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:	06 October 2025
Centre ID:	OSV-0008976
Fieldwork ID:	MON-0048296

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 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
Monday 6 October 2025	09:00hrs to 15:30hrs	Anne Marie Byrne	Lead
Wednesday 8 October 2025	10:00hrs to 16:15hrs	Anne Marie Byrne	Lead
Monday 6 October 2025	09:00hrs to 15:30hrs	Ivan Cormican	Support
Wednesday 8 October 2025	10:00hrs to 16:15hrs	Ivan Cormican	Support

What residents told us and what inspectors observed

This was an unannounced inspection to follow up on the actions taken by the provider since the last inspection of this centre in July 2025. That inspection identified a number of non-compliances relating to governance and management, health care, behavioural support, training, notification of incidents, risk management, safeguarding, and residents' assessment and personal planning. Following the outcome of that inspection, a warning meeting was held with the provider and the Chief Inspector of Social Services. Subsequent to that meeting, the provider submitted their compliance plan response to the Chief Inspector, outlining the actions that they planned to take to bring this centre back into compliance, with a time line of completion by 30th September 2025.

While there were some improvements made, this inspection found that many aspects of this compliance plan response had not been satisfactorily implemented, with the outcome of this inspection finding repeated non-compliances of a similar nature in relation to governance and management, safeguarding, notification of incidents, risk management, and residents' assessment and personal planning. This inspection also identified a number of concerning risks that had not been either identified or responded to by the provider, resulting in the issuing of two immediate actions and two urgent actions. The context of these will be discussed later on in the report. For note, due to a significant incident that occurred on the evening of first day of this inspection, the planned second day of this inspection was rescheduled to allow the provider time to address and respond to that incident.

This designated centre provided care and support to two residents. They both had complex behavioural support needs, with many identified risks associated with this aspect of their care. They each required two-to-one staff support during waking hours, which was being consistently provided to them. One resident in particular had multiple significant risks associated with their care and support needs. Since their admission to this centre in March 2025, they had engaged in multiple serious incidents, some of which had resulted in injury to themselves, and posed very challenging and high-risk situations for staff to respond to. Although the second resident also had complex behavioural management, they had transitioned well into the centre since they moved there in June 2025, which had seen an overall decline in the number of behavioural incidents that they engaged in since the last inspection. Both residents were also prescribed chemical and physical restraints, with inspectors observing a noticeable decline in the number of times chemical restraint had been given. However, in response to some of the more high-risk incidents that had occurred, staff had to implement physical holds so as to be able to support residents to return to baseline. Overall, due to the complexity of need presented by both residents, a lot of staff support, supervision, multi-disciplinary input, and clear care and support arrangements were required by each resident in order to keep them safe. The layout of this centre allowed for both residents to live independently of one another, but they did still meet from time to time. At the time of this inspection, they had gotten on well when they did meet, with no negative

interactions having occurred between them. They were both generally quite active, and liked to get out and about most days with staff to go shopping, go for drives, have takeaways, with one of the resident having recently commenced a course in an external college. Both residents had the transport means and staffing levels available to them to do so, and it was clear from various documents reviewed by inspectors, that staff were proactive in ensuring these residents got out and about regularly.

The centre compromised of one large purpose-built bungalow house that had four separate apartments contained within. In the main aspect of the building was a communal kitchen, office, bathroom, with each apartment opened out onto a shared living area. Each apartment provided residents with and en-suite bedroom and their own kitchen/living/dining area. Double doors within each bedroom provided an additional fire exit to each resident, while also giving them direct access to the external grounds of the centre. As was found upon the last inspection, this centre was very tastefully furnished, bright and spacious, and was maintained to a very high standard.

Upon inspectors' arrival to the centre, they were greeted by one of the team leaders, who were soon joined by the person in charge, regional manager, and director of development and training. On the second day, they were also joined by the director of governance who was also the appointed designated safeguarding officer for this centre. Due to the presentation of one of the residents on the first morning of this inspection, staff had already left with this resident to go for a drive. Following an incident that occurred later that day when they returned back to the centre, inspectors did not get to meet with this particular resident. On the second day of this inspection, an inspector got to briefly meet with the other resident in their apartment, where they had spent much of their time resting over this two day inspection. They said a quick hello to the inspector, and were planning to head out with staff to collect a take-away. Due to the behavioural support needs of this resident, their supporting staff remained within close proximity of them at all times, which was observed by inspectors to be very much adhered to by staff over the course of this inspection.

The lines of enquiry into this inspection were driven by the findings of the last inspection, and also by the nature and context of some of the incidents that had happened in this centre within that time frame. This inspection did find that the provider had improved staff training arrangements, revised local and senior management structures, and had also made some progress in moving towards compliance with regards to health care and behavioural support. More noticeably, was the overall decline in the inconsistent use of physical and chemical restraint, which now had better arrangements in relation to their use and increased multi-disciplinary involvement. However, fundamental issues in relation to the provider's governance, management, and oversight of this centre very much remained.

The last inspection of this centre identified that since this centre had opened in February 2025, it had faced significant and repeated challenges in relation to the provision of a safe and good quality of service. An attributing factor to this had been the lack of robust oversight by the provider around the specific incidents that were

happening in their service, with the findings of this inspection in that regard being no different. Despite the provider assuring the Chief Inspector that they would be completing monthly incident trends, this was being carried out informally, with much of the key information about the number, nature, severity, and response to these incidents being missed and poorly managed through this informal approach. This again resulted in incidents of a serious nature not being detected or recognised by the provider as being such, with continued poor learning from serious incidents that had put residents and staff at considerable risk. In the absence of a robust system for overseeing all incidents, the provider was again found to not be able to demonstrate how they knew what exactly was going on in their service, or show how they were assuring themselves of the safety and quality of care in this centre. This was a centre that was home to two residents who had very complex care and support needs, some of whom had engaged in some very serious incidents over the previous months, one of which happened only a few weeks prior to this inspection. However, despite this, inspectors found that there was still a significant lack of understanding on the part of the provider, with regards to how vital it was to robustly gather and trend pertinent information about these incidents, so as to inform their risk management and monitoring arrangements, to assure themselves that they were providing the type of service that these residents required in order to keep them safe.

As well as the repeated failings found in relation to oversight arrangements, there was also little improvement found across residents' assessment of need and notification of incidents. More concerning was the continued multiple failings still found in relation to risk management, with safeguarding arrangements also found to have declined since the last inspection. Over the course of this inspection, inspectors reviewed an alleged safeguarding incident that was reported to provider in August 2025; however, the provider's initial response to this was not proportionate to the severity of the allegation made, was subsequently very poorly managed, placing the resident involved at significant potential risk of harm. Although there had been considerable changes made to this centre's local and senior management structures and monitoring systems since the last inspection, neither of these changes had identified or raised any concerns in relation to how this alleged incident was responded to, managed or monitored. Coupled with the informal incident trending process that the provider had adopted, the management of this incident was also missed by senior members of management, resulting in it being one of the immediate actions issued to the provider to have addressed before close of this inspection.

Separate to this, although revised audits and monitoring systems had been put in place since the last inspection, these still required further revision to ensure they were fit for purpose in effectively identifying specific issues in this centre so that the necessary improvements could be implemented. Since the last inspection, the provider had endeavoured to utilise their meeting structures more efficiently to allow for better discussion around specific aspects of this centre that needed regular oversight. However, the continued failings found in relation to incident trending, risk management, residents' assessment of need, and safeguarding meant that the provider had missed fundamental information and findings relating to these aspects

of service, resulting in these not being subject to the discussion needed with all staff at this meetings, so as to bring about necessary changes.

Fundamentally, the failings again found upon this inspection ultimately resulted from the provider not having the robust oversight of what was going on in this centre. They had not made the necessary improvements required to maintain oversight of the incidents that were happening, or to their own internal monitoring systems, which directly impacted their ability to detect the multiple failings that still were impacting many aspects of the service they delivered. Over the course of this inspection, many questions were raised by both inspectors as to how despite the changes implemented, the provider was still failing to identify, respond, manage and trend serious incidents that had the potential to place residents at significant risk of harm.

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

Capacity and capability

Although the provider did recognise and accept the multiple non-compliant failings from the last inspection, and submitted a compliance plan to the Chief Inspector as to what specific action they were planning to take, many of these actions had little impact on making the necessary improvements required to improve the overall quality and safety of care in this centre. The provider had failed to maintained effective oversight of the implementation of this compliance plan, to ensure it was adequately addressing the specific issues in this centre, with repeated and similar failings again found upon this inspection across a number of the same areas. This was particularly found with regards to oversight and management arrangements, risk management, safeguarding, notification of incidents, and residents' assessment and personal planning.

Since the last inspection, the provider had revised their staff training arrangements, ensuring all staff had now completed and were up-to-date with all mandatory training. In addition, the provider had also revised the local and senior management structures, with clearer lines of accountability and responsibility in place for each member of management.

However, in relation to the other aspects of the provider's compliance plan, there was little traction in addressing fundamental issues in this service that were impacting on the quality and safety of care. Of significant concern upon the last inspection, was the provider's own knowledge, review and monitoring of incidents that were occurring in this centre. To assist the provider to do so, was the decision to implement an electronic incident reporting system that would allow for trending reports to be generated; however, at the time of this inspection, this new system wasn't fully operational. In the meantime, the provider had not made any provisions for an interim system to be put in place to formally trend all incidents that had

occurred since the last inspection, and were again found to have very poor oversight and knowledge of the number, type and severity of incidents occurring within that time period.

Although there was a revised monitoring and review process in place in this centre, this was still found not to be fit for purpose in identifying where specific improvements were required within this service. Even though provider-led visits and other internal audits were occurring, many of the issues raised over the course of this inspection, not identified by the provider themselves through these monitoring systems, despite them having monitored the same aspects of their service that were reviewed by inspectors.

Regulation 14: Persons in charge

The person in charge held overall responsibility for this centre, and was based there on a full-time basis. They were familiar with the assessed needs of the residents and with the operational needs of the service delivered to them. They were supported in their role by their staff team, two team leaders, and line manager. This was the only designated centre operated by this provider in which they were responsible, giving them the capacity they needed to carry out all duties associated with their role.

Judgment: Compliant

Regulation 15: Staffing

The staffing arrangement for this centre was subject to on-going review, to ensure that an adequate number and skill-mix of staff were at all times on duty. Since the last inspection, the provider had further revised the staff-skill mix for this centre, following changes to some residents' health care status. Nursing support was available to residents who were assessed as requiring this level of support, and where residents were assessed as requiring two-to-one staff support, this was consistently provided. There was also a well-maintained staff roster in place, which clearly outlined each staff members full name, and their start and finish times worked.

Judgment: Compliant

Regulation 16: Training and staff development

Following on from the findings of the last inspection, the provider revised the staff training schedule for this centre to ensure all staff had received up-to-date training

in all areas, appropriate to their role held. The training matrix for this centre was reviewed by inspectors, which gave assurance of this, and also demonstrated the dates in which refresher training would need to be rescheduled for staff, when required. In addition, all staff were scheduled to receive regular supervision from their line manager.

Judgment: Compliant

Regulation 23: Governance and management

A key failing from the last inspection was in relation to the provider not ensuring that their own governance systems were fit for purpose in overseeing and monitoring for key aspects of this service. Fundamental to this, was the failure in the provider's own oversight and knowledge of the incidents that were occurring in this centre, and in their response and monitoring of the risk to the quality and safety of care in this centre posed by these incidents. Although the provider committed to addressing this, inspectors found little improvement in relation to these oversight arrangements. Incident trending had commenced since the last inspection; however, it was occurring on an informal basis. Similar to the last inspection, there was no robust analysis being maintained to show how the provider was now governing and overseeing baseline information about these incidents, or in how they were now monitoring that appropriate action was taken in response to these, to assure themselves that care in this centre was being delivered safely and of good quality. This fundamentally resulted in inspectors again identifying incidents upon this inspection that had not been appropriately escalated and responded to, along with the severity of the occurrence of some incidents not being recognised at senior management level.

Following on from the last inspection, the provider did review the schedule of audits in this centre, however, the overall effectiveness of how this centre was being monitored still required considerable review. Inspectors again found that the provider had not used information that was readily available to them in relation to incidents that had happened in their centre, so as to inform what areas of their service required very specific monitoring. Of the audits that were completed since the last inspection, these were found to be ineffective in identifying where considerable improvements were required. For instance, very recent to this inspection, an audit of residents' assessments and personal planning was carried out, which failed to identify that residents' assessments still did not reflect or consider all aspects of their care and support arrangements, as was found by inspectors upon this inspection. In addition to this, the last six monthly provider-led visit which was also conducted in September 2025, extensively looked at multiple aspects of the service to include, complaints management, behavioural support, policy and procedures, safeguarding, fire safety, and health care. The manner in which this visit was conducted was very prescriptive in nature, only requiring review of certain aspects of these areas of service, with no consideration to incorporate the incidents that had occurred relevant to those areas, as part of the lines of enquiry

for that visit. This resulted in the outcome of this visit failing to identify the same improvements across a number of these areas as were identified by inspectors upon this inspection, most specifically in relation to the failed recognition of a serious safeguarding allegation which was made by a resident a few weeks prior to when that visit was conducted. Furthermore, although the review of risk management systems was also included as part of this visit, the provider again failed to identify the multiple issues across this system, that formed a significant finding of this inspection.

With regards to internal communication systems, the provider did revise what areas were subject for discussion as part of their local and management team meetings, and ensured these were included on a meeting minute templates. Evidence of these meetings was provided to inspectors, to include, staff team meetings, senior management meetings and governance meetings, all of which were occurring very frequently. Although these minutes demonstrated that high-risk incidents were subject to discussion, due to the failings in the provider's own trending and oversight of other incidents that had happened, and failure to identify key improvements within their service from audit findings and significant event reviews, much of this key information was missed, and not presented or subject to the discussion needed at these meetings.

Judgment: Not compliant

Regulation 31: Notification of incidents

Over the course of this inspection, inspectors reviewed an incident pertaining to a significant alleged safeguarding concern. Similar to the last inspection, the provider had again not recognised that this was an incident that required notification to the Chief Inspector. Despite this issue having being raised with the provider upon the last inspection of this centre in July 2025, and them subsequently submitting within their compliance plan response assurances that action would be taken to ensure this would not re-occur, they had failed to again submit notification of this incident within three working days, as required by the regulations.

Judgment: Not compliant

Quality and safety

Although there was some improvement found to health care and behavioural support arrangements, the overall quality and safety of care provided to residents in this centre had not improved to a sufficient standard since the last inspection. Issues remained in relation to the review of incidents, and inspectors also found

continuing concerns in relation to the application of risk management systems and in the understanding of risks in this centre, resulting in an immediate action and two urgent actions being issued to the provider in response to significant risks identified by inspectors. Of serious concern to inspectors, was the oversight and application of safeguarding procedures, with a second immediate action issued to the provider to complete a review of an alleged safeguarding incident of a significant nature, which was directly reported to them by a resident six weeks prior to this inspection. Furthermore, upon the previous inspection of this centre, the provider did not demonstrate that a suitable assessment of need had been completed in relation to the care needs of residents. Although the provider had submitted within their compliance plan the actions they would be taking to address this, these actions also failed to bring this area of care back into compliance with the regulations.

Risk management systems continued to be inappropriately implemented. Despite the considerable identified risks associated with the assessed needs of both residents living in this centre, the provider was still failing to recognise the requirement for a robust risk management system to be implemented, so as to ensure both residents were receiving a service that was maintaining them safe from harm. Although the number of incidents occurring had decreased since the last inspection, there continued to be very poor arrangements in place for the trending and oversight of incidents that were happening, which had resulted in continued failings for appropriate control measures to be put in place in response to these incidents. Discrepancies were found in relation to how risk was being rated in this centre, which greatly impacted consistency in the response by, and escalation to senior management. Concerns were again raised in relation the quality of significant reviews that were being conducted following serious incidents, which again were found to not recognise or adequately address repeated patterns in occurrence, or identify the need for safer arrangements to be put in place for staff, when such incidents occurred. Failings were again found in relation to how risk was being assessed, both at a resident and organisational level, with an overall lack of understanding of how this assessment process needed to inform the active management and monitoring of identified risks.

The assessment of residents' needs was an area of concern which was highlighted to the provider on the centre's last inspection. As with safeguarding and risk management, the provider’s compliance plan outlined the actions they were taking to bring this area of care back into compliance with the regulations, which was also found to have not been effectively implemented. These assessments form the foundation of the provision of care, and considering the complexity of care required by both residents, these assessments required comprehensive consideration and completion so as to inform on the level of care and support that both residents required. The information gathered and recorded within residents' assessment of need differed greatly from their day-to-day care requirements, and only from talking to those facilitating this inspection and reviewing additional documents, were inspectors able to attain a better understanding of both residents' care and support needs, which was key information that did not form part of residents' revised assessments of need.

Regulation 26: Risk management procedures

Two urgent actions were issued to the provider on the first day of this inspection in relation to two separate risks pertaining to a resident that lived in this centre. In addition, an immediate action was also required to be issued to the provider in relation to a resident, relating to a potential risk posed to this resident due to the provider not ensuring that substances posing harm to this resident were securely locked away. Subsequent to this immediate action being issued, this was addressed.

The first urgent action issued was in relation to the provider failing to adequately risk assess for any potential harm posed to a resident while attending an external education facility. This particular resident was assessed as requiring the support of two staff at all times; however, when attending this facility, they done so independent of direct staff support, with their supporting staff remaining on the grounds of the facility for the duration of the resident's stay. This resident had significant identified risks that were well-known to the provider that required multiple control measures so as to ensure their safety and welfare. Some of these identified risks pertained to significant risk of harm, high risk of absconsion, they required complex behavioural management, with this resident also having engaged in a number of high-risk incidents that placed themselves and others at considerable risk of harm, since their admission in March 2025. However, despite this knowledge, the provider had failed to carry out an appropriate risk assessment of this resident attending this education facility independent of direct staff support, had failed to appropriately visit the facility to assess for any potential risks that may have placed the resident and others at risk of harm, and ultimately failed to put any mitigating additional control measures in place to ensure the safety of this resident and others.

The second urgent action issued to the provider was in relation to the re-assessment and management of a potential environmental risk for a resident. This resident's behaviour support plan stated that the accessibility of certain items presented a risk to them. During a visit of their apartment, an inspector observed multiple items of such nature in the resident's immediate living environment, that the provider had not appropriately risk assessed or considered as a potential threat to the safety and welfare of this resident. The provider was required to urgently carry out a re-assessment of this risk and ensure that all necessary action was taken to make their environment safer, based on the outcome of that re-assessment. Subsequent to this inspection, written assurances were received from the provider that both of these urgent actions had been addressed.

Within their compliance plan response the provider committed to adopting a clear process for learning from incidents and adverse events. Key to this was the conduction of a significant event review that was to be completed by senior managers, when incidents of such nature occurred. Following a serious incident that occurred in September 2025, members of senior management did conduct a meeting to carry out a significant event review of this incident, with this not being the first time an incident of this nature occurred in this centre. However, similar to the last inspection, this review was found to be of poor standard, failed to identify

clear and obvious patterns that had potentially led to another incident of this nature reoccurring, and overall inhibited any learning to be achieved.

The inspectors again also raised concerns upon this inspection with regards to the appropriate escalation of risk. Although since the last inspection, the provider did revise their risk management policy to include additional guidance in relation to this, this guidance was found to inadequately support staff and local management in how to do so. Inspectors observed a significant discrepancy within the provider's risk rating system which had not been detected by the provider, and overall posed a significant impact on ensuring risk was escalated in a consistent manner.

Judgment: Not compliant

Regulation 28: Fire precautions

The provider had taken fire precautions seriously and equipment such as fire doors, alarm system, emergency lighting and fire extinguishers were in place and had a completed service schedule where required. Both staff and residents had participated in fire drills and a review of associated records indicated that both parties could evacuate the centre in a prompt manner.

Some improvements were required in regards to fire safety, to include, support plans to assist with the evacuation of the centre did not guide staff in relation to residents' supervision requirements post evacuation, or the requirement to include a resident's rescue medication as part of evacuation procedures. In addition, fire containment measures between resident's individual living and bedroom areas required review to ensure residents were protected from the risk of smoke and fire at all times.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

The provider had appropriate storage in place for medicinal products and a review of medication practices indicated that there were no trends of concern in relation to medication errors. Staff had undertaken training to administer medicinal products and a review of prescription sheets indicated that all the required information for the safe administration of medication was in place.

Medication management plans were in place to guide staff in the administration of 'as required' medications and an inspector found that these plans required some further attention. For example, both medication plans reviewed outlined the

recommended use of intramuscular injection; however, this form of medication had been discontinued prior to this inspection. Better clarity was also required in terms of the maximum dose of one medication which could be administered in 24 hours, and also the recommended interval between administrations.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

In response to the findings of the last inspection, the provider committed to implementing a new assessment of need in this centre. Although inspectors found that this had been implemented, there was still considerable improvement required to ensure that this assessment gave due consideration to the extent of each resident's needs and identified risks. These were again found to only provide limited information around the specific arrangements that were required to provide appropriate care and support arrangements to these residents.

As part of this inspection, inspectors reviewed the new assessment of need that had been completed for both residents. From their engagement with those facilitating this inspection, inspectors were made well-aware of the extent of the identified risks and complexity of behavioural support that both of these residents required. However, this information was not considered or gathered as part of these residents' assessment of need. For example, one of these residents had very complex behavioural support needs, to include, significant risk of harm to themselves and others, they had been involved in a number of high risk incidents since their admission, they were at risk of absconsion, and they required very specific support from staff so as to manage and respond to the complexity of this aspect of their care. However, their assessment of need failed to comprehensively identify the extent of this, only referencing the requirement to be supported with self-injurious behaviour. Similar to this, the other resident also had complex behavioural support needs, and they too had identified risks associated with this. However, the re-assessment of their needs also failed to provide sufficient detail around this, as to as to inform what level of care and support they would require.

Judgment: Not compliant

Regulation 6: Health care

There had been improvements noted in relation to supporting a resident with a specific health care need since the centre's previous inspection. A specific complex epilepsy health plan had been developed and senior staff on duty had a good understanding of this area of care.

Although this had been a positive change, this care plan required further adjustments to guide staff in the delivery of their care. For example, an inspector read that a high temperature could induce a seizure but there was no detail in terms of what temperature reading was considered high and how staff should proceed to prevent a seizure from occurring. In addition, the plan failed to account for known issues in relation to this resident's tendency to refuse their medications, and also the how to care for the resident post seizure activity.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

There had been some improvements in relation to the provision of behavioural support since the last inspection of this centre. Each resident had a comprehensive behavioural support plan in place in direct response to significant care needs, which included, self harm, verbal and physical aggression, self harm and leaving the centre without staff support. A number of restrictive practices were in place in response to these needs which included the use of physical, environmental restrictions and also the use of chemical interventions.

The last inspection of this centre highlighted that the least restrictive practice was not always utilised and resulted in an escalation of behaviours of concern, and in the implementation of physical restrictive practices which potentially could have been avoided. This inspection found that the provider had made good progress in relation to the reduction of restrictive practices and it was clear that the provider was aiming to implement the least restrictive practices where possible. Although this had been a positive change, some further adjustments were required with further consideration required in relation to the consent for the use of remaining restrictive practices.

The two behavioural support plans were reviewed by an inspector and they were found to give a good account of each resident's behavioural support needs. Both plans gave detail around how each resident should be assisted should they engage in self harm, with a measured response outlining four separate levels of an escalated response by staff. In addition, both support plans outlined a traffic light system in terms of general behavioural support with recommended responses and interventions, when escalating from a calm and relaxed state to actively engaging in behavioural of concern. In addition, each identified behaviour of concern had an individual recommended response and intervention which promoted a consistent approach to care.

Although there were improvements in this area of care, some further adjustments were required. For example, a resident was prescribed two separate medications in response to behaviours of concern, but the associated behavioural support plan lacked detail in terms of which medication should be used and at what point in the escalation of behaviours, should its administration be considered. In addition, one

behaviour support plan failed to include recommendations from an external body should the resident decide to leave the centre without staff support.

Judgment: Substantially compliant

Regulation 8: Protection

An immediate action was issued to the provider on the first day of inspection to complete a full review into the management of a safeguarding concern which was reported to them in August 2025. This action was completed and a preliminary safeguarding plan was implemented by the provider. This was reviewed by an inspector on the second day of inspection, with this plan outlining the actions taken to protect all parties from harm. The centre's designated safeguarding officer who was present at the centre, stated that a referral had been made to an external agency, and that this agency would be making contact with the Gardai in relation to the allegation. In the absence of the provider recognising the requirement for they themselves to notify the Gardai in line with their own procedure, an inspector was required to bring this to this attention of the designated safeguarding officer to do so. The designated officer made the necessary report to the Gardai, who attended the centre prior to the conclusion of the inspection to gather statements.

Of concern to inspectors was the lack of recognition of this safeguarding concern, which had the potential to impact on one of the residents that lived in this centre. Furthermore, the provider failed to take appropriate action at the time it was reported to them, to determine if any other vulnerable person was involved in this alleged safeguarding concern. In addition, procedures which were in place in this centre to promote safeguarding and protect residents from harm were not implemented, and of greater concern, was that this incident had not been recognised by those at senior or local management level as carrying the potential of placing one of their own residents at significant risk of harm, prior to it being brought to their attention by inspectors.

Ultimately, the provider had failed to follow their own safeguarding policy, they failed to follow national guidance on adult safeguarding, and failed in their obligation to report this incident to an external child protection agency.

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 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	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	Substantially compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Not compliant

Compliance Plan for Ivy Lodge Residential Care Service OSV-0008976

Inspection ID: MON-0048296

Date of inspection: 08/10/2025

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 23: Governance and management	Not Compliant

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

The overall management structure within the Provider's Disability division has been reformulated and updated to clearly define the lines of authority and accountability. This revised structure ensures 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.

Xyea, the online Quality Management and Information System (QMIS), is now fully operational within Ivy Lodge.

Audits are prioritised based on high-risk areas and adjusted where necessary to ensure they provide meaningful data and identify areas requiring improvement. Where areas requiring improvement are found, specific measures will be put in place to meet these identified needs in a timely manner. The QMIS is used to track and follow through on audit findings to ensure that required improvements are implemented and maintained.

A clear process for learning from incidents has been embedded into management systems. All members of the Senior Management Team are automatically and immediately notified by email if an incident with a moderate or higher rating is recorded on the QMIS. When a significant incident occurs, a management meeting is convened to address it within 3 working days. Any required changes following these meetings are promptly disseminated to the broader team and recorded on the QMIS.

At the scheduled divisional management meetings, which occur fortnightly, more robust discussion regarding incidents is taking place, and learnings disseminated to the staff team promptly, along with any required changes. This includes a review of significant incidents (including any emerging trends), risk escalations, behavioural support implementation, use of restrictive practices, safeguarding concerns, and outstanding actions from audits or incident reviews. A standing agenda has been implemented to

ensure these topics are consistently addressed. Meeting minutes are maintained and monitored to ensure appropriate actions are taken and followed up in a timely manner.

The Provider's Risk Policy and procedures have been updated to include escalation pathways and tighter timeframes to address major and catastrophic risks. There has also been a streamlining of matrices in relation to risk assessment ratings and impact ratings. These updated documents have been disseminated to the Person in Charge and discussed with the staff team so they are aware of the changes.

In light of the discharge of one of the residents on 7 October 2025, and with the proviso that plans are in place to transfer the sole remaining resident to a more suitable service model under the Provider's aegis by 31 March 2026, it is intended that the cohort of residents who will be residing in Ivy Lodge going forward will be individuals with lower support needs who do not present with mental health challenges which are likely to put themselves or others at serious risk of harm. The new cohort of service users will not require assessment in relation to risks such as ligature, significant self-harm or PICA.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
All staff are trained in Children First and Safeguarding Vulnerable Adults.

Safeguarding is a standing agenda item at all staff and resident meetings.

The unreported incident referenced in this report was retrospectively reviewed and notified to HIQA, the HSE, Tusla and the Gardai prior to the conclusion of the inspection. In the event of a similar incident occurring in the future, a more inquisitorial and robust initial screening will take place to rule out potential involvement of a minor.

All potential 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 Provider's Risk Policy and procedures have been updated to include escalation pathways and tighter timeframes to address major and catastrophic risks. There has also

been a streamlining of matrices in relation to risk assessment ratings and impact ratings. These updated documents have been disseminated to the Person in Charge and discussed with the staff team so they are aware of the changes.

At the scheduled divisional management meetings, which occur fortnightly, more robust discussion regarding incidents is taking place, and learnings disseminated to the staff team promptly, along with any required changes. This includes a review of significant incidents (including any emerging trends), risk escalations, behavioural support implementation, use of restrictive practices, safeguarding concerns, and outstanding actions from audits or incident reviews. A standing agenda has been implemented to ensure these topics are consistently addressed. Meeting minutes are maintained and monitored to ensure appropriate actions are taken and followed up in a timely manner.

One of the residents was discharged from the service on 7 October 2025, and there are plans in place to transfer the now-sole remaining resident to a more suitable service model under the Provider's aegis by 31 March 2026. New admissions to Ivy Lodge going forward will be limited to individuals with lower support needs who do not present with mental health challenges which are likely to put themselves or others at serious risk of harm. While all appropriate risk assessments will take place for all future admissions, the new cohort of service users will not require assessment in relation to risks such as ligature, significant self-harm or PICA.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Support plans to assist with the evacuation of the centre now guide staff in relation to residents' supervision requirements post evacuation, and provide for the carrying of rescue medication as part of evacuation procedures.
Fire containment measures between residents' individual living and bedroom areas have been reviewed and the relevant doors adjusted appropriately to ensure residents are protected from the risk of smoke and fire at all times.

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
All prescriptions and medication plans are accurate and up to date, and include all relevant information regarding PRN medication.

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 individual assessment and personal plan for the remaining resident have been updated to outline in greater detail all pertinent information regarding needs and risks, and now include signposts for staff to access additional information where required (such as in Positive Behaviour Support plans, Epilepsy Care Plans, etc). Individual assessments and personal plans for any future admissions to the service will maintain this standard.

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
The resident's health care plan has been updated to include detail on pyrexia and advice to support staff should the resident present with same. The plan also now explains how to care for the resident post seizure activity.
There is a written protocol in place to guide staff should the resident refuse their medications.

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
The resident's Positive Behavioural Support plan has been updated to include all pertinent details, including in relation to the administration of medications.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
All staff are trained in Children First and Safeguarding Vulnerable Adults.

Safeguarding is a standing agenda item at all staff and resident meetings.

The unreported incident referenced in this report was retrospectively reviewed and notified to HIQA, the HSE, Tusla and the Gardai prior to the conclusion of the inspection. In the event of a similar incident occurring in the future, a more inquisitorial and robust initial screening will take place to rule out potential involvement of a minor.

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

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	19/11/2025
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	19/11/2025

Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Not Compliant	Orange	19/11/2025
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	19/11/2025
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 and bringing them to safe locations.	Substantially Compliant	Yellow	19/11/2025
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	Substantially Compliant	Yellow	19/11/2025

	prescribed to the resident for whom it is prescribed and to no other resident.			
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	07/10/2025
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 resident is carried out subsequently as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.	Not Compliant	Orange	19/11/2025
Regulation 06(1)	The registered provider shall provide appropriate health care for each resident, having regard to that resident's personal plan.	Substantially Compliant	Yellow	19/11/2025

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.	Substantially Compliant	Yellow	19/11/2025
Regulation 07(3)	The registered provider shall ensure that where required, therapeutic interventions are implemented with the informed consent of each resident, or his or her representative, and are reviewed as part of the personal planning process.	Substantially Compliant	Yellow	19/11/2025
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Red	07/10/2025