Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	Dunmanway Residential
Name of provider:	CoAction West Cork CLG
Address of centre:	Cork
Type of inspection:	Unannounced
Date of inspection:	13 March 2025
Centre ID:	OSV-0002110
Fieldwork ID:	MON-0046648

About the designated centre

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

Dunmanway Residential consists of a large purpose built single storey building located in a town. The centre provides a respite service for up to six residents of both genders primarily for those between the ages of 0 and 18 although it can support those up to the age of 20 if they are still in their final year of education. The centre supports those with intellectual disabilities. Support to residents is provided by the person in charge, nurses, social care workers and health care assistants. Individual bedrooms are available for residents and other facilities in the centre include bathrooms, a dining area, a kitchen, a living room, a sunroom and staff rooms.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	0

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Thursday 13 March 2025	11:30hrs to 17:50hrs	Deirdre Duggan	Lead

What residents told us and what inspectors observed

From what the inspector observed and from speaking to staff and management, residents who received respite supports in this centre were offered a good quality service tailored to their individual needs and preferences. Overall, the findings on this inspection indicated that the service provided was safe. Some issues were identified with a fire door, staff rotas, personal planning and staff training.

The centre comprises a large purpose-built bungalow that provides respite accommodation for up to six residents at any one time. The building is also used to provide day supports on occasion, such as when residents are transitioning into the centre. The centre is located close to the local town and amenities. Residents have access to a secure outdoor area and the use of an adjoining playground. At the time of this inspection seventeen residents were identified on the the directory of residents as receiving respite supports in the centre.

This was an unannounced risk inspection and as such was focused on specific lines of enquiry. As outlined in the statement of purpose this centre does not open seven nights a week and this inspection was planned for an evening when residential supports would ordinarily be provided in the centre to provide an opportunity for the inspector to meet with residents in the centre. However, the centre was closed on the inspectors arrival and there were no residents receiving residential supports in the centre on the evening of this inspection. This occurred following a change in the scheduling of service hours to facilitate a family emergency of a resident.

As there was nobody present when the inspector arrived at the designated centre, the inspector announced the inspection to the person in charge by telephone, and made arrangements to commence the inspection. Aside from a walk around of the centre, which was empty during the walk around, documentation was reviewed in a nearby administration building. The inspector assessed the care and support of residents by speaking with management and reviewing the documentation present in the centre. The inspector spoke with family members of a resident also that had recently been admitted to the centre for residential respite supports.

Overall, the inspector saw that the centre was generally well maintained. The centre was designed and laid out to meet the needs of the residents that stayed there on respite breaks and was accessible throughout. Equipment such as hoist facilities were available to residents if required. One window was observed to have a crack in it and the glass panel in an internal fire door had been removed and replaced with wood following an incident of property damage. The person in charge reported that this had been actioned and following the inspection they informed the inspector that both the window and the fire door had been repaired.

As noted on the previous inspection the centre was warm, bright and homely and decorated in line with the age profile and needs of residents that used the service. Décor was seen to be bright, cheerful and welcoming. Residents had the use of

individual bedrooms and ample shower and toilet facilities. The outdoor yard area was equipped with a trampoline and other play equipment and outdoor furniture.

There were communal areas where residents could relax together or apart from each other and sensory and play equipment was available to residents including computer games, sensory lighting equipment and board games. While there were some restrictions in place in this centre for health and safety reasons, these were seen to be considered and put in place in a manner that would have the least impact on residents.

The inspector did not have an opportunity to meet with any staff working in the centre during this inspection. The parents of a resident who had recently been admitted to the respite services in the centre met with the inspector. The inspector also viewed feedback from family members contained in the most recent annual review and six monthly report. Some family members reported difficulties and concerns in relation to the timeliness of access to the service and the amount of respite available to their children. However, they reported that the service provided to their children while staying in the centre was overall very good and that the premises and services available to children during overnight stays were safe. Feedback indicated that overall family members were happy with the service provided by the staff working with their children. It is acknowledged that family members were experiencing difficulties in accessing respite services but as outlined later in this report, the services provided in the centre at the time of this inspection were seen to be in line with the statement of purpose the centre was registered under.

Some feedback was also received in relation to the information provided from the centre following a stay and another requested that their child be supported to engage is more specific activities such as swimming. A number of actions noted in the annual review indicated that the provider was responding to the feedback provided. A number of compliments were recorded also from family members of residents about the services provided in the centre.

Overall, this inspection found that there was evidence of good compliance with the regulations in this centre and this meant that residents were being afforded safe and person centred services that met their assessed needs during planned respite breaks. The next two sections of the report present the findings of this inspection in relation to the governance and management arrangements in place in the centre, and how these arrangements impacted on the quality and safety of the service being delivered.

Capacity and capability

The findings of this inspection showed that the management systems in place were ensuring that good quality services were being provided to the residents while they were receiving supports in this designated centre. This inspection found that overall

there was good evidence of compliance with the regulations. This was an unannounced risk inspection and the previous inspection of this centre had taken place in early 2023. Documentation reviewed during the inspection included resident information, the annual review, the report of the unannounced six-monthly provider visit, audit schedule, risk register and team meeting minutes. There was evidence that the provider was identifying issues and taking action in response to them.

There had been some changes to the persons participating in management since the previous inspection and a new assistant director of services, who was also a person participating in the management of the centre (PPIM) had been appointed in 2024. There was a clear reporting structure present and there was evidence that the management of this centre were maintaining good oversight and maintained a strong presence in the centre. The person in charge (PIC) reported to an Assistant Director of Services (ADOS), who in turn reported to the Director of Services (DOS), who reported to the Chief Executive Officer/Board of Management. The person in charge of this centre was present on the day of the inspection. This person had occupied this role for some time and was very familiar with the residents that lived in this centre. Since the previous inspection, the remit of this individual had reduced and they now no longer had responsibility for home support services. The inspector had an opportunity to speak with this individual and the ADOS/PPIM during this inspection. The inspector also had an opportunity to meet with the DOS briefly.

The management team spoken with were familiar with the assessed needs of residents and the care and support residents received in the centre and any issues in the centre. The person in charge was very experienced in this role and was seen to be knowledgeable about the residents that were supported in the centre and their assessed needs.

The inspector was informed that staff recruitment remains a pertinent issue for the this provider. However, this inspection found that while family members had raised concerns in relation to the amount of respite they were offered, at the time of this inspection this designated centre had in place staffing resources to provide for the effective delivery of care and support in accordance with what was set out in the current statement of purpose for the centre. Although staffing levels were generally adequate to provide for a five day service as outlined in the statement of purpose, the person in charge reported some challenges in relation to staffing periods where additional staff supports were required due to the assessed needs of residents. However, there was no evidence that any scheduled respite breaks had been cancelled or curtailed due to staffing levels falling below safe levels. Staff had access to appropriate training. Some refresher training was seen to be overdue.

In summary, this inspection found that there was evidence of overall good compliance with the regulations in this centre and the findings of this inspection indicated that residents were being afforded safe and person centred services. The next section of the report will reflect how the management systems in place were contributing to the quality and safety of the service being provided in this designated centre.

Regulation 15: Staffing

The registered provider had ensured that staffing arrangements in place were appropriate to the the number and assessed needs of the residents in this centre. At the time of this inspection, there was a sufficient number and appropriate skill mix of staff to provide care and support in line with residents assessed needs while they were receiving scheduled supports in the centre.

The staffing arrangements for the centre were set out in the statement of purpose. The centre was allocated a total of 6.3 WTE (whole time equivalents) and a person in charge who held a full time role. Fifteen staff in total were employed by the provider to maintain these staffing levels. A mix of social care, nursing and health care assistants provided supports in the centre. Staff vacancies were discussed with the person in charge. There were two temporary vacancies due to long term leave and one full time vacancy otherwise. Despite ongoing recruitment efforts, these vacancies had not been filled and were being covered by current staff, relief staff and agency staff.

By day, usually two to four staff worked in the centre providing supports to one to four children at any one time, depending on their assessed needs. At night one to two staff provided supports with waking night staff if required. The registered provider had made efforts to ensure that the staffing arrangements in place were appropriate to the the number and assessed needs of the residents when they received a service in this respite centre. Staffing arrangements were set out on a week-to-week basis on overview sheets due to the constant changing staffing requirements required to facilitate different residents' assessed needs. The person in charge was seen to have very good oversight of these and a review of eight weeks of these records showed that staffing was as set out in the statement of purpose and indicated that there had been no cancellations of confirmed respite services in that period due to staffing and that staffing was adequate to meet the number and assessed needs of residents when they received services. However, there was no planned or actual rota in place that clearly outlined the staffing arrangements in the centre, such as staff roles, and this meant that in the event the person in charge or someone familiar with these overview sheets was available it would be difficult to maintain full oversight of staffing matters in the centre.

The person in charge spoke about the challenges staffing issues in the centre posed. While staffing levels were not impacting planned respite breaks provided in the centre, the person in charge told the inspector that there were some challenges to offering additional respite requested by families. Overall, staff records viewed indicated a consistent core staff team supported residents and where agency staff were employed, a familiar staff member would be rostered alongside them.

Judgment: Substantially compliant

Regulation 16: Training and staff development

The training needs of staff were being appropriately considered, although some refresher training was overdue. Following the inspection the inspector was provided with a training matrix for twelve staff that were working in the centre. This matrix showed that staff were provided with training appropriate to their roles and that the person in charge was maintaining oversight of the training needs of staff. Training provided included training in the areas of medication management, fire safety and safeguarding. Some staff training was not up-to date. For example, Two staff had not completed safety intervention training and one was overdue refresher training in this area. One staff member was overdue refresher training in fire training and four staff were overdue refresher training in hand hygiene.

Judgment: Substantially compliant

Regulation 19: Directory of residents

A directory of residents was being maintained for this centre which was made available for the inspector to review during this inspection. This contained of the information required as per Schedule 3 or the regulations. This included residents' names, residents' dates of admission to the centre and details of residents' next-of-kin.

Judgment: Compliant

Regulation 23: Governance and management

Since the previous inspection, there had been two changes of CEO and vacancies including a finance manager and a human relations administrator had been filled. At provider level, a regulatory oversight committee had been replaced by a clinical quality and risk team in November 2024. While there was some evidence that vacancies among the senior management team had impacted on areas such as recruitment and on-boarding of staff, some of these vacancies had been filled within the previous year and this was reported to have resulted in improvements in these areas. However, some challenges remained evident such as the recruitment of staff. It was seen that the person in charge was making significant efforts to ensure that this did not impact on the service provided to residents.

Management systems were in place to ensure that the service provided as outlined in the statement of purpose was appropriate to residents' needs. Documentation reviewed by the inspector during the inspection such as provider audits, team meeting minutes, the annual review, and the provider's report of the most recent six

monthly unannounced inspection, showed that the provider was maintaining oversight of the service provided in this centre and that governance and management arrangements in the centre were effective in identifying and addressing issues arising in the centre.

There was a clear governance structure in place and the centre was resourced to provide a good quality service to residents when they were receiving respite in the centre in line with the statement of purpose in place at the time of this inspection. The management team, consisting of the assistant director of services and the person in charge, were seen to have the capacity to maintain good oversight of this centre. The inspector was provided with evidence that the person in charge had been supported by the ADOS to engage in formal supervision in the month prior to this inspection.

While some issues relating to the retention and ongoing recruitment of staff was identified, recruitment efforts were ongoing and staffing levels at the time of this inspection had not impacted the provision of the stated services provided in in the centre. Staffing levels were being maintained to allow the centre to be open during the periods specified in the statement of purpose and to meet the individual needs of the residents while they were accessing the service and where required agency staff were supplementing the existing staff team. Residents had access to transport to facilitate social and leisure activities, staffing was tailored to the needs of residents scheduled for respite and overall the premises was fit-for-purpose and maintained to a reasonable standard. Action had been taken since the previous inspection to address non compliance with the regulations. For example, some premises issues had been addressed and improvements were noted in personal planning, although some issues remained as outlined under Regulation 5.

An annual review had been completed in respect of the centre for the period of September 2023-September 2024 and this included details of consultation with residents and their family members. A report on the most recent unannounced six monthly visit to the centre to review the care and support provided to residents was also reviewed. It was seen that where issues were identified, action was taken to rectify them and the inspector saw that an action plan arising from the six monthly review indicated a number of actions that had been identified and completed.

Judgment: Compliant

Regulation 24: Admissions and contract for the provision of services

The admission process was set out in the statement of purpose for the centre. The registered provider was ensuring that admission policies and practices take account of the need to protect residents from abuse by their peers. There were no peer to peer incidents recorded in this centre and the management of the centre told the inspector about ongoing and continuous efforts to ensure that resident cohorts were compatible and that the assessed needs of residents were considered when planning

respite breaks and admitting residents to the centre. A resident that had recently been admitted to the centre had been provided with a number of opportunities to visit the centre prior to their admission. There was evidence that the resident and their representative had visited the centre and that feedback received following a visit was recorded and documented in the residents' file.

The registered provider had in place contracts of care for residents. A sample of these reviewed showed that they were being updated annually and updated copies were signed by representatives of residents. There was one outstanding contract but the provider had made attempts to complete this.

Judgment: Compliant

Regulation 3: Statement of purpose

The registered provider had ensured that a statement of purpose was prepared in respect of the designated centre and that this contained all of the information as specified in Schedule 1 of the regulations. This document was available in the centre and was reviewed by the inspector.

Judgment: Compliant

Regulation 34: Complaints procedure

The provider had in place a complaints policy with a review date of April 2025. An easy-to-read/visual complaints procedure was on display in a prominent place in the centre and information on accessing advocacy was also displayed.

A complaints, compliments and concerns folder was viewed that was kept for the designated centre and the complaints recorded since the previous inspection were reviewed. These complaints were recorded and details were included about how they were responded to locally and also by the provider. One complaint was recorded as resolved to the satisfaction of the complainant but recorded as "ongoing". Subsequent to this, a similar complaint was logged from the same individual and this was recorded as resolved internally but not to the satisfaction of the complainant.

Some complaints were not recorded in this log. For example, the inspector viewed some correspondence from a parent indicating that they were unhappy with a specific aspect of the service provided. This had not been logged as a complaint in this logbook. A family member spoken with also told the inspector that they were not satisfied with how their complaints were being managed by the provider. The inspector discussed this with the management of the centre and was told that

specific complaints were being held by the providers' CEO and therefore were not documented in the centre specific logbook. This was seen to be in line with the providers policy. The inspector requested further information in relation to some of these complaints and the information received indicated that the provider had maintained a record of these complaints including details of any investigation into a complaint, outcome of a complaint, any action taken on foot of a complaint and whether or not the resident, or in this case, their representative, was satisfied.

Judgment: Compliant

Quality and safety

The information reviewed during this inspection indicated that the wellbeing and welfare of residents in this centre was maintained by a good standard of evidence-based care and support. Findings of this inspection indicated that overall safe and good quality services were provided that were in line with the assessed needs of residents. Some issues were identified under Regulation 5: personal planning and Regulation 28: fire precautions.

No staff or residents were met with during this inspection so the quality and safety of care provided was reviewed through speaking with the management of the centre, reviewing documentation, and speaking to family members that were available on the day of the inspection.

The residents in the centre were for the most part supported by a familiar and consistent staff team. Guidance was available in residents' personal plans that outlined the care and support needs of individual residents. Weekly house meetings were documented that showed that residents were offered choices and information about day-to-day matters such as menus, activities and what staff would be on duty. These indicated that residents were supported with a wide variety of activities including day trips to parks, beaches and pet farms, playground visits, bus drives, the cinema, dancing and birthday celebrations.

Resident information viewed indicated that residents were supported to access healthcare and medical services if required. Residents with specific behavioural or medical needs were provided with additional staffing supports if required to ensure that their needs could be safely met. Measures were in place to protect residents from harm and risk management systems were in place.

Some of the residents that availed of respite in this centre presented with very specific behavioural and/or medical needs. The person in charge and PPIM present told the inspector about the efforts made to ensure that the service could fully meet the needs of these individuals while they were on planned respite breaks. For example, some children required 2:1 staff supports as per their assessed needs, some required sole occupancy and some children required specific controlled medications to be administered. The inspector was told about and saw that

residents' files outlined the efforts that the person in charge and provider were making to ensure that suitable and safe services could be offered to these children. For example, additional staffing was required to admit some residents and agency staff were used to supplement existing staff numbers to facilitate this if required.

As seen on the previous inspection, there were some restrictions in place for some residents due to their assessed needs and for health and safety reasons. Overall, these appeared to have been considered and put in place in a manner that would have the least impact on residents.

The inspector viewed a number of documents throughout the day of the inspection, including a sample of residents' most recent assessments of need, person centred plans, support plans, some medication management records and positive behaviour support guidance. The documentation viewed was seen to be overall well maintained and provide information about residents that was up-to-date and person-focused.

Regulation 17: Premises

The registered provider had ensured that the premises was designed and laid out to meet the aims and objectives of the service and the number and needs of residents. A walk around of the premises was completed by the inspector. The premises was seen to be well maintained and of a suitable size and layout to meet the needs of the residents the service was designed for. New overhead hoist equipment had been installed in some of the bedrooms since the previous inspection.

Resident bedrooms and living areas were seen to be decorated in a manner that reflected the service was provided for children. The centre was observed to be clean throughout on the day of the inspection and communal areas were seen to be homely and welcoming. For example, colourful murals were displayed in the hallway and the furnishing in the communal areas was in keeping with a "home" environment. There was suitable outdoor areas available for the use of residents and consideration had been given to making this area a welcoming place for children to spend time and play in. Laundry facilities were provided in a separate utility room. These were not accessible to residents due to restrictions in place for the safety of residents. A large crack was noted in a kitchen window. Repair works had been scheduled to address these issues and following the inspection, the person in charge confirmed that these works had been completed.

Judgment: Compliant

Regulation 26: Risk management procedures

The registered provider had put in place systems for the assessment, management

and ongoing review of risk. Processes and procedures relating to risk were set out in an organisational risk management policy and this had been reviewed as appropriate and was submitted by the provider for review following this unannounced inspection. This was due for review in March 2026.

The inspector reviewed the risk register and saw overall, this identified risks present in the centre and the control measures in place to mitigate against them. All of the risks specified under the regulations had been included in the risk register including the unexpected absence of any resident. Risk assessments provided information relating to the controls in place to manage identified risks. Where required, risk assessments were in place that detailed how the provider would manage specific individual risks identified for residents in the centre and risk management plans were in place for residents if required. For example, there was risk assessments in place around specific behaviours of concern, medical concerns and matters relating to service provision and staffing. Known allergies were very clearly identified in resident information.

There were systems in place for review of risk and the inspector saw that all risks identified in the risk register had been recently reviewed and that both the person in charge and the ADOS/PPIM had oversight of the centre specific risk register.

Judgment: Compliant

Regulation 28: Fire precautions

The registered provider was ensuring that effective fire safety management systems were in place in this centre at the time of this inspection and that overall adequate precautions were taken against the risk of fire. The centre was provided with appropriate fire safety systems including a fire alarm system, emergency lighting, a fire blanket and fire extinguishers and these were observed during the walkaround of the centre. Personal emergency evacuation plans were seen in a sample of resident files reviewed. Staff had access to fire safety training. Oxygen was no longer stored in this centre. However, containment measures in place were not fully effective at the time of this inspection.

- A glass panel in a fire door located in a corridor between two compartments had been damaged and removed and replaced with plywood as a temporary measure. The inspector was told that this was due to be replaced. This had the potential to render the containment measures in place in part of the centre ineffective but was unlikely to pose a significant risk to residents given the other fire safety measures in place and the staffing levels in the centre. Repair works had been scheduled to address these issues and following the inspection, the person in charge confirmed that these works had been completed.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

The person in charge had ensured that an assessment of health, personal and social care needs was completed prior to residents being admitted to this centre. The registered provider had ensured, insofar as is reasonably practicable, that arrangements were in place to meet the assessed needs of each resident, as identified. For example, to ensure a safe service could be provided and meet the needs of a resident with very specific healthcare needs, an additional nursing staff was provided during this residents' stay. The person in charge was overall ensuring that the designated centre was suitable for the purposes of meeting the assessed needs of each resident. Healthcare plans were viewed to be in place, including epilepsy care plans. Specific protocols and procedures were seen to be in place to guide staff in relation to a controlled medication and a risk assessment was in place that detailed the control measures in place to ensure that this was administered as prescribed. The person in charge had oversight of staffing arrangements in the centre that would ensure residents would be provided with the appropriate care and support they required while staying in the centre.

The inspector reviewed the personal plans and files of four residents, including a recently admitted resident. Improvements were noted overall in this area since the previous inspection. All residents in the sample viewed had personal plans in place. Plans reviewed provided clear guidance for staff about residents care and support needs and the sample viewed were updated at least annually or as required. However a positive behaviour support plan reviewed in respect of one resident was seen to require review.

However, similar to the previous inspection, there was little evidence in residents' files to show that reviews of personal plans were conducted in a manner that ensures the maximum participation of each resident, and where appropriate his or her representative, in accordance with the resident's wishes, age and the nature of his or her disability. For example:

- planning meetings were not documented as occurring in the resident files viewed
- while plans viewed included some goals related to activities of daily living goals identified did not include meaningful goals that were indicated to be in line with the resident's wishes.

Judgment: Substantially compliant

Regulation 8: Protection

The registered provider had taken steps to protect residents from abuse:

- The provider had in place a Child Protection and Welfare Policy that was due for review in 2027.
- There were no open safeguarding concerns documented at the time of this inspection and none were identified by the inspector during the inspection. One three day notification in respect of safeguarding had been submitted to the office of the Chief Inspector since the previous inspection. This was discussed with the person in charge who outlined the actions taken to protect the resident. The person in charge confirmed that due to the arrangements in place and ongoing review of resident compatibility very few safeguarding concerns were reported in this centre.
- The training matrix provided for the centre provided details of the dates that Garda Vetting disclosures had been obtained in respect of staff working in the centre. The inspector reviewed this and saw that this indicated that all staff had been appropriately vetted.
- Staff had received training in the area of safeguarding and Children's First training.
- Intimate care plans were viewed in files reviewed.
- Minutes of team meetings showed that safeguarding and child protection was discussed with staff during these.

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	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 19: Directory of residents	Compliant
Regulation 23: Governance and management	Compliant
Regulation 24: Admissions and contract for the provision of services	Compliant
Regulation 3: Statement of purpose	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 8: Protection	Compliant

Compliance Plan for Dunmanway Residential OSV-0002110

Inspection ID: MON-0046648

Date of inspection: 13/03/2025

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 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: Staff roster has been updated to identify each staff members role within the roster and their job title. A review of the roster system will occur to improve oversight and ease of use.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: A review of the training matrix has been completed and mandatory training will be completed in line with requirements. Training will also be a standing item in PIC Meetings for review which will identify trainings due and provide for oversight planning on these trainings.	
Regulation 28: Fire precautions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: A glass panel in a fire door has been fixed on the 26th of March 2025.	
Regulation 5: Individual assessment and personal plan	Substantially Compliant
Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan: The person in charge will ensure ongoing communication with multi-disciplinary teams regarding the updating of support plans to ensure that these are updated in a timely manner.	

A systematic review of the process for documenting and recording the planning meetings will occur to maximum participation of the people supported and their families and implement an appropriate recording system.

A Person Centred Plan Working Group has been scheduled organisationally for May 2025 which will review the framework for CoAction's person centred plans.

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 15(4)	The person in charge shall ensure that there is a planned and actual staff rota, showing staff on duty during the day and night and that it is properly maintained.	Substantially Compliant	Yellow	31/05/2025
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	31/05/2025
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	26/03/2025
Regulation 05(6)(b)	The person in charge shall ensure that the	Substantially Compliant	Yellow	30/08/2025

	personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall be conducted in a manner that ensures the maximum participation of each resident, and where appropriate his or her representative, in accordance with the resident's wishes, age and the nature of his or her disability.			