Report of an inspection of a Designated Centre for Disabilities (Adults).

Issued by the Chief Inspector

Name of designated centre:	Rose Lodge
Name of provider:	Resilience Healthcare Limited
Address of centre:	Kildare
Type of inspection:	Announced
Date of inspection:	05 February 2026
Centre ID:	OSV-0008576
Fieldwork ID:	MON-0040611

About the designated centre

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

Rose Lodge is a designated centre operated by Resilience Healthcare Limited. The centre provides full-time residential services for up to four male or female adult residents. It is situated on the outskirts of a large town in Co. Kildare. There are a number of vehicles available in the centre to support residents to visit their family and friends and to access their local community. Rose Lodge can provide a high support service for adults with Prader-Willi Syndrome who may present with complex needs. The house is sub divided into four self-contained apartments and there are a number of communal areas such as a living room, sun room, kitchen, utility room, and office. Residents' apartments have a living room, kitchenette, bedroom and bathroom. There is a driveway at the front of the house and a garden to the back. Residents are supported 24/7 by a staff team consisting of a person in charge, service manager, and support workers.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	4

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
Thursday 5 February 2026	10:10hrs to 17:20hrs	Erin Clarke	Lead

What residents told us and what inspectors observed

This was an announced inspection carried out to inform a decision regarding the provider's application to renew the registration of the designated centre. It was the fifth inspection conducted within the current registration cycle, arising from concerns identified during previous inspections. However, the provider had demonstrated sustained and ongoing improvement over time, with evidence of the capacity to effectively address areas of non-compliance and implement required actions. Some further improvement was required in relation to care planning and the development of the provider's annual review to ensure these fully met regulatory requirements and reflected current practice within the centre.

The designated centre consists of a spacious two-storey dwelling located in a rural area in Co. Kildare. The centre is registered to accommodate up to four residents with Prader-Willi Syndrome and was operating at full occupancy at the time of inspection. The inspector met with all four residents living in the centre, as well as the person in charge, the team leader, four staff members, and the person participating in management (PPIM).

The premises are arranged to provide each resident with self-contained, apartment-style accommodation within the main house. Each living space includes a private bedroom, bathroom, kitchenette, and sitting area, supporting residents to live as independently as possible while retaining the opportunity for social engagement in shared parts of the home. Communal facilities include a large sitting room and a bright sunroom available for residents' use. A separate kitchen area is provided for staff to prepare meals. Since the previous inspection, improvements had been made to increase residents' access to the utility room. One resident demonstrated to the inspector how they independently completed their own laundry, outlining the skills they had developed.

Three residents were present during the inspection, and each welcomed the inspector into their individual apartments. Residents proudly showed personal possessions of importance to them, including photographs of a family pet and soft furnishings they had selected themselves, which reflected their personal tastes and preferences. Residents communicated that they were content living in the centre and spoke positively about the staff team who supported them. Residents were observed to have positive, familiar interactions with staff and management, and a friendly, relaxed atmosphere was evident throughout the centre. Residents and staff engaged in light-hearted conversation and humour during the inspection.

Residents were supported to engage in a range of individual interests and community-based activities. For example, one resident showed the inspector their bedroom, which contained jigsaws, perfumes and personal items of interest. They had also recently commenced an art class and were volunteering in a local charity shop, supporting the development of social and vocational skills. Two residents who

regularly attended the annual Prader-Willi Syndrome (PWS) conference were due to speak at the event the day following the inspection, sharing their experiences of residential services. Residents demonstrated confidence in expressing their positive views and experiences of living in the centre. Another resident had commenced a hairdressing course since the previous inspection.

The hallway and other communal areas of the centre had also been redecorated, contributing to a more homely and personalised living environment. Photographs were displayed throughout the centre depicting residents engaging in shared activities, visits from the centre mascot dog, and celebrations such as exchanging presents at Christmas. These visual displays reflected a warm atmosphere and highlighted positive social interactions and meaningful experiences for residents.

Four questionnaires issued by the Chief Inspector to gather additional insights into the centre were returned and reviewed by the inspector. Overall, responses were positive, with residents indicating satisfaction with the support provided by staff, and the range of activities available to them. While feedback was largely positive, some residents described occasional challenges in peer relationships. These included instances where other residents became upset or displayed behaviours that could be distressing. Residents reported that staff were available to support them during these times, although the situations could still impact on their sense of comfort at times. They also reported feeling listened to and supported to make their own choices and decisions in daily life, including education, volunteering, and community participation. Residents outlined that they were encouraged to be involved in their care planning, attend regular meetings, and had opportunities to express their views on how the centre was run.

Families had completed satisfaction questionnaires for the provider in respect of the centre and reported a high level of satisfaction with the care and support provided. Feedback indicated that residents were well supported by both staff and management, and that any issues raised had been addressed in a timely manner. Families also commented positively on the homely atmosphere of the centre, noting the thoughtful personal touches throughout the house. An action had been identified by management in response to feedback, including consideration of equipping the centre with a smaller vehicle, as opposed to a larger bus, to better meet residents' needs and reduce unnecessary attention when accessing the community.

Improvement was required to ensure that feedback from families, and the inclusion of residents' views, were clearly captured and reflected in the provider's annual review in line with regulatory requirements.

The inspector spoke with one family member during the inspection. They expressed a high level of satisfaction with the care and support provided to their relative and described clear improvements in the resident's overall wellbeing and outcomes since transitioning to the centre. They reported that their family member was now settled, content, and thriving in their environment, having experienced some initial challenges during the early stages of the transition.

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

Capacity and capability

Overall, the inspector found that the centre was well governed and resourced, with effective leadership arrangements in place to ensure the delivery of safe and consistent care. The provider had demonstrated capacity to respond to previous areas of non-compliance, with evidence of sustained improvement over the course of the current registration cycle. Improvement was required in the annual review to ensure it fully demonstrated consultation with residents and families and provided a detailed, centre-specific analysis of the service.

The previous inspection of the centre took place in July 2025, at which time two areas of non-compliance were identified in relation to risk management and restrictive practices. On review during this inspection, the inspector found that these actions had been appropriately addressed and completed by the provider.

There was a clearly defined management structure in place. The person in charge was employed on a full-time basis for this centre only and was found to have the appropriate qualifications, skills, and experience to fulfil the role. They were supported by a team leader who had designated administrative time to support governance systems, including oversight of rosters and statutory notifications.

Staffing arrangements were found to be stable and appropriate to meet the assessed needs of residents. Each resident was supported by either one-to-one or two-to-one staffing arrangements, in line with their individual care plans.

Staff were appropriately trained and supported in their roles. A training matrix was in place and demonstrated that staff had completed mandatory and role-specific training, including safeguarding, fire safety, human rights, and the management of behaviours of concern. Systems for probation and formal supervision were implemented, supporting staff development and performance.

The statement of purpose had been reviewed and updated, and was found to accurately describe the service provided. It reflected the current operation of the centre and met the requirements of the regulations.

Regulation 14: Persons in charge

The person in charge was employed with sole responsibility for this designated centre. They were found to have the appropriate qualifications, skills and experience to effectively oversee the operation of the service.

From observations during the inspection, the person in charge was familiar to residents and engaged with them in a warm and respectful manner. Staff spoken with reported that the person in charge was accessible and supportive in their role, providing guidance and oversight as required.

Judgment: Compliant

Regulation 15: Staffing

Overall, the staffing arrangements were found to be well managed and sufficient to meet residents' needs in a consistent and person-centred manner. A total of 14.5 whole-time equivalent (WTE) frontline staff were employed in the centre.

There was evidence of a stable and consistent core staff team in place, comprising both support staff and nursing personnel. At the time of inspection, there were no staff vacancies, and there was minimal reliance on agency or relief staff, with no requirement for either at the time of inspection. This supported continuity of care and the development of positive relationships between residents and staff.

Judgment: Compliant

Regulation 16: Training and staff development

Overall, staff were appropriately trained, supported, and supervised to deliver safe and effective care. A training matrix was in place and demonstrated that staff had completed mandatory and relevant training to support them in their roles. This included training in the management of behaviours of concern, human rights, fire safety, and safeguarding. Training was found to be up to date and aligned with the assessed needs of residents.

There were clear arrangements in place for staff support and development, including the completion of probationary periods and the provision of regular formal supervision. Records reviewed demonstrated that these processes were implemented in line with the provider's policy and supported staff in their roles.

The inspector reviewed documentation which demonstrated that any staffing matters arising previously had been addressed through established governance and support processes, in line with the provider's policies.

Judgment: Compliant

Regulation 23: Governance and management

Overall, there was evidence of effective leadership and day-to-day management within the centre, with appropriate oversight from the provider. Governance systems were in place to monitor the quality and safety of care, including regular reviews and audits. Improvement was required to ensure the annual review fully met regulatory requirements and provided a comprehensive and meaningful evaluation of the service.

The provider had completed six-monthly unannounced visits to the centre, with the most recent taking place in December 2025. These visits assessed the quality and safety of care and identified areas for improvement. This review included updates on actions taken in response to previous compliance plans, identification of trends and common themes, and progress on incident outcomes.

The inspector found that improvements were required in the annual review for 2025, as it did not fully meet regulatory requirements. While the review provided a general overview of the service, it did not clearly demonstrate that residents and their families had been consulted as part of the process. In addition, it lacked a sufficiently detailed and centre-specific analysis of the quality and safety of care and support provided.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

Amendments had been made to the statement of purpose since the submission for renewal of registration. During the inspection, the provider submitted an updated statement of purpose, which was found to clearly set out the service's aims, objectives, as well as the facilities and services provided.

The document accurately described the designated centre, including its layout, staffing arrangements, and the needs of the residents it is intended to support. It was aligned with the requirements of Schedule 1 of the Regulations and reflected current practices within the centre.

Judgment: Compliant

Quality and safety

Overall, the inspector found that residents were supported to live meaningful and person-centred lives in a safe environment. There was evidence of good quality care and support, with residents actively engaged in their daily lives and supported to achieve personal goals. Residents' needs were assessed and care plans were in place to guide practice; however, improvement was required to ensure that all healthcare needs were clearly reflected and that care plans were consistently reviewed and updated.

Residents were actively involved in goal-setting and there was strong evidence of participation in activities such as education, volunteering, and community engagement. Access to a multidisciplinary team, including dietetics, occupational therapy, and behavioural support, ensured that residents' complex needs were appropriately supported.

The premises were found to be suitable, clean, and well maintained. Residents had access to private, personalised living spaces as well as comfortable communal areas. Improvements had been made since the previous inspection, including repairs and redecoration, all contributing to a homely and safe environment.

Effective systems were in place to identify and manage risk within the centre. Risks were assessed and reviewed regularly, and control measures were implemented to ensure residents' safety while supporting their independence. Previously identified risks, including those relating to fire safety and the premises, had been addressed.

Residents were supported through positive behavioural support approaches . While some restrictive practices were in place, these were proportionate, regularly reviewed, and had reduced over time in line with a decrease in behaviours of concern. There was evidence of a commitment to reducing restrictions and promoting residents' rights.

Systems were in place to identify, report, and respond to safeguarding concerns. Staff demonstrated knowledge of safeguarding procedures, and residents were supported to understand their rights and how to stay safe. A reduction in safeguarding incidents was noted, reflecting improved consistency in staffing and management and the implementation of appropriate supports

Regulation 13: General welfare and development

Residents were supported to engage in a range of meaningful activities in line with their interests, preferences, and assessed needs. There was evidence of individualised planning, with residents working towards personal goals such as participating in music lessons, engaging in volunteering opportunities, and accessing community-based activities including Special Olympics.

Residents were encouraged and supported to develop and maintain independent living skills, including areas such as budgeting and financial management. Opportunities for social inclusion and community participation were actively promoted, and residents were supported to maintain links with their local community.

Relationships with friends and family were actively encouraged and facilitated. Residents were supported to maintain regular contact with those important to them, in line with their wishes, through visits, phone calls, and participation in family events.

Judgment: Compliant

Regulation 17: Premises

The premises were found to be clean, well-maintained, and suitable for the number and needs of residents. The layout and design of the centre supported residents' independence, with each individual having access to their own apartment-style accommodation within the house.

Areas of the centre had been further personalised and maintained since the previous inspection. This included the replacement of previously damaged or worn furniture, such as torn items, which had improved both the comfort and presentation of the living environment. Additional painting works had been scheduled at the time of inspection to further improve the overall condition of the premises.

Judgment: Compliant

Regulation 26: Risk management procedures

Overall, the centre had effective risk management procedures in place, ensuring that risks were appropriately controlled and regularly monitored. Risks were regularly reviewed and updated in response to any changes in circumstances.

There was evidence of improved oversight and follow-through on identified risks since the previous inspection. Risks associated with the premises, fire safety, and financial management had been reviewed and mitigated, with clear systems in place to identify, assess, and manage risk on an ongoing basis. There was evidence of ongoing monitoring and review of incidents, with trends and learning informing practice.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The centre was found to overall meet the assessed needs of residents, including those associated with Prader–Willi Syndrome (PWS). However, improvement was required in the development and maintenance of care planning documentation.

Residents were supported to pursue meaningful goals and develop life skills in line with their preferences. For example, one resident had commenced tin whistle lessons, another was planning to re-engage with Special Olympics activities, and another was due to begin a voluntary role in a wildlife sanctuary. There was clear evidence of ongoing goal-setting between residents and their key workers, including areas such as budgeting and financial management.

Residents had access to a multidisciplinary team, including dietetics, occupational therapy, and behavioural support services. These professionals provided regular input, reflecting the specific needs of the service, and were available to support both residents and staff. There were established lines of communication between the multidisciplinary team and centre management, ensuring that any changes to care were appropriately informed and implemented.

On review of residents' healthcare needs, including those relating to prescribed medications, the inspector found that these were not consistently or clearly reflected within individual healthcare plans to guide staff practice. In addition, care plans were maintained on an electronic system; however, it was not always evident when they had last been reviewed or updated. This limited assurance that care documentation was current, clearly presented, and reflective of residents' assessed needs.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

The inspector found that restrictive practices in place in the centre were proportionate, regularly reviewed, and aligned with residents' assessed needs.

The inspector found that the use of restrictive practices had reduced since the previous inspection, in line with a decrease in incidents of behaviours of concern. There was evidence that restrictions were regularly reviewed with a focus on reduction and removal where possible. For example, access to the laundry room, which is located off the kitchen, had been facilitated following a review of restrictions, supporting increased independence for residents.

The inspector was informed that a perspex screen installed over a television in a communal area was due to be removed as part of the planned redecoration works.

This measure was no longer considered necessary from a risk management or restrictive practice perspective, reflecting a review of previous controls and a move towards a less restrictive environment. In addition, a restrictive measure previously in place in the centre's vehicle had been removed at the request of a resident, as the associated risks had reduced and incidents were no longer occurring.

A restrictive practices committee was in place to oversee and review all restrictions. The committee met on an annual basis, with the most recent review completed in October, at which time all restrictions in the centre had been considered and approved.

Judgment: Compliant

Regulation 8: Protection

Overall, residents were protected from abuse and supported in a manner that promoted their safety, rights, and wellbeing. The provider had implemented safeguarding measures following incidents of negative peer interactions between residents in 2025. On review, the inspector was satisfied that the measures introduced, including some environmental restrictive practices, had been effective in reducing the frequency of such incidents. There was evidence that relationships between residents had improved as a result, contributing to a safer and more stable living environment.

Any incidents or allegations of a safeguarding nature had been appropriately identified, reported, and subject to review and investigation in line with the provider's policies. These matters were also discussed at team meetings, with a focus on staff awareness, learning, and the importance of timely reporting.

Safeguarding was further promoted through regular discussion at residents' meetings, where topics such as dignity, respect, personal safety, and communication were explored in an accessible manner.

Systems were in place to safeguard residents' finances, and residents were supported to have full access to and control over their own money in line with their preferences and abilities.

There was evidence of a reduction in safeguarding incidents in the centre, which was attributed to a consistent management structure, a stable staff team, and the implementation of positive behavioural support strategies.

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 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Quality and safety	
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Rose Lodge OSV-0008576

Inspection ID: MON-0040611

Date of inspection: 05/02/2026

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The provider acknowledges the findings regarding governance and management, and we recognise the importance of providing a detailed and centre-specific analysis of the quality and safety of care and support provided, with the input from families and service users highlighted. To address these concerns, the provider has taken the following action:
The 2025 annual review has been amended by the PIC. This includes the original annual review using the HIQA template and an appendix has been added to include a detailed analysis of the quality reports – HIQA and Internal inspections, feedback from service users and families as per surveys completed. A review of staffing levels, skill mix and staff recruitment/retention. It also includes an overview of achievements of the service users in Rose Lodge, works completed in the house and highlights the significant reduction in incidences over the course of the year

Regulation Heading	Judgment
Regulation 5: Individual assessment and personal plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
The provider acknowledges the findings regarding individual assessment and personal plan, and we recognise the importance of providing comprehensive, accessible, accurate information.

To address these concerns, we have taken the following actions:
• A review of all person centered and support plans has been completed to ensure that all needs are clearly reflected in the plan.
• IT support has assured that evidence of reviews/time stamps for changes in person centered and support plans can be accessed at request and provided to the service.
• Additional care plans have been developed for all service users to provide accessible information and provide a roadmap to source additional information (e.g. behavior support plans etc.). Any review of or changes made to these care plans can be seen in the "audit view" section of the care plan.

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 23(1)(d)	The registered provider shall ensure that there is an annual review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards.	Substantially Compliant	Yellow	30/03/2026
Regulation 23(1)(e)	The registered provider shall ensure that the review referred to in subparagraph (d) shall provide for consultation with residents and their representatives.	Substantially Compliant	Yellow	30/03/2026
Regulation 05(4)(a)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which reflects the	Substantially Compliant	Yellow	30/03/2026

	resident's needs, as assessed in accordance with paragraph (1).			