Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	Keenagh Gardens
Name of provider:	Orchard Community Care Limited
Address of centre:	Longford
Type of inspection:	Announced
Date of inspection:	01 April 2025
Centre ID:	OSV-0008771
Fieldwork ID:	MON-0044732

About the designated centre

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

Keenagh Gardens is a residential centre for up to four individuals who present with an intellectual disability and/or Autism that are aged 18 years and older. Residents are supported by a staff team of healthcare assistants, social care workers, a team leader and with overall oversight from a manager called the person in charge. The centre is situated in a countryside location and has a large back garden. There are a number of communal areas for residents to use, for example multiple sitting or living room areas. Each resident has their own bedroom.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	1

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 April 2025	10:16hrs to 18:15hrs	Karena Butler	Lead

What residents told us and what inspectors observed

On the day of the inspection, the inspection findings were positive. The resident was receiving a good standard of care by a dedicated staff team who were aware of and ensured their assessed needs were being met. Additionally, the provider and staff team were supporting the resident to learn and develop new life skills, numeracy and communication skills as well as exploring new recreational and leisure activities.

The inspector did note that some improvements were required and they will be discussed in more detail later in the report. However, those areas were not directly impacting the resident in a negative manner. They related to:

- governance and management with regard to fire safety audits, and in order to ensure mandatory staff training and probation meetings were timely and occurring as required
- ensuring records were maintained appropriately, for example some personal plans contained no longer applicable information.

The inspector had the opportunity to meet, speak with and observe the resident that was living in the centre at different times of the day. With the support of the team leader, the resident communicated that the staff that worked with them were nice and that they were happy living in the centre. The resident had greeted the inspector when they first arrived and then they were observed to move freely around their home during the inspection.

The inspector had the opportunity to speak with the two staff on duty and the team leader. They demonstrated that they were familiar with the resident's support needs and preferences. The team leader spoke very fondly of the resident and were very proud of the achievements the resident had made since moving into the centre. For example, prior to moving to the centre, the resident had not spoken verbally and at the time of this inspection they had learnt to say some words and simple sentences. Also at the time of the inspection, they were participating in their personal care which they previously struggled to undertake. For example, they were now showering and brushing their teeth whereas previously this would have been a challenge for them and their carers and could have resulted in the resident engaging in self-injurious behaviour.

The resident appeared to be comfortable in the presence of the staff on duty. They were observed answering staff questions and smiling at them and staff were observed to often smile in response. Staff interactions towards the resident were observed to be respectful. For example, the team leader was overheard explaining to the resident why they would support them for a few minutes while the inspector had a chance to speak to the other staff members. The team leader asked the resident was that okay. It was observed that staff took the resident's lead as to when each part of their day was to happen and in what order. This demonstrated to the inspector the resident was involved in how they spend their day and that they

were offered choice.

The inspector observed many pictures displayed of the resident doing different activities. For example, they had attended bowling, a trampoline park, and went for walks in many different parks and forests. On the day of this inspection, the resident went out for a walk and had lunch out. They later wanted to go out for another walk in a different area and staff facilitated that. The centre staff confirmed that activities the resident participated in depended on their interests and were chosen by the resident themselves. Since moving to the centre the resident had re-engaged with swimming and was now attending regularly after not going swimming for several years.

The provider had arranged for some staff to have training in human rights. The staff member spoken with communicated how they had put that training into every day practice. They communicated that in the past they may have made assumptions with regard to choices for the resident and that they may not have looked for specific choices to come from the resident themselves. They felt the training had focused them to be more specific to gather the resident's preferred choice on something and ensure choices are provided.

The inspector observed the house to be nicely decorated and it was observed to be clean and tidy. The sitting room and the living area in the open plan kitchen and dining room both had televisions for use.

The resident had their own bedroom and it was decorated very minimally which was how the resident wanted it. The bedrooms had adequate storage facilities for any personal belongings. In addition, the resident had a sensory room with a fog machine, sensory lights and different sensory items for use. They also had a personal gym that contained three exercise machines. The team leader communicated that the rowing machine was also being used to help the resident learn how to count and it was working really well for them.

There was an accessible front and back garden. The back garden had a swing that the resident had taken from their family home. The garden also had a large trampoline.

The inspector had the opportunity to speak with one family representative on the phone. They were extremely complimentary of the service. They communicated that "I cannot get over how amazing it's been." They said that their family member is "a new person since moving in and doing stuff they haven't done for years." They said they "couldn't get over how caring and in tune the staff were and respectful at all times." They said they felt "so at peace" with their family member living there and that their family member was "living it up". They were particularly complimentary of the team leader saying that they were "inspiring" and their "positivity was brilliant".

At the time of this inspection there were no visiting restrictions in place and no volunteers were used in the centre. There were three vacancies and it was communicated by the team leader that there was no one in the process of admission to the centre.

The next two sections of this report present the findings of this inspection in relation to the governance and management in the centre, and how governance and management affects the quality and safety of the service being provided.

Capacity and capability

This inspection was short notice announced and was undertaken as the first inspection of this centre since it was registered.

The findings of this inspection indicated that the provider had the capacity to operate the service within substantial compliance with the S.I. No. 367/2013 - Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (the regulations). The provider and the team leader were operating the service in a safe manner which ensured the delivery of care was meeting the resident's needs. Some improvement was required with regard to governance and management as well as how the records in the centre were maintained and they will be discussed in more detail under the regulation sections.

For example, some of the resident's plan had not been reviewed in light of some changes to medication, and staff had not received their required probation meetings since commencing their role. Due to the fact the staff team knew the resident so well and were supporting the resident as per their assessed needs, the identified issues found on this inspection were not negatively impacting on the resident.

The inspector reviewed the provider's governance and management arrangements and found that for the most part there were appropriate systems in place in order to ensure the quality and safety of the service. For example, there were local audits scheduled for completion of how the centre was operating in order to assure the provider that the arrangements were adequate.

The inspector found that there was appropriate staffing arrangements in place to meet the assessed needs of the resident. From a review of a sample of rosters across five months, staffing levels had never went below the required two-to-one staffing ratio. In addition, staff were found to be in receipt of necessary training, for example in relation to fire safety.

There were sufficient arrangements in place for admissions, and complaints. For example, the resident had the opportunity to visit the centre prior to admission, and there was a nominated complaints officer should someone wish to make a complaint.

Regulation 15: Staffing

There were appropriate arrangements in place at the time of this inspection to meet the requirements of this regulation.

There was a full staff team complement which meant no staff vacancies for the centre. There was a planned and actual roster maintained by the team leader and a person in charge from another centre. A sample of rosters were reviewed over a five month period from December 2024 to April 2025. The roster review demonstrated to the inspector that staffing arrangements in the centre were effective in meeting resident's assessed care needs and the resident was staffed on a two-to-one basis 24 hours a day as per their assessed needs.

The staff on duty, on the day of the inspection, were observed to be kind and knowledgeable with regard to the resident. As previously mentioned, the resident was observed to be very comfortable in the presence of the staff on duty and was observed smiling at them.

The inspector reviewed a sample of the two staff members' Garda Síochána (police) vetting (GV) certificates that were on duty on the day of the inspection. Both were found to have received GV since October 2024 and in addition also were in receipt of police vetting from other countries they had lived in previously. That demonstrated to the inspector that the provider had arrangements for safe recruitment practices in place.

Judgment: Compliant

Regulation 16: Training and staff development

There were suitable arrangements in place to support training and staff development.

There was an oversight document in place of training the staff had participated in. The inspector reviewed that document and reviewed a sample of the certification for seven training courses of all the staff that worked in the centre. Those reviews demonstrated to the inspector that staff received a variety of trainings in order for them to carry out their roles safely and effectively.

Staff received training in areas determined by the provider to be mandatory as well as training to support the resident's assessed needs.

Examples of training staff had completed included:

- fire safety
- medication management with one staff booked to attend the day after this inspection
- studio 3 which guides staff with regard to positive behavioural supports
- first aid

- manual handling
- epilepsy awareness.

Staff also received a range of training related to the area of infection prevention and control (IPC). For example, standard and transmission based precautions and hand hygiene.

Staff had received additional training to support residents. For example, staff had received training in human rights. Further details on this have been included in what residents told us and what inspectors observed section of the report.

The inspector also reviewed supervision files for six staff along with the supervision schedule for 2025. While staff had not received supervision prior to the team leader taking up their post, the inspector found that there were now formalised supervision arrangements in place which facilitated staff development with all staff having received a supervision session in March 2025. Additionally, sessions were scheduled to occur in 2025 as per the organisation's performance supervision policy.

Judgment: Compliant

Regulation 21: Records

All required records were for the most part adequately maintained and available for inspection, including records of staff meetings and fire equipment servicing.

However, some records were not as thoroughly maintained as others. For example, the inspector reviewed the resident's intimate care plan and found that it contained some information that was no longer applicable, such as that the resident did not like showers. The team leader communicated that they had updated the plan; however, it could not be located. Some other personal plans that described supports the resident required and their likes and dislikes were also found to contain inaccurate information regarding showers and also with regard to teeth brushing.

Additionally, the resident's hospital passport to guide hospital staff should the resident require a hospital stay contained inaccurate information regarding their medication and did not contain all their applicable heath diagnosis. While staff demonstrated that they knew the resident well. those identified areas had the potential to misguide staff as to the actual supports the resident required and to how best to assist them.

From a review of a sample of the resident’s individual risk's, and the centre specific risk assessments, the inspector observed that the risk rating scale being used was not as described in the provider’s own risk management policy. It appeared that a six by six scale was being used instead of the prescribed five by five. The resident’s risk management plan that described the risks that may affect them was observed to be outside of it's review period as they were due for review in December 2024. One risk assessment for absconsion did not list all of the control measures in place

as it did not list that the gym and the resident's bedroom doors were kept locked.

Notwithstanding these issues they did not negatively impact on the resident as the risks and control measures were known to the staff that were on duty.

Furthermore, the contract of care was vague in relation to some aspects of additional costs that the resident could occur. For example, it was not clear if the resident had to pay for electricity or heating. The inspector was informed that there was no cost to the resident for those utilities. The contract was found not to be signed by the provider, resident or the resident's family representative. Upon realised this, the team leader had made arrangements to have the contract signed on the next family visit that was due to take place within a week of this inspection.

Judgment: Substantially compliant

Regulation 23: Governance and management

The inspector found that for the most part there were appropriate governance and management systems in place at the time of this inspection. The person in charge had recently resigned from their post and the provider was actively recruiting to fill the position. In the meantime, they had arranged for a staff member to take on a team leader role with protected administration time in order to provide oversight with the support of the regional director. The team leader demonstrated on this inspection that they were extremely knowledgeable with regard to the resident's supports and preferences and they were very person-centred in how they provided support to the resident.

There were clear lines of authority and accountability in this service. The centre had a clearly defined management structure in place which was now led by the team leader. Two staff spoken with were clear on the reporting structure if required.

Management systems ensured that the service provided was safe, consistent and for the most part that it appropriately monitored. For instance, there were arrangements for annual reviews and six-monthly unannounced provider led visit reports as per the requirements of the regulations and the team leader explained the arrangements to the inspector. At the time of this inspection neither were due to have taken place as the centre was only recently since November 2024. In addition, there were local audits completed by staff and the team leader with support from the director. They included:

- medication audits
- monthly governance and oversight audits
- vehicle audits

However, one staff member had started working on duty with the resident approximately two months prior to undertaking their safeguarding of vulnerable adults training. While the training was now completed, this training is considered

mandatory and is in place to ensure staff have the appropriate knowledge and to promote culture within the centre that ensures the resident is appropriately safeguarded.

In addition, the inspector observed that prior to the team leader facilitating formal supervision with all staff in the centre in March 2025, no supervision had taken place or probation meetings for new staff as required. For example, one staff member and the team leader had been in their role longer than six months and had not received a probation meeting. This was outside of the provider's own probation policy dated December 2024 which stated staff should receive a probation meeting at three and six months into commencing their new roles. This meant that potential issues with a staff member's performance may not be appropriated addressed in a timely manner and therefore would not allow for them to be given due process to improve where required. The above areas had not been identified on the provider's own audits.

Additionally, the inspector identified some issues with regard to fire containment doors. While the provider has post inspection confirmed those issues are now addressed, they had not been identified on the provider's own audits and this requires review.

The inspector observed from a review of the records of the minutes of three team meetings that they were occurring periodically. The minutes demonstrated that if any incidents were to occur within the centre that they would be reviewed for shared learning with the staff team. Topics at meetings included, a discussion on the resident, safeguarding, fire safety, restrictive practices, infection prevention, medications, and complaints.

Furthermore, from the two staff and one family representative spoken with they communicated that they would feel comfortable going to the team leader if they were to have any issues or concerns and they felt they would be listened to.

Judgment: Substantially compliant

Regulation 24: Admissions and contract for the provision of services

The resident was supported in moving to the centre through an individual transition plan. From speaking with the team leader, a family representative and from a review of the transition plan for the resident, the inspector noted that, the resident was observed to be involved in the move to the centre. Staff visited the resident in their family home on several occasions prior to admission in order to support the resident to become familiar with them. The resident was also provided with an opportunity to visit the premises on several occasions in advance of their admission.

Additionally, the inspector reviewed the resident's contract of care and saw that the services provided and fees to be charged were included in the document as required by regulations. However, the contract was vague at times and was observed not be

to be signed. This is being actioned under Regulations 21: Records.

Judgment: Compliant

Regulation 34: Complaints procedure

The provider had suitable arrangements in place for the management of complaints. For example:

- there was a complaints policy in place dated March 2023
- complaints was a standing agenda item for discussion at team meetings
- there was a complaints procedure displayed in the hall of the centre and it identified who the complaints officer for the centre was.

There had been no complaints in the centre since it opened. A family representative spoken with said that they had no concerns over the care and welfare of their family member. If they were to have a concern they said they would feel comfortable bringing it to the attention of the staff team or management. This demonstrated that there was an open culture within the centre to facilitate and encourage complaints if they occurred.

The centre had received two compliments from a family representative in November and December 2024 whereby they thanked staff for their support. They also thanked them for getting to know their family member so well and supporting them to settle into the centre.

Judgment: Compliant

Quality and safety

Overall, the inspection found that the resident was receiving a good standard of care that promoted and respected their views and wishes.

There were systems in place to meet their assessed needs with regard to assessment of need and personal plans, healthcare, positive behaviour support, their rights, communication, and general welfare and development.

For instance:

- they had personal plans in place for identified needs, for example with regard to epilepsy, and communication
- they had access to different healthcare professionals, such as a general practitioner (GP)

- the resident was supported to develop their capabilities and skills to maximise their potential and independence, for example learning to count, and brushing their teeth daily
- they had a positive behaviour support plan in place to guide staff as to how best to support them should they be experiencing periods of distress
- the resident was provided choices about how they spend their days, for example what external activities they would like to do.

There were adequate arrangements in place to meet the requirements of the risk management regulation, for example there was a risk management policy in place.

There were suitable arrangements in place to ensure they were safeguarded in the centre and in the community. For example, staff were suitably trained to recognise and and escalate any safeguarding concerns.

The inspector observed the premises to be clean and tidy. Additionally, there were suitable fire safety management systems in place. For example, there were fire containment doors in place where required and they were fitted with self-closing devices.

Regulation 10: Communication

Communication was found to be facilitated for the resident in accordance with their needs and preferences. For instance, when the resident first moved into the centre a visual schedule was used to support the resident's understanding of what was due to happen that day and facilitate choice. While that schedule was still available and used occasionally, the resident at the time of this inspection preferred using a verbal communication arrangement of 'first, then and finished' which, from communication with the team leader, was working really well for the resident.

The resident had been assessed by a speech and language therapist (SLT) prior to moving to the centre and the resident was being supported using the recommendations from the therapist. For example, to use simple language when speaking with the resident and respond immediately to them.

There was a communication plan and profile in place in order to guide staff as to how best to communicate with the resident and support their communication. The two staff and the team leader on duty demonstrated they were familiar with how the resident communicates and how staff should respond. For example, the team leader explained that if the resident discusses self-injurious behaviour that they are looking for reassurance and that staff are to respond 'what do we use?' and that the resident will respond 'nice hands'. This had a significant impact on the resident as due to the consistent support and communication with the staff team the resident had not engaged in any self-injurious behaviour since admission to the centre and previous to admission would have engaged regularly in those behaviours.

The inspector also observed that the resident had access to televisions, phones and

Internet within the centre.

Judgment: Compliant

Regulation 13: General welfare and development

The team leader had ensured that the resident had access to opportunities for leisure and recreation. The resident engaged in activities in the centre and in the community as per their preference. At the time of this inspection the resident was supported with a wrap around service provided by the staff team and did not attend an external day service programme. A long term goal for the resident was to explore a day service programme or work experience opportunities. Other goals they were being supported with related to developing a tolerance for or independence with personal care tasks as well as other independent living skills, for example doing their own laundry, and being more comfortable having their teeth brushed daily. This would support the resident to be more independent and promote their dignity and privacy.

From a review of the daily planner from sample weeks in February and March 2025, the resident was participating in many activities out of the centre. For example,

- pet farms
- a trampoline park
- they attended a barbers when they previously hadn't went in years
- swimming
- shopping.

When staff were preparing the resident to explore new activities, such as the trampoline park, they showed them videos on the Internet of what it would be like so that they knew what to expect. This meant that the resident understood what was to be expected by the activity and supported the activity to be a more positive experience for them and ease any anxieties they may have had.

The staff also supported the resident to decorate the centre at Christmas time and for Easter. The resident was involved in the purchasing of the decorations. This was considered quite an event for the resident as they previously would not have tolerated decorations and decorations used to cause them anxiety. According to the team leader and from observation of some pictures, the resident appeared to enjoy their decorations in the centre as was observed smiling while decorating at Christmas time.

In addition, the resident was supported to maintain relationships their family and this was done in line with the resident's preference. For example, the staff would drive the resident to the family home every second week. Regularly pictures of activities the resident had participated were sent to the family with the resident's consent. Video calls were trialled; however, the resident did not appear to like them

so they were discontinued. Again this demonstrates that the resident's preferences were respected in this centre.

Judgment: Compliant

Regulation 17: Premises

The design and layout of the premises met the assessed needs of the resident. The facilities of Schedule 6 of the regulations were available for the resident to use. For example, the resident had access to laundry and cooking facilities.

The premises was found to be aesthetically well kept. It was observed to be tidy and to be in a state of good repair. The inspector observed the centre was clean and there were systems in place to facilitate this. For example, colour coded chopping boards, buckets, and mops were available with signage in place to guide staff in order to minimise cross contamination and healthcare related illnesses.

The centre had separate bedrooms to cater for the number of residents which the centre was registered for. Bedrooms were observed to have sufficient space to store any belongings residents may have. The inspector observed that there was adequate communal space in the centre for residents. For instance, there was a separate sitting room and there was a living area in the open plan kitchen and dining room. These areas were available for use and it demonstrated that residents would have a space to have visits in private.

Judgment: Compliant

Regulation 26: Risk management procedures

There were appropriate systems in place to manage risk. While there were some minor areas identified that required improvement with regard to risk management documentation, they are being actioned under Regulation 21: Records as they did not negatively impact on the resident.

There were centre specific and individual risk assessments on file with control measures in place to mitigate identified risks so as to support resident's overall safety and wellbeing.

No incidents, such as falls, medication errors, episodes of self-injurious behaviour had occurred in the centre since it opened. Notwithstanding that, a staff member spoken with was aware to complete an incident report and ensure that any incidents would be reported to management should they arise. As part of the standing agenda items for staff meetings, whenever an incident might occur they would be discussed

with the staff for shared learning.

On review of other arrangements in place to meet the requirements of this regulation the inspector found the provider had in place:

- a risk management policy last reviewed September 2024
- a centre specific safety statement that was last reviewed in September 2024
- there was also a risk register which was last reviewed December 2024
- there was a system to ensure lint was removed from the dryer to prevent the possibility of it posing a fire risk
- the centre's boiler was observed to last be serviced March 2025 to order to ensure it was safe for use
- the centre's car was found to be serviced in march 25, had a national car test (NCT) in date until November 2026, was taxed and insured which would ensure the car was road worthy and safe for use by the resident.

Judgment: Compliant

Regulation 28: Fire precautions

There were suitable fire safety measures and arrangements in place in order to safeguard the resident from the risk of fire.

They included:

- fire detection, emergency lighting and firefighting equipment
- the fire detection and emergency lighting was serviced quarterly and the inspector observed the last two quarterly servicing since the centre opened
- the firefighting equipment's last annual service was March 2025
- there were fire containment doors in place were required and they were fitted with self-closing devices
- staff had received training in fire safety.

Periodic fire evacuation drills were taking place and the inspector reviewed the last three drill's records which demonstrated that the provider was able to evacuate the resident to safety. Drills included using alternative doors and a drill was practiced during hours of darkness. This was to ensure the resident and staff were used to evacuating under different conditions.

From a review of the resident's file there was personal emergency evacuation plan (PEEP) in place to guide staff as to their support requirements. A fire evacuation plan was in place in order to guide staff and there was a clearly identified fire evacuation meeting point in the garden.

Some doors were found to not fully close by themselves. Two doors including the utility room had a larger than recommended gaps and there were no intumescent strips where the utility room double doors met. The provider arranged for these to

be reviewed by a competent fire person the day after the inspection and evidence submitted post inspection to show they were completed.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

There were appropriate systems in place to meet the requirements of this regulation. While improvement was required to some plans with regard to updating them to ensure accurate information, this is being actioned under Regulation 21: Records. This is due to the fact than the information required to support the resident was known by the staff team and at the time of this inspection was not negatively impacting the resident.

Based on a review of the resident's assessment of need, it was found to be up to date and identified the resident's health, social and personal care needs.

The inspector found that the assessment informed the resident's personal support plans and for the most part suitably guided the staff team. Personal plans reviewed included an epilepsy care plan and a plan to manage a specific diagnosis. Plans were also informed by relevant professionals' recommendations and assessment, for example a speech and language therapist, and a psychologist. This would promote a holistic approach in order to ensure the resident received appropriate supports and in the right manner.

Judgment: Compliant

Regulation 6: Health care

The healthcare needs of the resident were suitably identified and catered for. Healthcare plans outlined supports provided to them to experience the best possible health. The resident had access to and was facilitated to attend appointments with health and social care professionals as required. For example, the resident had access to a GP, psychologist, and a neurologist. Prior to moving to the centre, the resident would not tolerate attending appointments or having tests done. Since their admission they they have attended appointments and with the support of staff allowed professionals to undertake certain tests, for instance blood pressure checks.

Judgment: Compliant

Regulation 7: Positive behavioural support

Where required, the resident had access to a behaviour support therapist to support them to manage behaviour positively.

The inspector found that the resident had a behaviour support plan in place that guided staff as to how best to support them which would help minimise the impact the resident's behaviour may have on themselves or others. The plan was observed to have been reviewed in February 2025 and provided clear information for staff. The team leader and a staff member were clear on the steps to support a resident which aligned with the resident's behaviour support plan.

There were some restrictive practices in use in the centre for the resident's safety, for example locked doors at the back of the house. There were arrangements for periodic review by the human rights and restrictive practice committee and they were last reviewed in March 2025.

The previous person in charge had completed a self-assessment questionnaire in November 2024 focused on restrictive practices to establish if improvements were required within the centre. The results were mostly complaint with one substantially compliant which related to the resident's understanding of restrictive practices. Staff had since completed a session with the resident on the restrictive practices in place.

Judgment: Compliant

Regulation 8: Protection

There were suitable arrangements in place to protect the resident from the risk of abuse. For example:

- there was an organisational adult safeguarding policy in place which was last reviewed March 2025
- staff had training in adult safeguarding
- there was a reporting system in place with a designated officer (DO) nominated for the organisation and a staff spoken with was able to identify who the DO was to the inspector.

There were no safeguarding incidents in the centre since it opened. Notwithstanding that, a staff member spoken with was familiar with the steps to take should a safeguarding concern arise.

From a review of the resident's file, the inspector observed that there was an intimate care plan in place to guide staff as to supports they required.

Additionally, the inspector found, from a review of March 2025 records, that a daily finance check was being completed of the resident's finances. This was in order to assure the provider that there was appropriate oversight of the resident's finances in

order to ensure their money was safeguarded.

Judgment: Compliant

Regulation 9: Residents' rights

The resident's rights were upheld in various aspects of their daily life, reflecting a person-centred and rights-based approach within the centre. The resident was supported to make choices and have control over their routines, activities, and personal preferences. This included flexibility in meal planning, social engagements, and how they spent their time, ensuring their voice was heard and respected.

For example, the resident wanted their room to look a particular way with the wardrobe empty and left open so they could see it was empty. This preference was respected by staff and the team leader communicated that otherwise it would cause anxiety to the resident. The resident wanted their bed covers to be stripped on the majority of days and remade at a certain point in the evening of their choosing and this was facilitated by staff. The resident did not like to be woken in the mornings. Instead they wanted to get up in their own time and regulate in a particular manner before staff engaged with them which was facilitated by staff. The team leader communicated that consistency of this approach was very important and ensured the resident's day started in a positive way for them.

When the resident wished to have alone time this was respected with the staff following the resident's cues. This was also observed on the day of this inspection when the resident was communicating that they wished to be alone. The team leader asked the inspector if the resident could not be disturbed until they were ready to come out of their room as they were self-regulating and the inspector respected the resident's wishes.

As previously mentioned in the first section of this report, the resident made choices about their daily activities and were facilitated to have a meaningful day.

Additionally, house meetings with the resident and meetings around advocacy were taking place regularly in order to keep the resident informed and support them to make choices. For example, the inspector reviewed the minutes of a meeting that explained what restrictive practices were.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 24: Admissions and contract for the provision of services	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Keenagh Gardens OSV-0008771

Inspection ID: MON-0044732

Date of inspection: 01/04/2025

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 21: Records	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records: 1. Behavior Specialist attended site visit and updated PBSP (positive behavior support plan) and communication dictionary was updated also. A digital copy and printed copy of both of these are now kept so they cannot be misplaced. 2. BS also reviewed updated intimate care plan, personal care plan and all updated supported plans to ensure all information was applicable. 3. Monthly review and update of all support plans put in place and to be completed by Team Leader and Keyworkers. 4. Hospital Passport updated with appropriate information and accurate medication and health diagnosis, to be reviewed monthly going forward. 5. Risk assessments updated and in line with current risk management policy, sent to quality assurance department for approval 6. Contract of care updated by DOO and signed by family members	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: 1. Two new staff have started and Team Leader is now allocated more administration time over five days. Team Leader still has dedicated time each day on the floor with resident and equally with the staff for implementation of updated plans for resident to ensure mentoring and guidance. 2. All probations are completed and probation schedule in place for new staff to keep	

track of upcoming probations at 3 months and 6 months in line with policy. Initial meetings completed within five days of new staff completed, also in line with policy.

3. Internal audits to include up to date supervision schedules and probation schedules.

4. Two fire officers appointed and daily checks completed on fire doors, staff complete checks throughout the doors to ensure locks are kept open – ongoing monthly key working sessions completed with resident about the locking of fire doors. Fire checks now documented on internal audits.

5. Safeguarding training was complete internally at team meeting in April and two posters have been presented to staff with QR codes so they can access further information about safeguarding on the HSE website. This has also been documented in April team meeting minutes.

6. Team leader now has access to Personio platform, were all staff HR files are kept, meaning Team leader can ensure all staff have completed mandatory training such as safeguarding before starting duty.

7. PIC has been recruited and is going through the onboarding process at present and a start date to be agreed on receipt of vetting, references etc.

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 21(1)(b)	The registered provider shall ensure that records in relation to each resident as specified in Schedule 3 are maintained and are available for inspection by the chief inspector.	Substantially Compliant	Yellow	05/05/2025
Regulation 21(1)(c)	The registered provider shall ensure that the additional records specified in Schedule 4 are maintained and are available for inspection by the chief inspector.	Substantially Compliant	Yellow	09/05/2025
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents'	Substantially Compliant	Yellow	30/06/2025

	needs, consistent and effectively monitored.			
Regulation 23(3)(a)	The registered provider shall ensure that effective arrangements are in place to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.	Substantially Compliant	Yellow	30/06/2025