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:	Seirbhís Caladh Aisling
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Galway
Type of inspection:	Short Notice Announced
Date of inspection:	30 July 2025
Centre ID:	OSV-0008751
Fieldwork ID:	MON-0043311

About the designated centre

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

Seirbhís Caladh Aisling can provide a respite service for up to four individuals at any one time. The service can support individuals of mixed gender, with a mild to profound intellectual disability and/or autism and complex physical needs, who are over 18 years of age. Seirbhís Caladh Aisling is a large detached bungalow and is close to the local village and beach. Transport is available for residents to access activities and local amenities. Residents are supported by a staff team of a social care leader, social care workers, support workers and a nurse. Staff are on duty at all times when residents are present in the centre, and can provide either waking night or sleepover night support depending on the needs of those in receipt of respite.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	2

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 30 July 2025	09:30hrs to 18:00hrs	Jackie Warren	Lead
Wednesday 30 July 2025	09:30hrs to 18:00hrs	Maureen McMahon	Support

What residents told us and what inspectors observed

This was the first inspection of this designated centre.This inspection was short notice announced and was carried out to monitor compliance with the regulations. As the person in charge was absent, the inspection was facilitated by a manager who was deputising for the person in charge. Inspectors also met with a team leader, two staff members who worked in the centre and with the sector manager who was present at times during the inspection. The centre is primarily a respite service which can accommodate up to four residents at any time, although a full time emergency admission is currently being provided in the centre on a temporary basis while alternative accommodation is being secured for a resident. Overall, the inspection found good compliance with the regulations and standards. However, improvements were required in relation to notifications to the Chief Inspector of Social Services and management of restrictive practices in the centre. Minor improvement was also required to aspects of healthcare and safeguarding.

Throughout the day, inspectors met residents in passing and discreetly observed the resident's daily activities. Inspectors also spoke with the team leader and person in charge, and the two residents who were in the centre on the day. Documentation was also reviewed relating to the care and support of residents, and the ways in which residents were supported to make choices and have their rights upheld.

There were two residents in the centre on the day of inspection. An inspector met and spoke with one resident before they left for day service activities, but this resident did not wish to discuss their life in the centre and was only willing to discuss issues external to the centre. Another resident did not wish to meet and talk directly with inspectors but greeted inspectors throughout the day. Inspectors saw this resident appeared relaxed and content in the centre. On the day of inspection this resident went for a scenic drive locally and when they returned they told an inspector that they had enjoyed a meal out in their favourite restaurant. On return to the centre after the outing, an inspector spent some time in the company of the resident and their support staff. Staff explained that the resident liked variety and preferred to be involved in a variety of activities for shorter time spans. In-house activities that the resident engaged in on the day of inspection included hand massage and a foot spa, listening to music on their personal tablet, and making shapes with modelling clay. At all times the resident appeared to be relaxed and happy, was smiling, and clearly enjoyed these activities.

This was a centre that actively promoted residents' rights through involving them, and their families, in the planning of their care. Residents were involved in various activities of their choice, both in the local community and while in the centre. Some residents enjoyed swimming, outings and drives, going to restaurants and cafes for meals and coffee, and having barbeques at the centre when the weather was fine. Others preferred to spend time relaxing whilst availing of respite breaks or taking part in home based activities such as cooking, massage, board games or listening to music. Staff explained the ways in which each resident's day was planned, and told

inspectors how residents' interests were supported. Staff knew residents' development needs and capacities, and scheduled activities in accordance with these. Inspectors reviewed records which demonstrated that residents chose the activities they wished to do, and their choices were respected should they wish to change their minds.

Seirbhís Caladh Aisling is a single-storey detached house located in a quiet rural area on the outskirts of a village by the sea. The house was found to be visibly clean, spacious, bright and furnished in a comfortable and homely manner. The house was laid out so as to meet the needs of residents residing there. Each bedroom had adequate storage for personal belongings. There was a variety of communal spaces available, including a large open plan kitchen, dining and living area. There was also a separate sitting room. Residents had there preferred areas that they used to relax. To the rear of the house a patio area with garden furniture was accessible to residents. Residents had access to televisions, music and Wi-Fi in the centre.

Inspectors spoke to staff about the care and support needs of a resident. Staff were knowledgeable on the resident's needs and described strategies in use to communicate effectively, including a 'first-then' approach. Staff told inspectors they used communication and positive interactions to support this resident in the management of behaviours of concern. Staff and resident interactions were observed to be respectful and done in a manner that was understood, based on the communication needs of the resident.

Overall residents were supported to spend comfortable and meaningful time during respite breaks, and had various activities in accordance with their needs and preferences. There was a good standard of care and support in this designated centre, although improvements were required in the oversight of restrictive practices.

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

Capacity and capability

There were effective leadership and management arrangements in place to govern the centre and to ensure the provision of a good quality and safe service to residents who availed of respite breaks there. However, improvement to the oversight and management of incidents and restrictive interventions was required.

The management structure was clear, as were the roles and responsibilities of those involved in the management team. For example, the person in charge was supported by a team leader in the centre and had daily access and support from their line manager. There were arrangements in place to cover the absence of the person in charge and these arrangements were in place and were effective on the

day of inspection. The person who was deputising for the person in charge will be referred to as the person in charge throughout this report.

The provider had ensured that the centre was subject to ongoing auditing, including unannounced provider audits twice each year and an annual review. staff were also carrying out a schedule of planned checks and reviews in the centre. Overall, these reviews showed high levels of compliance and any identified areas for improvement gave rise to learning and improvement plans.

The provider had systems in place to collect information and monitor quality and safety, such as regular staff meetings, regular use of the provider's multidisciplinary team and oversight of the use of restrictive practices by a human rights committee. However, improvement was required in relation to the management of restrictive practices and incidents in the centre.

The staffing levels and skill-mix were in line with the assessed needs of residents and the size of the designated centre. The staff team were a newly established team and the person in charge had identified areas of support with planned training in record keeping and incident recording scheduled. The centre was suitably resourced to ensure the effective delivery of care and support to residents. Inspectors observed that these resources included the provision of transport, Wi-Fi and comfortable accommodation. The provider had also made a range of policies and guidance documents available to inform staff.

Regulation 15: Staffing

The provider had ensured that appropriate staffing levels and skill-mixes were being maintained in the centre to support residents in line with their assessed needs.

The person in charge had developed planned and actual staff rotas and these were accurate at the time of inspection. An inspector reviewed a sample of one month's planned and actual rota for July 2025. The rota showed that consistent staff were being allocated and reflected the staffing levels and skill mixes required to support residents. The staffing roster changes dependent on the needs of those availing of respite and the level of staffing support required. Some individuals require sleepover supports, while others require waking night staff. The centre had employed agency staff during the period reviewed by inspectors. A manager explained that these were consistent staff who were well known to residents and who were very familiar with their care needs. They also explained that a contract was in place between the provider and the agency to ensure that these staff were suitably qualified, trained and vetted.

Judgment: Compliant

Regulation 16: Training and staff development

The provider had ensured that staff who worked in the centre had received appropriate training to equip them to provide suitable care to residents.

During discussions with the management team, inspectors learned that the staff team was newly established, and new staff were settling into their roles and becoming familiar with the provider's processes. Mandatory and other training had taken place as part of the induction process with further formal training identified and planned in the coming weeks. For example, an inspector viewed records of bespoke training which had taken place for three new staff in the management of behaviour that is challenging as part of their induction to the centre. These staff were booked to complete further behaviour management training in the coming months. The provider had also identified two staff to complete communication champion training with a view to enhancing communication systems in the centre.

Supervision meetings were booked to take place with staff. The person in charge showed an inspector a supervision planner for the remainder of 2025. The team leader, who was recently appointed, told an inspector they have had support and supervision as part of their induction meetings and a schedule of learning is set out for the duration of induction.

Copies of regulations, national standards and guidance documents were available in the centre to inform staff.

Judgment: Compliant

Regulation 23: Governance and management

The oversight and management of the use of restrictive interventions required improvement. Improvement to an aspect of health care was also required.

The provider had developed a clear organisational structure to manage the centre and all staff were aware of this structure and their reporting relationships. There was a person in charge who held overall responsibility for the management of the centre, and was being supported by a team leader. The provider had recently appointed a new person in charge and team leader to the centre, although the person in charge had not yet commenced their role. There were suitable interim deputising arrangement in place and the person who was deputising for the person in charge was present in the centre for the inspection. The team leader had eight protected hours allocated each week to complete their administration duties.

Various monitoring and oversight systems were in place to ensure the quality of care of residents during respite breaks. An annual review of the quality and safety of care had been completed for 2024. An inspector read the annual review and found that it

was comprehensive and had provided for consultation with residents and families. In addition to the annual review, the service was subject to ongoing auditing and review. This included unannounced audits on behalf of the provider which were carried out twice each year. The provider and management team were proactive in addressing any areas for improvement which had been identified. For example, they had identified that record-keeping, including recording of incidents and restrictive interventions, required improvement, and had arranged staff training in record keeping and the provider's incident management system. This training was booked to take place for staff in September 2025.

A senior manager, who came to the centre for the inspection, described to inspectors how they maintained oversight of the service. They explained that the provider's computerised recording system gave them good access to all relevant information relating to the centre. The said that they found the computerised system very beneficial as they could maintain regular review and oversight of areas such of risk management, incidents and trends, and restrictions in the centre.

Overall, the centre was suitably resourced to ensure effective delivery of care and supports to residents. For example, inspectors saw adequate levels of suitably trained staff to support residents' preferences and assessed needs. Inspectors also observed that suitable, safe and comfortable accommodation and furnishing, transport vehicles, Wi-Fi, and televisions were provided for residents. However, a resource required to monitor an identified healthcare need had not been provided in the centre.

Inspectors also found that the provider's oversight, management and reporting all physical restrictive practices in use in the centre required improvement.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

Overall, inspectors found that there were systems in place for the recording of incidents and notification of the required incidents to the Chief Inspector. However clearer guidance was required around the criteria for submissions of NF06 notifications. Improvement to the notification of restrictive interventions was also required.

An inspector reviewed records of all incidents and accidents that had occurred since the centre opened.These were recorded on the provider's internal accident and incident recording system. Although records showed that there had been no previous history of negative interactions between residents, two peer-to-peer incidents had occurred in July 2025. The person in charge had not made notifications of these incidents to the Chief Inspector. An inspector also identified from a review of these records that restrictive physical holds had been used on some occasions, and that these had not been notified to the Chief Inspector at the

end of each quarter.

Judgment: Not compliant

Quality and safety

Overall, inspectors found that the provider had arrangements in place to ensure that residents availed of a safe and comfortable service during respite breaks. Staffing levels and arrangements meant that residents could be out and about in the local community as well as availing of day services on weekdays. However, this inspection did identify gaps in oversight in the management of restrictive interventions. Improvement to fire safety and management of a healthcare issue were also required.

The support and care observed by inspectors was respectful and appropriate to residents' assessed communication needs. Staff who spoke with inspectors were well informed about residents' communication needs. Communication passports were in place for residents and staff were knowledgeable regarding the residents communication methods. Residents had access to Wi-Fi, television, radio and personal electronic tablets to support them to communicate.

Inspectors saw that the premises was fitted with fire safety measures that included a fire detection and alarm system, emergency lighting and doors with self-closing devices designed to contain fire and smoke. Regular evacuation drills were completed that demonstrated evacuation could take place in a timely manner. However, the provider had identified that improvement was required in respect of one resident's evacuation plan and was actively addressing this.

The provider ensured that residents received person-centred care that allowed them to enjoy activities and progress personal goals in a way that suited their preferences. Person-centred planning was actively in place for all residents. Staff who spoke with inspectors were familiar with residents' personal goals and support needs. The provider used the personal outcome measures (POM's) process to support personal planning. The POM's assessment was completed annually in conjunction with the multidisciplinary team. Residents had comprehensive health management plans. However, on the day of inspection a resource specified in a resident's care plan was not available in the centre. The person in charge confirmed this plan was due for review to ensure staff had the most up-to-date guidance on managing a health condition.

Residents who required positive behaviour support were assessed and supported to manage their behaviour. Inspectors saw that there were up-to-date detailed behaviour support plans in place. Inspectors also saw evidence of ongoing multidisciplinary team support. However, The recording and management of restrictive interventions required review to ensure that it was used appropriately and

suitably recorded.

The provider had taken measures to safeguard residents from any form of harm or abuse. All staff had attended safeguarding training. Inspectors saw detailed intimate care plans to guide staff. Staff spoken with were aware of the procedure to follow in the event of a safeguarding concern. The provider had measures in place to manage potential risk to residents.

The provider did have systems for identifying, assessing and managing risks and for responding to and reviewing incidents. The person in charge could clearly describe how these systems worked including the support provided by the multidisciplinary team. In addition, each resident had an individualised risk management plan.

Regulation 10: Communication

There were effective systems in place to support residents to communicate.

Inspectors saw that residents in the centre were supported to communicate in line with their assessed needs and wishes. Throughout the centre, visual aids were available to support communication and understanding. For example, menu planning was available in a visual format to support residents to make choices and understand the menu. Staff were observed using Lámh, which is a form of sign language, to communicate with a resident and offer choice on activities. Inspectors saw a communication system in place for one resident using a 'first-then' approach. Wi-Fi access was provided in the centre to support residents to use computerised technology and staff told inspectors that a resident used their electronic tablet device to contact their family through social media. Inspectors viewed a sample of two communication profiles and plans, which were informative and included clear guidance on communication techniques.

Residents who availed of respite service did not communicate verbally, while others were familiar with Irish or English languages or were bilingual. Residents whose first language was Irish did not always have access to staff who spoke the Irish language. A senior manager told inspectors that the provider was mindful of this. They explained that this is identified as desirable at recruitment level, and staff are provided with the opportunity to learn Irish, which is supported by the provider by offering training.

The person in charge told inspectors that the provider had a communication initiative, digital and accessible technology (DAT) project to promote the use of technology for residents and staff, including assistive technology and accessible communication methods. This initiative along with planned communication champion training is intended to enhance access for residents to assistive technology to aid communication.

Judgment: Compliant

Regulation 17: Premises

The design and layout of the centre met the aims and objectives of the service, and needs of residents who availed of respite breaks there. Inspectors saw the centre was well maintained, clean, comfortably decorated and personalised. The centre can accommodate up to four residents for respite breaks.

It consists of five bedrooms in total, two of the bedrooms have en-suites, one of these bedrooms is also the office and sleep over room for staff. One bedroom has been adapted and connected to a large wet room which caters to the needs of individuals who require wheelchair accessibility or have complex needs, which ensures privacy and dignity and more comfort for the individual.

Throughout the centre, there was adequate communal space,where residents could relax or take part in activities that they liked. During a walk around the centre, inspectors found the house was clean, comfortable and nicely furnished. Each resident had their own bedroom during respite breaks and these had adequate furniture such as wardrobes, bedside lockers and chests of drawers, in which residents could store their clothing and belongings. The centre was served by an external refuse collection service and there were laundry facilities for residents to use. The centre was provided with Wi-Fi to support residents to use technology to communicate and for leisure, and there was access to garden space.

Judgment: Compliant

Regulation 18: Food and nutrition

Resident's nutritional needs were being supported appropriate to their assessed needs.

The centre had a well equipped kitchen where food could be stored, prepared and cooked in hygienic conditions. Inspectors observed supplies of fresh food in the kitchen. Residents also had access to snacks and refreshments outside of meal times.

There were systems in place to help residents who required communication support to make meal choices.The centre had a visual menu planner prominently displayed in the kitchen, supporting residents to understand and choose different meals. Staff told inspectors, and records confirmed, that some residents took part in aspects of meal preparation alongside staff. Meals were being prepared in line with residents' preferences and assessed needs. For example, modified diets were catered for in the centre and inspectors observed the preparation of these in line with the correct

consistency. An inspector observed dinner being served to one resident. This was freshly prepared and appeared wholesome and nutritious.

Judgment: Compliant

Regulation 28: Fire precautions

The provider had good measures in place to protect residents, staff and visitors from the risk of fire. However, improvement was required to an aspect of evacuation.

On a walk through the building, inspectors saw that the centre was fitted with a fire detection and alarm system, emergency lightening, fire-fighting equipment and doors with self-closing devices to contain fire and smoke. An inspector viewed servicing records which showed that this equipment was being serviced by external companies at the frequency agreed with the provider.The central heating boiler was also being serviced annually. An inspector also viewed records of internal safety checks of fire extinguishers, alarms, emergency lighting and fire exits being carried out by staff and these were up to date.

An inspector viewed records of fire drills which were carried out on a regular basis and involved residents and staff, although some drills were simulated having regards for the assessed needs of residents. Overall, the outcomes of fire drills demonstrated that staff could support residents to evaluate the centre in a timely manner. However, due to identified support needs, evacuation of one resident had not been completed quickly enough, or within a time frame acceptable to the provider. This had been taken seriously by the provider, and the provider had engaged relevant members of it's multidisciplinary team were now working to find a safe and acceptable alternative for evacuation of the resident in a timely manner.

There was a clear fire procedure available, outlining how staff were to respond, should a fire occur, and all staff had attended fire safety training.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

There was a personal planning process in place to ensure that residents' needs were identified and were being met during respite breaks. Individualised personal plans had been developed for residents based on a combination of assessments of their health, personal and social care needs and information supplied by their families.

There were comprehensive personal plans in place for residents. Inspectors viewed

a sample of two personal plans, which documented how residents' needs had been assessed and how their personal goals were being managed. These plans were being reviewed on at least an annual basis and were updated as required to reflect changes in residents' care needs.This ensured that residents received consistency of care while availing of respite breaks. Goals that had been identified for residents and were in progress were documented in personal plans, and were visually displayed in each resident's bedroom in a format that residents could understand. For example, one resident was interested in swimming and was being supported to do activity. This goal was visually displayed for the resident in line with their assessed communication needs. Due to the short nature of residents' stays in the centre, their plans had been developed in collaboration with their families and day care staff and were aligned with the development goals taking place in their homes and day services.

Judgment: Compliant

Regulation 6: Health care

Residents had access to medical and healthcare services to ensure their well-being during respite breaks. However, improvement was required to ensure that an identified healthcare need of a resident could be managed as required.

Inspectors viewed the healthcare records of two residents and found that residents received appropriate healthcare that took into account their personal plans. Comprehensive assessments of residents' healthcare needs had been carried out and plans of care had been developed as required. The care plans viewed by inspectors were well recorded, informative and provided clear guidance for staff. An inspector read the care plan for the management of an identified healthcare need and found that a clear plan of care was in place to guide staff in the management of this resident's condition. However, the plan specified the use of specific monitoring equipment, although it was found that this resource was not available in the centre. Therefore, this healthcare need could not be managed in line with healthcare recommendations. The person in charge acknowledged this healthcare plan required review and this would be done within the coming days.

As residents' stays in the centre were for short breaks, their healthcare needs were primarily managed by their families with support from day care staff. However any required healthcare interventions were supported during respite breaks. The management team confirmed that all residents attended their family general practitioners in the community as required, and that this would also be supported if required during respite breaks. Residents also had access to other relevant allied health professionals, such as speech and language therapists, as required. The person in charge and staff described the clinicians and services that residents had access to, and records of referrals and reviews were maintained.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

The provider failed to demonstrate that each restrictive practice was used in line with the national policy and evidence based practice, was reviewed as part of the personal planning process and was only used as a last resort.

Inspectors reviewed incident reports completed by staff between July 2024 and July 2025, and inspectors noted on four occasions that staff reported they had intervened physically with a resident during an incident. However, there records viewed did not include information about the type of holds used, how they were administered and the duration of the holds. When the process behind these physical interventions was queried by inspectors, this information was not available. Inspectors reviewed the restrictive practice log in place for a resident and found that it did not accurately describe the restrictive practices in place such as physical interventions and an environmental restriction recently put in place. Furthermore records failed to demonstrate that restrictive interventions were used as a last resort. For example, a resident was administered a chemical restraint for periods of agitation, and records reviewed showed that this had been administered four times between May and July 2025. However, the corresponding daily notes from the days that it was administered did not consistently outline what alternative measures were trialled before using this chemical restraint as a last resort measure. Similar failings were also found in relation to when physical restraints had been applied.

Documents reviewed and discussion with staff showed that the person in charge had put restricted access between the sitting room and kitchen by locking an interconnection door between these rooms, although both rooms were still accessible through other doors and residents had free access to all rooms. Sufficient staff were on duty to provide one-to-one supervision as required.

Judgment: Not compliant

Regulation 8: Protection

While the provider had arrangements in place to safeguard residents from any form of harm, the procedures for responding to and managing alleged or suspected abuse required strengthening.

While reviewing incident records, inspectors saw that two peer-to-peer incidents had occurred in July 2025. There had been no previous incidents of negative peer-to-peer interactions in the centre involving these or other individuals. One of these

incidents had been referred for safeguarding screening, while the other, where physical contact had been deflected by staff, had not. This had not been upheld as a safeguarding concern by the safeguarding team. Inspectors spoke to staff to gain a better understanding of the incident, and found that both staff and the person in charge were aware and familiar with the incident. However, this second incident had not been subject to the providers usual review process.

Judgment: Substantially compliant

Regulation 9: Residents' rights

There were systems in place to support residents' human rights during respite breaks. Review of information, discussion with staff and observation of practice in the centre, indicated that residents had choices around how they spent their days, and how their lifestyles were being managed. As residents were only present in the centre for short stays, their religious, political and civil rights were mainly being supported by their families, although the staff in the designated centre supported these rights as required during respite stays.

Records that the inspector viewed showed that staff had established and recorded residents' likes, dislikes and preferences, based on assessments, input from residents and their families, observation, and knowledge of each individual. There were effective measures in place to support residents and staff to communicate with staff and with each other. The provider had both complaints and advocacy processes available to residents and their families. The inspector saw that each resident had choice and control in their daily life. The staffing levels and availability of transport ensured that each resident was being supported in an individualised way to take part in whatever activities or tasks they wanted to do. The management team explained that the provider was at an advanced stage of developing a new human rights policy which was due to be in effect in September. They said that this policy would be more comprehensive and detailed that the previous one and they explained that an external expert advisers had been involved in the writing of the policy. The provider was providing human rights training to all staff throughout it's organisation and training was being delivered to staff in this centre on a phased basis.

The centre was comfortable and spacious. Residents had their own bedroom while taking respite breaks. In the centre, residents had access to kitchen and laundry facilities, should they wish to prepare food or carry out their laundry tasks during respite breaks. Staff explained that all residents' religious preferences were supported during respite breaks and that all residents residents had access to their own money which they could spend as they wished.

Judgment: Compliant

Regulation 26: Risk management procedures

There were good systems in place for the management of risks in the centre. The provider's risk management arrangements ensured that risks were identified, monitored and regularly reviewed.

An inspector viewed the risk register and found that it identified a range of risks associated with the service and had documented interventions to reduce these risks. The inspector also saw that further individualised risk assessments had been carried out for to identify and manage risks specific to each resident. These risks were being reviewed and updated as required.

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 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 31: Notification of incidents	Not compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 17: Premises	Compliant
Regulation 18: Food and nutrition	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Substantially compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Compliant
Regulation 26: Risk management procedures	Compliant

Compliance Plan for Seirbhís Caladh Aisling OSV-0008751

Inspection ID: MON-0043311

Date of inspection: 30/07/2025

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:
In accordance with Regulation 23(1)(a) to ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose, the Person in Charge has reviewed the healthcare records of an individual, ordered the required monitor for the identified healthcare need, and staff have been booked on Diabetes training to be completed on 16.10.2025.

In accordance with Regulation 23(1)(c) in order to 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, the Person in Charge has reviewed incident management records for the designated centre to identify physical restrictive practices in use in the centre to ensure that they are in line with organisational policy. Management met with the relevant staff member on 03.09.2025 and discussed the incidents involving restrictive practices identified during the review. The Person in Charge implemented an immediate response plan which included: One to one skills training with the relevant staff member delivered by the Advanced Nurse Practioner on 03.09.2025 focusing on least restrictive practices and the appropriate implementation of the behaviour support plan in line with the on-site Studio III proactive and reactive strategies training delivered on 23.06.2025. Onsite support for staff in the designated on the implementation of the behaviour support plan with Studio III proactive and reactive strategies using least restrictive practices in line with the organisation policy completed on 12.09.2025 to ensure the safety and wellbeing of the resident.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
In accordance with Regulation 31(1) to provide the chief inspector notice in writing within 3 working days of an adverse incident occurring in the designated centre, the Person in Charge completed a review peer to peer incidents over the last 12 months to identify peer to peer incidents that may have led to a suspicion of abuse. One suspected peer to peer incident which could have potentially led to the harm of a resident was referred to the Designated Officer and a retrospective NFO6 is being submitted to the Chief inspector on 24/09/2025. The Person in Charge has requested the Designated Officer to provide, by 26/09/2025, clearer guidance around the criteria for referral and consultation with the designated officer to ensure the time bound submissions of NF06 notifications to the Chief Inspector.

In accordance with Regulation 31 (3)(a) to ensure that a written report is provided to the chief inspector at the end of each quarter of each calendar year in relation to and of the following incidents occurring in the designated centre: any occasion on which a restrictive procedure including physical, chemical or environmental restraint was used, the Person in Charge reviewed incident management records for the designated centre to identify physical restrictive practices in use in the centre and to ensure that they are in line with organisational policy. Restrictive practices were identified four occasions. A retrospective written report outlining the restrictive practice will provided to the chief inspector by 06/10/2025 inclusive of Q2 and Q3 incidents.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
In accordance with Regulation 28 (2)(d) to make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations, the Person in Charge reviewed the evacuation of one resident requiring an time frame for evacuation. While the Person in Charge and the respite team continue to engage with relevant members of the multidisciplinary team to find a safe and acceptable alternative for evacuation of the resident in a timely manner, effective from 26.08.2025 the resident is being supported in an alternative respite house with bed evacuation to meet the needs of the resident.

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care: In accordance with Regulation 06 (1) to provide appropriate health care for each resident, the Person in Charge has reviewed the healthcare records of an individual, ordered the required monitor for the identified healthcare need, and staff have been booked on Diabetes training to be completed on 16.10.2025.

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support: In accordance with Regulation 07(1) 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, the Person in Charge implemented an immediate response plan which included: One to one skills training with the relevant staff member delivered by the Advanced Nurse Practioner on 03.09.2025 focusing on the appropriate implementation of the behaviour support plan in line with the on-site Studio III proactive and reactive strategies training delivered on 23.06.2025. Onsite support for staff in the designated on the implementation of the behaviour support plan with Studio III proactive and reactive strategies in line with the organisation policy completed on 12.09.2025 to ensure the safety and wellbeing of the resident. In accordance with Regulation 07(5)(a) to ensure that, where a resident's behaviour necessitates intervention under this Regulation every effort is made to identify and alleviate the cause of the resident's challenging behaviour, the Person in Charge implemented an immediate response to ensure that the Advanced Nurse Practitioner provided on-site support in the implementation of the behaviour support plan to all staff by 12.09.2025. In accordance with Regulation 07(5)(c) to ensure that, where a resident's behaviour necessitates intervention under this Regulation every effort is made to identify and alleviate the cause of the resident's challenging behaviour management, the Person in Charge implemented an immediate response to ensure the review and training provided on the Behaviour Support Plan completed on 16.09.2025.

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection: In accordance with Regulation 8(2) to ensure the active safeguarding of residents from

abuse, the Person in Charge completed a review peer to peer incidents over the last 12 months to identify peer to peer incidents that may have led to a suspicion of abuse, and inconsistency in the application of procedures to actively safeguard residents from abuse. The Person in Charge has requested the Designated Officer to provide wriiten guidance for staff in the designated centre on the consistent application of procedures to actively safeguard residents from abuse, to ensure the initiation of an investigation if any incident, allegation or suspicion of abuse occurred to be completed 26/09/2025.

In accordance with Regulation 8(3) the Person in Charge reviewed peer to peer incidents over the last 12 months to identify peer to peer incidents that may have led to a suspicion of abuse. One suspected peer to peer incident which could have potentially led to the harm of a resident was referred to the Designated Officer and a retrospective NFO6 is being submitted on 24/09/2025.

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 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.	Substantially Compliant	Yellow	03/09/2025
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.	Substantially Compliant	Yellow	12/09/2025
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where necessary in the	Substantially Compliant	Yellow	26/08/2025

	event of fire, all persons in the designated centre and bringing them to safe locations.			
Regulation 31(1)(f)	The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: any allegation, suspected or confirmed, of abuse of any resident.	Not Compliant	Orange	26/09/2025
Regulation 31(3)(a)	The person in charge shall ensure that a written report is provided to the chief inspector at the end of each quarter of each calendar year in relation to and of the following incidents occurring in the designated centre: any occasion on which a restrictive procedure including physical, chemical or environmental restraint was used.	Not Compliant	Orange	06/10/2025
Regulation 06(1)	The registered provider shall provide appropriate health care for each resident, having regard to that resident's personal	Substantially Compliant	Yellow	16/10/2025

	plan.			
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	12/09/2025
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.	Not Compliant	Orange	03/09/2025
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 resident's challenging behaviour.	Substantially Compliant	Yellow	16/09/2025
Regulation 07(5)(b)	The person in charge shall ensure that, where a resident's behaviour	Substantially Compliant	Yellow	12/09/2026

	necessitates intervention under this Regulation all alternative measures are considered before a restrictive procedure is used.			
Regulation 07(5)(c)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation the least restrictive procedure, for the shortest duration necessary, is used.	Substantially Compliant	Yellow	18/09/2025
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Substantially Compliant	Yellow	26/09/2025
Regulation 08(3)	The person in charge shall initiate and put in place an Investigation in relation to any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.	Substantially Compliant	Yellow	26/09/2025