffing:

St. Aidan's Services has implemented an intensive and ongoing recruitment campaign throughout 2025 to address staffing shortages and build a more sustainable workforce. Key initiatives to enhance recruitment activities include:
Enhanced level of Recruitment:
• A new standalone Recruiter role has been introduced, and a Recruiter is in post since January 2025.
• The Recruiter completes a review of all recruitment platforms daily for any new applicants and responses in regard to posts advertised.
• The Recruiter has implemented a structured calendar to ensure specific job opportunities are posted regularly across our social media platforms.
• Three recruitment fairs held to date within 2025 with interviews accommodated on the day.
Enhanced level of Job opportunity promotion:
• Through social media, local radio, Indeed, and community pages.
• St Aidan's Services have increased our recruitment presence on LinkedIn and the HSE job portal to reach a wider, professional candidate base.
• Collaborations with WWETB Gorey and local third level education providers have led to student placements and better awareness of our roles within the community.
• Staff Testimonial Videos commenced in May 2025 and to date 6 have been posted online to social media accounts and included in St Aidan's newsletter. These videos aim to increase interest in employment at St. Aidan's by sharing real experiences of current employees.
• In addition to recruitment, St. Aidan's is reviewing staff feedback and exit interview trends to identify areas for improvement in retention, which will support roster stability.
Staff vacancies:
• There has been a successful applicant for the post in Crossroads to date.
• Job offer issued in July 2025.
• Currently progressing through compliance, with a plan to be in post by 28th July 2025 pending Garda vetting completion.
Recruitment is ongoing for remaining posts.

Regulation 16: Training and staff development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:

• Review of the training schedule completed by PIC on 15.6.25.
• 2 areas identified as requiring action: (FEDS & First Aid)
• FEDS: all staff training is was complete by 06.07.25.
• First Aid: training is booked and will be complete by 28.07.25

• A local training matrix has been implemented within the center and will be reviewed on a monthly basis by Team lead/PIC.

• The Provider level training audit has been updated to include location specific training alongside mandatory training.

Regulation 12: Personal possessions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 12: Personal possessions:

External Supports:
• Safeguarding and protection team: PIC contacted the Safeguarding and protection team 16.07.25, who confirmed that the scenario relating to individuals financial management does not fall within the parameters of safeguarding. Recommendations for family and individual support given.
• Decision Support Service (DSS): PIC contacted DSS for guidance on individual financial management on 15.07.25. The DSS gave recommendations for different types of support available in this scenario.
• National Advocacy Service (NAS): PIC contacted NAS for guidance on individual financial management on 16.07.025. NAS recommended a referral be completed online. This to be done by 27.07.25.
• Money Advice and Budgeting Service (MABS): PIC contacted MABS on 16.07.25 for guidance on individual financial management, who advised that they can provide support in this scenario and gave a variety of suitable options.
• HSE Social Work Team: PIC contacted HSE Social Work Team on 16.07.25 for guidance on individual financial management. Social Worker advised to submit a referral for same. This will be completed by 27.07.25.

Individual Supports:
• All of the above advice and options will be explored via Easy read documentation with the individual by 31.07.25, to confirm will and preference.

Family Collaboration:
• A request to meet the family and the individual, to explore the options above, will occur by 30.09.25. However a timeline for implementation of a system to effectively maintain oversight and safeguard finances will be dependent on the options chosen from the list above and therefore a timeline of 31.12.26 will be given to allow scope for same.

Provider review:
• Learnings from external support interactions listed above will be considered and a Finance Policy review completed pending the outcome of above. This work will be completed by 31.12.26.

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 12(1)	The person in charge shall ensure that, as far as reasonably practicable, each resident has access to and retains control of personal property and possessions and, where necessary, support is provided to manage their financial affairs.	Substantially Compliant	Yellow	31/12/2026
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 16(1)(a)	The person in charge shall	Substantially Compliant	Yellow	28/07/2025

	ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.			