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:	Dun Siog
Name of provider:	Health Service Executive
Address of centre:	Sligo
Type of inspection:	Unannounced
Date of inspection:	03 March 2026
Centre ID:	OSV-0008038
Fieldwork ID:	MON-0049627

About the designated centre

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

Dun Siog is a bungalow located in a rural location. It provides care for up to 3 individuals and can support residents who have severe/profound intellectual disabilities. Each resident has their own bedroom. Dun Siog can support residents with all aspects of daily living and support residents to access community and day services. The service has a mandatory training schedule in place for all staff to ensure they are adequately equipped to meet the care and support needs of residents. Service specific training is arranged as required. Residents are supported to manage their medical appointments, social goals, and links with family and friends in accordance with their will and preference. Each resident has an identified key worker to support them. All residents have access to a local GP. Residents can attend the local health centre. There is transport available in the centre suitable to the needs of the residents.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	3

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 3 March 2026	11:40hrs to 15:55hrs	Alanna Ní Mhíocháin	Lead

What residents told us and what inspectors observed

This inspection was an unannounced focused inspection to review the arrangements the provider had in place to ensure compliance with the Care and Support of Residents in Designated Centres for Persons with Disabilities Regulations (2013) and the National Standards for Adult Safeguarding (2019). It followed a regulatory notice issued by the Chief Inspector of Social Services in June 2024 in which the safeguarding of residents was outlined as one of the most important responsibilities of a designated centre and fundamental to the provision of high quality care and support. Furthermore, that safeguarding is more than the prevention of abuse, but a holistic approach that promotes people's human rights and empowers them to exercise choice and control over their lives.

The service in this centre was of a good quality and was person-centred. The provider had implemented systems to maintain oversight of the quality and safety of the service. The health, social and personal needs of residents had been assessed. The staff in the centre were familiar to the residents and they had completed training in modules that were relevant to the safeguarding of residents. Some improvement was required to ensure that residents were given the necessary supports to make decisions about their financial affairs and to give consent in relation to all aspects of their care and support. Improvement was also required to ensure that the provider completed annual reviews and unannounced inspections of the centre in line with the regulations.

The centre consisted of a bungalow in a rural location. Each resident had their own bedroom. One bedroom had an en-suite bathroom. Other residents had access to a shower room and separate bathroom. The centre also had a kitchen-dining room, a separate sitting room, and utility room. The house was warm, clean, bright and welcoming. It was nicely decorated throughout and in a very good state of repair. The house was accessible to all residents with level access at the front and back doors. The hallway and doorways were wide and rooms were spacious. Outside, the grounds were well maintained.

The inspector had the opportunity to meet all three residents. The inspector spent time in the kitchen with residents as they prepared to leave the centre for the afternoon. Residents told the inspector about the plans they had for the afternoon and for the coming weekend. They appeared very comfortable in each other's company and in the company of staff. Residents chatted comfortably with staff about topics that were of interest to them. Staff and residents shared jokes and familiar stories. When residents made requests, staff were quick to respond. Staff provided reassurance to residents when they asked about upcoming events. Residents were offered choices about their meals and activities.

In addition to the person in charge, the inspector had the opportunity to speak with two staff members. The staff members were knowledgeable of the needs of

residents and the supports that the residents required to meet those needs. They were knowledgeable of the provider's safeguarding procedures and the steps that should be taken if a safeguarding incident occurred. The staff members gave specific examples of ways that they supported residents to reduce the risk of negative interactions and this was in line with the residents' behaviour support plans.

The next two sections of this report present the inspection findings regarding the governance and management in the centre, and how this impacts the quality and safety of the service provided.

Capacity and capability

The provider had systems for the oversight of the quality of the service. This included audits of systems used to safeguard residents. Any incidents that occurred in the centre were recorded and escalated appropriately. The provider's own policies and procedures in relation to the management of safeguarding incidents was followed. Improvement was required to ensure that the provider completed unannounced visits to the centre and an annual report into the quality and safety of care and support in line with the timelines outlined in the regulations.

Residents were supported by a familiar team of staff who had received training in modules that were relevant to the care and support of residents. This included modules in safeguarding, communication supports, human rights and open disclosure.

Regulation 15: Staffing

The staffing arrangements were in line with the needs of residents. This meant that the required number of staff with the correct skill-mix was on duty at all times.

The inspector reviewed the staff rosters from 1 June 2025 to the day of inspection. This showed that the centre was staffed with the appropriate number of staff at all times. The staff team was consistent. Planned and unplanned leave was covered from within the staff team. There were no vacancies in the centre on the day of inspection. This meant that the staff were familiar to the residents.

Judgment: Compliant

Regulation 16: Training and staff development

Staff had training in modules that were suited to the needs of residents. This included modules that provided knowledge and skills to staff in relation to safeguarding residents.

The inspector reviewed the training records in the centre and found that staff had largely up-to-date training. Where refresher training was required, this had been identified by the person in charge. Staff received training in safeguarding vulnerable adults. Staff had also received training in other modules that were relevant to the protection of residents; for example, training in human rights-based care, open disclosure, and training relating to assisted decision making.

Judgment: Compliant

Regulation 23: Governance and management

The provider had clear management structures and lines of accountability. There were systems in place to provide oversight in relation to the quality of the service. Some improvement was required to ensure that the annual report and provider-led unannounced visits happened in line with the timelines set out in the regulations.

The lines of accountability were clearly defined in this centre. Staff were aware who to contact should any issues or safeguarding incidents arise. There was an on-call rota of managers to provide support to staff outside of regular business hours.

The provider had a suite of audits that were completed regularly in the centre. The inspector reviewed the records of these audits for 2025 and found that audits were completed in line with this schedule. The audits covered areas relating to the safeguarding of residents; for example, staff knowledge of safeguarding, restrictive practices, incident reviews and audits of the residents' finances. The provider had recently amended the procedures and the audit tool used in relation to residents' finances to strengthen oversight in this area.

The provider had completed an annual report into the quality and safety of care and support in this centre. This was reviewed by the inspector and it was found that safeguarding of residents was included in this report. The rights of residents was also included in this report. There was evidence that residents had been supported to understand their rights. The report was completed in December 2024. This meant that a report had not been completed within the previous 12 months as outlined in the regulations.

The provider completed unannounced visits to the centre. Again, the most recent visit to the centre had occurred in June 2025, which was outside of the timeframes set-out in the regulations. However, the report following the last visit to the centre

was comprehensive and the safeguarding of residents was reviewed as part of this visit. The report identified specific actions to improve the quality of the service and set-out target timelines for the completion of these actions.

Judgment: Substantially compliant

Quality and safety

The service in this centre was person-centred and of a good quality. Residents received the necessary supports to meet their health, social and personal care needs. This included specific supports for resident to understand information that was presented to them and to express their needs, preferences and wishes.

Risks to residents were identified and measures put in place to reduce those risks. This included specific measures to safeguard residents and reduce negative interactions between residents.

Improvement was required to ensure that the rights of residents were promoted in this centre. Improvement was required to ensure that residents were fully supported to make decisions about their finances. Residents had not been consulted in relation to night time checks that impacted on their privacy and minutes of residents' meetings needed improvement to ensure that residents were offered choices.

Regulation 10: Communication

The provider had systems in place to support residents with their communication. This meant that residents were supported to understand information and to express their needs and wishes.

The inspector reviewed the guidance documentation for two residents in relation to their communication. This showed that communication profiles and care plans had been developed for both residents. The documents were regularly updated. Guidance had been sought from a speech and language therapist in developing these documents. Staff were observed implementing some of the strategies outlined in the guidance documents. For example, staff were observed using Lámh signs with one resident in line with the information outlined in the resident's communication profile. Staff were familiar with residents' communication styles and strategies. They knew the residents' preferred topics of conversation. Staff were observed chatting comfortably with residents.

Judgment: Compliant

Regulation 26: Risk management procedures

There were systems for the identification, assessment and management of risk in this centre. This meant that the provider had identified any safeguarding risks to residents and had specified ways to reduce that risk. It also meant that staff were given clear information to implement strategies to protect residents from abuse. Clear risk assessment gave a point of reference to the provider against which they could audit the service to ensure that all safeguarding strategies were implemented.

The inspector reviewed the risk assessments that had been developed for two residents. The risk assessments were comprehensive and mirrored the findings from the residents' assessments of need. They had been developed within the previous 12 months and were regularly updated. They gave clear information to staff on how to reduce risks to residents and signposted staff to relevant documents; for example, behaviour support plans.

The inspector also reviewed the risk register that had been developed for the centre. This outlined risks to the service as a whole. Risks relating to safeguarding residents were outlined in this register; for example, the management of money, and the use of the internet. Again, risk assessments signposted staff to relevant documents and policies to guide practice.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The provider completed an assessment of the residents' health, personal and social care needs.

The inspector reviewed the records of two residents and found that a comprehensive assessment of the residents' health, social and personal care needs had been completed within the previous 12 months. An annual review of the residents' personal plan had been completed within the previous 12 months. This review included the residents' views. The previous year's goals were reviewed and new targets set for the year ahead.

Judgment: Compliant

Regulation 7: Positive behavioural support

The provider ensured that the residents received necessary supports in relation to their behaviour.

The inspector reviewed the behaviour support plans that had been developed for two residents. These plans had been developed and were recently reviewed by a clinical nurse specialist in behaviour. The plans clearly outlined the steps that should be taken to support residents to manage their behaviour. There was also information contained within the plans on how to support residents at certain times to reduce the risk of negative interactions between residents to avoid any safeguarding incidents.

The person in charge completed quarterly audits of the restrictive practices in the centre.

Judgment: Compliant

Regulation 8: Protection

The provider had systems in place to protect residents from the risk of abuse.

There were no open safeguarding plans in the centre on the day of inspection. The inspector reviewed a closed safeguarding plan from October 2025. This showed that the provider had managed the safeguarding incident in line with their policies and procedures. The incident was reported appropriately and the provider was responsive when engaging with external agencies. Supports from relevant members of the multidisciplinary team had been sought and a plan had been implemented in the centre to avoid a recurrence of the incident. The inspector observed staff implementing this plan on the day of inspection to avoid any negative interactions between residents.

Staff in the centre had up-to-date training in safeguarding and, when speaking with the inspector, demonstrated good knowledge of the steps that should be taken if a safeguarding incident occurred.

The inspector reviewed the intimate care plans that had been developed for two residents. These had been developed in recent months and gave specific guidance to staff on how to support residents.

Judgment: Compliant

Regulation 9: Residents' rights

Improvement was required to ensure that the rights of residents were fully promoted in this service.

Improvement was required to ensure that residents were provided with all of the necessary information to make informed choices about their finances. The inspector reviewed the records maintained by the provider in relation to the day-to-day spending of one resident. This showed that all monies received and spent were recorded and receipts available for audit. However, residents in this centre were not provided with statements relating to their savings. Therefore, the residents did not have all of the information needed to make decisions about their personal finances. In addition, there were discrepancies between the fees that residents paid in standing charges to the provider and those outlined in their contracts of care. The inspector reviewed the contracts of care for three residents and an email from the provider's finance department. This showed that residents' identified fees in their contracts did not match the amount paid. For one resident, there was no information in the contract that outlined the fees that they would be charged. This issue had been identified by the provider and was in the process of investigation but had not been addressed on the day of inspection.

The person in charge reported that night time checks were happening in this centre. This meant that staff checked on residents at night at set time periods. This practice was also recorded in a resident's risk assessment. However, residents had not been consulted in relation to this practice and had not given their consent. The impact of this practice on the residents' right to privacy had not been assessed by the provider.

The inspector reviewed the minutes of the two most recent residents' meeting that had taken place in the centre. These minutes showed a record of activities undertaken by residents and a record of recent appointments. It did not outline how residents were offered choices in relation to food choices or preferred activities.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Substantially compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Dun Siog OSV-0008038

Inspection ID: MON-0049627

Date of inspection: 03/03/2026

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 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • The annual report for Quality & Safety of Care was completed, the report timeline captured information for the designated center from December 2024 to December 2025. • The six-monthly unannounced visit report was completed and captured information from June 2025 to December 2025. • There is now a schedule in place which is monitored monthly by the provider to ensure all reports are completed within the specified timeframe. Completed 5th March 2026	
Regulation 9: Residents' rights	Not Compliant
Outline how you are going to come into compliance with Regulation 9: Residents' rights: • Each resident now has access to their statements pertaining to their savings accounts. • The financial assessments have been updated by the provider's financial department and each resident's contract of care now reflects the fees paid to the service as outlined in their financial assessment. This has been discussed with each individual resident. • The Service Resident Financial Audit is completed monthly and any actions arising from these audits are transferred to the monthly QIP and closed out within an agreed specified timeframe. Actions that cannot be closed out within agreed timeframes will be escalated to Senior Management for further action. • The person in charge has updated the residents' meeting template to ensure residents preferred communication style is documented and used throughout the meetings. • The person in charge has ensured that the residents' meetings records are clear about the topics discussed with the residents at each meeting. • Easy read tools are used to capture choice and preferred activities. Easy read tools such as the menu choice book, events information are a sample of the resources used within the centre to support residents' understanding and right to choose. • The person in charge has completed a gaining consent form with each resident using easy read information to ensure each resident understands and has consented to the current nighttime checks that are in place.	

• In line with the Policy and Procedure on the use of Restrictive Practice an individual risk assessment has been completed, and each resident requiring a check now has a comfort check protocol. This has been updated in the applicable assessment of need.
• A Service Self-Audit on Restrictive Practice is completed on a quarterly basis. Any actions arising from these audits will be included on the centers QIP and monitored monthly. Completed on 13/04/2026

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 23(1)(d)	The registered provider shall ensure that there is an annual review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards.	Substantially Compliant	Yellow	05/03/2026
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of care and support provided in the centre and	Substantially Compliant	Yellow	05/03/2026

	put a plan in place to address any concerns regarding the standard of care and support.			
Regulation 09(2)(a)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability participates in and consents, with supports where necessary, to decisions about his or her care and support.	Not Compliant	Orange	13/04/2026