Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Disabilities (Mixed).

Issued by the Chief Inspector

Name of designated centre:	Ivy Lodge Residential Care Service
Name of provider:	Communicare Agency Ltd
Address of centre:	Galway
Type of inspection:	Unannounced
Date of inspection:	01 July 2025
Centre ID:	OSV-0008976
Fieldwork ID:	MON-0047475

About the designated centre

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

Ivy Lodge Residential Care Service is a designated centre operated by Communicare Agency Ltd. The centre can provide residential care for up to three residents, who are over the age of 18 years, and who have a disability, and can also provide care for residents with high behavioural support needs. The centre is located within a village in Co. Galway, and comprises of a purpose built bungalow, that has four separate apartments, and a communal area that contains an office, kitchen, bathroom, laundry room, and living space. There is also a front and rear outdoor space for residents to avail of. Each apartment provides residents with their own en-suite bedroom, and open plan kitchen, dining and living area. Staff are on duty both day and night to support residents who reside in this centre.

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
Tuesday 1 July 2025	09:00hrs to 16:30hrs	Anne Marie Byrne	Lead
Wednesday 2 July 2025	09:00hrs to 15:15hrs	Anne Marie Byrne	Lead
Tuesday 1 July 2025	09:00hrs to 16:30hrs	Ivan Cormican	Support
Wednesday 2 July 2025	09:00hrs to 15:15hrs	Ivan Cormican	Support

What residents told us and what inspectors observed

This was an unannounced inspection to assess the provider's compliance with the regulations. This was the first inspection of this centre since it was registered in February 2025, which found high levels of non-compliance with the regulations. There were significant concerns raised in relation to restrictive practice management, behavioural support arrangements, safeguarding, risk management, residents' assessment and personal planning arrangements, and in the provider's oversight of the delivery of care in this centre. There was also a key failing in undefined roles of responsibility and accountability between local and senior management levels, which had resulted in very poor overview of fundamental aspects of this service.

Prior to this inspection, the provider submitted notifications to the Chief Inspector of Social Services, pertaining to serious incidents, with the nature of this information raising concerns around the overall provision of care within the centre. Upon this inspection, the provider could not clearly demonstrate that there were adequate arrangements in place to protect and promote the welfare of the resident that had been involved in these incidents, to include, their legal status and if further steps were necessary or not, to give the provider authority to deliver the care to this resident in a safe manner. This resident had significant care needs and without staff support they could potentially place themselves at serious and life threatening risk of harm. This lack of clarity on their legal status posed a considerable risk to operations of this centre and this resident, should they choose to leave the centre without staff support, and/or place themselves at any risk of harm of injury. The significance of this risk resulted in an immediate action being issued to the provider, which will be discussed in more detail later on in this report.

At the time of this inspection, this centre wasn't operating at maximum capacity, and was providing full-time residential care and support to two residents. The morning of the first day of this inspection was facilitated by the centre's person in charge and by two local managers who worked solely in this centre, with the remainder of that day facilitated by these two local managers. The second day was again facilitated by these two managers, and also attended by the director of disability care services and by a director of the company. Inspectors also had the opportunity to meet with both residents that lived in this centre, and with a number of staff that were on duty both days.

The lines of enquiry for this inspection were driven by the incidents that had occurred since the centre opened. Due to failings found upon this inspection in the provider's own oversight of these incidents, over the course of this two-day inspection, inspectors conducted their own review of these incidents, so as to establish key information around care and support arrangements. This inspection was initially scheduled to occur over one day; however, due to difficulties in acquiring accurate and relevant information, a second day was added to ensure inspectors had the full picture in terms of the provision of care. The members of

senior management who attended on the second day were able to provide additional clarity in regards to some issues which inspectors had highlighted on the first day of this inspection.

The two residents that lived in this centre both had complex behavioural support needs, had significant risks identified in relation to absconsion, self-injurious behaviours, and required specific risk management to ensure their safety. Both required environmental, chemical and physical restrictions due to known and active safety concerns. Key-pad locks were applied to both internal doors and external exits within this centre, and windows had restriction devices added. Due to the considerable risk of self-harm that both residents' presented with, there was also restrictions in place around the use of crockery and utensils. Environmental safety checks were also occurring of their apartments multiple times a day, to ensure they didn't have access to any object that they could use to place themselves at risk of harm or injury. One of these residents also had a specific health care needs that required rigid medication management and very specific health care interventions. They each were assessed as requiring two-to-one staffing both day and night, which they were consistently provided with.

The centre was a large, single storey purpose built facility, comprising of four separate apartments, with each having an individual open plan kitchen/dining/living area and an en-suite bedroom. The main aspect of the centre had a central communal living area, bathroom, laundry room, staff office and kitchen, and was directly accessible to each resident from their apartment. There was an outdoor patio area that was available to residents, with the provision of garden furniture made to this area in recent weeks. The centre was modern, bright, spacious, and comfortably furnished throughout.

When inspectors' arrived to the centre, they were greeted by members of local management that were present, and by some of the staff team. There was a calm and relaxed atmosphere, with a resident who was recently admitted sitting in the communal living area. They greeted both inspectors, and brought one of them to see and visit their apartment. They also spent some time speaking with the other inspector, and told of how they recently moved in and were getting to know everyone. The second resident was being supported by staff with their morning routine, and over the course of the two days an inspector got to speak briefly with them. They had celebrated their birthday a few days before, and had kept some of the balloons and banners from the celebrations in their living area. They told of how they had enjoyed their weekend, and about their plan to later head out with staff, and were also preparing for a meeting. They spoke of how they were familiar with their staff team, and showed off artwork that some staff had created for them, which they proudly displayed in their living area. They also had a planner hung up on a wall, that they referred to so as to know what the plan was for the day. This resident did enjoy getting out and about, but due to their assessed behavioural support needs, staff were required to carry out a dynamic risk assessment prior to each outing, to ensure it was safe for the resident to head out with the support of staff each time. Both residents had built a rapport with staff since they moved in, and both appeared very comfortable in the company of the staff that were on duty. Staff who met with inspectors at various intervals throughout this inspection spoke

very respectfully about these two residents, and were observed to be friendly and warm in their interactions with them.

Over the course of the inspection, inspectors found that since the centre opened, it had faced significant challenges in relation to the provision of a safe and good quality service, with a lack of oversight at senior management level being a contributing factor to this. This was a centre that experienced a high volume of incidents, some of which had resulted in a resident placing themselves and others at serious risk of harm and injury, on more than one occasion. To give context to the significance of these, a number of these incidents had been responded to and managed locally by staff; however, some of them resulted in the resident needing urgent medical attention for their injuries. The incident review conducted by inspectors clearly indicated the complexity of care of each resident, and the threat they both potentially placed upon their own personal safety, from multiple incidents that had happened since they were admitted to this centre. However, throughout the inspection, the provider failed to demonstrate that suitable oversight arrangements were in place around incidents that had happened, which had a direct impact on the provider's ability to assure themselves of the safety and quality of care in this service.

The oversight of behavioural and restrictive practice management was also found to be poorly managed by the provider in this centre, despite it being a fundamental aspect of both residents' care and support needs. Inspectors read multiple incidents, whereby, residents had engaged in behaviours of concern which resulted in the use of physical restraint and/or chemical interventions, with little to no information sometimes recorded around any alternatives trialled to manage residents' behaviours, before using these last resort measures. Also of concern to inspectors was the inconsistent manner in which restrictive practices were used, particularly in relation to chemical restraints. As well as this, inspectors found the provider was unable to clearly demonstrate the multi-disciplinary assessment process behind the use of these restrictive practices, account for the inconsistencies in how each restriction was being recorded and reported, and had not ensured that protocols were in place to guide staff on the appropriate use these restrictions.

In conjunction with the failings found to the provider's oversight of the above mentioned areas, there were also multiple deficits found across risk management practices, staff training, the system for assessing resident' needs, identifying and responding to safeguarding risks, and also with regards to some aspects of health care arrangements. Although there was a defined management structure in place for this centre, with regular meetings occurring at local and senior management level, these were failing to review pertinent information about how care was being delivered in this service, based on the information gathered from incidents that were happening. Separate to this, the audits and monitoring systems that the provider had utilised since the centre opened, didn’t give consideration to what aspects of this service were of priority to be monitored, and subsequently didn’t provide any direction as to what improvements were needed in these areas, that would have benefited the residents and the service they received.

Fundamentally, the failings found upon this inspection, ultimately rest with the

provider not ensuring that they had robust oversight of what was going on in this centre. They had not maintained regular overview specific incidents that were occurring, which clearly informed of inconsistencies in the approach to positive behavioural support, raised questions around the use of restrictive practices, and clearly indicated that more robust governance and oversight arrangements were required in this centre in order to keep residents safe, and to ensure they were receiving a good quality of service.

The specific findings of this inspection will now be discussed in the next two sections of this report.

Capacity and capability

This inspection found multiple failings at a provider level, whereby, the provider had not used their management structure effectively, had not implemented robust monitoring systems into this centre, failed to respond to and monitor risk appropriately, and overall were not overseeing very key areas of care and support arrangements to ensure safe and quality care was being provided.

The local management team in this centre comprised of the person in charge, a residential services manager, and two team leaders, one of whom was only recently appointed. At a senior management level, there was a disability care services manager, a clinical care manager, a general manager, operations manager and a managing director. However, there was disconnect and confusion clearly evident throughout this inspection with regards to the specific roles of accountability and responsibility for overseeing local and operational issues. Local management were responsible for the running of this centre; however, the provider was failing to recognise that they held the overall responsibility for the service that was being delivered, and did not have effective oversight arrangements in place to enable them to do so. Given this centre had only been in operation a few months and the high volume of incidents that had happened since the first resident transitioned, this hadn't led to robust oversight from the provider despite this defined management structure, which had resulted in poor outcomes for the quality and safety of care delivered to these residents.

There was also significant consideration needed to be given by the provider in terms of what aspects of this service they deemed subject to regular monitoring and oversight, as audits that had been conducted since the centre opened had not led to specific improvements required in this centre being identified. Staff training arrangements also required review by the provider, to ensure that the staff working in this centre had the training they required, specific to the care and support they provided daily to these residents.

Over the course of this inspection, it was also identified that an alleged safeguarding incident was reported to have occurred in the weeks prior. This incident will be discussed in more detail under quality and safety; however, this incident had not

been notified to the Chief Inspector of Social Services, as required by the regulations.

Regulation 15: Staffing

The provider had a planned and actual rota in place which clearly detailed the staffing arrangements each day and night in the centre. Residents who lived in this service had high support needs and required a high level of staffing to maintain their safety and to facilitate social access.

Each resident was supported by two staff throughout the day and night, and included a nurse on duty at all times. Inspectors met with five staff in total over the two day inspection and spoke for a period of time with two staff. They were found to have a good understanding of both residents' care needs in terms of behavioural support and their social care needs.

The inspection was also facilitated by two nurses who were also part of the management structure, and again they were found to have a good understanding of the residents' assessed needs.

Judgment: Compliant

Regulation 16: Training and staff development

The provider had a system in place for staff training; however, this required review as a several training was outstanding for multiple staff members, most of which related to specific mandatory site training that the provider had deemed all staff to have. This training was specific to management of challenging behaviour, fire evacuation, risk management, epilepsy management, specific medication training, mental health, and ligature training. From the records made available to inspectors, there were a number of staff without up-to-date training in these areas. For example, of the 16 named staff members on the centre's training schedule, six of them had not received up-to-date training in any of these areas, with four others not having received up-to-date training in all of these areas.

Judgment: Not compliant

Regulation 23: Governance and management

This provider had a defined management structure for this designated centre, comprising of a local and senior management members. However, there was a

considerable confusion in terms of the lines of accountability and responsibilities each management team held for all areas of this service provision, that required review by this provider.

There were considerable failings at a provider level in ensuring that their own governance systems were fit for purpose, in overseeing and monitoring key aspects of this service. This had resulted in the provider having very poor oversight of what incidents that were happening, not having robust oversight of the response and management of significant events, and they had not gathered pertinent information around level and type of restrictive practices that were being used in their centre. The failings in these governance and oversight arrangements significantly impacted the provider to be able to clearly demonstrate and assure themselves, that the care in this centre was being delivered safely and of a good quality of standard.

Regular meetings were occurring at a local management, senior management, and provider level; however, these meetings were not being effectively utilised to review fundamental aspects of this service. For example, following a significant incident at this centre in May 2025, the next management meeting didn't occur until a number of weeks following this incident. Minutes from this meeting were reviewed by inspectors, which failed to demonstrate that any learnings or review of current risk management in response to this incident, was subject to robust discussion and review. Furthermore, due to failings in the provider's oversight arrangements for this centre, this meant that many of issues and risks in this centre, were not part of the agenda at these meetings. For example, this inspection identified multiple failings in relation to risk management, restrictive practice and behavioural support arrangements, safeguarding, and assessment arrangements, which the provider had not identified for themselves. This meant that these areas were not subject to the scrutiny and discussion that was needed at local, senior, and provider meeting level, so that they could be addressed.

There were also failings found in relation to the provider's other systems for monitoring for the quality and safety of care. Since the centre opened, senior management conducted audits to review infection prevention and control arrangements, along with medication management practices. However, it was unclear to inspectors how these areas of service were prioritised for monitoring by the provider, given the level of complex behavioural support and safety arrangements that governed most of the care that was delivered in this centre.

Judgment: Not compliant

Regulation 31: Notification of incidents

Inspectors reviewed an incident report where information was recorded alleging a potential safeguarding concern. This potential safeguarding issue had not been identified by the provider and the associated notification had not been submitted to

the Chief Inspector, as required by the regulations.

Judgment: Not compliant

Quality and safety

Inspectors found that improvements were required in relation to the quality and safety of the service provided to both residents. Significant issues were highlighted in regards to safeguarding, behavioural support, the implementation and oversight of restrictive practices, and risk and incident management. An immediate action was also issued to the provider prior to the conclusion of the inspection in relation to the safety of one resident.

At the time of this inspection, the provider had not made sufficient progress in determining the legal status of one resident, or in establishing if further steps were necessary or not, to give the provider authority to deliver care and support to this resident in a safe manner. Since their admission, this resident had been involved in incidents of a serious nature, one of which occurred a few weeks prior to this inspection. Despite this, coupled with their undetermined legal status, the provider did not have any protocols in place to guide staff should this resident wish to leave the centre against the advice of staff, and/or place themselves at serious risk of harm. An immediate action was issued to the provider in relation this.

Inspectors found considerable failings in relation to the provider's oversight of behavioural support arrangements, and the associated implementation of physical and chemical restrictive practices, which were a regular use in this centre. There was an inconsistent approach found in relation to this area of care and as a result, the provider was unable to demonstrate that the least restrictive option was utilised at all times. There were also multiple aspects of the provider's risk management system that was failing to support effective identification, assessment, response and monitoring of risk in this centre. Fundamental to this, was the deficits in arrangements for the escalation, review and response to high-rated risks.

The assessment of residents' needs was also found to require review, as the current way in which this was being completed, was not focused on providing a clear overview of the specific care and support that residents required. Due to the care and support needs of these residents, nursing support was available in this service. However, there was a failing to ensure that comprehensive health care planning of a critical health care need had been completed.

Regulation 26: Risk management procedures

A significant incident occurred a few weeks prior to this inspection, where a resident

left the centre, and subsequently placed themselves and others at serious risk of harm. This resident had significant risks associated with their care, and along with the aforementioned incident, other incidents had occurred in the months prior to this inspection where they had also caused themselves harm and injury. Despite this, there were no protocols in place to guide staff on what to do, should this resident leave the centre again against the advice of staff, or again place themselves at risk of serious harm or injury. An immediate action was given on the second day of the inspection, requiring the provider to develop these protocols and make them available to staff at the centre, and to ensure these were agreed with the Commissioner of Services, and subject to revision as and when required. Assurances were provided by those facilitating this inspection that this would be completed before the end of the day.

Due to the lack of oversight the provider had of incidents in this centre, inspectors conducted their own review of the incidents that had happened since the centre opened. This review identified that a resident that was admitted after the centre was registered had 22 recorded incidents since their admission, while the second resident who was admitted a few weeks prior to this inspection, had 18 recorded incidents since their admission. This incident review gave clear insight into how restrictive practices had been used, raised questions in relation to inconsistencies in how behavioural support interventions were applied, and also provided key information around potential risks to the quality and safety of care delivered in this service. Inspectors spoke with the members of senior management who were present for the second day of this inspection, where it was identified that senior management were not fully aware of exactly what type of incidents were occurring in this centre, and were not robustly trending, or monitoring these incidents, to allow for effective mitigation of any existing, new or potential risks.

When more serious incidents had occurred, there was a process for these incidents to be subject to an additional significant event review; however, this review was found not to be fit for its intended purpose. A significant event report from a recent serious incident was reviewed by an inspector, was only found to provide a description of the incident and the immediate response and action taken at the time. This review provided no critical review of follow-up actions, learning from the incident, or any risk management activities that needed to be implemented on foot of this incident. There was also no evidence of senior management involvement, or oversight into this significant event review process.

The way in which risks were assessed in this centre required considerable review. For one resident, there were 47 risks identified for them, with 11 of these rated as high risk. There was no formal oversight of the response required to these identified high-rated risks, or as to how they were impacting on the quality and safety of care for this resident. The quality of information provided within these risk assessments also required significant review. For instance, observed within another resident's risk assessments, was the repeated reference to the same control measures, to include, the provision of a contract of care, consent forms, and contact with emergency services, regardless of what the identified risk was for the resident. This resident had significant risks associated with their personal safety and behavioural support arrangements, with the risks assessment of these not providing any detail around

what specific control measures that had been put in place in response these, or reference to any additional controls needed to further safeguard this resident from harm.

The risk management policy also required significant review. This policy provided no indication as to what the required response would be, both at a local and senior management level, should risks be risk-rated as high. There was also no guidance in terms of the formal review and escalation of these from local to senior management level, or as to how these were robustly monitored by the provider.

There was also considerable review required to this centre's risk register, which did not identify key risks associated with the operations of this designated centre, or provide any assurances as to how the provider was robustly assessing for these risks. For example, this centre had a number of operational risks in relation to recent admissions to this centre, behavioural support arrangements, oversight of restrictive practices, and monitoring for the re-occurrence of serious incidents. However, the risk register failed to account for these.

Judgment: Not compliant

Regulation 28: Fire precautions

The provider had taken fire safety seriously and fire safety equipment, such as, an alarm, extinguishers, fire doors and emergency lighting had been installed. This equipment had a complete service schedule in place and staff were completing daily, weekly and monthly checks of this equipment to ensure that it was in good working order at all times. Fire procedures were also displayed and there were an ample number of emergency exits throughout the building

Both residents and staff had participated in fire drills and a review of associated records indicated that both parties could leave the centre in a prompt manner of required. A staff member also explained the evacuation arrangements and they had an overall good knowledge of fire safety in the centre.

Although fire safety was promoted, some improvements were required to residents' personal evacuation plans. Better clarity was required within these plans in relation to the residents' understanding of the fire alarm and around how they would evacuate the centre. In addition, the evacuation plans also failed to outline the residents' individual supervision requirements, should they need to leave the centre in the event of an emergency.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

The provider had secure storage in place for medicinal products and registered nurses were on duty throughout the day and night for the administration of medications. Complete prescriptions were in place, which had the required information to aid the safe administration of medications. Associated medication administration records indicated that regular medications were administered as prescribed.

One resident had a complex medical need and a staff member informed inspectors that due to the assessed behavioural support needs of this resident, circumstances could arise where an as-required medication may be needed, to aid in the administration of their regular medications. However, there was no medication protocol or guidance in place to guide staff in the administration of this as-required medication for this purpose.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

The provider had failed to ensure that the assessment of need for a resident took into account changes in their circumstances and new developments. One of these residents was admitted to this centre in March 2025 and since then, their overall circumstances had changed. However, the re-assessment of their needs failed to sufficiently acknowledge this change and any interim care and support arrangements needed by this resident.

The process for assessing residents' needs also required considerable review by the provider. The current assessment of need that was in operation in this centre, was focused on assessing for the level of staffing required by residents, and didn't comprehensively assess for the care and support needs of residents. For example, an inspector reviewed a recently revised comprehensive assessment of need for a resident with complex behavioural support needs, and who also had significant risks pertaining to their personal safety and had been involved in a number of high-risk incidents since their admission. Although this assessment was very clear around the level of staff support required by them, it failed to fully consider the extent of their needs and identified risks, and only provided very limited information around the specific arrangements that were needed to provide safe care and support arrangements for them.

Judgment: Not compliant

Regulation 6: Health care

A resident who used this service had a complex medical need. Inspectors were informed that this resident required the emergency services to be contacted, should they refuse their medications, or receive their medications one hour outside of the prescribed administration time.

Considering the critical nature of their complex medical need, comprehensive care planning was required to ensure a consistent approach to the delivery of their care. At the time of this inspection, the resident had resided in the centre for 28 days; however, a formal care plan to guide staff in the delivery of this complex care need had not been completed. This was of concern to inspectors considering that extensive nursing support was in place since their admission to the centre.

Inspectors reviewed medication administration records which indicated that on one occasion the resident did not receive their medications on time; however, the emergency services were not contacted. Inspectors identified this issue through a standard review medication administration records. Of concern to inspectors, is that both local management and the provider were unaware of the delay in administration, as there was insufficient oversight and care planning in relation to the management of this resident's specific healthcare need. Inspectors found that lack of recognition, planning and oversight of the healthcare arrangements in this centre had placed this resident at risk of harm.

Judgment: Not compliant

Regulation 7: Positive behavioural support

The provider was failing to demonstrate that each restrictive practice in use in this centre was subject to multi-disciplinary assessment and review. For example, in recent weeks, the use of physical restraint had been used in response to incidents that involved a particular resident. However, when the assessment process behind this was queried by inspectors, information was unable to be provided in relation to this. Inspectors also requested information around the assessment process for a number of environmental restrictions that were in place in this centre, again assessments informing their application were unable to be provided.

The provider had not ensured that there was adequate guidance and protocols in place with regards to the restraints that were being used. For one resident, they were recently prescribed a chemical restraint for agitation; however, the protocol guiding its administration didn't clearly outline the specific presentation of this resident that staff were to observe for so as to identify that they were in an agitated state. It also failed to guide what staff were to do, should its administration not result in its intended therapeutic purpose. With regards to the use of physical restraints, there was brief reference to the use of these in behaviour support plans, stating that these were to be implemented in response to absconsion and self-

injurious behaviour risks. However, there were no protocols in place to guide staff on the specific circumstances that would warrant this intervention, or in how staff would determine what type of physical restraint was appropriate and proportionate to use.

When restrictive practices were used, the provider was failing to demonstrate that these were used as a last resort. For example, a resident was recently prescribed a chemical restraint for agitation, and records reviewed showed that this had been frequently administered since it was prescribed. However, the corresponding daily notes from the days that it was administered didn't consistently outline what alternative measures were trialled before using this chemical restraint as a last resort measure. Similar failings were also found in relation to when physical restraints had been applied. Corresponding daily notes also failed to clearly outline what alternative measures had been implemented prior to resorting to this measure, and more concerning also failed to record the duration of each hold.

In addition to this, there was also inconsistencies in the use of restraints. A resident's behaviour support plan outlined that a chemical restraint should be used if the resident was agitated. However, an inspector reviewed an extensive incident whereby the resident was highly agitated and the chemical intervention was not used, while the inspector subsequently read several other incidents whereby the resident was reported to be in a clearly less agitated state and chemical restraint was administered. The inspector also read two other incidents whereby the same resident was physically restrained by staff. In both incidents, the resident had requested a cup of tea which was refused by staff without cause or reason, with documentation stating on one occasion that the resident was informed that the kitchen was closed for the night. In both situations, the resident responded by engaging in behaviours of concern and was subjected to a physical hold. All of these incidents had been signed off by local management, and no one at senior management level questioned the use of these physical and chemical restraints or inconsistencies in the provision of this resident's behavioural support care.

Inconsistencies were also observed in how staff reported when restraints had been used. From the incident review completed by inspectors, it was noted that where physical restraints had been implemented, incident reports were completed for these. However, when chemical restraints were administered, incident reports were not completed for these. The rationale for which were unable to be provided to inspectors when it was queried, despite both being last resort measures.

Although there were behaviour support plans in place, aspects of these required considerable review. This was particularly found in relation to better guidance being required around the specific reactive strategies to be applied in response to specific behaviours, and also to provide some linkage between the escalation of behaviours and where consideration for the use of last resort measures, may be required.

Judgment: Not compliant

Regulation 8: Protection

An inspector read an incident where an episode of challenging behaviour had occurred involving a resident. Following this incident, the other resident said that they had been scared. Although they had not been directly part of the incident, they had heard the incident occurring and voiced their concerns with the staff on duty. This incident had been reviewed by management of the centre; however, it had not been recognised as a safeguarding issue which raised concerns in relation to the safety of residents and the oversight of safeguarding in this centre.

Up until a few weeks prior to this inspection, one resident resided in this centre, with the admission of another resident in early June 2025. Due to the layout and design of this centre, neither resident had met each other, with their first meeting occurring on the first morning of this inspection. Despite the complex behavioural support needs that both residents were assessed with, coupled with the aforementioned incident that had occurred, there was no comprehensive planning behind this meet between these two residents, to ensure that all measures had been considered and taken to prevent any risk of a safeguarding incident occurring.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Not compliant
Quality and safety	
Regulation 26: Risk management procedures	Not compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 6: Health care	Not compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Not compliant

Compliance Plan for Ivy Lodge Residential Care Service OSV-0008976

Inspection ID: MON-0047475

Date of inspection: 02/07/2025

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: We have carried out a full audit of staff training records to identify all training gaps. Mandatory training will be prioritised, followed by mandatory site-specific training (including management of challenging behaviour, fire safety & evacuation, risk management, epilepsy management, medication management ligature risk, and suicide awareness). A training schedule will be created to ensure all identified staff complete the required training by 30 September 2025. Thereafter, monthly checks will be implemented to ensure training is completed and refreshed in line with policy. Over the medium term, all training will be recorded and monitored on the electronic QMIS currently being implemented at the centre.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The provider is undertaking a full review and revision of the current governance and management arrangements to ensure robust oversight, clarity of roles and responsibilities, and effective service delivery. The defined management structure will be updated to clearly outline the lines of authority and accountability – locally and at the senior management level and between the two. This revised structure will ensure that each tier of management understands and discharges its responsibilities effectively, particularly in relation to incident management, risk management, safeguarding,	

restrictive practices, and behavioural supports. This action will be complete by 15 August 2025.
Regular scheduled management meetings (to occur fortnightly) will be strengthened and standardised to include structured review and follow-up of all key areas of service provision. This will include a review of significant incidents, risk escalation, behavioural support implementation, use of restrictive practices, safeguarding concerns, and outstanding actions from audits or incident reviews. A standing agenda will be implemented to ensure these topics are consistently addressed. Meeting minutes will be maintained and monitored to ensure appropriate actions are taken and followed up in a timely manner.

Audits will be prioritised based on high-risk areas and adjusted where necessary to ensure they provide meaningful data and identify areas requiring improvement. The QMIS will be used to track and follow through on audit findings to ensure that required improvements are completed and sustained.

A clear process for learning from incidents and adverse events will be embedded into management systems going forward. When a significant incident occurs, a management meeting will be convened to address it within 3 working days.

To ensure ongoing oversight and quality improvement, the provider will implement a structured framework for the review and escalation of risks, and will monitor these on a continuous basis on the newly-implemented electronic QMIS. The governance team will also ensure that there is clear communication between local and senior management, including timely reporting, review and trending of incidents and emerging risks. The QMIS section will be implemented within the service by 30 September 2025.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
The unreported incident referenced in this report was retrospectively reviewed and notified to HIQA and the Safeguarding team on 8 July 2025 and has since been closed off.

All staff are trained and compliant in Children First and Safeguarding Vulnerable Adults.

Safeguarding will be a standing agenda item at all staff and resident meetings going forward.

All safeguarding incidents will be notified within 3 working days as required.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
The risk management policy will be revised to include defined responses and escalation processes for, and enhanced monitoring of, high-rated risks by 31 August 2025.

Emergency response protocols, including for unaccompanied leave against advice and engaging in self-injurious behaviours, were implemented immediately as directed on 2 July 2025.

All residents' risks will be reassessed, and the risk register updated by 12 August 2025.

Monthly incident trend reviews will be conducted and actions escalated to senior management. The provider has invested in a new QMIS, which will aid in the governance, oversight and management of all incidents and risks. Staff at the centre have already commenced training in the use of the new system, and it will be rolled out in the service by 30 September 2025.

Local management staff will receive training from an external provider on the completion of risk assessments before 30 September 2025.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
All staff will participate in further on-site Fire Safety and Evacuation training by 31 August 2025.

All residents’ Personal Emergency Evacuation Plans (PEEPs) and the Centre Emergency Evacuation Plans (CEEPs) have been updated to include clarity on alarm awareness for each Service User, evacuation procedures and post-evacuation supervision needs. Residents have been consulted regarding procedures to be followed in the event of a fire in the centre. Staff will be briefed on the revised PEEPs and CEEPs and learnings from recent fire drills during a team meeting scheduled for 6 August 2025.

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
A full review of as-required (PRN) medication protocols is being conducted. Revised protocols specifying the purpose, indications, de-escalation techniques and non-pharmaceutical interventions to be carried out prior to administration of a PRN psychotropic medication will be implemented by 10 August 2025.

A protocol for non-compliance with medication administration has also been implemented.

These protocols have been developed and updated in collaboration with the MDT (GP & Behaviour Support Therapist, Social Care Worker, Consultant Psychiatric and Clinical Manager).

All staff will be trained on the new protocols by 10 August 2025.

Regulation 5: Individual assessment and personal plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
The assessment process will be revised to ensure it provides a comprehensive and multidisciplinary evaluation of each resident's health, personal and social care needs. The revised assessment tool will move beyond a staffing-focused approach and instead provide a holistic overview of the individual's support requirements, risk profile and behavioural support needs. This process will include input from a range of relevant professionals, including behavioural specialists, clinical leads and social care practitioners.

All current assessments will be reviewed and revised as appropriate to reflect the most up-to-date information. The provider will ensure that all assessments of need are responsive to changes in residents' circumstances and are updated promptly following significant events.

Furthermore, all assessments will directly inform the development and review of the residents' personal plans. Personal plans will be updated in a timely manner following changes in need and will clearly set out the supports and interventions required to deliver safe and person-centred care. Each plan will include detailed guidance for staff, particularly in relation to high-risk areas such as behavioural support and health-related interventions.

To enhance oversight and consistency, a system of internal audits will be introduced to

monitor the quality and completeness of both the assessments and the personal plans. These audits will be recorded on the QMIS and their outcomes will be discussed at regular governance meetings to ensure accountability and timely action on any identified gaps.

The above actions will be completed by 31 August 2025.

Regulation 6: Health care	Not Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
The provider will ensure that all residents have appropriate and responsive healthcare planning in place. A comprehensive care plan will be developed for any resident with complex medical needs immediately upon admission, with clear guidance for staff on required interventions including changes in presentation or deterioration, time-sensitive medication protocols, and escalation procedures in the event of non-compliance or refusal.

All care plans will be reviewed and updated regularly, and following any significant change in health status or incident. A formal oversight process will be implemented to ensure staff consistently follow care plans and that deviations, such as delayed medication administration, are promptly identified and addressed.

Protocols for the management of critical health needs, including when to contact emergency services, will be finalised and communicated to all staff.

Targeted training will be provided where necessary to ensure staff are equipped to manage complex healthcare situations effectively. Oversight will be strengthened through regular clinical audits and management review to ensure consistent, safe and effective care delivery in line with residents' assessed needs.

All care plans will be reviewed and updated as required by 31 August 2025.

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
All restrictive practices will be reviewed by the Positive Behaviour Support Specialist (PBSS) and relevant clinicians by 31 August 2025 to ensure MDT input and adherence to

least restrictive practice. Clear protocols will be developed for the application of physical and chemical restraint, including defined indicators and alternatives. A process for assessing and reviewing environmental restrictions will be implemented. Staff training in PBS and restriction reporting will be refreshed by 31 August 2025. A restrictive practice register will be maintained and audited monthly.

Positive Behaviour Support Plans (PBSP's) are being reviewed and updated by an external Positive Behaviour Support Specialist (PBSS) in consultation with management, staff team and where appropriate the resident. The updated PBSP's will ensure that there are clear guidelines for staff in terms of proactive and reactive strategies in specific circumstances. The PBSP's will be cognisant of the need for a low arousal approach and provide guidance for circumstances where an escalation in behaviours may necessitate the utilisation of last resort measures. These plans will be reviewed, updated and thereafter disseminated to staff through team meetings by 30th September 2025. Any staff training required to ensure safe implementation of the updated PBSP's will be completed by 30th September 2025. PBSP's will be reviewed on a quarterly basis, and sooner if required.

There will be weekly oversight by senior management to review incidents, and to ensure appropriate liaison with MDT to support residents.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
The unreported incident referenced in this report was retrospectively reviewed and notified to HIQA and the Safeguarding team on 8 July 2025 and has since been closed off.

All staff are compliant with safeguarding training, and monthly training analysis by the PIC will highlight any gaps or needs for refresher training.

Safeguarding will be a standing agenda item on all resident and staff meetings, and the PIC will ensure all incidents with emotional or psychological impacts are screened under safeguarding.

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.	Not Compliant	Orange	30/09/2025
Regulation 23(1)(b)	The registered provider shall ensure that there is a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.	Not Compliant	Orange	15/08/2025
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in	Not Compliant	Orange	30/09/2025

	place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.			
Regulation 26(1)(d)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: arrangements for the identification, recording and investigation of, and learning from, serious incidents or adverse events involving residents.	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	Red	30/09/2025
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre	Substantially Compliant	Yellow	01/08/2025

	and bringing them to safe locations.			
Regulation 29(4)(b)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine which is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.	Substantially Compliant	Yellow	10/08/2025
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	08/07/2025
Regulation 05(1)(b)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each	Not Compliant	Orange	31/08/2025

	resident is carried out subsequently as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.			
Regulation 05(6)(d)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall take into account changes in circumstances and new developments.	Not Compliant	Orange	31/08/2025
Regulation 06(1)	The registered provider shall provide appropriate health care for each resident, having regard to that resident's personal plan.	Not Compliant	Orange	31/08/2025
Regulation 07(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.	Not Compliant	Orange	30/09/2025
Regulation 7(5)(a)	The person in	Not Compliant	Orange	30/09/2025

	charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation every effort is made to identify and alleviate the cause of the resident's challenging behaviour.			
Regulation 07(5)(b)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation all alternative measures are considered before a restrictive procedure is used.	Not Compliant	Orange	30/09/2025
Regulation 07(5)(c)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation the least restrictive procedure, for the shortest duration necessary, is used.	Not Compliant	Orange	30/09/2025
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	08/07/2025