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:	Rose Lodge Residential Care Service
Name of provider:	Communicare Agency Ltd
Address of centre:	Clare
Type of inspection:	Unannounced
Date of inspection:	16 June 2025
Centre ID:	OSV-0008627
Fieldwork ID:	MON-0047480

About the designated centre

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

Rose Lodge is a residential care service providing residential care for adults with mild to moderate intellectual disability, an acquired brain injury, physical and sensory needs. A maximum of four residents over the age of 18 years are accommodated. The premises is a spacious four bedroom bungalow on its own generous site located midway between two well-serviced towns. Transport suited to the needs of the residents is provided. Each resident is provided with their own bedroom three of which have ensuite sanitary facilities. An additional bathroom is provided and the residents share communal areas that include an open plan kitchen and dining area and two living rooms. The design and layout of the house supports accessibility. Day-to-day management and oversight of the service is delegated to the person in charge with support from a team leader and the wider management team. The house is staffed at all times and there are a minimum of two staff members on duty by day and by night. The night time staffing arrangement is a staff member on waking duty and a staff member on sleepover duty.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	3

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
Monday 16 June 2025	09:45hrs to 17:30hrs	Mary Moore	Lead

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 and, the National Standards for Adult Safeguarding (2019). This inspection followed up on the findings of the last HIQA inspection completed in May 2024 and also took into consideration notifications the provider had submitted to the Chief Inspector of Social Services.

There were positive findings and evidence of systems of governance and oversight. However, as outlined in a regulatory notice issued by the Chief Inspector of Social Services in June 2024, safeguarding is more than the prevention of abuse. It is a holistic approach that promotes resident's human rights and empowers residents to exercise choice and control over their lives. Overall, in that regard, the inspector found that the governance systems and arrangements in place did not consistently underpin the safe delivery and oversight of the service or ensure that residents' rights were always respected and promoted. The provider had taken the actions it said it would in response to the findings of the last HIQA inspection. However, these actions were not sufficient to ensure residents were always in receipt of a safe quality service. For example, the inspector again found that much improvement was needed in the area of positive behaviour support.

This designated centre is operated from a spacious bungalow type residence in a populated but rural area. The centre is a short commute from local towns that offer a range of services and amenities and approximately a thirty minute drive from the nearest city. Two service vehicles are available. The centre is registered to accommodate a maximum of four residents and is at full capacity.

This inspection was unannounced. The inspector was greeted by the person in charge who facilitated this inspection in conjunction with their line manager the local regional manager who arrived later in the day. There were two staff members on duty and these staffing levels were consistent with the staffing levels assessed as needed by the provider and the staff duty rota for the day of this inspection. The inspector noted that the house was well-maintained externally and internally and visibly clean. When the inspector arrived the staff members on duty were attending to some household tasks included cleaning.

One resident was not present for this inspection as they were on leave with family. Of the three residents that were present one resident had left the centre to attend their off-site day service. The two remaining residents were in the designated centre. During the inspection the inspector had the opportunity to speak with these three residents on a one-to-one basis about their experience of living in the designated centre. The assessed needs of the residents are broad and include acquired brain injuries, sensory and physical disabilities. The inspector explained to the residents the purpose of the inspectors visit and the role of HIQA in ascertaining

the quality and safety of services. The residents chatted easily with the inspector and gave a good account of what their day-to-day life was like, their general interests, what they liked about living in the centre but also what they felt could improve their quality of life.

One resident had plans to go swimming and said that they liked to go swimming at least twice a week. The resident was delighted that they had progressed from using a walking aid to walking with the support of a walking stick. The resident had recently been supported to access and use public transport independently. The resident discussed family, holidays spent with family and the purchase of a smart-phone to maintain contact with their family. When the resident returned in the afternoon they reported that they had thoroughly enjoyed their swimming session.

One resident spent much of their day in bed in their bedroom coming to the dining room to enjoy a late breakfast. The resident chatted with the inspector at a time that was suitable to them. The resident was watching a news channel and said that they liked to keep themselves updated about what was happening in the world. Pictures on display sparked a conversation about the joy family pets brought and the resident confirmed visits from his dog were facilitated and very much enjoyed. The resident confirmed that they continued to attend an off-site day service one day each week, liaised with and saw their general practitioner (GP) as needed. The resident told the inspector that they were awaiting new controls for their wheelchair as the controls originally supplied were not easy for them to use. The inspector saw that the resident had within their reach their call bell and used it at intervals during the day when they required staff assistance.

The inspector noted that the person in charge was present, available to residents, chatted and interacted easily with the residents. Residents spoken with also mentioned the access they had to the regional manager. Overall however the house was very quiet during the day of inspection with staff on duty largely attending to household and administration duties and the resident who spent the day in the centre requesting staff assistance as needed.

The third resident chatted with the inspector when they returned from their day service. The resident said that they had enjoyed their day but was also happy with their decision to attend the day service three to four days a week rather than the full five days.

In general, the feedback provided by all three residents was positive. Residents said they liked their bedrooms and had enough storage for their personal belongings. Residents said that they had no complaints about the meals provided. Residents said they were happy with the opportunities that they had for activities and engagement outside of the designated centre. All three residents had enjoyed lunch out together the day before this inspection. Residents knew the members of the management team and said that would speak with them if they had a concern or worry. However, while the provider had completed the annual quality and safety review of the service for 2024, the review had not sought or included feedback from the residents or their representatives.

There was evidence that residents were consulted with. For example, residents had input into their personal plan and the inspector reviewed records of house meetings convened between residents and staff. However, the matter arising on this inspection as on the last HIQA inspection was that residents were not always heard and did not always have choice and reasonable control over the support and care they were provided with.

Residents told the inspector that they liked living in the house and raised no concerns about the support and care provided by the staff team. One resident said that they just wanted to be treated the same way as everyone else (persons without a disability) and said they were.

However, one resident told the inspector that while they liked living in the house they found the location of the house very quiet. The resident said that they missed the independence afforded by more urban locations serviced by footpaths where they could walk independently to buy a newspaper or a cup of coffee.

Another resident said that there was only one thing about living in the house that they did not like and that was listening to behaviours of concern. The resident said that the behaviour was not directed at them but they could hear it, heard what was said and they did not like it. The resident said that they wanted the behaviour to stop. The resident was very assured when voicing their discontent to the inspector. The resident told the inspector that they had told the provider about this but said the concerns they had raised had made no difference and the behaviours continued.

In that regard, the inspector found that the provider did not have in place adequate and appropriate arrangements for supporting residents to manage their behaviour and for ensuring staff had the tools, knowledge and skills to understand, prevent where possible and respond to behaviour that challenged. The person in charge confirmed that staff decisions in relation to not facilitating a reasonable request from a resident had acted as a trigger for behaviour in the days prior to this inspection. There were similar findings from the last HIQA inspection.

Staff had completed safeguarding training and had also been provided with site specific positive behaviour training since the last HIQA inspection. However, this recent incident reflected deficits in staff understanding of person-centred care, of a rights based approach to support and care and, a poor understanding of how staff practice could constitute abuse in the form of rigid routines or inadequate responses that ultimately did not uphold the dignity and human rights of residents.

The inspector saw that the person in charge did identify this issue and it was addressed and responded to in conjunction with the regional manager. The provider did address incidents and did submit notifications required to the Chief Inspector of Social Services. However, based on the findings of this inspection and these incidents the provider needed to implement more robust and proactive systems of governance and management. This was needed to ensure that safeguarding and respecting residents' rights were embedded in the day-to-day operation of and practice in this service. For example, ensuring staff had access to support plans and guidance that were evidence based, ensuring staff knowledge post training was

evaluated and that systems of governance were in place that ensured appropriate oversight and monitoring of staff including out-of-hours.

The inspector requested the regional manager to submit, on behalf of the provider, assurances to the Chief Inspector of Social Services as to the action the provider would take, to improve the appropriateness, quality and safety of the service based on the verbal feedback of these inspection findings. Those assurances were submitted on the day after this inspection and included liaison with the local safeguarding and protection team, the scheduling of safeguarding training for staff facilitated by an external trainer, enhanced systems for supervising staff and prioritisation of the behaviour support needs in the service.

The next two sections of this report will describe the leadership, governance and management arrangements in place and how they sought to but did not always protect residents from harm or ensure that their individuality, their rights and quality of life were consistently respected and safeguarded.

Capacity and capability

Based on the findings of this inspection there was a commitment to provide each resident with a safe quality service and efforts that reflected that commitment. However, the systems the provider had in place were not sufficient to underpin the safe delivery and oversight of the service.

The management structure was clearly defined as were individual roles and responsibilities. Day-to-day management and oversight of the centre was undertaken by the person in charge. The person in charge was recently appointed to that role. The person in charge confirmed they had good opportunity to familiarise themselves with the service as they had worked alongside the departing person in charge for a significant period of time. This was evident from the duty rotas seen by the inspector.

The person in charge said that they had good access to and support from their line manager the regional manager who maintained an active presence in the centre. Residents spoke positively of both managers and mentioned the regional manager by name. Both the person in charge and the regional manager articulated a good understanding of and a commitment to continually improving the quality and safety of the service.

The person in charge had recently completed designated safeguarding officer training. There was also a designated safeguarding officer available within the wider organisational structure. The person in charge implemented the systems in place for monitoring the service. For example, the person in charge reviewed the daily handover notes completed by staff, reviewed incident reports completed by staff, held regular staff meetings and formally supervised staff. The person in charge described changes made to enhance the local systems of management and

oversight. For example, a facility for staff to log on remotely to the staff team meetings had recently been introduced. This was done to improve staff attendance at the meetings and the person in charge said there was almost full attendance at the most recent meeting.

Records seen by the inspector indicated that the wider management team met at regular intervals to discuss the quality and safety of the service and support and advice was sought as needed from, for example, the human resources department.

However, the inspector found that these systems of management and oversight were not sufficient for the needs of this service and did not ensure that all aspects of the service provided were consistently appropriate and safe. For example, narrative notes completed by staff and seen by the inspector would not have enabled the person in charge or any other person reading those notes to identify deficits in the support and care provided. While the provider had many systems for quality assuring the service the information gathered was not used effectively to improve the service. For example, ensuring that a comprehensive evidence based positive behaviour support plan was in place informed by the analysis (completed by an appropriate professional) of information gathered by staff. The absence of such a plan was a repeat HIQA inspection finding.

Data from incidents that had occurred was not used to inform the monitoring and supervision arrangements needed. Specifically how staff were and would be supervised when the person in charge was not on-site such as at night and at weekends.

The staffing levels and arrangements in the centre presented as adequate. There was a minimum of two staff members on duty at all times by day and night. The person in charge said that additional staffing was available as needed to support the preferences of individual residents such as attending mass at weekends. This additional staffing was evident in the planned and actual staff duty rotas reviewed by the inspector for the month of June.

The matter arising was how staff were supported and provided with the tools needed to consistently deliver care that was person centred, promoted a human rights based approach to care, to recognise support that compromised resident rights and had the potential to be abusive.

Regulation 15: Staffing

The management team was satisfied that the staffing levels and arrangements in place were suited to the needs of the residents. The person in charge prepared the staff duty rota. The inspector reviewed the planned and actual staff duty rotas for June 2025. The rotas clearly identified the staff members on duty, including the person in charge, and the hours that they worked.

The staffing levels and the staff members on duty on the day of this inspection were in line with the rota and presented as adequate to meet the needs of and the number of residents present on the day of inspection. For example, one resident was provided with transport and support to go swimming while one staff member was in the house and available to the other resident. The inspector saw risk assessments setting out the number of staff and the equipment needed for safe moving techniques in resident care. These were in line with the number of staff that would be on duty and the person in charge was actively monitoring for possible changes in resident needs.

The night-time arrangement was a staff member on waking duty and a staff member on sleeping duty. There had been some turnover of staff but there were no staff vacancies. The staff members on duty and met with had either worked in the service for sometime or worked with the provider's community based services and were therefore familiar with the provider's structures, policies and procedures.

Nursing advice and oversight if needed was available from a recently recruited regional nurse manager.

Judgment: Compliant

Regulation 16: Training and staff development

Based on the findings of this inspection, the previous inspection findings and notifications submitted to the Chief Inspector of Social Services, the inspector was not assured of the adequacy of the arrangements in place to supervise staff, for ensuring all staff completed mandatory training and for evaluating staff learning so that the provider was assured all staff were informed and had the knowledge to deliver safe, person centred care.

For example, the inspector reviewed the staff training records maintained by the person in charge. There was a training record in place for each staff member listed on the current staff duty rota. The training record indicated and the person in charge confirmed that one staff member employed since February 2025 had not yet provided to the provider evidence that they had completed training in safeguarding adults from abuse.

The remaining staff had completed safeguarding training. The person in charge confirmed that the training was completed on-line. There was no process in place for evaluating staff knowledge and learning from this safeguarding training and other training that was completed such as in a human rights based approach to support and care and, the positive support of behaviours that challenged. The latter had been provided on site in July 2024 following the last HIQA inspection. The person in charge confirmed that further on-site training was scheduled and imminent. However, it was evident from a recent incident that had occurred that despite the training provided and completed there were potential staff deficits in

staff knowledge and staff awareness in all of these areas. This deficit impacted on the appropriateness, quality and safety of the support provided.

Staff were formally supervised while on induction and on an ongoing monthly basis. The inspector had sight of these supervisions and further documentary evidence that the person in charge addressed matters as needed with staff. However, the inspector found that the arrangements in place for supervising and supporting staff were not responsive to the needs of this service. This is addressed in Regulation 23: Governance and management.

Judgment: Substantially compliant

Regulation 23: Governance and management

The provider had not ensured that their management systems were fully effective in ensuring that the service provided was consistently appropriate and safe and effectively monitored. The provider had failed to ensure that the plans and supports needed were in place so that all residents lived in a centre that was safe and that met their needs. The provider was not effectively using the information that it collected about the quality and safety of the service to improve the service.

For example, the provider had systems of quality assurance and those systems included a review of how residents were safeguarding from harm and abuse. However, the provider did not demonstrate how the information gathered and the improvement plans that issued, assured what was in place and brought about improvement. For example, in relation to assuring the adequacy and evidence base of positive behaviour support planning and practices in the centre.

While this will be discussed again in the next section of this report this was a repeat HIQA inspection finding. This indicated that the actions taken by the provider in response to that inspection were not sufficient to improve and underpin the safety and appropriateness of the service.

The provider did investigate and manage incidents that occurred and concerns that were made known to it. The provider did identify the need for learning and improvement. However, there was a repeat inspection finding of staff practice that did not respect the rights, will and preference of a resident meaning that learning did not occur or improvement was not consistently maintained. Overall, more proactive systems of monitoring, supervision and oversight informed by and responsive to the needs of this service were needed.

The management systems in place did not provide for this level of oversight and monitoring particularly when the person in charge was not on site. For example, the provider itself, had in October 2024, identified the need for additional supervision at night but it was not evidenced on inspection that this supervision was continued on an ongoing basis.

The role of team leader had been part of the management structure to support the person in charge in the management and oversight of the service; this post was vacant at the time of this HIQA inspection.

The annual review while completed did not include feedback sought and-or received from residents or their representatives so as to inform how the service received by residents could be improved. One resident very clearly told this inspector that he did not like the behaviours exhibited by another resident in the service. The resident told the inspector that voicing their concerns to the provider had made no difference.

Judgment: Not compliant

Quality and safety

In this designated centre residents were provided with a comfortable home, had opportunity to maintain friendships and relationships and to receive visitors. Residents told the inspector that generally they liked living in the centre and they were happy with the opportunities that they had to access amenities and services that they enjoyed.

However, as discussed in the previous section of this report the inspector again found that improvement was needed in the systems and arrangements in place that underpin safeguarding, resident safety and wellbeing and, the promotion of residents' rights.

The inspector followed a particular safeguarding line of enquiry and purposefully reviewed one personal plan. The inspector saw that the resident, representatives and others such as representatives of the Executive participated in the plan. However, while the resident was consulted with and had input into their plan a recent incident indicated that the resident did not always have choice and control over decisions that were made about their support and care. This was a repeat inspection finding.

The previous HIQA inspection findings pertained to how staff decided to meet the resident's personal care needs. On this occasion, it had been identified by the provider in the days prior to this inspection that staff had denied the residents requests for snacks and refreshments at night. The inspector reviewed a sample of narrative notes completed by staff for June 2025. It would be difficult for the provider or any other person to ascertain if this was an isolated incident as staff recorded the requests made by the resident for refreshments but did not always record if they had accommodated the residents requests or not.

The person in charge had good knowledge of residents needs and described the ongoing monitoring of residents' needs. For example, the person in charge discussed the reassessment needed of a resident's mobility chair as mentioned to

the inspector by the resident themselves. The person in charge was also arranging for a reassessment of a resident transfer abilities and needs. The person in charge and the regional manager were satisfied that there was no obstacle to residents accessing community based allied health professionals.

However, the inspector found that while the personal plan contained much information about the resident including evidence of MDT review the plan was still fragmented. The plan did not provide the clear guidance needed in this centre so that staff decision-making was always guided by or in line with the plan. For example, while there was a personal and intimate care plan it did not strongly reference the residents known choices and preferences.

The personal plan did not always provide a clear documentary pathway to evidence the actions taken following MDT (multi-disciplinary) review. For example, confirmation that referrals to and reviews by allied health professionals were completed.

A particular deficit in the process of assessment and planning was in relation to behaviour of concern or behaviour that challenged. This was also a repeat HIQA inspection finding and one that the provider had committed to address. The inspector was not assured as to the evidence base of the guidance that was in place or the sufficiency of the guidance in relation to both the prevention and the response to behaviours that challenged. There were systems for monitoring the behaviour; the ABC tool (antecedent, behaviour and consequence charts) and these tools were reviewed by the person in charge. The person in charge did review and purposefully use the ABC charts. However, it was not evidenced how the completion of these tools informed the positive behaviour support guidance in place.

There were no reported or evident physical or environmental restrictions. However, the provider needed to give due consideration to the risk for unsanctioned restrictions on residents rights. Based on the findings of this inspection the support and care provided had not supported a resident to exercise choice and control in their daily lives or over decisions made about their own care and support. The choice expressed was a simple but very important matter when a residents life is confined to a chair or a bed and they do not have the physical ability to follow-through on their own choices and require staff support to do so.

Regulation 10: Communication

All four residents were reported to be good and effective verbal communicators. The person in charge reported that there was no assessed need for augmentative and alternative communication methods. The three residents the inspector spoke with competently initiated and engaged in conversation with the inspector and discussed a range of topics in relation to their life in the designated centre, their interests and how they liked to spend their time.

The inspector also reviewed the three service user meeting records that were on file. Matters such as staff and management team changes, staying safe, making a complaint, meal planning and planning social activities were discussed at these meetings. Residents choose whether they wished to attend these meetings or not. Residents had their own mobile phones and televisions and a range of television channels.

However, the provider did need to ensure that residents were always listened to. The provider needed to explore communication in the context of both triggering behaviour and the use of behaviour as a form of communication. This is addressed in Regulation 7: Positive Behaviour Support and Regulation 9: Residents' rights.

Judgment: Compliant

Regulation 26: Risk management procedures

The inspector reviewed a resident's individual risk management plan. While risks such as for behaviour that challenged and the risk for poor skin integrity were identified the controls to manage these risks were not adequate. For example, the risk assessment for behaviour that challenged advised staff to be familiar with the ABC chart which is a monitoring tool only. An adequate and evidence based positive behaviour plan was not in place.

The risk management plan made reference to the use of an evidence based clinical assessment tool and the resultant score. The score recorded would indicate a very high risk for a break in skin integrity. However, while a recent skin break had occurred and was reported to be resolved, the inspector was advised that no such objective assessment tool was in use in the service. Objective reassessment of the risk was needed to identify the current risk to the resident and for considering any other support that may have been needed to prevent a reoccurrence

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Further improvement was needed in the assessment of needs and in the planning of the support and care that residents needed. The personal plan was still somewhat fragmented. For example, the plan did not always provide a clear documentary pathway to evidence the actions taken following MDT (multi-disciplinary) review. For example, confirmation that referrals to and reviews by allied health professionals were completed as agreed at these reviews.

While there were plans of support and care in place they were not always specific to the needs and abilities of the resident and their known wishes and preferences. For example, while the inspector noted feedback received from a dietitian there was no specific plan outlining the residents dietary needs, choices and expressed preferences. The absence of such plans and guidance meant that different staff could make and guide staff decisions about the support and care provided meaning that there was a risk that the support provided was not based on the assessed needs and known preferences of the resident. For example, the inspector was advised that there was no objective reason why the resident could not have snacks and refreshments at night.

While the model of support was social, the provider needed to ensure that the assessment of needs was at all times evidence based and completed by an appropriate health care professional.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

Adequate and appropriate arrangements were not in place for the support of behaviours that challenged. This meant that behaviours of concern continued to impact on the quality and safety of the service. The provider needed to comprehensively explore the possible aetiology of the behaviours, the purpose of the behaviours, resident understanding of the behaviours, staff understanding of and responses to the behaviour and, the possible contribution of staff responses in triggering behaviour.

The inspector reviewed a sample of records completed by staff between February 2025 and June 2025 including incident reports, ABC charts and daily narrative notes. The inspector also had sight of staff supervision meetings. The provider had, following the last HIQA inspection, provided on-site training for staff on positive behaviour support and the person in charge confirmed that further on-site training was scheduled. The inspector noted that the behaviour recorded was challenging and staff reported during supervision meetings that they were challenged by the behaviours exhibited in the centre. However, tools to support and guide staff practice and to complement the training provided such as an evidence based behaviour support plan were not in place.

The inspector saw a document called "care planning template for service user assessment of behaviours which challenge on outings and activities". The person in charge confirmed that this was the document in place to guide behaviour support practice. The document did set out behaviours that could be exhibited, possible triggers for the behaviour and what might help. Of note, it was stated that the resident liked to make their own decisions and enjoyed a cup of tea and biscuits in

bed. Notwithstanding the limitations of the plan, the recent refusal of refreshments meant that staff were not familiar with this document.

The document did not set out guidance for staff on how they should respond to the behaviour that was exhibited in the context in which it was exhibited such as during personal care.

There was no system in place where the ABC charts completed by staff were analysed by an appropriate health professional with the required expertise such as a positive behaviour support specialist. This meant that relevant data so as to gain insight into the behaviour such as when and why behaviour was exhibited was not extracted so as to reduce the risk for behaviour to occur and to ensure staff responses did not escalate the behaviour.

Judgment: Not compliant

Regulation 8: Protection

The provider did respond to and address any concerns made known to it. However, the provider had not implemented all measures to ensure that all residents were protected from abuse.

For example, safeguarding adults from abuse training for one staff member was outstanding since February 2025. While the remaining staff had completed on-line safeguarding training the inspector was not assured by a recent incident that had occurred as to staff ability to recognise practice that was potentially indicative of institutional abuse. This meant that there was a deficit in how the provider could be assured that all potential safeguarding matters were identified, reported and investigated.

Behaviours that challenged impacted on resident safety. The risk to residents came from matters such as staff practice that had the potential to trigger these behaviours and from the impact of the behaviours on residents. One resident told the inspector that they did not like listening to the behaviours, that the behaviours upset them and they wanted them to stop.

Judgment: Substantially compliant

Regulation 9: Residents' rights

The provider had not ensured that residents rights were consistently promoted and protected in this designated centre.

Residents spoken with told the inspector that they were happy with the opportunities that they had to engage in social activities outside of the centre. Residents were facilitated to have ongoing access to friends, family and home as appropriate to their individual circumstances. One resident liked to attend mass and this was facilitated. Residents were consulted with in relation to the general operation of the centre.

However, based on the findings of this inspection the support and care provided had not recently supported a residents expressed will and preferences and meant that the resident did not have choice and control in their daily lives and over decisions made by staff about the residents care and support. The narrative notes completed by staff were not sufficient for the inspector to establish and be assured that this was an isolated incident. The residents requests were documented but how staff responded was not always documented. Not listening to and respecting the expressed choices and preferences of a resident was a repeat inspection finding.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Rose Lodge Residential Care Service OSV-0008627

Inspection ID: MON-0047480

Date of inspection: 16/06/2025

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 16: Training and staff development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
All staff members are fully compliant with Safeguarding training on HSE Land. The training certificate which was not available in the Centre on the date of inspection related to a staff member who had in fact completed the relevant training. A copy of their certificate (which is in date) was obtained from another area of the Provider's Disability Care division the following day, 17 June 2025, and is now recorded on the Training Matrix available in the Centre.

Monthly PIC audits and Training Matrix reviews are being carried out to ensure governance and oversight of staff compliance with mandatory trainings (to include Safeguarding), and the PIC will follow up promptly if any outstanding or near-expiration training needs are identified.

Communicare has also recently employed a Disabilities Coordinator to support training compliance and to highlight any gaps to the PIC on regular basis.

In-person Safeguarding Training was completed in the Centre on 26 June 2025.

Going forward, safeguarding will be a standing agenda item at resident and staff meetings and typical scenarios will be outlined to assist with staff understanding of the Safeguarding process.

Staff will participate in training on Responsive Behaviours on 25 July 2025 and will complete refresher training on the human rights-based (FREDA) approach on HSE LanD by no later than 14 August 2025.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
Effective from 18 June 2025, both staff members on the nighttime roster work a waking night.

Since 19 June 2025, one staff member on each weekend shift is assigned 'Lead Carer' status on the roster. This senior carer will have a vital role in maintaining governance and oversight when the PIC is off duty.

Communicare has a robust and long-standing internal Management On-Call service which is available to staff out of hours should they need advice or reassurance.

We are actively recruiting for a Social Care Worker to join the staff team. This person will have a senior role within the team and will help to manage and supervise the practices in the service.

On 17 June 2025, the PIC held a feedback session with residents in the Centre following the inspection. Any concerns raised during that session will be actioned. Both positive and negative feedback will be discussed with residents individually. The Centre's Annual Report will be amended to include the feedback from residents.

Communicare is currently engaging with providers regarding the implementation of a QMIS system within its Disability Care division. Such systems allow (amongst other things) for the live reporting, tracking and management of incidents; recording and management of audits; and recording and tracking of training compliance within individual services.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
We have engaged the services of an external Behaviour Support Specialist, who commenced work in the Centre in mid-July 2025. This Specialist will review all incidents and ABC charts and provide guidance and support to staff in relation to Positive Behavioural Support Plans on a regular basis and as needed.

A Waterlow assessment was carried out on 19 June 2025 by a senior Clinical Manager

within our Disability Care division.

The PIC will ensure that needs assessments are updated for each of the residents within the facility by no later than 1 August 2025. The PIC will also ensure that individualised care plans are updated regularly. These items form part of the PIC audit.

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 PIC will ensure that needs assessments are updated for each of the residents within the facility by no later than 1 August 2025. The PIC will also ensure that individualised care plans are updated regularly. These items form part of the PIC audit.

A Dietitian has been consulted for guidance on the nutritional intake of a particular resident. Their advice will inform the care/support plan for that resident. This action will be completed by 25 July 2025.

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
To ensure the compliance with Regulation 7: Positive behavioural support, we have enlisted the expertise of an external Positive behaviour support specialist, who began working in the center in mid-July 2025. This specialist will conduct a thorough review of all incident reports and ABC charts, providing ongoing guidance and support to the staff on developing and implementing Positive behaviour Support plans.

Incorporating a therapeutic approach, the specialist will focus on understanding the underlaying causes of behaviours and promote strategies that enhance the residents wellbeing.

Positive behaviour support plans will be regularly updated based on this specialist input and will become a standard agenda at team meeting to foster continuous discussion and improvement. The implementation of these plans will be adaptive, ensuring they are tailored to best meet the needs of the residents involved.

Additionally, staff will participate in training on Responsive Behaviours on the 25TH July, enhancing their skills in therapeutic interventions and promoting a supportive environment.

Regular reviews from PIC of the Positive Behaviour Support Plans will help to ensure they remain effective and responsive to the needs of each service user.

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
All staff members are fully compliant with Safeguarding training on HSE LanD. The training certificate which was not available in the Centre on the date of inspection related to a staff member who had in fact completed the relevant training. A copy of their certificate (which is in date) was obtained from another area of the Provider's Disability Care division the following day, 17 June 2025, and is now recorded on the Training Matrix available in the Centre.

Monthly PIC audits and Training Matrix reviews are being carried out to ensure governance and oversight of staff compliance with mandatory trainings (to include Safeguarding), and the PIC will follow up promptly if any outstanding or near-expiration training needs are identified.

In-person Safeguarding Training was completed in the Centre on 26 June 2025.

Going forward, safeguarding will be a standing agenda item at resident and staff meetings and typical scenarios will be outlined to assist with staff understanding of the Safeguarding process.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
The PIC will discuss report-writing with staff during the team meeting scheduled for 23 July 2025. A revised reporting system will be implemented. The PIC will emphasise to staff the importance of clear and effective report writing, including the need to document whether tasks have been completed and to ensure that residents' rights are upheld and clearly reflected in the documentation. Further discussion on the FREDA principles (Fairness, Respect, Equality, Dignity and Autonomy) will take place during upcoming supervision sessions and team meetings.

Staff will complete refresher training on the human rights-based (FREDA) approach on HSE LanD by no later than 14 August 2025.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	26/06/2025
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	01/09/2025
Regulation 23(1)(e)	The registered provider shall ensure that the review referred to in subparagraph (d) shall provide	Not Compliant	Orange	01/08/2025

	for consultation with residents and their representatives.			
Regulation 23(3)(a)	The registered provider shall ensure that effective arrangements are in place to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.	Not Compliant	Orange	01/09/2025
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	01/09/2025
Regulation 05(1)(b)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out subsequently	Substantially Compliant	Yellow	15/08/2025

	as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.			
Regulation 05(6)(b)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall be conducted in a manner that ensures the maximum participation of each resident, and where appropriate his or her representative, in accordance with the resident's wishes, age and the nature of his or her disability.	Substantially Compliant	Yellow	15/08/2025
Regulation 05(7)(c)	The recommendations arising out of a review carried out pursuant to paragraph (6) shall be recorded and shall include the names of those responsible for pursuing objectives in the plan within agreed timescales.	Substantially Compliant	Yellow	14/08/2025
Regulation 05(8)	The person in charge shall ensure that the	Substantially Compliant	Yellow	14/08/2025

	personal plan is amended in accordance with any changes recommended following a review carried out pursuant to paragraph (6).			
Regulation 07(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.	Not Compliant	Orange	14/08/2025
Regulation 07(3)	The registered provider shall ensure that where required, therapeutic interventions are implemented with the informed consent of each resident, or his or her representative, and are reviewed as part of the personal planning process.	Not Compliant	Orange	14/08/2025
Regulation 7(5)(a)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation every effort is made to identify and alleviate the cause of the	Not Compliant	Orange	14/08/2025

	resident's challenging behaviour.			
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Substantially Compliant	Yellow	26/06/2025
Regulation 08(7)	The person in charge shall ensure that all staff receive appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse.	Substantially Compliant	Yellow	26/06/2025
Regulation 09(2)(b)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability has the freedom to exercise choice and control in his or her daily life.	Not Compliant	Orange	14/06/2025