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:	Sycamore 4
Name of provider:	Cheeverstown House CLG
Address of centre:	Dublin 6w
Type of inspection:	Unannounced
Date of inspection:	04 September 2025
Centre ID:	OSV-0008712
Fieldwork ID:	MON-0048016

About the designated centre

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

Sycamore 4 is a designated centre registered to provide residential care and support on a full-time basis for up to four adults with an intellectual disability as well as additional health social and personal support needs. Residents in this centre are supported by a mix of nursing and social care staff, with access to multidisciplinary services as required. This designated centre consists of a bungalow located on a campus setting in Dublin. Each resident has a private bedroom and access to living, dining, and garden facilities. The house has exclusive use of an accessible vehicle to travel into the community.

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 4 September 2025	11:35hrs to 17:40hrs	Erin Clarke	Lead
Thursday 4 September 2025	11:35hrs to 17:40hrs	Karen Leen	Lead

What residents told us and what inspectors observed

This risk-based inspection was carried out due to a trend of findings within the wider organisation regarding resident transitions, assessment of needs, and governance arrangements. While inspectors identified some areas requiring improvement in relation to support planning and oversight of clinical supports, residents reported being happy in their home. Inspectors also found evidence of good staff supervision and a stable workforce within the centre.

Sycamore 4 consists of a four-bedroom bungalow within a larger congregated setting that includes several designated centres, a school, an administration building, a restaurant, and a number of unused buildings. The provider had acknowledged that the location was not suitable for the long-term delivery of residential services due to its congregated nature and was actively exploring community-based options for residents. One resident's planned transition to a community setting had been delayed, which the provider was working to resolve.

On arrival at the centre, inspectors observed one resident going for a walk with a support staff member. Inspectors were welcomed by the CNM1, who introduced them to the centre. Inspectors met with one resident who chose not to engage directly and expressed hesitancy about having visitors in their house. In response, parts of the inspection, such as document reviews and follow-up queries, were completed in a nearby office. Inspectors subsequently returned to the centre to ensure that all residents were met with during the course of the inspection.

Inspectors observed one resident with an individual impairment independently mobilising around the centre. The resident demonstrated good awareness of their surroundings, using touch to navigate, while staff supported this independence by maintaining an uncluttered environment. Inspectors also observed the resident being supported by staff to go for a walk using a wheelchair. However, there was some ambiguity regarding the rationale for the use of the wheelchair. It was unclear whether its use was primarily due to the resident's mobility needs or their visual impairment.

Inspectors met with three support staff in the afternoon, who discussed the activities that residents enjoyed both within their home and the local community. Staff spoken with, described frequent community outings and activities that residents participated in; however, they acknowledged that duplication of documentation sometimes made it difficult to record these consistently.

On the day of inspection, a new staff member was being inducted into the designated centre. Inspectors observed that this staff member was not included in the active roster numbers but was instead shadowing regular, familiar staff to gain a better understanding of residents' individual care and support needs before working directly with residents. Inspectors also observed staff interacting respectfully with

residents, offering choices, and maintaining privacy and dignity, for example, by knocking on doors before entering and using introductions appropriately.

One resident was resting in their bedroom after returning from day services. They acknowledged the inspectors with a wave but preferred to remain engaged in their own activity. The person in charge showed inspectors a bathroom with an external door that had been fitted with an alarm system to alert staff if the door was opened, this had been implemented following a recent incident.

Overall, while personal planning systems were in place, improvements were needed in reviews, goal implementation, and recording to ensure residents' rights to meaningful lives and community participation were consistently upheld. The next two section of the report present the findings of this inspection in relation to the governance and management arrangements and how these arrangements affected the quality of care and support being provided to residents.

Capacity and capability

The inspectors found a stable staff team in place and a newly established governance structure that provided assurances to inspectors on the day. However, improvements were required in the provider's annual review of quality and safety to ensure it adequately captured and reflected residents' views and experiences of living in the centre.

A new person in charge was appointed on 21 July 2025. This individual is a Clinical Nurse Manager (CNM) Grade 2 who also has responsibility for another designated centre on the campus. They are supported in their role by a CNM1 who provides day-to-day oversight within the centre. Although newly appointed, the person in charge had already held meetings with the CNM1 and senior management to familiarise themselves with the centre and to identify key priorities. These included staff supervision and performance reviews, training compliance, the management of notifications, and a review of risk management systems.

Inspectors found that there had previously been a gap in staff meetings. This had been addressed under the new governance arrangements, with a staff meeting held in August 2025 that considered areas for improvement as raised by staff. Staff induction and guidance materials were available, and there was evidence that training requirements were monitored to ensure compliance.

Inspectors found that the systems in place supported staff to deliver safe and consistent care, and that training and supervision arrangements were satisfactory.

Regulation 14: Persons in charge

The person in charge was employed on a full-time basis and held the necessary skills and qualifications to carry out this role in the designated centre. The person in charge was a qualified nurse and was responsive to the regulatory process. They attended the centre on a regular basis, and they also provided scheduled out-of-hours managerial cover to the staff should they require assistance. They are responsible for one other designated centre under this provider. In order to ensure effective oversight of the care and support needs of the residents on a day-to-day basis, a clinic nurse manager is also employed.

Judgment: Compliant

Regulation 15: Staffing

Overall, a review of the rosters showed improved staff continuity since the previous inspection, with a reduced reliance on agency personnel. On the previous inspection, frequent use of agency staff had resulted in unfilled shifts and inconsistent support for residents

The staffing complement consisted of one CNM1, three nurses, and eight healthcare assistants. Vacancies that had been in place were recently filled. A person participating in management (PPIM) had also commenced in their role one month prior to this inspection. Three to four staff were rostered each day, depending on residents' needs, with one staff member on duty at night. The CNM1 split their role between administrative duties and rostered frontline work.

Inspectors saw evidence that staff were knowledgeable about residents' needs and provided consistent support. Residents reported being happy in their home, and inspectors observed warm and respectful interactions between staff and residents. Staff rosters were well maintained, and there were contingency arrangements in place to cover absences, ensuring safe staffing levels at all times.

Judgment: Compliant

Regulation 16: Training and staff development

Inspectors found that staff had access to appropriate training to meet the assessed needs of residents. Training records reviewed on the day of inspection showed staff were up to date with mandatory requirements, including safeguarding, fire safety, manual handling, and medicine management.

Supervision arrangements were in place, both formally through scheduled performance reviews, and informally through day-to-day oversight by the CNM1.

Staff meetings had previously lapsed but were reinstated under the new governance arrangements, with a meeting taking place in August 2025 to address staff concerns and operational matters.

Judgment: Compliant

Regulation 23: Governance and management

The provider had produced a report following their mandatory six-month unannounced visits to the centre to assess the quality and safety of care provided. The January 2025 visit identified deficits, including an absence of social goals for residents, no evidence of staff meetings, and no audits being carried out in the house. A follow-up visit in August 2025 demonstrated improvements in these areas, though further actions remained outstanding in line with the findings of this inspection.

While the provider had completed the 2024 annual review as required, inspectors found it required improvement to ensure that residents' and family representatives' views were adequately captured, and that personal information had appropriate anonymity.

Judgment: Substantially compliant

Quality and safety

Overall, residents were well supported in relation to their healthcare needs, and inspectors observed that care was delivered in an attentive and respectful manner. However, improvements were required to ensure that residents had consistent access to meaningful activities within the centre and that assessments more effectively guided the delivery of care and support.

With regard to residents' day service access, inspectors noted that one resident who had recently transitioned from their family home was engaged in a formalised day service programme. However, the other three residents had not returned to day services since their closure during the pandemic. Further exploration was required to ensure this reflected informed decisions made by residents themselves, rather than resource constraints. The resident attending day services consequently had broader access to meaningful activities than their peers.

Inspectors found that while assessments of need were in place for all residents, there were gaps in reviewing goals and some day-to-day supports required by

residents. This limited the provider's ability to ensure that care planning reflected residents' current needs and promoted their independence and quality of life.

Overall, inspectors found that the systems in place ensured residents were protected from harm, and that concerns were appropriately addressed through review, reporting, and multidisciplinary involvement. Staff had completed safeguarding training, and inspectors found a clear culture of reporting and review within the centre.

Regulation 13: General welfare and development

The centre's statement of purpose commits to residents having access to formalised day services and educational programmes. Inspectors found evidence that one resident was engaged in a structured day programme; however, three residents had not returned to day services since their closure during the COVID-19 pandemic. Further exploration was required to ensure this reflected residents' informed choices rather than resource constraints.

Judgment: Substantially compliant

Regulation 17: Premises

The centre comprised a bungalow located within a larger campus. Inspectors found the house was clean, generally well-maintained, and free from immediate hazards. Residents each had their own bedroom, with suitable bathrooms, living, and dining areas, and access to a back garden. Improvements identified at the previous inspection had been completed, such as bathroom upgrades.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

Improvement was required to ensure that residents' plans were consistently reviewed and implemented. Inspectors found that goals were not being reviewed on a quarterly basis as required by provider policy, and there was insufficient evidence to confirm whether activities were taking place as intended. For instance, while 'salt cave' visits were planned monthly for one resident, no records of attendance were available for July and August 2025. Similarly, goals to attend horse stables twice weekly were only recorded once in August, and goals such as swimming and clothes shopping were not actioned. Furthermore, some activity records noted "drives" but

did not specify whether residents disembarked and engaged meaningfully in the community.

Inspectors found that while assessments of need had been completed for residents, these were not always up-to-date, and in some cases professional recommendations were not informing day-to-day practice. A review of documentation indicated that in 2022 a relevant healthcare professional had assessed the resident as being able to walk outdoors for up to eight minutes, supported by a gait belt and two staff members. Inspectors found no evidence that this recommendation had been implemented in practice or that the assessment had been updated since 2022. This posed a risk that the resident's independence, mobility, and overall quality of life were not being fully promoted in line with their assessed needs. It also highlighted a broader gap in ensuring that professional assessments were reviewed and updated annually, as required, and that they informed the resident's personal plan and everyday care.

Judgment: Not compliant

Regulation 8: Protection

In March 2025, the provider submitted 14 retrospective safeguarding notifications, primarily related to unexplained bruising or injuries. In response, the provider carried out a structured system of bruising reviews and quarterly accident/incident trend analyses for each resident. At the time of inspection, four safeguarding plans were active.

Inspectors found that safeguarding issues were discussed at team meetings, and where appropriate, additional assessments were commissioned. For example, an occupational therapist assessed environmental risks following incidents of bruising linked to mobility, which led to environmental adjustments and maintenance repairs. A case conference was also convened, involving social work, management, and clinical staff, to improve safety and mitigate future risk.

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
Quality and safety	
Regulation 13: General welfare and development	Substantially compliant
Regulation 17: Premises	Compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 8: Protection	Compliant

Compliance Plan for Sycamore 4 OSV-0008712

Inspection ID: MON-0048016

Date of inspection: 04/09/2025

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The provider will develop and implement a structured process to gather residents' views and opinions for inclusion in the Annual Review Report. The consultation outcomes will inform the review of quality and safety and guide service improvements. The Annual Review Report for 2025 will be completed and made available to residents.	
Regulation 13: General welfare and development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 13: General welfare and development: The provider will work closely with residents and their circle of support to explore day services opportunities or New Directions services from the individuals home. The provider will ensure residents have access to meaningful activities and opportunities for community engagement in line with the individuals will and preference. Statement of purpose will be updated to reflect individuals needs and informed choices.	

Regulation 5: Individual assessment and personal plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
All residents' current 'My Life Plan' and associated goals will be reviewed and updated to ensure they reflect opportunities for meaningful participation in community-based activities aligned with each individual's interests, abilities, and preferences.
As part of this process, a new structured 'My Life' planning framework will be introduced. This will include: A dedicated 'My Life' folder that captures broader life aspirations and community engagement goals.
The review will document the supports required to help residents develop and maintain personal relationships and connections within the wider community, in line with their expressed wishes.
Progress will be monitored quarterly, with measurable outcomes including the number of residents actively participating in community activities and the number of new or sustained personal/community connections facilitated. In order to achieve this, the Person in Charge (PIC) will continue using a weekly social experience record sheet, which will be reviewed and discussed during staff meetings to ensure all residents are supported in their community involvement

A professional assessment was completed and was held on a new digital care planning system however this was not available on the day of inspection. This is now in place in the individuals personal plan folder and guides day-to-day practice. Old assessments have been removed from personal plan folder and archived. The provider will ensure all staff have full access to the online digital care planning system and are able to retrieve and review the necessary documentation in real time.

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 13(4)(a)	The person in charge shall ensure that residents are supported to access opportunities for education, training and employment.	Substantially Compliant	Yellow	31/01/2026
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	31/01/2026
Regulation 05(4)(b)	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 outlines the supports required to maximise the resident's personal	Not Compliant	Orange	31/10/2025

	development in accordance with his or her wishes.			
Regulation 05(6)(c)	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 assess the effectiveness of the plan.	Not Compliant	Orange	15/12/2025