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:	Listowel Respite Services
Name of provider:	Kerry Parents and Friends Association
Address of centre:	Kerry
Type of inspection:	Unannounced
Date of inspection:	24 March 2026
Centre ID:	OSV-0005683
Fieldwork ID:	MON-0050074

About the designated centre

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

Listowel Respite Services consists of one detached house located in a rural area but within close driving distance to a nearby town. The house can provide respite for up to five residents. In total the centre can support a maximum of five residents of both genders over the age of 18 with intellectual disabilities and Autism. Individual bedrooms for residents are available and other rooms include a kitchen, sitting rooms, utility room and bathroom and conservatory. Residents are supported by the person in charge, social care workers and care assistants.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	4

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 24 March 2026	10:15hrs to 19:15hrs	Deirdre Duggan	Lead

What residents told us and what inspectors observed

This was an unannounced inspection carried out to assess compliance with the regulations. Substantial non-compliance was identified during the previous inspection of this centre in October 2023 and following this the provider attended a cautionary meeting. Subsequently, one resident transitioned out of the centre. One unit was removed from the footprint of the centre and the registration of the centre was renewed with this reduced footprint. This inspection found overall good compliance with the regulations but some issues were identified in relation to access to fully comprehensive positive behaviour supports for some residents.

At the time of this inspection this centre comprises one two-storey house that offers respite supports to seventeen individuals. Up to five respite residents may be supported at any one time.

Four gentlemen were accessing respite services on the day of this inspection and were supported by three staff members. All had stayed in the centre the previous night and were attending day services when the inspector commenced the inspection but returned to the centre in the afternoon. The inspector had an opportunity to meet with all four residents at this time and spent the remainder of the inspection based mainly in the communal areas of the centre observing practice, interacting with residents and reviewing some documentation.

On their return from day services the gentlemen accessing the respite service were welcomed by the aromas of a home cooked meal prepared by staff. Residents were seen to be supported by staff to settle into the centre and were offered refreshments. This transition appeared to be difficult for one resident and staff managed this in a patient and kind manner, offering the resident preferred choices and plenty of time. One individual showed the inspector their bedroom and throughout the evening residents were seen to spend time in the kitchen, eating dinner in the company of peers and staff, spending time in the conservatory and sitting room. Residents were observed to be overall relaxed and move freely around the house and also outside.

Staff were familiar with the preferences of residents including, for example, their favourite television shows, drinks and routines. Staff were seen to be very familiar and attentive to residents' individual needs and provide attention or time and space where required. One resident interacted at intervals with both the inspector and the management of the centre present and engaged in good humoured banter. It was evident that they were familiar with and knew and trusted the local management of the centre. Another gentleman was seen to spend time moving in and outside of the house, as appeared to be their preference.

Overall, the residents sharing a service at the time of the inspection appeared to know each other well and were content in one anothers company. At times one

resident attempted to turn off the television that another resident was watching and was seen to be redirected by staff, who were vigilant in relation to this. Staff were seen to respond quickly and make efforts to minimise the impact on all residents when a resident was vocal while waiting to go on the bus as per their preferred routine. It was seen that the presence of familiar staff who knew this resident well helped to reduce the impact of this.

While some residents did not wish to interact at length with the inspector, residents that did speak with them indicated to the inspector that they liked attending respite in this centre and were happy with the staff supporting them and felt safe in the centre. The provider had consulted with residents and their representatives about their satisfaction with their service as part of the annual review process and this was seen to be generally positive. Two staff who spoke with the inspector told the inspector that they felt the individuals that used this service were offered a good quality, safe and person centred service.

The care and support offered to residents was observed to be overall good and this inspection found there was evidence of overall good compliance with the regulations. This meant that residents in this centre were being afforded overall safe and person centred services that met their assessed needs. 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.

Capacity and capability

Management systems in place in this centre were ensuring overall good quality services that met residents' needs were being provided to the individuals that used this respite service. There was a clear management structure present and overall there was evidence that the local management of this centre were maintaining good oversight and maintained a strong presence in the centre. Action had been taken to bring the centre into compliance with the regulations since the previous inspection and overall a good level of compliance was found on this inspection.

At the time of this inspection 17 residents were catered for on a respite basis with between one and four residents usually availing of respite services at any one time, depending on the assessed needs of residents. Generally residents received between three and nine nights respite per month. At the time of the inspection one resident was receiving emergency respite for one month.

The management team in the centre had changed since the previous inspection and a new person in charge had been appointed. Both the person in charge and the assistant director of services (ADOS), who was a person participating in the management of the centre (PPIM) were met during this inspection. Some challenges the provider had faced in relation to absences in their governance team in the

previous year were discussed and the inspector was told about specific actions the provider had taken in response to this.

The person in charge had remit over this designated centre only in that role but also had a large remit of other duties with the provider. The person in charge was knowledgeable about residents' care and support needs and maintained a strong presence in the centre. A team of social care workers and care assistants provided support to residents.

Residents were supported by a core team of familiar staff. While agency staff were used to supplement staffing and cover vacancies, the provider was making efforts to ensure that consistency of support was provided. Staff in the centre presented as committed to the residents they supported and were appropriately trained for their roles. Staffing levels were appropriate to meet the needs of the residents supported in the centre. Staff spoken with were familiar with safeguarding procedures in place in the centre and were positive about the management team that supported them. The inspector was told issues raised were responded to promptly by the management team and the provider.

Overall, this inspection found that there was evidence of very good compliance with the regulations in this centre and this meant 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 for the most part ensured that staffing arrangements in place were appropriate to the the number and assessed needs of the residents in this centre. Some issues were identified in relation to the induction of agency staff. 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. Generally three staff provided supports by day and by night a waking staff and sleepover staff available to residents.

A regular core staff team worked in the centre providing continuity of care to residents and some staff members had worked in the centre and with these residents for a number of years . A planned and actual staff rota was maintained in the centre and a six-week sample was reviewed.

While there was not a significant number of vacancies in the centre at the time of the inspection, the inspector was told that there had been an increase in the amount of agency staff employed in the centre in the previous months due to unanticipated leave on the staff team. Some staff had recently returned to their roles and this was anticipated to reduce this reliance on agency staff. Where agency staff were used to

fill gaps in the staff rota, efforts were made to employ regular agency staff and to ensure that agency staff worked alongside familiar staff.

The inspector was told about the provider systems to ensure that agency staff working in the centre were appropriately qualified and vetted for their roles. Records related to a sample of three agency staff who had recently worked in the centre were reviewed and contained the details required under Schedule 2 of the regulations.

- Induction records for agency staff were not in place at the time of the inspection. This meant that there was no clear process or documentation to demonstrate if or how agency staff were provided with all relevant information prior to commencing duties in the centre. The provider was in the process of developing an induction policy and the inspector viewed a draft of this and also viewed a proposed emergency induction checklist.

Judgment: Substantially compliant

Regulation 16: Training and staff development

The training needs of staff were being appropriately considered and this meant that residents could be provided with safe and good quality care and support appropriate to their needs. The inspector reviewed a training matrix for fourteen staff actively employed in the centre. This matrix showed that overall staff were provided with training appropriate to their roles and that overall the person in charge had maintained good oversight of the training needs of staff.

Mandatory training provided included training in the areas fire safety and evacuation, safeguarding, manual handling, and positive behaviour support. For the most part this was up-to-date and where training was identified as required this was booked. Staff that spoke with the inspector told the inspector about some of the training they had completed and staff confirmed that they were well supported in the centre. A supervision schedule in place showed that had access to formal supervision regularly.

Judgment: Compliant

Regulation 23: Governance and management

Management systems were in place to ensure that overall the service provided was appropriate to residents' needs. Some issues in relation to access to specific allied health professionals are covered under Regulation 7: Positive behavioural support. 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 governance and management arrangements in the centre were effective in providing oversight and that the provider was actively considering the oversight arrangements on an ongoing basis. Provider audits were identifying issues arising and there was evidence that action was being taken in response to these.

There was a clear governance structure in place and the centre was overall adequately resourced to provide a good quality service to residents. The appointed person in charge was intended to be in place on an interim basis while the post was filled and while there was evidence that they were maintaining oversight in the centre, they also had a significant remit with the provider outside of this role. Some additional administration supports had been provided to the person in charge to assist with this. Due to difficulties filling this role attributed to this being advertised as a specified purpose contract, the provider had submitted a business case to the funder to make this role permanent. Another business case had also been submitted to make fire safety upgrades in the centre.

Staff spoke with the inspector and reported that they felt comfortable to raise concerns and that issues raised were taken seriously and responded to by the management of the centre. Staff were aware of the reporting structures in place.

Judgment: Compliant

Regulation 3: Statement of purpose

The statement of purpose was present in the centre and viewed by the inspector. This had been updated to reflect accurately the management arrangements in the centre and contained the details set out in the regulations.

Judgment: Compliant

Regulation 31: Notification of incidents

The person in charge had notified the chief inspector in writing, as appropriate, of any incidents that had occurred in the designated centre. A review of nine months incident reports was completed by the inspector on the day of the inspection.

Judgment: Compliant

Quality and safety

The wellbeing and welfare of residents in this centre was maintained by a good standard of evidence-based care and support. Overall safe and good quality services were provided to the respite residents that availed of services in this centre. Some issues were identified in relation to access to psychology supports for residents and this is covered under Regulaton 7: Positive behavioural support.

Staff working with residents on the day of the inspection were observed to be familiar with residents and their preferences and support needs. Residents that spoke with the inspector told the inspector that they were well supported by the staff team in the centre and the inspector observed that residents were familiar and comfortable with the staff supporting them and there was a calm and relaxed atmosphere during the inspection. Staff in the centre presented as having a strong awareness of the needs of the residents' they supported and how to support residents in a rights based manner.

Documentation in place about residents was seen to provide overall good guidance to staff about the supports residents required to meet their healthcare, social and personal needs. The inspector saw that there was ongoing consideration of the current and future needs of residents. There was evidence that residents were actively consulted with about their time in the centre and the supports offered to them.

While limited healthcare supports were offered due to the respite nature of the service provided, residents had in place healthcare support plans to guide staff in this area. As previously mentioned, at the time of this inspection, residents did not have full and timely access to psychology supports, and this was impacting on some residents, particularly in relation to the impact of responsive behaviours some residents' displayed and how this was managed during respite stays. This impacted both the residents' who engaged in these behaviours and also the other individuals who shared their respite service.

Finance systems were reviewed and systems were in place in relation to supporting residents to safeguard and manage their monies while in the respite service.

Regulation 12: Personal possessions

The inspector completed a walk-around of the service. Residents were seen to have ample storage space for their belongings during respite stays to allow them to retain control over their own possessions. There was access to laundry facilities in the centre if required.

Where desired, residents were supported to manage their finances and there were appropriate safeguards and systems in place to protect residents' monies. A review of this was completed with a staff member who showed the inspector how residents'

monies were received and accounted for in the centre. For example, money held for safekeeping for residents was counted and signed for daily by two staff at least daily and receipts were retained for purchases. Some residents' retained control over their own personal spending monies and were supported to do this.

Judgment: Compliant

Regulation 13: General welfare and development

The registered provider was endeavouring to provide each resident with appropriate care and support. Some issues in relation to the provision of positive behavioural support are covered under Regulation 7. Since the previous inspection the provider had taken steps to transition one resident from the centre and reduce the footprint of the centre and this meant that the provider was now overall meeting the assessed needs of the residents that used this respite service.

Residents were provided with access to facilities for occupation and recreation and opportunities to participate in activities in accordance with their interests and capacities. Residents were seen to be well supported in this centre in line with their assessed needs and wishes. The inspector spoke with staff and residents and reviewed documentation including person centred request sheets in the centre about resident's respite stays and saw that residents were supported to attend a variety of activities if they desired including community based activities.

Judgment: Compliant

Regulation 17: Premises

Overall, the premises was seen to be suitable to meet the assessed needs of the residents that lived there. 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. Four residents could be accommodated on the ground floor and one resident on the first floor. Overall, the premises was seen to be homely and decorated in line with the profile of residents that used the service. Residents had access to kitchen, bathroom and laundry facilities and communal areas including a conservatory, dining area and sitting room. Externally, residents had access to an outdoor area if they wished. While overall the property was seen to be well maintained some maintenance was outstanding. This included paintwork in some areas and some flooring in bedrooms and communal areas that was observed to be worn.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

The registered provider had put in place systems for the assessment, management and ongoing review of risk and were in the process of embedding a new digital system to support both local and provider oversight of risk.

The inspector reviewed the risk register and documentation in relation to risk and saw that overall this identified risks present in the centre and the control measures in place to mitigate against them. This was subject to review. However, an individual risk assessment in place for a resident was not reflective of the current circumstances in the centre and did not take into account that the resident no longer had access to specific allied health supports. Also, while incidents were recorded and action taken in response to incidents, some improvements were required to ensure that it was clear if any residents were impacted or not.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

There were good systems in place to safely store and manage medications in this centre. A staff member provided the inspector with a thorough outline of the providers' medication management systems and procedures and how they were applied in the centre.

The inspector viewed the facilities in place for storing medications and saw that they were appropriate for the services offered. Each resident in situ had in their own section a locked medication press and their medications boxes and administration records were clearly identified including pictures of the resident. Medications were clearly labelled also and documentation systems provided for a clear pathway to administer medications to residents as prescribed. There were facilities for the storage of controlled medications if required and there were arrangements in place that meant that medications were stored securely. There were also appropriate arrangements in place for the safe transportation of medication and medical information to and from the centre and a system for the receipt and return of medications to and from residents' homes and day service.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The person in charge had ensured that personal plans were in place for residents. Some of these required review to ensure they were fully reflective of the current needs of each resident. Individualised plans for a sample of three residents were reviewed. Assessments of need, healthcare support plans and details of multidisciplinary input received by residents were documented and the plans in place to support residents were seen to be subject to review. However, although the evidence reviewed indicated that residents were receiving the care and supports they required some of the information contained in residents' plans was not fully up-to-date. These oversights appeared to be in the main a documentation issue, whereby some documentation was not always fully updated to reflect recent changes. However, staff and management spoken with were very knowledgeable and aware of residents' support needs and this did not appear to be impacting significantly on a day-to-day basis.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

While the person in charge had made efforts to provide staff with the knowledge and skills to respond to behaviours of concern and support residents to manage their behaviour, some residents did not have access to comprehensive positive behaviour supports they required. The inspector was told by management and staff that this was impacting on occasion on some residents' experiences in the centre. A review of incident reports, risk assessments and positive behaviour support guidance in place also indicated that residents' were at times impacted by a lack of adequate resources in this area.

Information and guidance to support residents in this area had been developed by staff and management in the centre and was viewed in some residents' files. However, residents in this centre did not have access to specific allied health supports that they required, including psychology supports. While there were mechanisms in place to refer residents to external services for positive behaviour supports, it was reported that access to this was limited. This meant that the guidance in place was not always subject to timely scrutiny or review by a competent professional to ensure that it would always adhere to best practice or was fully appropriate or sufficient for residents. The lack of these supports had been recognised by the provider as impacting on some residents in particular. The inspector also observed that one residents' responsive behaviours did appear to impact on other residents in a minor way during the inspection. While staff were seen to be vigilant in relation to this, it was not fully evident that staff had the knowledge or skills to respond to this in line with best practice in this area.

Judgment: Not compliant

Regulation 8: Protection

Overall, measures were in place to protect residents from abuse on the day of this inspection. Staff had received appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse.

-The training matrix reviewed showed that safeguarding training was provided to staff working the centre and safeguarding was discussed regularly by the staff team.

-A sample of documentation in respect of six safeguarding incidents that had been reported to the Chief Inspector was reviewed. Safeguarding plans had been put in place to respond to incidents and all of the sample reviewed had been reported to the Safeguarding and Protection team also as required.

-Staff reported a good culture in relation to safeguarding in the centre and were aware of the safeguarding procedures in place.

-Intimate care plans were in place in personal plans.

-The provider had in place an up-to-date Garda Vetting Policy that set out the arrangements for ensuring that all staff working in the centre were appropriately vetted. However, records provided indicated that one relief staff member who had recently returned from leave required an up-to-date garda vetting disclosure. Follow up action taken by the provider was indicated on the day of the inspection.

Judgment: Compliant

Regulation 9: Residents' rights

The evidence found on this inspection indicated that residents' rights were respected in this centre. Residents were seen to have freedom to exercise choice and control in their daily lives and to be encouraged to participate in decisions about their own care and support. Residents were afforded privacy in their own personal spaces and staff were observed to interact with residents in a dignified and supportive manner. For example, staff were seen to consult with residents about their preferences, to knock before entering bedrooms, and to provide support with in a dignified and relaxed manner.

- Residents’ will and preferences were considered in the centre. For example, one resident had been facilitated to travel separately to day-services on the morning of the inspection after they indicated they did not wish to travel with their peers on the bus.
- -Residents’ were also supported to retain autonomy if desired. For example, one resident retained control over their own medications. Residents were also

consulted with in relation to meals in the centre and what they wished to achieve while visiting the centre.

- Resident meetings were documented and there was easy-to-read information available to residents on a variety of topics including safeguarding, complaints, food choices and restrictions .There was a system in place to ensure that each resident was offered an opportunity to participate in these meetings at least monthly if they attended respite.

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	Compliant
Regulation 23: Governance and management	Compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 12: Personal possessions	Compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Listowel Respite Services OSV-0005683

Inspection ID: MON-0050074

Date of inspection: 24/03/2026

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:

The provider is in the process of implementing a formal updated induction process for all agency staff working within the designated centre. A draft emergency induction checklist is currently in draft form. The draft emergency induction checklist was discussed at the Quality and Standards meeting on the 26th of May, 2026 and circulated to all managers for monitoring the highest risk relating to emergency agency/unplanned cover or redeployment. Following a review period by Managers of 3 weeks, this checklist will be implemented as a compliance measure until the full induction policy has been reviewed.
All staff have been reminded of the importance of ensuring that agency staff receive an appropriate induction prior to commencing duties in the centre. The induction process will ensure agency staff are provided with essential information relating to residents' assessed needs, safeguarding, fire safety procedures, risk management, infection prevention and control, and emergency procedures.
A system will be put in place to ensure completed induction checklists are maintained within the centre as evidence that agency staff have received the required orientation and information. The Person in Charge and local management team will maintain oversight of this process through regular review and monitoring of induction records. It is included in the provider audit to ensure ongoing compliance.
A full review of the KPFA Induction Policy is currently underway and is scheduled for completion by December 2026. The review will adopt the HSE 3PsG approach and aims to strengthen governance, oversight, and consistency in induction processes across the organisation.
The review has identified that the existing induction arrangements were primarily designed around planned onboarding of new employees and did not sufficiently differentiate between the varying induction requirements and risks associated with different staff entry pathways. The revised framework is planned to introduce a risk-based induction model, aligned to multiple entry scenarios and levels of risk as follows:
1. Highest Risk – Emergency Agency/Unplanned Cover/Redeployment
2. High Risk – New Staff (external Recruitment)

3. Medium – Internal Promotion/Role Change
4. Medium/Low - Internal Transfer (same role/different location)
The revised framework will include:
• A phased induction model aligned to the above pathways
• Step-by-step procedures for managers
• Development of practical tools including induction checklists, shift support tools, induction review records and emergency induction templates
• Guidance and SOPs to support emergency / agency induction processes and local service preparedness
Additionally, the provider has established a Residential Compliance Action Tracker within our online audit system for each designated centre. The tracker supports recording, allocation, and monitoring of actions arising from HIQA inspections, PARs, H&S audits and quality improvement plans etc. Actions can be assigned to responsible persons and tracked as open, in progress or completed. The tracker also supports escalation where actions cannot be progressed at centre level, strengthening governance oversight and provider assurance. Accordingly, all actions from this monitoring report will be actioned through this system.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
The provider has reviewed the maintenance issues in the designated centre and has commenced actions to address these.
The registered provider is currently in the process of obtaining quotes from painting contractors to complete outstanding paintwork within the centre. In addition, quotes are being sourced for the replacement and updating of worn flooring identified in residents' bedrooms and communal areas.
Following completion of the quotation process, a schedule of works will be agreed and the required maintenance works will be carried out to ensure the premises remains well maintained, safe, and in line with the assessed needs and comfort of residents.
The Person in Charge and local management team will maintain oversight of these works to ensure they are completed within an appropriate timeframe and that the premises continues to provide a homely and comfortable environment for residents.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:

The Person in Charge will complete a review of all risk assessments and risk management documentation on the ViClarity system to ensure that risks are current, accurate, and reflective of residents' present support arrangements. Particular attention will be given to ensuring that individual risk assessments accurately reflect access to allied health supports currently available to residents, including the non-availability of in-house psychology supports. Risk assessments and associated control measures will be updated where required to ensure they are reflective of current circumstances within the centre. The PIC will create and monitor a Risk Assessment in relation to behaviour support and MDT input for the Designated Centre.
All service gaps related to MDT are recorded on a tracker to inform Business case for MDT support. The DOS escalates MDT service gaps by email and at HSE Operations meetings and SLA meetings.
All incidents are monitored and reviewed by the Person in charge, Services Department (PPIM, DOS and Compliance Lead) to ensure incidents are being managed effectively and escalated as required.
The local management team will also maintain ongoing oversight through regular audits and reviews of the Viclarity system to ensure risk management documentation remains up to date and effective.
Additionally, the service is trialing an enhanced Behaviour-Driven Incident Review process to support managers in identifying underlying clinical and systemic risks at an earlier stage. This was discussed at the Quality and Standards meeting on the 26.5.2026, feedback is positive. It will be formally adopted by the association as part of our incident management processes.
Incident recording practices will be reviewed with staff to ensure that documentation clearly identifies whether residents were impacted by incidents and outlines the actions taken in response. Staff will be reminded of the importance of maintaining clear and comprehensive records to support effective risk management and oversight. The incident module is being strengthened on ViClarity to ensure consistent and comprehensive approach to incident management.

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 complete a review of residents' personal plans and associated documentation to ensure all information is fully up to date and reflective of residents' current assessed needs and supports.

Any documentation identified as requiring amendment will be updated to accurately reflect recent changes in residents' care, healthcare supports, multidisciplinary input, and support arrangements. While residents were observed to be receiving appropriate care and staff demonstrated good knowledge of residents' needs, greater oversight will be implemented to ensure documentation remains current at all times.
Staff will be reminded of the importance of timely updating of residents' personal plans and associated records following any changes to supports, assessments, or multidisciplinary recommendations.
The Person in Charge will maintain ongoing oversight through regular audits and reviews of personal plans to ensure compliance with regulatory requirements and to ensure documentation accurately reflects the care and support being delivered to residents.
A broader organisational review of person-centred practices is currently underway through the development of the Person-Centred Practices Framework, which is presently at final editing stage with an estimated completion date of 26/06/2026.
The revised framework has been aligned to the HSE National Framework for Person-Centred Planning and includes a redesign of the assessment and support planning process within respite services to further strengthen compliance with Regulations 5, 6, 7, 8 and 9.
As part of this work, a new Respite Assessment of Need (AON) and Personalised Care and Support Planning (PCSP) system has been developed for residents attending respite services. The revised approach adopts an integrated Assessment of Need and Support Planning model, creating an individualised support profile for each identified support area. The new system requires completion of an online AON and PCSP document, intended to support improved version control of yearly assessments. Under the new system, only identified and active support needs arising from assessment will be transferred into the Respite Everyday Supports Folder. This represents a significant change from the previous approach and is intended to:
• Reduce the overall size and complexity of support folders;
• Increase visibility and accessibility of current support requirements for staff;
• Support timely review and updating of documentation;
• Ensure staff are presented with active and relevant support information only;
• Strengthen translation of assessed needs into day-to-day support practice.
To support implementation and consistency, a Respite Staff Guide has also been developed to assist staff in completing support profiles and to provide clear guidance regarding expected standards and indicators of good-quality support documentation.
This service improvement work is expected to strengthen documentation quality and support more timely review processes while maintaining the person-centred and rights-based approach already evident in practice.

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
The provider will continue to seek and facilitate access to appropriate positive behavioural support services for residents, including referral to external specialists where required. The provider has recognized the impact that limited access to psychology and behavioural support services may have on some residents and is actively reviewing supports available to ensure residents' needs are appropriately met. The Director of Services is attempting to source private Positive Behaviour Support Specialists and Psychology so that they can be contracted to bridge the behaviour support gap. Preliminary discussions have commenced with one Behaviour Support Specialist willing to provide a service on a private basis, to prioritise review of Behaviour Support Plans.

The Person in Charge will review residents' behaviour support plans to ensure guidance in place is current, appropriate, and reflective of residents' assessed needs. PBSPs will be reviewed with the clinical supports available in-house – CPI instructor, clinical nurse manager, PIC, keyworker. Where required, plans will be updated in consultation with relevant multidisciplinary professionals to ensure they are in line with best practice e.g. OT, MHID. Ongoing oversight will be maintained by the Person in Charge through regular review of incidents, residents' support plans, and staff practices to ensure that positive behavioral supports remain effective, appropriate, and least restrictive.
In addition, staff support and training needs will be reviewed to ensure staff have the necessary knowledge and skills to respond appropriately and consistently to behaviours in a manner that is person-centered and in line with positive behavioral support approaches. Staff will receive guidance and support in relation to managing behaviours of concern and reducing the impact of such behaviours on other residents living in the centre. Referrals will continue to be submitted to the external regional service provider providing behaviour support services.
A Business Case will be submitted to the HSE to fund two Senior Behaviour Support Specialists (one for North and South of the County). The MDT gaps are tracked on an internal tracker and gaps are regularly highlighted with the funding body at Operations and Service Level meetings.

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	31/12/2026
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Substantially Compliant	Yellow	30/09/2026
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and	Substantially Compliant	Yellow	31/08/2026

	ongoing review of risk, including a system for responding to emergencies.			
Regulation 05(8)	The person in charge shall ensure that the personal plan is amended in accordance with any changes recommended following a review carried out pursuant to paragraph (6).	Substantially Compliant	Yellow	30/06/2026
Regulation 07(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.	Not Compliant	Orange	31/12/2026