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:	Baile Geal Residential Service
Name of provider:	Barróg Healthcare Limited
Address of centre:	Cork
Type of inspection:	Unannounced
Date of inspection:	14 August 2025
Centre ID:	OSV-0008798
Fieldwork ID:	MON-0047473

About the designated centre

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

Baile Gael is a detected bungalow residence in the outskirts of a large town. The centre can provide full-time residential support to three adults over the age of 18, of both genders, with an intellectual disability and/or autism. Residents are supported by social care workers, support workers, the person in charge and a team leader. Each resident has their own bedroom and other rooms in the centre include bathrooms, a multipurpose room and a kitchen.

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
Thursday 14 August 2025	09:25hrs to 19:30hrs	Lisa Redmond	Lead

What residents told us and what inspectors observed

This was an unannounced risk based inspection completed in the designated centre Baile Gael Residential Services. This centre had been inspected in April 2025 where a high level of non-compliance with the regulations was identified. The purpose of this inspection was to identify if the registered provider had addressed the areas of non-compliance as outlined in the compliance plan responses submitted by the registered provider to the Chief Inspector of Social Services. It was also carried out to review the actions taken by the registered provider in response to solicited information submitted to the Chief Inspector.

This inspection identified that appropriate actions had not been taken by the registered provider to address the areas of non-compliance identified at the previous inspection in April 2025, or in response to adverse events occurring in the designated centre. The findings of this inspection identified that there was a lack of effective oversight in the designated centre, with evidence of actions not been addressed in a timely manner. This had a direct impact on the safety of residents living in the designated centre.

The inspector had the opportunity to meet with each of the three residents living in the designated centre on the inspection day. However, one of these residents was only met with briefly as they were unwell on the day of the inspection. The inspector met this resident while they were completing a walk around of the external areas of the centre. The resident was observed lying on the couch in their living area with the door open. The inspector did say hello to the resident and wished them a speedy recovery. The resident gave the inspector a thumbs up and continued to lay on the couch resting.

This designated centre was divided into three separate living areas, one for each of the three residents that lived there. This centre had been inspected on two occasions since it had been registered as a designated centre in May 2024. These inspections took place in December 2024 and April 2025. At these inspections, it was identified that the layout of the centre meant that each of the residents did not have access to a separate kitchen area in line with the regulations. Management in the centre noted that two residents could access the main kitchen in the centre, however due to safeguarding risks a third resident could not access this area. Since the April 2025 inspection some electrical cooking equipment had been added to the third resident's sitting room area. It was noted that the addition of this equipment did not ensure that this resident had access to sufficient cooking facilities in line with their assessed needs. It was also evident that the layout of the centre did not meet the assessed needs of this resident. This will be discussed under Regulation 17 premises.

Renovations had taken place in the centre since the inspection completed in April 2025. This involved all three residents moving to alternative accommodation for the period of time the works were completed. At this time, one resident went on a

planned holiday to Kerry. However, the registered provider moved the other two residents to an unregistered centre. As a result of this, the registered provider was issued with a warning letter at a warning meeting with the Chief Inspector of Social Services in June 2025. In their response to this warning letter, the registered provider outlined that they fully acknowledged this breach of Section 46 of the Health Act 2007. In the response the registered provider stated that they were committed to the highest standards of resident safety, regulatory compliance and continuous service improvement.

It was noted that the changes made to the layout of the centre in one resident's living area had a positive impact as it meant that this resident now had a living room. It was observed that the emergency evacuation route from this resident's bedroom no longer went through a kitchen. However, assurances that this was a protected escape route were not provided. This will be further discussed in the inspection report.

The inspector met with the other two residents living in the centre throughout the inspection day. One resident was going to visit their family on the day of the inspection. This resident was observed to be laughing and smiling as they excitedly jumped up and down while holding hands with a staff member. Staff told the inspector that the resident was in 'great form' and that they were looking forward to seeing their family. It was also noted that they planned to go swimming while they were with their family. Staff members noted that the resident enjoyed swimming and that they were provided with this activity as part of their daily routine. As they waited until it was time to leave, the resident was observed listening to music on their tablet device.

This resident lived in a self-contained apartment area which had a bedroom and a sitting room which opened onto a private back garden. A mural of the sea and fish was being painted by staff members in the hallway of the resident's home. A mural of cartoon characters had also been completed by staff to reflect the resident's likes and interests. The resident showed the inspector this mural and their bedroom which was decorated with fairy lights and their teddies. Staff members told the inspector that the resident had taken their bedding off their bed to wash and launder it, and that when this was completed the resident would dress their bed independently.

The inspector met with a second resident and spent some time chatting with them in the sitting room of their home. As previously mentioned, works had been carried out in this area of the resident's home. This included the addition of the sitting room where the resident could relax and spend time engaging in hobbies. The resident told the inspector that as part of their personal planning goals, they were looking forward to decorating the sitting room area to reflect their likes and interests. At the time of the inspection, this area was observed to be filled with artwork completed by the resident, and photographs of them with their family and friends. A karaoke corner had also been developed in the sitting room area. The resident's karaoke machine was located in this area and they had decorated the wall with song lyrics of songs by their favourite band. Later in the afternoon, the resident was observed singing songs on their karaoke machine with staff members. At this time, the

resident and staff members were observed smiling and laughing as they sang together.

Throughout the inspection day, the inspector observed the interactions between staff and residents in the centre. Interactions were observed to be respectful in nature, and took into consideration the behavioural support needs of residents. The inspector spoke with staff members and it was evident that they were aware of the likes, interests and assessed needs of residents. For example, one resident had recently gotten a pet fish. Staff spoken with noted this was a recommendation by the behavioural support therapists who were supporting the staff team to develop and review the resident's behaviour support plan. It was noted that efforts were being made by the staff team to develop the relationships between residents living in the centre. Staff spoken with discussed how two residents had been supported to go to the zoo together, while one of these residents and another resident had been to an aquarium.

Local management in the centre noted that there had been an increase in the number of allegations of safeguarding concerns raised since the April 2025 inspection. For example, incidents had occurred in the centre where staff members had not adhered to the support plans of residents, which was a contributory factor to some safeguarding incidents occurring in the centre. There was also evidence that the layout of the centre posed a risk to residents' safety. It was not evident that actions were taken by the registered provider in response to these adverse events, to ensure learning and prevent reoccurrence of such events. The next section of the report will reflect how the management systems in place were contributing to the quality and safety of the service being provided in this designated centre.

Capacity and capability

The inspection of this designated centre in April 2025 identified a high level of non-compliance with the regulations. In response to the findings of this inspection, the registered provider outlined the actions they would take to address the areas of regulatory non-compliance. At that time, the chief inspector was not assured by the response submitted to address the areas of non-compliance to the following regulations;

- Regulation 26 Risk management procedures
- Regulation 23 Governance and management
- Regulation 28 Fire precautions
- Regulation 8 Protection.

In response to the findings of this inspection, the registered provider attended a warning meeting with the Chief Inspector in May 2025. At this meeting, the areas of non-compliance were outlined to the registered provider. A discussion was also held where the registered provider was informed that the house it was planned that the residents would move to while renovations to the designated centre was completed,

must be registered as a designated centre in line with the regulations. Following this meeting, the Chief Inspector was informed that two residents had moved to this premises. This constituted an unregistered centre and as a result, the registered provider attended a second warning meeting in June 2025.

In response to the warning letter issued to the registered provider in May 2025, the registered provider stated that they were committed to ensuring that all areas of non-compliance were addressed, and that they would like to reassure the Chief Inspector that they will take this situation seriously and ensure that any similar situations do not arise in the future.

The purpose of this inspection was to identify if the registered provider had addressed the areas of non-compliance as outlined in the compliance plan responses submitted by the registered provider to the Chief Inspector of Social Services. It was also carried out to review the actions taken by the registered provider in response to solicited information submitted to the Chief Inspector. This inspection found that the registered provider had not taken appropriate action to address the areas of non-compliance with the regulations. It was also identified that the provider had not adhered to a number of actions as set out in the registered provider's responses to the Chief Inspector.

This inspection included the review of regulations that had been deemed not compliant on the day of the April 2025 inspection. At the introductory meeting on the inspection day, the inspector requested evidence of the actions taken to remedy deficits in relation to fire safety. This information was not provided as requested. Subsequently, an urgent action was issued to the registered provider under Regulation 21, Records. The response was not submitted in the time frame set out by the Chief Inspector, and did not provide assurances that the registered provider had taken appropriate action to address the non-compliance. This will be further discussed in the inspection report.

Regulation 21: Records

The registered provider had not ensured that the records specified in Schedule 4 were maintained and available for inspection by the chief inspector. At the introductory meeting completed on the inspection day, the registered provider was asked to provide a record of any actions taken to remedy any defects found in the fire equipment as referenced in the inspection report completed on 16 April 2025. This information was not provided to the Chief Inspector for review as requested, to ensure compliance with the regulations.

An urgent action was issued to the registered provider under this regulation. The response provided by the registered provider was not provided in the timeline set out by the Chief Inspector. The response that was submitted did not provide assurances that urgent actions would be taken to come into compliance with the regulations. This will be further discussed under Regulation 28, fire precautions.

Judgment: Not compliant

Regulation 23: Governance and management

It was noted at the April 2025 inspection that a number of members of the senior and local management team in the designated centre were due to depart their roles in the weeks and months after the inspection took place. This included the person in charge, a regional manager (who was assigned as a person participating in management in the centre), a quality assurance manager and an assistant director. These persons had since left their posts as mentioned in the previous inspection report. A new reporting and management structure had been put in place following the recruitment of a new management team, and a restructuring of the organisation. This included;

- A new person in charge had been appointed in the designated centre in June 2025. This person was met with during the inspection day.
- A new person participating in management had commenced their role in the designated centre in June 2025.
- A previous regional manager in another area of the organisation was now employed as head of operations for the organisation. This person had also covered the role of person participating in management in this centre for an interim period while the restructuring and recruitment had taken place.
- A quality and audit officer had commenced their role in the organisation. This person had visited the designated centre to meet with residents and staff members. They had also commenced audits in the designated centre.
- A new maintenance officer had commenced their role in the organisation. They had oversight of the premises works carried out in this designated centre since the April 2025 inspection.

In addition, the budget allocated to the centre's petty cash had increased since the inspection in April 2025. The petty cash budget included groceries for the three residents and the staff on duty each day, art supplies, and for staff to engage in activities with residents. Staff spoken with identified that this had improved the resources available to the staff team and it was noted that additional financial resources could be requested to facilitate holidays. For example, staff spoken with noted that additional finances had been provided to support one resident on a recent holiday to Kerry. Local management in the centre were reviewing the increased resources to identify if this was appropriate. A meeting had been scheduled with management in the centre to review this on the day of the inspection however it was postponed as a result of the inspection taking place.

Despite this, the registered provider had failed to complete a number of actions outlined by the registered provider in the compliance plan responses submitted to the Chief Inspector on the inspection completed in April 2025. As a result, the registered provider had failed to ensure that management systems were in place in the designated centre to ensure that the service provided was safe, appropriate to

residents' needs, consistent and effectively monitored. Examples of actions not addressed in line with information provided to the Chief Inspector included;

- The registered provider had not addressed all of the fire issues raised in the inspection report by the end of May 2025 as outlined. This will be further discussed under Regulation 28, fire precautions.
- The registered provider had not ensured that all residents had appropriate access to kitchen facilities. This will be further discussed under Regulation 17, premises.
- Evidence of a review into the fire risks, quality of past works and the use of facilities during adverse weather was not provided to the inspector as requested on the inspection day. It was noted that the scope of this report was also to include verification of fire doors, remediation of the issues raised in fire risk assessments completed in 2024 and 2025 and assurances that all contractors were qualified and certified. This was due to have been completed in April 2025. It was noted that the registered provider stated that when this report was completed, a full implementation update would be submitted to the Chief Inspector. This had not been submitted, and was not available for review on the inspection day.
- It was stated in the compliance plan response that a new process was in place for raising serious risks directly with the registered provider. Management in the centre were not aware of this process. Documentation relating to this process could not be provided to the inspector to evidence that this process had been put in place as outlined to the chief inspector.
- A number of documents related to the safeguarding of residents to include evidence of notification of such events in line with statutory guidance and safeguarding plans put in place to ensure the safety of residents were not available for the inspector to review. This will be further discussed under Regulation 8, protection.
- A compatibility assessment for residents living in the centre had not been completed as stated by the registered provider in the compliance plan response, following the changes to the centre layout. This was submitted to the inspector and dated as having been completed the day after the inspection had taken place. It was noted that incidents of a safeguarding nature had occurred in the centre following the changes to the layout of the centre.

This inspection was completed with local management in the centre to include the person in charge and a deputy manager. Throughout the inspection, it was evident that the person in charge had not been provided with documentation and evidence required to ensure compliance with the regulations. For example, at the introductory meeting the person in charge noted that they were not aware if a full review of the fire safety systems in the centre had been completed since the changes were made to the layout of the centre and the addition of electrical cooking equipment in a resident's living area. They had been informed that an engineer had completed a walkaround of the centre, but the person in charge had not been provided with a report outlining this review by the registered provider. It was noted that the person in charge was due to have a planned meeting with senior management on the inspection day. This meeting was to include discussions about safeguarding and fire

safety systems in the centre, following the person in charge's appointment to the role in June 2025. However, this was postponed due to the inspection taking place. It was noted by the inspector that a number of the issues identified on this inspection were due to be raised at this meeting by the person in charge.

The inspector requested to review the designated centre's annual review of the quality and safety of care and support provided to residents in the designated centre. This is a requirement of the regulations to ensure effective oversight of the services provided to residents in their home. It was confirmed the day after the inspection that an annual review had not been completed since the centre was registered in May 2024. This did not provide assurances regarding the oversight and management of the centre since it was registered in May 2024.

Judgment: Not compliant

Quality and safety

The registered provider had developed a statement of purpose which outlined the care and support that residents would receive in their home. This stated that the layout of the centre promoted residents' safety, dignity, independence and well-being. It also stated that each resident had the right to feel safe and secure. It was evident throughout the inspection that the registered provider had not taken effective action to ensure that the premises of the designated centre was designed and laid out to meet the aims and objectives of the service and the number and assessed needs of all residents. It also noted that the centre's layout did not promote residents' safety and well-being as stated in the centre's statement of purpose.

A number of adverse events occurred in the designated centre since the inspection completed in April 2025. These had been notified to the chief inspector and were reviewed as part of this inspection. It was found that appropriate actions had not been taken to protect residents to prevent such incidents occurring, or following these incidents to prevent reoccurrence. For example;

- An incident had occurred in August 2025 where a resident had entered another resident's living area as a restrictive practice had not been implemented in line with the resident's assessed needs. This resulted in the resident having access to a known behavioural trigger. After this occurred, the resident engaged in behaviours that challenge. This included the resident's whereabouts being unknown for a period of approximately 15 minutes until the resident was found safe in the garden of their home. The resident's risk assessment for absconding had not been updated following this incident. It was also noted that this document referenced a control measure that had not been in place since the resident lived in this designated centre. This required review to reflect the controls in place to ensure the resident's

safety, and to ensure staff members had clear guidance on the controls in place to protect the resident.

- A risk assessment was in place to outline the risks associated with one resident having access to the main living area of their home. It was noted that this risk assessment had been reviewed in May 2025. However, it had not been reviewed following an incident in July 2025. It was also noted that this was risk assessed as low risk despite two incidents of the resident having accessed the other resident's living area. On one of these occasions a resident had received injuries which required medical attention.
- During the inspection day, the inspector was informed that a resident had tested positive for an infectious illness. Staff members had access to face masks and gloves however they did not have access to disposable plastic aprons or gowns in the designated centre. Staff members collected personal protective equipment (PPE) from the organisation's office and returned to the centre with the PPE over two hours after the resident had been tested and diagnosed. It was noted that the resident was displaying symptoms including a fever prior to them testing positive for this illness.

Improvements were required to the oversight and management of the centre to ensure residents could live in a home that was suitable to meet their assessed needs and that was safe.

Regulation 17: Premises

In response to the April 2025 inspection, a number of premises issues had been addressed.

- The changes to the layout of one resident's living space meant that they now had a private sitting room area where they could spend time relaxing in their home. The resident was observed using this room throughout the inspection day.
- A hot water tank had been moved from a resident's bedroom to the boiler house in the centre.
- Portable appliance testing had been completed.
- Sewerage and drainage issued had been addressed.
- An external wooden fence had been repaired.
- Each of the three showers in the centre were now working. It was noted on discussions with staff members that residents' showers had not been working previously as there were issues with the wiring to the electrical showers. Showers were now attached to the hot water tank, bypassing the wiring issues identified in the April 2025 inspection of the centre.
- A funding request to build an external covering to minimise the risks posed to a resident accessing an external area in adverse weather had been submitted.

The previous inspections of the centre in December 2024 and April 2025 identified

that one resident did not have access to a separate kitchen area with suitable and sufficient coking facilities, kitchen equipment and tableware to promote their independence. This is a requirement of the regulations as outlined in Schedule 6. The registered provider had added some cooking equipment to this resident's sitting room which included a small fridge, a toaster, an air-fryer, a kettle and a microwave. However, the addition of this equipment did not ensure compliance with the regulations for the following reasons;

- Staff spoken with told the inspector that most of the resident's meals were prepared in the kitchen in the main house that they were unable to access due to safeguarding concerns. A restrictive practice of a locked door with a combination code was in place to prevent the resident from entering this area of the centre.
- The resident did not have access to an oven or a hob to cook food in their living area. Staff spoken with noted that there was a risk that the resident may flick on and off electrical switches when alone. However, this was not outlined as a risk in the resident's associated risk assessment. It was also noted that the resident had access to a hob and oven when they were on holidays in Kerry and staff reported that the resident had enjoyed being involved in the cooking and preparation of food. This did not promote their independence in line with the centre's statement of purpose.
- A sink with suitable hand-washing facilities for the preparation of food was not provided in the resident's living area. There was a sink in the resident's bathroom, however no hand soap was provided in this area due to the behavioural support needs of the resident. There was no evidence of hand soap or an alcohol-based hand gel in the resident's living area until this was requested by the inspector to facilitate the use of personal protective equipment.
- There was no access to water in the resident's living area to facilitate them to heat water for cooking other than the bathroom sink. Staff members noted that they used bottled water however there was no bottled water in the resident's living area on the inspection day.

To access the resident's meals, water and appropriate hand-washing facilities, staff members had to open the locked door in the hallway dividing two of the residents' living areas. This restrictive practice had been put in place due to the behavioural support needs of one resident and the safeguarding risks to the second resident. It was noted that since the April 2025 inspection, there had been two occasions where one of the residents had entered the other resident's living area when staff members were going between these two areas. On one occasion, this had resulted in a resident receiving injuries which required medical attention. The incident report completed following this incident had recorded the 'poor layout of the house' as an area for learning following the incident. It was evident that the layout of the designated centre was not in line with the assessed needs of residents and as a result, this posed a risk to the safety of residents living in the designated centre.

The inspector could not complete a full walk-around of the designated centre on the day of the inspection as one resident was unwell. Therefore this resident's living

area could not be inspected on the inspection day.

Judgment: Not compliant

Regulation 26: Risk management procedures

The registered provider had not ensured that there were systems in place for the assessment, management and ongoing review of risk in the centre including responding to emergencies. A number of these areas had not been addressed as outlined by the registered provider in the compliance plan response submitted to the chief inspector;

- As previously noted, evidence of a review into the fire risks, quality of past works and the use of facilities during adverse weather were not provided to the inspector as requested on the inspection day.
- The compliance plan response stated that a risk register had been updated to reflect all fire safety risks in the centre, which was reviewed weekly. The inspector observed two fire risk assessments completed in the designated centre. It was noted that both of these risk assessments were dated as having being reviewed before the April 2025 inspection had taken place. Therefore it was not evident that they had been updated following the inspection completed in April 2025. There was no evidence provided of any other risk assessment documentation to reflect the findings of the April 2025 inspection, and the current status of risk in relation to fire safety in the centre since the changes to the centre's layout.
- The compliance plan submitted after the April 2025 inspection stated that a new process had been put in place for raising risks directly with the registered provided. An updated response outlined that this process involved any fire safety risk rated as 'medium' would be reported directly to the registered provider within one hour with immediate authorisation available to complete emergency interventions. It was noted that members of the senior management team were not aware of this protocol. The inspector requested to review documentation relating to this protocol however this was not provided on the inspection day.
- The fire risk assessment completed in July 2024 had recommended that a review of potential asbestos containing materials was completed in the centre. The inspector requested to review evidence that this was carried out, however this could not be provided on the day of the inspection.

The registered provider had developed a risk management policy which was most recently reviewed in February 2025. It was noted that the risk ratings identified in the provider's policy were not in line with those in the risk assessments reviewed by the inspector. For example, the risk policy stated that a high level risk was a risk rated between six and nine, whereby risk assessments reviewed stated that a high risk was a risk rated between 13 and 25. This required review.

Judgment: Not compliant

Regulation 28: Fire precautions

At the April 2025 inspection, it was noted that a fire risk assessment by an external suitably qualified competent person identified a number of concerns in related to fire safety. This noted a number of actions to be taken as a result of the assessment that had been completed in February 2025. This resulted in the registered provider receiving an urgent action under this regulation at the April 2025 inspection. In their response to this urgent action, the registered provider acknowledged the delays in addressing fire safety recommendations. The registered provider stated that they were fully committed to rectifying the matters raised under this regulation to meet regulatory compliance. Assurances that all of these issues had been addressed were requested at the introductory meeting. Records to outline that these deficits in the fire safety systems were not provided on the day of the inspection. Therefore, it was not evidenced that the following issues had been addressed as recommended by the competent person;

- The competent person had identified that inappropriate material had been used along escape routes and enclosures in the centre. Such materials used did not provide for suitable fire containment as some of these materials when conducting premises works for the centre were "combustible". It was not evidenced that this had been addressed as part of the changes to the centre's layout.
- Gaps in ceiling joints and around ducts, cables and pipes were identified which also did not promote fire containment. It was not evidenced that these had been adequately addressed.
- A number of fire doors at the April 2025 inspection were noted not to be 'acceptable' fire doors by the competent person. A number of internal doors had been replaced since the April 2025 inspection. However, there was no evidence that these doors were certified, fire-rated door sets to ensure effective containment in the event of a fire. It was noted that this had also been identified in the six-monthly unannounced visit to the designated centre completed in July 2025, and that the newly appointed person in charge was awaiting an assessor to review the fire doors.
- The fire competent person had identified that additional fire safety signage was needed in certain areas. It was not evidenced that this had been addressed. It observed at this inspection that emergency exit signage was not in place at the exit of one resident's living area.
- At the April 2025 inspection, it was identified that one resident's bedroom exited into a kitchen. Changes to the layout of the designated centre meant that resident's bedroom now entered into a corridor. The inspector sought assurances that this was a protected escape route, however this was not provided on the day of the inspection.

A fire alarm panel was in place in the centre. The panel alerted staff members to the

location of smoke and fire in the event of an emergency by stating the zone where this was detected. It was noted that there were two different guides for staff member beside the fire alarm panel which stated conflicting information as to where the zones were located in the building. For example, one area stated that zone 1 referred to the kitchen while the second guide stated that zone 1 was at the back of the building which was not near the kitchen. Staff spoken with on the day of the inspection were uncertain which zoning guide was correct. It was also identified on the day of this inspection that only one of the centre's doors were connected to the designated centre's fire alarm. This meant that these doors would not automatically close in the event of smoke of fire to promote effective containment.

Judgment: Not compliant

Regulation 8: Protection

The registered provider had a policy on the safeguarding of vulnerable adults. This policy stated that where reasonable grounds for concern exist, a safeguarding plan must be developed to address concerns and reported in line with statutory guidance. The inspector requested to review the documentation following a number of allegations of suspected abuse and neglect in the designated centre. The inspector found that information relating to the safeguarding of residents was not available to staff and the inspector to ensure the residents were protected from all forms of abuse.

At the April 2025, it was noted that notifications of a safeguarding nature were reported to the Chief Inspector which alleged neglect by the registered provider as they had not addressed the matters raised in the February 2025 fire risk assessment. The documentation relating to this was reviewed by the inspector on the inspection day.

- In their compliance plan response, the registered provider identified that the safeguarding risk this posed to residents had been removed as all fire related works were being completed in the centre. However, as noted on the day of this inspection, it was evident that a number of fire safety risks had not been adequately addressed by the registered provider.
- The inspector requested to review evidence that these allegations had been notified in line with statutory guidance and the registered provider's policy to the safeguarding and protection team. This evidence was not provided as requested.
- The inspector reviewed the safeguarding plans that had been developed in response to the allegations of neglect by the registered provider. These safeguarding plans had identified that there were reasonable grounds for concern. The inspector requested to review evidence that an investigation into these allegations had been initiated in line with the regulations. Evidence that an investigation had taken place was not provided to the inspector. It was noted that local management who had recently commenced working in

the centre were not aware of such an investigation having taken place.
- These safeguarding plans stated that necessary building works would be completed to ensure fire compliance by 31 May 2025. It was evident from the findings of this inspection this had not taken place in line with the timeline set out by the registered provider. It was noted that the safeguarding plans had not been updated to reflect that this action was outstanding.

As previously stated, local management had identified that there had been an increase in the number of allegations of a safeguarding nature since the April 2025 inspection. The person in charge had completed a review into the management of allegations of abuse the designated centre in July 2025, shortly after they commenced their role. In doing so, they identified there was no safeguarding plan available to staff members following an incident in April 2025, and that there was no evidence this had been reported in line with statutory guidance. The person in charge had retrospectively reported the allegation at this time, and in doing so developed a safeguarding plan. This safeguarding plan was requested for review however, this could not be provided on the day of the inspection. Therefore, this information was not available to staff members to ensure the resident was protected from potential abuse.

In addition, an incident had occurred in the designated centre in August 2025 whereby a resident's whereabouts were unknown for 15 minutes. This had been reported to the Chief Inspector as it was noted that staff members had not adhered to the resident's personal plan. The inspector requested to review the safeguarding plan in place following this alleged incident however this could not be provided to the inspector on the day of the inspection. Therefore, this information was not available to staff members to ensure the resident was protected from potential abuse.

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 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 8: Protection	Not compliant

Compliance Plan for Baile Geal Residential Service OSV-0008798

Inspection ID: MON-0047473

Date of inspection: 14/08/2025

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 21: Records	Not Compliant
Outline how you are going to come into compliance with Regulation 21: Records: The registered provider acknowledges the non-compliance identified under Regulation 21(1)(c) and has taken immediate and sustained actions to ensure all Schedule 4 records are now maintained and available for inspection as required under the Health Act 2007. A full review of Schedule 4 documentation requirements has been completed. A dedicated Schedule 4 Tracker has been developed and implemented within the designated Centre. This tracker outlines all Schedule 4 requirements and includes: document descriptions, location (digital/hard copy), responsible person, last review date, and follow-up actions. This system ensures that all required records are traceable, assigned, and regularly maintained. It was identified that an Annual Review had not previously been completed for the designated center. This has now been rectified: a comprehensive Annual Review has been completed based on the previous 6-monthly audits and inspection findings. This process is now embedded into the center's governance schedule and will be completed annually going forward. All previously unavailable records including the engineer's report, fire safety documentation, and the newly completed Annual Review have been retrieved and filed in both a physical Schedule 4 folder onsite and a dedicated digital Schedule 4 folder on Microsoft Teams. These are now available for internal review and regulatory inspection. To strengthen oversight and ensure ongoing compliance, the registered provider has introduced two new forms: Contractor Oversight Form captures details of works completed and is signed off by the Maintenance Lead and/or Person in Charge. Contractor Competency Review Form records contractor insurance and referral details prior to approval of works. All staff responsible have been briefed and trained on the tracker, Schedule 4 requirements, and documentation expectations. The registered provider is committed to maintaining full compliance with Regulation 21(1)(c) and ensuring that all records remain accurate, accessible, and inspection ready.	

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:

The registered provider acknowledges that governance systems were not sufficiently embedded at the time of inspection. Since then, the following measures have been implemented and are now operational to ensure effective governance:

An Annual Review of the Quality and Safety of Care and Support has been completed in line with Regulation 23(1)(d) and is available for inspection. In addition, six monthly unannounced provider visits are in place and documented as well as the annual reviews.

A Governance Calendar is in use, maintained by the Quality and Audit Officer, tracking all statutory reviews, audits, and key meetings.

Governance meetings are now held every six weeks additional meetings can be convened if deemed necessary. The meeting is chaired by senior management, with actions tracked and minutes available for review.

A Schedule 4 Records Register has been created and is maintained under Operations oversight to ensure all required records are up to date and accessible to the Person in Charge.

A Maintenance Tracker is in place and monitored by Persons in Charge to ensure all works are raised promptly, allocated to the appropriate team or contractor, and closed out once completed. Evidence of completed works is logged and available for inspection.

A Post-Significant Event Notification (SEN) Review Form has been introduced and is actively used to ensure all notifiable incidents are reviewed at SEN meetings.

Fortnightly support meetings between the Operations Manager and the Person in Charge commenced in September 2025. These provide supervision, guidance, and accountability, with minutes available.

A new Governance Escalation Form has replaced the previous one-hour protocol. This process is now in place and has been used to escalate issues requiring senior oversight, ensuring clarity and accountability.

Safeguarding oversight has been strengthened: historical issues were reported to the HSE safeguarding team, and full reviews took place on 2/9/2025 and 9/9/2025 (minutes available). Ongoing safeguarding meetings are scheduled every six weeks, or more frequently where concerns are flagged at post-incident quality reviews.

These systems are already operational and evidence of their implementation (meeting minutes, safeguarding reviews, escalation records, maintenance logs) is available for inspection. The provider is committed to ensuring that governance and management oversight remains consistent, transparent, and continuously informs quality improvement.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
The provider acknowledges non-compliance under Regulation 17. At the time of inspection, one resident did not have access to suitable kitchen facilities. Currently, residents use an air fryer in their accommodation while all main meals are prepared in a separate locked kitchen. While this arrangement was introduced to manage safeguarding risks, it restricts residents' independence and does not fully align with the Statement of Purpose.
An environmental risk assessment regarding this resident's space was completed in September 2025. The provider will retrofit a safe kitchen in the resident's accommodation, including a hob, oven, sink with running water, and food preparation space. Safety measures will include a hob isolation switch, appliance cut-offs, and fire safety equipment. The resident's risk assessment, safeguarding plan, and care plan will be updated to reflect structured and supervised use of the kitchen.
The assessment further identified the potential benefit of a staff observation/breakout space, and feasibility is under review. In the interim, staff safety will be maintained through a 2:1 staffing ratio, clear access to multiple escape routes, and six-weekly review of incidents at Significant Event Notification (SEN) meetings.
The engineer's report confirmed that directional signage was in situ. The revised layout had been inspected as part of the engineer's fire safety reviews in 2025, and no concerns were raised. One additional emergency exit sign identified during HIQA inspection has been installed, with evidence retained in the fire safety folder.

Ongoing compliance will be monitored through SEN reviews, updated risk assessments, staff training in safeguarding and de-escalation, routine house audits, and six-monthly provider visits. All future environmental changes will require joint review by governance, maintenance, and staff teams to ensure safety and independence remain balanced.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
The registered provider acknowledges the non-compliance identified under Regulation 26.
Since inspection, the Person in Charge has ensured that all risks are recorded in the operational risk register, including the addition of an adverse weather/service disruption risk in September 2025. Fire risks have been reviewed and updated in line with independent engineer inspections carried out in January, April, and June 2025, with a further fire door inspection scheduled to be completed on 02 OCT 2025.

The fire risk assessment completed in July 2024 recommended a review of potential asbestos-containing materials (ACMs). This has since been addressed: the engineer's updated report confirms that previously exposed asbestos cladding in the interior of the externally accessed former boiler house has been encapsulated in accordance with good practice. This encapsulation seals the ACMs, preventing the release of fibers into the air, and is supported by other passive precautions provided within the premises. No further asbestos-related risks have been identified. Should a competent assessor raise additional concerns in future, the provider will ensure full review and immediate remedial action.
The risk management policy is being amended to align with the HSE 2017 Framework for Corporate and Clinical Risk, ensuring consistency between the 5×5 risk rating matrix, the risk register, and individual risk assessments. This will address the discrepancy identified by HIQA between policy and practice.
Going forward, the Person in Charge will maintain the operational risk register, all new risks will be discussed at governance meetings, and high-level risks will be escalated to the registered provider for immediate oversight using the Governance Escalation Form. Provider governance meetings every six weeks will review the central risk register to ensure sustained compliance.
Corrective actions include the addition of the adverse weather risk, updating fire safety risks following engineer inspections, and policy alignment commenced in September 2025, with governance monitoring continuing from October 2025.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
The registered provider acknowledges the recurring non-compliance under Regulation 28 Immediate corrective actions have now been taken, and independent professional oversight confirms that the center is operating in line with fire safety requirements.
Independent fire inspections were carried out by Infinite Focus Consulting Engineers on 29/01/2025, 30/04/2025, and 10/06/2025. These reports confirm that the fire detection and alarm system, emergency lighting, extinguishers, directional signage, and fire-rated doors with self-closing devices were installed and observed in situ, and that the premises satisfies the requirements and obligations under the Fire Services Act 1981 & 2003, the Building Regulations 1997–2024, and the Code of Practice for Fire Safety in Community Dwelling Houses (2017).
All fire doors have been checked and confirmed to close under their own weight and are kept in the closed position. The hold-open device linked to the alarm has been confirmed as operating correctly, and all other devices remain disengaged. Staff have been re-briefed on the correct zoning guide, and all conflicting information has been removed from the panel. The new layout of the premises has been reviewed by the fire engineer, and no issues were identified regarding escape routes, with no concerns arising during evacuation drills.
One additional emergency exit sign identified during HIQA inspection and has been installed, with evidence retained in the fire safety folder. Fire doors are scheduled to be reviewed by a competent assessor on the 2/10/2025 to verify requirements and ensure

any necessary work is proportionate and evidence based. Recommendations confirmed as required for compliance with fire safety standards will be implemented and closed out by 30/10/2025.
All engineer reports and fire safety documentation are now filed in the Schedule 4 folder in both physical and digital format. The registered provider is satisfied that immediate risks have been addressed and commits to maintaining ongoing compliance with Regulation 28 through professional oversight, timely contractor engagement, and documented governance monitoring.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
The registered provider acknowledges the non-compliance identified under Regulation 8: Protection.
Since inspection, the Person in Charge has re-engaged with the HSE Safeguarding and Protection Team to request all safeguarding correspondence. Where documentation was

unavailable due to staff changes, the original concern was resubmitted and the safeguarding plan reinstated. Two safeguarding reviews have since taken place, on 02/09/2025 and 09/09/2025, to address historical issues, with minutes available. A safeguarding folder and tracker have been established on Microsoft Teams, with secure access for the Person in Charge and all Baile Geal staff. Historical safeguarding plans have been reviewed and updated.
Going forward, all safeguarding concerns will be notified, investigated, and documented in line with Safeguarding Vulnerable Persons at Risk of Abuse: National Policy & Procedures (HSE, 2014). Evidence of all correspondence, plans, and outcomes will be uploaded immediately to Teams to ensure continuity. Safeguarding plans will be reviewed monthly by the Person in Charge until closed, safeguarding will be a standing item at fortnightly Operations meetings, and provider-level governance will review safeguarding every six weeks.
All staff have been reminded of their responsibilities in reporting and documenting safeguarding concerns. Refresher safeguarding training will be provided where required to ensure ongoing awareness and compliance.
Corrective actions, including the creation of the safeguarding folder and tracker, confirmation of staff access, completion of historical reviews, and development of a safeguarding checklist (Preliminary Screening PSF3, action plan status, and correspondence), were completed or initiated in September 2025. Ongoing monthly reviews and governance monitoring will continue from October 2025. The Person in Charge will maintain safeguarding documentation, with provider oversight to ensure compliance.

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 17(1)(a)	The registered provider shall ensure the premises of the designated centre are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.	Not Compliant	Orange	31/12/2025
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Not Compliant	Orange	30/10/2025
Regulation 21(1)(c)	The registered provider shall ensure that the additional records specified in Schedule 4 are maintained and are available for inspection by the chief inspector.	Not Compliant	Red	15/08/2025
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to	Not Compliant	Orange	31/10/2025

	ensure the effective delivery of care and support in accordance with the statement of purpose.			
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	30/09/2025
Regulation 23(1)(d)	The registered provider shall ensure that there is an annual review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards.	Not Compliant	Orange	30/09/2025
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.	Not Compliant	Orange	31/10/2025
Regulation 28(1)	The registered provider shall	Not Compliant	Orange	30/09/2025

	ensure that effective fire safety management systems are in place.			
Regulation 28(2)(a)	The registered provider shall take adequate precautions against the risk of fire in the designated centre, and, in that regard, provide suitable fire fighting equipment, building services, bedding and furnishings.	Not Compliant	Orange	31/10/2025
Regulation 28(2)(b)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Not Compliant	Orange	31/10/2025
Regulation 28(2)(c)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Orange	30/09/2025
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	31/10/2025
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	30/09/2025
Regulation 08(3)	The person in	Not Compliant	Orange	30/09/2025

	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.			