



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

Issued by the Chief Inspector

Name of designated centre:	The Spires
Name of provider:	Talbot Care Unlimited Company
Address of centre:	Kildare
Type of inspection:	Announced
Date of inspection:	29 January 2026
Centre ID:	OSV-0008515
Fieldwork ID:	MON-0040205

About the designated centre

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

The Spires provides a residential service for up to six adults with intellectual disabilities, autism and/or acquired brain injuries who may also have mental health difficulties and behaviours of concern. This designated centre is located in a rural setting outside of a town in County Kildare with local amenities in the area such as shops, pubs, restaurants, and sports and recreation services. The premises consists of a single building containing four apartments, two of which are single-occupancy and two which can accommodate two people. Each apartment features separate living areas and residents are provided with private bedrooms, accessible bathroom facilities, and access to suitable vehicles. There is an open plan office in the main lobby.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	6
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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
Thursday 29 January 2026	09:30hrs to 18:30hrs	Brendan Kelly	Lead

What residents told us and what inspectors observed

This was an announced inspection completed in 'The Spires' to help inform a decision on the provider's application to renew the registration of the designated centre. The inspection also monitored the providers ongoing compliance with The Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) With Disabilities) Regulations 2013.

Overall the inspection found that the provider met the requirements of the regulations which informed the decision on the application to renew the registration of the centre. The inspector also found for the most part high levels of compliance with the regulations reviewed. However, issues were identified in regard to the welfare and protection of residents and with residents' rights. These issues will be discussed further in the report.

The Spires is a large premises located in a rural setting in Co. Kildare. The premises consisted of four single apartments, two of the apartments are single occupancy apartments and two are occupied by two residents. The centre is currently registered for six residents and on the day of inspection there were no vacancies in the centre.

The inspector had the opportunity to meet with and speak to all six of the residents living in the premises. Throughout the day of the inspection the inspector also met with the assistant director of services, person in charge, house manager and three of the staff front line staff team.

On arrival at the centre the inspector was met by the person in charge. The inspector conducted a walk around of the premises with the person in charge. The centre had a large reception area where staff were able to complete paper work and use the provider's online systems. The inspector then visited each of the four apartments.

Three of the four apartments were located on the ground floor. The first apartment observed by the inspector was home to two residents. The inspector observed that the apartment was spacious, homely and well decorated. The residents each had their own bedroom. One resident met the inspector in their bedroom where they were using their electronic tablet. The resident appeared happy and comfortable in their room and with the presence of staff.

The second resident met with the inspector in a large sitting room. The resident was having some breakfast while watching television. Again the resident appeared happy and comfortable in the presence of the staff team. The inspector observed the use of visuals throughout the apartment to support both residents who required communication supports. The inspector observed the use of visuals represented

choices for the residents to make around their day, a visual roster and visual goals for both residents for the month.

In the second apartment the inspector again observed ample space for the two residents who lived here. The apartment had a bedroom for each resident one of which was en-suite. The inspector observed a second bathroom and a large kitchen and sitting area. The provider had submitted a notification outlining a safeguarding concern with the residents in this apartment. The inspector observed that both had sufficient space for themselves and both residents appeared happy and comfortable in their home.

The inspector met one resident in their bedroom. The room was decorated to the residents liking. The resident who is visually impaired appeared happy to engage with the person in charge and also the staff member who was supporting the resident. The inspector met the second resident in this apartment briefly as they were heading out in the centre vehicle with staff on an activity. The inspector viewed the second resident's bedroom which again was decorated to the residents individual preferences.

The third apartment was occupied by one resident. The resident lived on their own due behavioural challenges including self-injurious behaviour. Due to incidents that had occurred with the resident the provider had removed the kitchen in this apartment. In its place the provider had made a person-centered dining area that the resident had helped decorate. The resident had their own bedroom which was decorated to their wishes.

The inspector briefly met with the resident who appeared at ease the staff supporting them. The resident indicated after a short time that they wished the inspector and person in charge to leave the apartment to allow them to engage in their chosen activity.

The inspector was shown around around the fourth apartment by the resident who's home it was. The resident lives alone and after showing the inspector around their home they sat with the inspector to talk about their experience in the centre.

The resident indicated that they are very happy in their home. They talked about liking the space they have. The resident indicated that they get on well with staff who work with them and that the staff can 'have a laugh with me'. The resident talked positively about the activities they engage in with staff. They spoke about going fishing, going for walks and going for drives in the car.

The resident spoke about how they had helped to decorate their home, they had painted the apartment and photographs of family and friends were observed by the inspector throughout their home.

Prior to the inspection, residents were given the opportunity to complete questionnaires regarding their experiences in the centre and relations with staff and peers. Questionnaires were completed in regard to all six residents in the centre. Staff supports were required for each resident in order that they could complete fully their questionnaires. The residents all described their satisfaction in the centre,

positive relations were identified with the staff team and with peers. One resident raised the issue of noise they can hear in their bedroom from the apartment below but stated that it was not too much of a concern.

For the duration of the inspection the inspector observed positive interactions between staff and residents. The staff who met with and spoke to the inspector were knowledgeable of key plans and strategies for each resident they supported.

The next two sections of this report will outline in greater detail the providers capability and capacity to effectively manage the service provided and how this impacts on the quality and safety of lived experiences of the residents.

Capacity and capability

The provider had a clear governance structure in place. The front line staff team were supported by team leaders who were in turn supported by a house manager. The house manager worked alongside and reported to the person in charge who reported to the assistant director of services. Each role within the centre had clear responsibilities identified.

The person in charge had responsibility for another centre operated by the provider. In reviewing the governance arrangements in place the inspector was assured the person in charge had both the capacity and capability to effectively manage both locations.

The provider had ensured the centre was fully staffed with no vacancies on the day of inspection. Staff working in the centre had been in receipt of comprehensive mandatory and location specific training.

The provider had a schedule in place for provider led unannounced audits and an annual review. These documents were aimed at service improvement and actioned accordingly. Locally, the management team had a meeting schedule in place that allowed for sharing of key information also aimed at service improvement.

Registration Regulation 5: Application for registration or renewal of registration

Prior to the inspection the inspector had reviewed the information submitted by the provider to the Chief Inspector of Social Services regarding the application for the renewal of the centre registration.

The provider had submitted the appropriate renewal application form alongside key documents for the centre. The statement of purpose, floor plans for the centre and insurance details were also submitted.

The provider had also submitted all relevant information regarding the management team who would be associated with the location. The inspector was assured that the provider had met the regulatory requirements for the information reviewed.

Judgment: Compliant

Registration Regulation 9: Annual fee to be paid by the registered provider of a designated centre for persons with disabilities

Prior to the inspection the inspector observed evidence that the provider had paid the appropriate fee to accompany their application.

Judgment: Compliant

Regulation 15: Staffing

The centre had no vacancies in their staff team on the day of inspection. The provider did not use agency staff in the location. The provider's contingency plan in regard to planned and unplanned leave consisted of regular relief staff and members of the permanent team working additional shifts.

The provider had both planned and actual rosters on site. As part of their oversight responsibility, the person in charge to maintained the rosters.

On the day of inspection the inspector reviewed the provider planned and actual rosters for January 2026. The inspector also met with and spoke to one of the house team leads and two direct support workers.

On review of the rosters, the inspector observed that all staff names and grades were listed. The location of the person in charge was noted on each day of the roster.

The inspector was assured regarding the level of governance in the location. Outlined on the roster was that the person in charge was in the centre two days a week, the house manager was present in the centre five days a week. At weekends a team lead was also present in the centre each day.

The inspector also observed evidence that during out of office hours the provider had a night manager roster for the month of January 2026 in place. The contact details of each night manager accompanied the roster.

In conversation with the staff team members the inspector observed a positive dynamic within the team. One staff member talked about a team where 'everybody is ready to help each other'. The staff who met with the inspector showed a strong understanding of key areas such as risk management, safeguarding and behavior support plans.

Judgment: Compliant

Regulation 16: Training and staff development

The provider had developed a suite of mandatory training for the staff team that had been outlined in their statement of purpose. By way of maintaining a record of both induction and refresher training the provider also had an online training log. The maintenance of the training log fell under the responsibility of the person in charge as part of their oversight role.

In terms of staff development, the person in charge, house manager and team leads facilitated supervision sessions for the staff. The person in charge developed a schedule of supervision sessions in line with the providers policy.

On the day of inspection the inspector reviewed the training log, supervision schedule, two supervision records and spoke with staff regarding the supervision process.

The training log showed that the staff team had completed training in areas such as the following:

- medication
- First Aid
- trust in care
- safeguarding
- fire
- epilepsy
- behavior support

The inspector observed that five staff required fresher training in behavior support and was shown evidence that all five staff had their refresher training booked for dates in February 2026.

The inspector reviewed supervision records from two of the front line staff team. The record showed that the staff received supervision in line with the provider's policy. Agenda items for the sessions included goals, training and competencies.

The inspector also observed that the provider had been developing staff to take on leadership roles within the organisation. In conversation with a team leader they outlined that they had progressed from a support worker to the role of team leader.

The centre's house manager also spoke positively regarding upcoming managerial opportunities.

Judgment: Compliant

Regulation 23: Governance and management

The provider had ensured a robust management team was in place. The provider had systems to ensure unannounced provider led reviews were occurring in line with regulatory requirements. The provider also completed an annual review each year.

The provider held governance meetings for persons in charge across the providers remit. These meetings were held monthly. In addition the provider also held person in charge cluster meetings monthly. These meetings were smaller in size between persons in charge and their assistant director of services.

Locally, the person in charge held monthly team meetings for all members of the front line team to attend. The person in charge also maintained a schedule of local audits.

On the day of inspection the inspector reviewed the records of the previous two provider led unannounced visits, annual review and local audits. The inspector also reviewed a sample of each of the governance and local meetings relating to the premises.

The inspector reviewed unannounced provider led audits from March and November 2025. Both audits are structured to identify actions using the 2013 Care and Support regulations. Audits identified actions for service improvement and identified time lines for actions to be completed.

The March 2025 audit identified actions such as staff signing updated policies, greater detail to be included in local audits, training needs and maintenance works to be completed. The inspector observed evidence that actions arising from this audit had been completed in line with time frames such as policy updates and maintenance works.

The providers audit from November 2025 captured actions regarding staff training, risk assessments and health care needs of residents. The inspector observed evidence of ongoing work to meet the agreed time lines in this audit. For example the inspector observed evidence of work completed to risk assessments identified in the audit.

The inspector reviewed the provider's annual review of 2025. The review was completed in January 2026. The review gave a comprehensive overview of service provision in 2025, however, the inspector noted that only two actions arose from the

review. The actions identified were in relation to handovers and exploring day service opportunities for a resident.

The inspector reviewed a sample of the local audits completed by the person in charge. Audits completed included infection prevention and control, complaints, positive behavior support, staffing training and directory of residents. The audits identified actions to be completed and time lines for each action.

The inspector reviewed minutes of person in charge meetings that were attended by persons in charge service wide and members of the providers senior management team. The inspector reviewed minutes from December 2025 and January 2026. Agenda items included incident reviews, shared learning from various HIQA inspections, needs assessments, staff training, policies, procedures and successes from various locations.

The cluster meetings which were held by the assistant director of services and the persons in charge in their remit were also reviewed by the inspector. The agenda items for these meetings included training, incidents, rosters, audits and governance.

The inspector also reviewed team meeting minutes for the local team meetings held by the person in charge. Agenda items for these meetings included resident presentation, goals, incident reviews, safeguarding, infection prevention and control, health and safety, fire, maintenance and complaints. The meetings were comprehensive and also outlined actions for the front line to complete in time for the next team meeting. The inspector observed that local team meeting minutes were reviewed and signed by all team members including those team members who could not attend the meeting.

The inspector observed an issue identified in the January 2026 team meeting that was of concern to the inspector. This involved a resident paying a significant amount of their own money each week to an external person. This is discussed in greater detail in the section of the report concerning regulation 8: Protection.

Judgment: Compliant

Quality and safety

The provider had systems in place in the main that allowed for residents to experience a safe and quality service. On the day of inspection the inspector was not assured the provider had adequate systems in place that allowed residents to make decisions on all aspects of their lives. The inspector was not assured that the provider had committed to exploring all available alternatives to current plans that

residents may have been able to access. These concerns are discussed in regulations 8: Protection and 9: Residents rights.

The provider had effective systems in place that allowed for appropriate identification, scoring and review of risk. This allowed residents to be active members in their communities.

The provider had comprehensive plans in place regarding health and care plans. These plans gave comprehensive guidance to staff in meeting resident assessed needs.

The residents had access to appropriate health and social care professionals who reviewed and supported in updating the various plans in place.

Regulation 26: Risk management procedures

The provider had ensured that the location had a risk register that identified local and individual risk. Maintaining the risk register was the responsibility of the person in charge. The inspector observed through local and governance meetings that risk was a standing item on the meeting agendas.

The inspector reviewed the locations risk register on the day of inspection. The inspector also met with and spoke to team members regarding risk in the location.

The inspector observed that each resident had individual risk assessments in place to meet their own needs. For example a resident who had a diagnosis of epilepsy had a corresponding risk assessment. The risk assessment identified control measures such as what can trigger a seizure and the rescue medications in place should they be required.

Risk assessments were also in place for a resident related to property damage, consuming inedible objects, manual handling, personal emergency evacuation procedure, aggression and transport. Risk assessments were observed by the inspector to be reviewed on a regular basis with all risk assessments for this resident reviewed between October 2025 and January 2026.

The inspector reviewed the risk assessments in place for another resident. The inspector observed that the risk assessments in place were individual and specific to this resident's individual needs. For example this resident had experienced difficulty in the provider's transport, with the inspector observing incident reports to this effect. The provider had ensured that there was a corresponding risk assessment in place. The risk assessment guided staff through detailed control measures and also signposted staff to other key documents such as the residents behavior support plan.

Risk assessments were also in place for this resident in regard to declining medical appointments, choking, missing persons, use of knives/sharps and aggression in the community.

The inspector also met with and spoke to team members regarding risk. The staff members spoke confidently and competently regarding key individual risks. Staff also spoke about how the guidance contained in the control measures gave them confidence in managing incidents associated with the risk assessments.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The provider utilised an online system to develop individualised assessments and associated care plans. The care plans were developed in conjunction with various members of the providers multi-disciplinary team (MDT). The plans were implemented by the front line team and reviewed on a regular basis by the person in charge. Reviews of plans were facilitated by the person in charge and the associated MDT member with plans updated and changed as required.

On the day of inspection the inspector reviewed the care plans in place for two residents and spoke with front line staff regarding the plans for the residents they were supporting.

For both individuals the provider had in place an overarching individual resident guide. This guide gave a detailed background of the residents. Following this there were more specific individual plans in place.

One resident had plans in place for identified needs such as communication, weight management, intimate care, epilepsy and food allergies. The inspector observed that the plans offered clear guidance to staff. For example this resident's communication plan outlined the things the resident likes and dislikes, things that affect the resident's day and how the resident prefers to communicate.

A second resident had plans in place that outlined the importance of sensory input. The resident had a sensory profile that guided staff on how to meet their sensory needs. The inspector also reviewed this resident's intimate care plan. The plan guided staff on resident preferences in shaving, oral care, toileting, skin care, showering and dressing. On review of a second intimate care plan the inspector observed that the guidance and preferences of both plans was individual to the resident choices.

All plans observed by the inspector had been reviewed by the person in charge between October 2025 and January 2026.

Staff who met with the inspector on the day of inspection spoke about the plans in place for the residents they were supporting. The inspector was assured that the

staff team had a strong knowledge of the plans and were comfortable in supporting the residents in all aspects of their care.

Judgment: Compliant

Regulation 6: Health care

The provider ensured that all residents had access to appropriate health and social care professionals. The inspector observed evidence of residents accessing these services both through the providers own multi-disciplinary team and also in the community.

The provider had ensured that each resident had an annual health assessment in place that identified diagnosed conditions for residents. The residents each had access to their own doctor. The residents' doctors completed and signed the residents annual health checks.

Each of the diagnosed conditions highlighted for residents had a corresponding care plan to guide staff in how to appropriately support residents in managing each condition.

On the day of inspection the inspector reviewed the health care plans of two residents. The inspector observed plans in place for areas such as epilepsy, health and well-being, weight management, oral care, eating drinking and swallowing and the refusal of health care.

The inspector observed clear guidance for staff in each of the plans. For example one resident who had a plan in place regarding eating, drinking and swallowing. The plan was completed by the provider's speech and language therapist. The plan guided staff in areas such as the ideal location for the resident to eat, what supervision requirements are needed from staff, the preferred seating position of the resident and what supports the resident requires at mealtimes. The inspector also observed an additional dietitian report for the resident.

Judgment: Compliant

Regulation 7: Positive behavioural support

The provider had systems in place regarding behavior support, restrictive practice implementation and review and incident recording and review.

Where required the provider ensured that each resident had access to behavior support specialists with behaviour support plans in place as needed. Restrictive practices were in use in the centre and the provider had a restrictive practice log

and reviews for each of the practices in use. The provider also had an online incident management system that recorded each incident and outlined a corresponding review following each incident.

On the day of inspection the inspector reviewed two of the residents' behavior support plans, the restrictive practice log and associated reviews, and the incident management system used by the provider.

The behavior support plans reviewed by the inspector were completed by the provider's behavior support specialist. The plans contained detailed background information regarding the residents and the sources of information used to inform the plan. The plans contained detailed information on behaviors of concern, triggers, proactive and reactive strategies and skills teaching. The inspector observed that each plan was individual to the residents' needs.

The behavior support plans gave clear guidance to staff in how to manage incidents with residents using a traffic light system to show behavior escalations. A graph indicated the number and type of incident that allowed for incident trending. This was used by the provider to judge the success of each strategy used. The data gathered by the front line team in respect of resident behavior was used for an annual review of the residents' plans.

The provider used what they termed a candid needs assessment in regard to each resident. From this needs assessment restrictive practices that may be required for residents were identified. The practices were added to a restrictive practice log. A monthly meeting occurred between the person in charge and the house manager where each restriction in use was reviewed. Any practices that required escalation were then discussed at provider level.

The inspector observed evidence of the person in charge reducing restrictions if possible. For example residents in one apartment are now cooking in their home. One of the restrictions in place is that residents use plastic cutlery. The inspector observed evidence that the person in charge trailed non-plastic cutlery with a resident. This was unsuccessful but the person in charge will re-visit this again and with other residents. The inspector also observed evidence of one of the apartments that did not require a lock on the front door with the resident in a position to come and go as they wish.

The inspector reviewed the restrictive practice log against the restrictions notified to the Chief Inspector via quarterly submitted notifications. The inspector was assured that all restrictions in use had been notified.

The inspector reviewed the online system in use for incident reviews for the month of January 2026. A serious incident had occurred in 2025, this incident was subject to a serious incident review with learning and subsequent actions identified. A weekly report of incidents is sent from the person in charge that outlined incident types and numbers. Incident trending takes place from these reports. The incident reviews observed by the inspector detailed the incident type, risk rating and post incident learning. The inspector also observed staff de-brief meetings post incident.

The inspector also observed evidence that the incident numbers and types fed into the behavior support plans as evidenced by the visual graphs of incidents in resident behavior support plans.

Judgment: Compliant

Regulation 8: Protection

In reviewing team meeting minutes from January 2026 the inspector identified that a resident in the centre was paying a significant amount of money each week (this amounted to greater than 50% of the resident's income) for an external person to meet with the resident for what the provider stated was personal therapy. The concern identified in these minutes was that a request had been received for a financial increase to the cost of sessions in January 2026. The inspector asked for the rationale behind the increase and what additional services the resident would receive as a result. No formal plans in relation to these sessions had been in place prior to a meeting in January 2026 which the resident had not attended nor participated in.

The inspector was not assured as to the arrangements the provider had in place to ensure that the resident was safeguarded financially and in their engagement with this process. It was not clear what type of therapy was being provided and whether the individual providing this was qualified or trained. There was no evidence that the provider had considered safeguarding processes in respect of the external person.

The provider had failed to ensure that the resident's money was fully safeguarded and that measures were in place to review the appropriateness of their spending. The resident had not been provided with independent advocacy services to review the consent given by them to the spending of and use of their monies.

The inspector sought a number of assurances from the provider on the day of inspection to demonstrate the safeguarding measures in place. These included qualifications of the person and the personal therapy they provided. The inspector also sought details of the Garda vetting status of the person in particular as the twice weekly sessions were conducted in the centre premises. The inspector found that in the past the resident had also left the centre with the person for sessions outside of the premises. The provider stated they had not conducted any such checks.

Judgment: Not compliant

Regulation 9: Residents' rights

The provider had in the main assured that resident rights were considered in the day to day activities of the centre. The provider had regular resident meetings that discussed areas such as meal planning, safeguarding, health and safety and activities. Staff who met with the inspector spoke positively about how they ensure residents are involved in day to day choices and how staff support residents with their choices.

However, the inspector was not assured that the rights of one resident were being considered in regard to attending an annual medical appointment. The resident attends an annual medical appointment for a diagnosed medical condition. The resident also has significant restrictions applied when they are in the service vehicle. The inspector reviewed records of behavioral incidents in the vehicle which if restrictions were not in place could potentially cause serious injuries. Despite this the resident was required to complete an at least six hour round trip to attend the annual appointment.

The inspector observed evidence that the provider had met with the resident's representatives regarding this matter. However the resident's representatives wished for the journey to this location to remain due to a longer term plan that the resident may move to a new location. The provider on conclusion of this meeting made the decision on the resident's behalf and did not demonstrate that they had explored the resident's perspective. Neither did they demonstrate that other options were considered, such as, an alternative clinic that would significantly reduce the time the resident spends in the service vehicle until a decision is made regarding the residents placement.

In the provider's six monthly audit carried out in November 2025 the issue of the resident travelling such distances despite knowing of the plans needed for the service vehicle was not identified.

Judgment: Substantially 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	
Registration Regulation 5: Application for registration or renewal of registration	Compliant
Registration Regulation 9: Annual fee to be paid by the registered provider of a designated centre for persons with disabilities	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Compliant
Quality and safety	
Regulation 26: Risk management procedures	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for The Spires OSV-0008515

Inspection ID: MON-0040205

Date of inspection: 29/01/2026

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 8: Protection	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 8: Protection: Regulation 8: Protection A review of protection measures within the centre has been completed.</p> <p>The Person in Charge and Assistant Director of Services have completed a full review of the arrangements in place, relating to Professional who is providing onsite tuition for a resident within the centre. This external contractor is employed directly by the resident and is Registered with the Irish Teachers council. The following documents are now held within talbot Group. Documentation relating to the teacher providing the support has since been obtained and placed on file within the service (which is available for review).</p> <ul style="list-style-type: none"> • Teacher's Registered Council number (Verified on the Teaching Council Ireland Portal) • Evidence of Garda Vetting • Confirmation of relevant qualifications and training associated with the support being delivered (LAMH). <p>The resident and their representative have clearly indicated they wish to continue with this arrangement. A review of the safeguards in place has been completed to ensure these are in line with the Talbot Groups policies and procedures. Additional control measures are being taken to further enhance the arrangements in place.</p> <ul style="list-style-type: none"> • PIC has engaged with an independent advocate to ensure the residents "Will and Preference" is being protected. • An independent Financial Audit is being conducted within the Spires to ensure all appropriate controls are in place for all residents. <p>An additional meeting has been arranged with resident's representative, who is currently going currently going through the DMR process.</p> <p>Following the completion of these actions, the arrangements will be subject to ongoing formal review to ensure they continue to reflect the resident's will and preferences and</p>	

to ensure that the supports and arrangements in place remain appropriate, proportionate, and in line with organisational governance, policies, and procedures. This process will ensure that the resident's rights, wellbeing, and best interests continue to be promoted while maintaining appropriate oversight and accountability within the service.

Regulation 9: Residents' rights

Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
Regulation 9: Resident Rights

A review of the annual review of this resident's health needs is underway. This resident has a long-standing arrangement in place with their current healthcare provider, which has been recognised as clinically important. The resident has attended some appointments in Person, when it's been assessed as safe to do so. On other occasions, these appointments have been completed by staff in the resident's absence. This is likely to be the case for any service arrangement as reasonable accommodation is made by the healthcare provider, in recognition of the residents support needs.

The following additional control measures are being explored to enhance this arrangement.

1. This arrangement will be discussed with the residents GP to seek their opinion on the appropriateness of exploring an alternative Healthcare provider.
2. Should the GP recommend this, referrals will be sought.
3. If the GP is satisfied with the current arrangement, the Talbot Group will engage with the resident's current healthcare provider, to seek "Video Consultations" when the resident is not able to travel.

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 08(1)	The registered provider shall ensure that each resident is assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection.	Not Compliant	Orange	30/04/2026
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	30/04/2026
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	Substantially Compliant	Yellow	30/03/2026

	or her care and support.			
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