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:	Laurel Court
Name of provider:	Kerry Senior Care Ltd t/a Dovida
Address of centre:	Kerry
Type of inspection:	Short Notice Announced
Date of inspection:	22 May 2025
Centre ID:	OSV-0008942
Fieldwork ID:	MON-0045875

About the designated centre

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

Laurel Court is a detached bungalow located in an estate on the outskirts of a large town. It provides a full-time residential service for up to three residents, for ages of 18 years and older with intellectual disabilities, autism and who have physical and sensory needs. Each resident in the centre has their own bedroom and other rooms provided include a living room, a kitchen and a bathroom. The staff team is comprised of a person in charge, A team leader and care workers. Residents are supported by staff day and night through a social model of care.

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
Thursday 22 May 2025	10:00hrs to 16:00hrs	Kerrie O'Halloran	Lead

What residents told us and what inspectors observed

This was a short-notice announced inspection completed in the designated centre Laurel Court. This was the first inspection completed since the centre became operational in December 2024 and the residents had moved into their new home. Since moving into the centre, the residents had been supported in the transition process and continue to grow their links in the local and wider community. From what the inspector observed and from speaking with the staff and management in Laurel Court, it was evident that the residents who lived in this centre received a good quality service which met their individual needs, likes and preferences.

On arrival to the centre the inspector was greeted by the person in charge and the person participating in management. The inspector did not have the opportunity to meet the residents living in this centre as they were in college/day services and enjoyed a planned trip that evening. The person in charge spoke to the inspector about the residents' transitions into the centre and that both residents enjoyed living in Laurel Court and appeared happy in their home. Respectful and good humoured interactions were reported as having been observed by the management of the centre since its opening. The person in charge discussed residents' goals to go on holidays and plans were being made to help residents achieve their goals.

The inspector held an introductory meeting with the person in charge and later in the day conducted a walk-through of the premises. The centre is located in a town in Co. Kerry. The centre is a one story detached bungalow and contained three bedrooms. The centre has capacity for three residents. At the time of the inspection two residents were living in the centre. The centre was observed to be decorated in a homely manner while also being clean and warm. Residents both had their own bedrooms which were seen to be decorated as they preferred. The premises was well maintained. Residents had access to an outdoor area with seating.

The inspector met the team leader of the centre. The team leader was knowledgeable about the residents and how the staff team supported the residents living in the centre. The team leader spoke about the likes of the residents and outings the residents enjoyed, such as a trip to a wildlife park, and plans that residents had to visit a shopping outlet. The team leader discussed the consistency within the staff team in place since the centre opened and the positive impact this had for residents in providing for a continuity of care.

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

Capacity and capability

While management systems had been put in place to ensure residents received a good quality of service in their home, some improvements were required relating to the directory of residents, staff supervision and staff training.

The inspector reviewed a sample of rosters. They indicated that there were sufficient staff on duty to meet the needs of the residents. The centre had a full-time person in charge with a remit over two other designated centres. The person in charge was supported in their role by a team leader.

The provider had suitable arrangements in place for the management of complaints. For example, there was an organisational complaints policy in place.

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.

Regulation 14: Persons in charge

The person in charge worked full-time in their role. At the time of the inspection they had a remit of two other designated centres and split their time between these centres. The inspector was informed that it was an interim measure that the person in charge held the remit of three centres and that this would be reduced in the coming months. The person in charge was suitably qualified and experienced for their role. They had good knowledge of the residents and their needs.

Judgment: Compliant

Regulation 15: Staffing

The staff team was fully resourced at the time of this inspection, with no vacant posts. The inspector reviewed the rosters from the beginning of April to May 2025. This clearly identified who worked in this centre and when. Staffing resource allocation was sufficient to meet the needs of the residents living in the centre. The centre had consistent staffing since opening in December 2024 which ensured consistent support for the residents living in this centre.

Judgment: Compliant

Regulation 16: Training and staff development

The person in charge maintained a training matrix for staff working in the centre. Staff had completed training in fire safety, human rights, assistive decision making, manual handling, medication training and autism awareness. Training had been identified for a number of staff in positive behaviour support and this was being completed in the coming weeks. Two staff working in the centre required refresher training in safeguarding, as it had expired in 2021.

One resident was in the process of being supported to develop a behaviour support plan with an external agency. The resident had moved into the centre in December 2024. Three staff had completed training in positive behaviour support and nine additional staff were identified for training in the coming weeks. A date for this training was identified in the training matrix for the centre.

The inspector reviewed the staff supervision matrix in place. The centre's core staff team had all completed supervision and had a planned supervision identified on the schedule for the next supervision. However, review was required to ensure all staff members working in the designated centre received supervision. From the rosters reviewed it was seen that the centre had five relief staff members. Two of these staff members had completed supervision as per the matrix in place.

Judgment: Substantially compliant

Regulation 19: Directory of residents

The designated centre had a directory of residents for the designated centre. However this required review as it did not include all the required information as per Schedule 3. For example the following was not included: address, date of birth, sex and marital status of resident, details of residents' next of kin, details of residents' general practitioner, and the dates when residents first resided in the centre.

Judgment: Not compliant

Regulation 23: Governance and management

This designated centre was resourced with a full complement of staff, had use of a vehicle and a premises which was suitable for the number and needs of the residents.

There was a clear management structure in place which identified the lines of accountability and authority. There were effective monitoring systems in place and systems to monitor the quality of care and support delivered to residents.

As the centre had opened the end of December 2024, it had not yet completed an

annual review. The centre had also not completed an unannounced six-monthly audit due to this. The inspector spoke to the person in charge and person participating in management who were both aware of these reviews and audits as required by the regulations.

The person in charge carried out various audits in the centre on key areas relating to the quality and safety of the care provided to the residents. These included medication audits, infection prevention and control audits, vehicle audits, support plan audits and human rights audits. Where areas for improvement were identified within these audits, plans were put in place to address these.

Regular team meetings were taking place in the centre which had a running agenda. Some items discussed included updates for the residents living in the centre, incidents, complaints and safeguarding. Management meetings also took place regularly with the person in charge and the person participating in management. A weekly report of the centre completed by the person in charge was sent to the person participating in management. this would be followed by an in-person meeting or online meeting to review the centre.

Judgment: Compliant

Regulation 3: Statement of purpose

The provider had in place a statement of purpose for the centre which contained information required under Schedule 1 of the regulations. This is an important governance document that details the care and support in place and the services to be provided to the residents in the centre. This included all the required information and adequately described the service.

Judgment: Compliant

Regulation 31: Notification of incidents

Under this regulation the Chief Inspector must be informed of particular events that happen in a designated centre within a specific time period. This is important to ensure that the Chief Inspector is aware of matters which could adversely impact the quality and safety of care and support received by residents. Amongst the events that must be notified are allegations or incidents of a safeguarding nature which must be notified within three working days.

However, despite the regulatory requirements in this area, this inspection found that one incident identified as a peer to peer type incident had taken place in April 2025. This incident was of a safeguarding nature had not been notified within three

working days or had not been notified at the time of this inspection as it had not been identified as a safeguarding concern by the provider. A retrospective notification was submitted to the Office of the Chief Inspector following the inspection.

Judgment: Not compliant

Regulation 34: Complaints procedure

The provider had suitable arrangements in place for the management of complaints. There was a designated complaints officer nominated. The inspector reviewed the complaints log. There had been one complaint received since the centre opened. The complaint had been addressed in line with the provider's policy and it had been recorded that the complainant was satisfied with the outcome. There was no open complaints on the day of the inspection.

Judgment: Compliant

Quality and safety

This inspection found that Laurel Court provided good quality care and support to residents. Residents' health and wellbeing were promoted and access to appropriate supports were sought. Some improvements were required with regard to protection, risk management procedures and fire precautions.

Residents' rights were promoted in the centre with residents consulted with how they would like live their lives. Residents were seen to attend a college/day service. Residents in the centre lived active lives which was promoted by the staff and management of the centre. Residents attended regular residents meetings.

Each resident in the centre was supported to develop a comprehensive individual support plan. This included a review of needs from a multidisciplinary perspective with plans providing guidance on supports such as health and social care. Through the completion of person-centred meetings, residents were consulted in the completion of their plan and in the development of goals such as planning holidays and day trips.

Regulation 13: General welfare and development

From the records reviewed and what staff and management in the centre told the

inspector, residents were being supported to enjoy a good quality of life and had access to numerous activities, both in their home and out in the community. This indicated that residents were supported to have a meaningful day and to be occupied in accordance with their preferences and abilities.

Preferred activities were clearly outlined and the likes and dislikes of each resident were recorded in the residents' support plans. Residents enjoyed going to cafes and restaurants, going to the cinema, meeting friends, getting a take away, socialising, playing sport and going for walks and day trips.

Judgment: Compliant

Regulation 17: Premises

The premises was comfortable and suitably decorated. It was found to be clean throughout. Each resident had their own bedroom and access to communal areas including a living room. The house had laundry facilities in place and adequate storage facilities. Residents' bedrooms were seen to be decorated with their own personal items. An outdoor garden space was also accessible to residents with a seating area. The person participating in management informed the inspector they had planned to get a barbecue in the coming weeks which residents could enjoy.

Judgment: Compliant

Regulation 20: Information for residents

A residents' guide was in place that contained all of the required information such as a summary of services and facilities, arrangements for visitors and how to access inspection reports.

Judgment: Compliant

Regulation 26: Risk management procedures

The provider had systems in place and processes in place for risk management at this centre. There was a policy in place for risk management. The centre had a risk register for the designated centre in place and these risks had been reviewed recently. Residents had individual risk assessments in place, where risks to their wellbeing and safety were identified, assessed and in general kept under ongoing review.

However the following required action:

- Some risk descriptors in place did not provide identification to the risk. For example, 'College' was the risk descriptor for a risk assessment in place.
- The centres risk register did not include a risk for lone-working, although the centre had one staff working by night.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Fire-fighting systems were in place including a fire alarm system, fire doors, fire extinguishers, and emergency lighting/signage.

Staff also completed regular fire checks. These checks documented that the centre had fire precautions in place and in working order, for example, exits were clear and fire doors in working order.

There was a clear procedure in place for the evacuation of the residents and staff. Fire drills were completed regularly. The centre also had one night staff on at night and fire drills were in place to reflect this minimum staffing at night.

Each resident had a personal emergency evacuation plan (PEEP) in place which provided guidance to staff on the arrangements to ensure a safe evacuation from the centre. However, one of these required review to ensure a plan was in place for a resident who was prescribed an emergency medicine.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

The person in charge had ensured safe and suitable practices were in place relating to medicine management. There were systems in place for the ordering, receipt, prescribing and administration of medicines.

The person in charge was knowledgeable of the medicine management procedures and on the reasons medicines were prescribed. The person in charge spoke to the inspector about how medications were checked once received from the pharmacy.

The provider had appropriate lockable storage in place for medicines. The inspector reviewed both residents medicine administration records which indicated that medicines were administered as prescribed.

Residents had also been assessed to manage their own medicines, one resident was

self-administering on the day of inspection. The person in charge discussed with the inspector about how they support the resident with this. For example, the resident had lockable storage in their bedroom for their medicines.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The person in charge had ensured that a comprehensive assessment of need was completed for each resident. The inspector viewed both of the residents' files that lived in the centre. Where a support need was identified, care and support plans were developed. These were seen to be kept under ongoing review and updated as required.

Residents were supported to identify and set goals for the future. These goals were found to be kept under ongoing review. Some of the residents' goals had been achieved with the support from staff. These included going on a night away and going to the gym. Other goals were seen to be ongoing such as going to a concert and planning a trip abroad.

Judgment: Compliant

Regulation 6: Health care

Residents had access to appropriate health care in line with their personal plans and assessed needs. Residents had a general practitioner (GP) in place.

There were detailed specific health care management plans in place for residents. The inspector reviewed some of these plans. For example, one resident had an allergy and may require emergency medication. The plan included a clear protocol for staff to follow which was seen to be regularly reviewed. All staff had received training to support the resident if required.

Residents had access to multi-disciplinary supports. Residents have the support of a multidisciplinary team within the provider that included occupational therapy, speech and language therapy and positive behaviour support. One resident was in the process of being supported to develop a behaviour support plan with an external agency. A mentioned under Regulation 16, staff training and development, the person participating in management and person in charge informed the inspector that the remainder of the staff team in Laurel Court would also be provided with training in positive behaviour support in the coming weeks, a date had been identified on the staff training matrix.

Judgment: Compliant

Regulation 8: Protection

Since the centre opened it had identified a safeguarding incident. A safeguarding plan had been developed in response to the incident to protect residents from abuse. Internal reviews of the safeguarding plan was completed by the person in charge to ensure the safeguarding plan was subject to regular review. This safeguarding plan had been recently closed in May 2025.

However, when reviewing the incidents for the centre, an incident which took place in April 2025. It was recorded by the staff on duty as peer to peer type incident. This incident identified a resident's mood changing as another resident returned to the centre. This caused the resident to become vocal, upset and banging door in same room as another resident. It also identified staff followed the safeguarding protocol in place. This incident had not been identified by the provider as an alleged or suspicion of abuse, therefore had not been reported in line with statutory guidance for the protection of vulnerable adults. Following the inspection, the incident was reviewed by the provider and a retrospective notification submitted to the the office of the Chief Inspector.

The person in charge had put in place safeguarding measures to ensure that staff providing personal and intimate care to residents who require such assistance did so in line with the residents' personal intimate care plan. From both of the residents' files the inspector viewed, it was seen that residents' independence was promoted and residents needs were clearly recorded.

Judgment: Substantially compliant

Regulation 9: Residents' rights

Residents were supported to maintain contact with their families and friends, and visitors were welcomed to the centre.

The person in charge described various ways in which they upheld the rights of residents, and supported them in making their own decisions and choices. For example, residents had weekly residents meetings. Topics discussed included upcoming social events, weekly menu plans, complaints and safeguarding. These meetings had actions recorded when required. The inspector reviewed meetings notes from April and May 2025.

Care in this centre was provided in a manner which was person-centred and which took into account the residents' expressed wishes and interests. The team leader told the inspector of how the staff team ensured that residents had choice and

control of their daily lives. Residents had access to easy read documents. Easy-to-read documents were in place in the centre such as, safeguarding and complaints.

Both residents had been supported in accessing educational and day service programmes of their interests outside of the centre. This has been successful for both residents enjoying their individual courses and day service of choice.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 19: Directory of residents	Not compliant
Regulation 23: Governance and management	Compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Compliant
Regulation 20: Information for residents	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Laurel Court OSV-0008942

Inspection ID: MON-0045875

Date of inspection: 22/05/2025

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: Staff who were due refresher safeguarding training have completed same. HR will liaise with Person in Charge and team members to arrange refresher training when it is due. Positive behaviour support training has been organised for staff who require same. All relief staff have been added to the supervision schedule and the management will ensure supervision is completed with all team members as per the schedule.	
Regulation 19: Directory of residents	Not Compliant
Outline how you are going to come into compliance with Regulation 19: Directory of residents: The directory of residents have been reviewed and the required information has been included: resident's photograph, address, date of birth, gender, marital status, next of kin, GP, date of admission, date of discharge (where applicable)	
Regulation 31: Notification of incidents	Not Compliant
Outline how you are going to come into compliance with Regulation 31: Notification of incidents:	

A retrospective NF06 has been submitted for one resident. Safeguarding and Protection Team has been notified of the incident. A safeguarding plan for the resident has been developed and implemented. Learnings in relation to the notification of incidents have been discussed in the management and the team meeting.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures: The risk assessments have been reviewed, and more detailed risk descriptors were added where required. A risk assessment for lone working has been developed and added to the risk register.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions: Residents' personal emergency evacuation plans have been reviewed, and the management of rescue medication has been added to the plan for residents who require rescue medication.

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection: A retrospective NF06 has been submitted for one resident. Safeguarding and Protection Team has been notified of the incident. A safeguarding plan for the resident has been developed and implemented. Learnings in relation to the notification of incidents have been discussed in the management and the team meeting.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	31/07/2025
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	31/07/2025
Regulation 19(3)	The directory shall include the information specified in paragraph (3) of Schedule 3.	Not Compliant	Orange	07/06/2025
Regulation 26(1)(a)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: hazard	Substantially Compliant	Yellow	07/06/2025

	identification and assessment of risks throughout the designated centre.			
Regulation 28(1)	The registered provider shall ensure that effective fire safety management systems are in place.	Substantially Compliant	Yellow	07/06/2025
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	13/06/2025
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	13/06/2025