



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

Issued by the Chief Inspector

Name of designated centre:	Slieve Rua Residential & Respite Services
Name of provider:	Western Care Association
Address of centre:	Mayo
Type of inspection:	Unannounced
Date of inspection:	24 November 2025
Centre ID:	OSV-0003916
Fieldwork ID:	MON-0048231

About the designated centre

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

Slieve Rua provides a residential and respite service to 12 adults in three separate houses. This centre supports residents with low to high needs and can also facilitate residents with reduced mobility. One house is dedicated to respite and one resident uses this house for planned breaks. Two houses provide residential care to up to five residents each. Each house in the centre is warm and comfortably furnished and residents' bedrooms are decorated with items of personal interest and photos of family and friends. The centre is located within walking distance of a small town in the West of Ireland. Some residents are offered an integrated service and some residents attend day services external to the centre. There is a staffing allocation to support residents during the day and there is either a sleep in arrangement or waking night in place during night-time hours.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	7
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This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Monday 24 November 2025	14:45hrs to 19:30hrs	Angela McCormack	Lead
Monday 24 November 2025	14:45hrs to 19:30hrs	Úna McDermott	Support

What residents told us and what inspectors observed

Overall, this inspection found that actions identified at the previous inspection by the Health Information and Quality Authority (HIQA) in May 2025 were completed or in progress. This meant that in one house, the staffing arrangements at night time were now in place to meet residents' needs and to ensure their safety. This also meant a reduction in the use of restrictive practices.

The centre comprised three houses all located within a short distance from each other, and in easy access of a small town. Two houses (House 1 and House 2) could accommodate five residents each, and the third house (House 3) could accommodate two residents for respite. Inspectors met with six residents throughout the inspection. Three residents in House 1 and three residents in House 2. Inspectors did not visit House 3 on this inspection.

This inspection was an unannounced inspection completed to follow up on areas of non-compliance found on the last HIQA inspection in May 2025. The inspection was completed by two inspectors. The inspection focused on one house (House 2), as this was the location where the areas of non-compliance were found on the last inspection.

At the last HIQA inspection completed on 26 May 2025 three regulations were found not compliant. These related to staffing, positive behaviour support and governance and management. In addition, improvements were required in the area of protection to include the appropriate identification and response to incidents that could have an impact on the protection of residents' personal possessions.

Following this inspection in May 2025 the provider was required to attend a warning meeting with the Chief Inspector of Social Service's delegate, where they were warned that the registration of the centre may be cancelled if ongoing non-compliance occurred. The provider submitted an action plan to address the areas of non-compliance. These actions were reviewed on this inspection.

Inspectors found that most actions were completed. Actions that were not fully completed included the finalization of the staff roster. However, arrangements were now in place to ensure that residents who required supports at night had appropriate staffing. This meant using temporary staff, including agency staff. This required completion so that residents received support and continuity of care from a consistent staff team.

Inspectors met three residents in House 1 and three residents in House 2 during the evening of inspection. Inspectors also met, and spoke with, three staff members across two houses. Residents were observed supported by staff members who were familiar with their needs and communications. During the evening, inspectors observed residents relaxing in their preferred areas of their homes, for example in the sitting-room and sensory-room. One resident went out for a drive with staff

member, returning later for dinner. All residents appeared relaxed and content in their homes.

Residents in House 2 used various forms of communication, such as gestures, social stories and objects of reference. Residents required familiar staff members who knew them well to support them in communicating their choices. Inspectors could see from observations that staff members knew residents' preferred communication methods and were using these to communicate with them throughout the inspection.

Inspectors completed a walk around of House 1 and House 2. Residents' bedrooms were observed to be personalised, and reflected each residents' likes and individual personalities. Residents in House 2 did not attend an external day service, but carried out preferred activities from their home. There were three staff members available at times during the day to support residents to do individual activities. The house had transport also. Residents had access to a range of recreational activities within their home, including music players, televisions, sensory items, art supplies and musical instruments. There was a beautiful sensory room in House 2 which provided a relaxing space for residents. However, the front garden area in this house required repair so that residents could use this space in their home. This was planned, but there was no clear time frame for it to be completed.

Overall, this inspection found improvements in the service provided to residents to ensure their support needs were met and that they were safe at night time. Improvements were required to further enhance the quality and safety of care provided. These are elaborated on under the regulation sections of this report.

The following sections of the report describe the governance and management arrangements and about how this impacts on the quality and safety of care and support.

Capacity and capability

Overall, this inspection found that the provider had made good progress on their actions to comply with the regulations since the previous inspection by HIQA completed in May 2025. This meant that the areas of risk identified previously had been addressed. Further improvements were required however, to complete the staffing recruitment and to address gaps in documentation.

Since the last HIQA inspection, staff members in House 2 had been offered further training in restrictive practices, residents' rights and safeguarding. Waking night staff had been implemented since 01 November 2025 in line with the agreed time line, however the night time shifts were covered by various temporary staff while the finalisations of the roster for the permanent staff team was in progress.

Improvements were also found in the governance and oversight of the centre. In

particular, the provider appointed an assistant manager to support the person in charge. They were based in the centre three days per week. They completed their induction in September and were getting involved in various operational tasks. In addition, increased supports were provided to the management team in the areas of risk management, reviewing of restrictions and ongoing support to comply with the staffing risks. However, further improvements in documentation and oversight were required to further enhance the quality of service.

Regulation 15: Staffing

Inspectors reviewed the actual and planned rosters for House 2, from 27 October 2025 to 30 November 2025. This showed that waking night staff was implemented from 01 November 2025 to meet the night time support needs of residents. This meant the addition of one waking staff member at night time, with two staff members doing sleep-in shifts, so that residents who were up during the night were supported to be safe. However, the following was found;

- The waking nights were covered by temporary staff since 01 November. Inspectors were informed, and could see through meeting notes reviewed and proposed planned rosters, that actions were in progress for permanent staff to fill these shifts. These actions included additional recruitment and negotiations with staff members and their representatives to agree the changes to staff working arrangements. Inspectors were informed that areas that required further review included discussions about the staff grades that could undertake waking nights, and permanent staff members' change in work patterns. Inspectors were informed that a further meeting was planned for 10 December 2025 to try to progress this. This action required completion so that residents receive support from a consistent staff team.
- In addition, the roster required review to ensure that it did not include a mix of the 12 hour and 24 hour clocks, which could create confusion about what hours staff members actually worked.

Judgment: Substantially compliant

Regulation 23: Governance and management

Overall, improvements were found in the governance, management and oversight of the centre since the last inspection by HIQA in May 2025. These included enhanced oversight by senior management of practices in the centre and the creation of an additional level of management in an assistant manager who supported the person in charge three days per week. This post commenced in September 2025.

Further improvements were required as the following was found;

- There were gaps in documentation which could pose a risk that residents' assessed needs and support plans were not followed. For example, an inspector observed food being prepared for a resident who was prescribed a modified diet by their speech and language therapist. This was prepared as prescribed. However, a review of the resident's personal risk management plan found that it had not been updated. Therefore, the written guidance for staff was out of date.
- Oversight of notifications regarding restrictive practices required improvements. Inspectors saw in documentation relating to residents' rights, that prior to waking night duty being implemented in House 2, that some internal doors (kitchen, sitting-room, utility room) were locked at night. However, these had not been included on the quarterly notifications about restrictive practices to the Chief Inspector.
- Actions to repair the front garden area in House 2 required timely completion. For example, the front garden area required repair since June 2024, meaning residents did not have safe access to their garden space since then.
- A provider unannounced visit occurred on two dates in June and July 2025, from which a report was devised. Inspectors reviewed this report and found it wasn't clear if all locations of the centre were visited (there was no reference to a visit of House 3). Also, not all actions affecting residents were identified, such as the need for the garden in House 2 to be completed so that residents could use this space.

Notwithstanding that, a number of actions to improve the safety and quality of care were completed. These included regular oversight and monitoring meetings that included the person-in-charge, area manager and representatives from human resources and quality department. Inspectors reviewed records of four meetings that occurred between July and October 2025 and found that actions required to ensure compliance with the regulations, were under ongoing review and monitoring for progression. Furthermore, the action plan agreed, following the warning meeting held with the provider, were kept under review by a 'compliance and oversight group' that included local and senior management personnel. A tracker system was used to monitor the agreed actions and was explained to inspectors by a member of the quality team who called to the centre to meet inspectors. They also described the supports provided to the service since the last HIQA inspection and the arrangements agreed for ensuring ongoing oversight of the support provided to residents.

Improvements were also found in staff training. Additional bespoke training and information sessions were provided to the staff team in House 2 since may 2025. Topics included risk, rights', safeguarding and restrictive practices and were completed in July 2025 and provided by members of the provider's multidisciplinary team (MDT). In addition, staff training records for staff members in House 3 were now available and monitored by the person in charge. This was an area that required improvements as noted during the last HIQA inspection.

Judgment: Substantially compliant

Quality and safety

Inspectors found that night time support to residents in House 2 had been addressed. This meant that residents who chose to get up during the night were now supported with waking night staff. This also meant that there was a reduction in restrictive practices used in this house affecting residents.

Assessments of residents' needs and care plans were found to be comprehensive; however there were some gaps in the documentation that required review and updating. This is covered under Regulation 23: Governance and management, and is related to the ongoing oversight and monitoring of the centre.

In addition, staff members had received additional training and information sessions relating to residents' rights, the use of restrictive practices and safeguarding. Regular team meetings were occurring also, where protection and restrictions were discussed. All of this promoted ongoing knowledge sharing and awareness about safeguarding issues and procedures.

Regulation 7: Positive behavioural support

Inspectors found that there were improvements in the monitoring and review of restrictive practices since the last inspection by HIQA completed in May 2025.

At that inspection inspectors found that there were restrictive practices in place in House 2 affecting residents without adequate review. Since then, a number of actions were completed. These included a review of all residents' rights and restrictions in place that may impact on their rights. Inspectors reviewed two residents' 'rights review checklists', that were updated by the person in charge in May 2025 and reviewed by the provider's 'Rights Review Committee (RRC)' in July 2025. These checklists showed an accurate reflection of what practices were in place in the home based on inspectors' observations and discussions with staff members.

Furthermore, the review by the RRC showed that there was improved oversight by the provider on restrictions to ensure that they were proportionate to risks and that they were used as a last resort. For example, the recommendations by the RRC included a recommendation that some restrictions affecting residents in House 2 be removed after the implementation of waking night staff. This had been completed since 01 November 2025. The person in charge was due to return to the RRC in December 2025 to provide an update and to provide an opportunity for further review. This meant that there was an ongoing process in place to ensure that restrictions were only used as required and based on an identified risk. In addition, there were now clear roles and accountability in relation to the review and

implementation of any restrictions in use, which aligned to the provider's policy.

Inspectors reviewed two residents' care plans and found that there were clear plans in place to support anxiety related behaviours, including triggers to behaviours. For example, staff spoke about using a headphones which played music that the resident enjoyed. A review of the resident's annual action plan (January 2025) found that this was recommended. Furthermore, a review of their daily logs found that this proactive strategy was recently used with good effect for the resident when they were anxious about a medical appointment. This meant that staff were aware of guidance provided and knew what to do.

Judgment: Compliant

Regulation 8: Protection

This inspection found improvements in the monitoring and oversight of practices by the management team. This promoted the protection of residents and their possessions.

Since the last inspection by HIQA in May 2025, staff were provided with additional training in the area of protection and safeguarding. This was completed in July 2025 at a staff meeting. Inspectors reviewed two staff meeting records that were held in July 2025, and saw that discussions on safeguarding and reporting obligations to the Chief Inspector of suspected and confirmed protection concerns, were discussed.

A preliminary screening was completed in line with the provider's procedures, following the identification of a protection concern at the May 2025 inspection, that was noted in one resident's daily notes. Actions were taken to protect residents including ongoing monitoring of residents' daily records by the staff team and person in charge, to ensure that any possible protection concern would be identified.

Residents had care plans in place that promoted their protection by providing clear guidance on supports required. Inspectors reviewed two residents' personal plans in house 2, where it could be seen that there were intimate and personal care plans in place that provided clear guidance on supports.

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 23: Governance and management	Substantially compliant
Quality and safety	
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Slieve Rua Residential & Respite Services OSV-0003916

Inspection ID: MON-0048231

Date of inspection: 24/11/2025

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
<p>Outline how you are going to come into compliance with Regulation 15: Staffing:</p> <p>Engagement is continuing with the staff team and their Union representatives with regards to the implementation of new roster incorporating waking night duty. The Organisation will be implementing the new roster from 12/01/26.</p> <p>The roster has been updated to a 24-hour clock format to ensure clarity and consistency for all staff.</p>	
Regulation 23: Governance and management	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 23: Governance and management:</p> <p>The Person in Charge (PIC) has undertaken, and will continue to undertake, a review of Personal Risk Management Plans to ensure they are current and reflect the needs of all people supported. This will be conducted in accordance with Circle of Support meetings, and/or as the need arises.</p> <p>Restrictions within the service have been reduced following the introduction of a waking night duty. There are no locked doors within the service presently. This is also outlined in guidance for night duty staff and will be reiterated again at staff meeting on 13th January.</p> <p>The decking area was identified as requiring remedial work and this has been referred to the Maintenance Department. Following consultation and consideration of potential barriers to completion, a target completion date of 30/04/2026 has been agreed.</p> <p>The Provider will continue to review and update guidance relating to the completion of</p>	

internal unannounced inspections. This guidance will be formally reviewed and discussed at management forums to ensure that all reviewers are fully aware of, and adhere to, the required standards and expectations.

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(3)	The registered provider shall ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.	Substantially Compliant	Yellow	31/01/2026
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Substantially Compliant	Yellow	30/04/2026