



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

Issued by the Chief Inspector

Name of designated centre:	Ait Aoibhinn Service
Name of provider:	Health Service Executive
Address of centre:	Mayo
Type of inspection:	Announced
Date of inspection:	14 July 2026
Centre ID:	OSV-0008660
Fieldwork ID:	MON-0042319

About the designated centre

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

Ait Aoibhinn comprises one spacious bungalow which is located in a rural location. The service provides full-time residential support to four adults with a moderate to severe intellectual disability. Staff support is provided by a team of nurses, healthcare assistants and health and social care workers. A waking night-time support arrangement is provided.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	4
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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 14 July 2026	10:50hrs to 18:25hrs	Alanna Ní Mhíocháin	Lead

What residents told us and what inspectors observed

Residents in this centre were supported to meet their health, social and personal care needs. The staff who met with the inspector were knowledgeable on the needs of the residents and the supports that should be offered to residents. The provider had introduced a new layout in the centre that promoted the safety of residents and behaviour support plans gave guidance to staff on how to support residents to avoid negative interactions. Significant improvement was required in relation to the governance and oversight of the service. The systems to monitor the quality of the service required improvement to ensure that all areas of service improvement and risks were fully identified and addressed. The resourcing of the centre required improvement to ensure that residents were supported by the correct number of consistent staff at all times. The rights of residents were impacted by the resourcing of the centre and the provider's policies. Improvement was required to the documentation in relation to fire safety and safeguarding plans.

This was an announced inspection of this centre. The inspection formed part of the routine monitoring activities completed by the Chief Inspector of Social Services during the registration cycle of a designated centre. The inspection was facilitated by the person in charge.

The centre consisted of a two-storey house in a very rural location. The house was situated outside of a small rural village. It was about a 15-minute drive to the nearest large town. Since the last inspection of this centre, the provider had relocated one resident's bedroom from the ground floor to upstairs in the house. This left a room available downstairs for a second sitting room. The provider had completed the appropriate application to vary their regulation conditions in relation to this change. The upstairs bedroom was spacious. It was laid out to accommodate the resident's bed and a seating area with a couch and television. The upstairs bedroom also had an ensuite bathroom and access to a storage room for the resident's clothing and belongings. Downstairs, there were three bedrooms. Each was spacious and suited the needs of the residents. There was storage available for the residents' belongings. There were two bathrooms downstairs with level access showers. There were also two sitting rooms, a kitchen-dining room, and a utility room. A staff office was located upstairs.

The house was bright, clean and nicely decorated. It was in a good state of repair. Where bedroom doors were open, the inspector noted that residents' rooms were nicely decorated and personalised with pictures, photographs and personal objects. One resident showed the inspector their bedroom and told the inspector that they had chosen the décor. The communal rooms in the house were nicely furnished and the furniture was modern and comfortable. Televisions were available in the sitting rooms. There was artwork throughout the house and this made for a homely and welcoming atmosphere. The inspector noted that the residents' choice of music was playing in the house and that the television showed the residents' choice of

television programme. The gardens around the house were very well maintained. There was a large patio area at the back of the house. There were raised beds with colourful plants and vegetables.

This centre was registered to accommodate four residents. On the day of inspection, only three residents were in the centre. One resident was residing in their family home. The person in charge reported that the resident could return to the centre at any time but that it was unclear when they would next be staying in the centre.

The residents required varying support with their health and personal care needs. The person in charge reported that the mobility needs of some of the residents had changed in recent months. This had resulted in referrals to members of the multidisciplinary team and outpatient services for assessments and support. Although all residents could walk independently, some residents had been identified as being at a risk of falling. Some residents required a wheelchair for longer distances. All residents required support with their social care needs and to access the community. For one resident, being able to leave the centre to go into town or out for a walk was identified as an important part of their positive behaviour support plan.

There was a history in the centre of negative peer-to-peer interactions. These had resulted in safeguarding incidents. These were reported to the Chief Inspector and other external agencies. The relocation of one bedroom upstairs formed part of a safeguarding plan to reduce the number of interactions between two residents. The creation of an additional sitting room downstairs also gave space to residents to spend time apart, if they wished. This had resulted in a reduction in the number of incidents in the centre.

The inspector had the opportunity to meet with the three residents who were in the centre on the day of inspection. Two residents met with the inspector on their own and the third resident met with the inspector with staff present in the room. Two residents said that they were happy in their home. When asked about living in this centre, one resident said 'I want a new house' and said that they did not like one of the other residents. All residents said that they liked the staff and that they were nice. Two residents spoke about members of staff by name and said that they liked to go places with those staff. One resident said that the staff were their friends. When asked if their fellow residents were their friends, the resident responded, 'not sure about that'. Two residents spoke about their interests and recent trips that they had taken. One resident said that they wanted to go on a holiday to Spain.

As part of the announced inspection, questionnaires were sent to residents in advance of the inspection. These questionnaires asked the residents' opinions on the centre and the service they received. Three questionnaires were returned and reviewed by the inspector. All residents required the support of staff to complete the questionnaires. In general, the questionnaires indicated that residents were happy with the service in the centre and with their home. Two residents indicated that there was some improvement needed when asked 'do you get along with the people you live with?' Another questionnaire recorded that familiar, regular staff were

important to the resident and that the resident became anxious when they did not know the person working with them.

The inspector observed interactions between residents and staff. These were caring and friendly. Staff were quick to respond when residents asked for help. They knew the residents' preferred topics of conversation and chatted comfortably with residents.

In addition to the person in charge, the inspector met with two other staff members. They were knowledgeable of the needs of residents and the supports required to meet those needs. They spoke about the positive behaviour supports offered to residents. They knew the steps that should be taken to reduce negative interactions between residents and gave specific examples of how they ensured this throughout the day. Staff knew how to support residents to evacuate the centre in the event of a fire. The staff members were knowledgeable of the staffing numbers required by residents within the centre and when out in the community. They noted that this might vary depending on the nature of the journey. For example, some residents required the support of two staff members to attend medical appointments but required one staff member when going to the shops. The importance of the provider's activation coordinator in supporting one resident was highlighted by the person in charge and by both staff members. The activation coordinator supported one resident to leave the centre four mornings a week. The activation coordinator had their own vehicle. This was in line with the resident's behaviour support plan. It meant that three staff members were available to support the other residents in the centre. It also meant that the centre's vehicle was available to the other residents on those days.

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

Significant improvement was required regarding the systems of oversight in the centre. The provider's routine audits were not always completed in line with the provider's schedule. In addition, provider-led audits were not completed in line with the regulations and had not identified all areas for service improvement.

On the day of inspection, staffing arrangements in the centre were in line with the needs of the three residents in the centre. However, it was unclear if these staffing numbers would be adequate if the fourth resident was in the centre. There was a significant reliance on agency staff in the centre. Though some agency staff were regularly employed in the centre, it was noted that there were also turnover of staff. This was a risk to residents as the importance of familiar, consistent staff was

highlighted in residents' behaviour support plans, risk assessments and in the questionnaires returned as part of this inspection.

The provider had submitted all documentation to Chief Inspector to progress the application to renew the registration of this centre.

Registration Regulation 5: Application for registration or renewal of registration

The provider had submitted the required documentation to progress the application to renew the registration of the centre. This was reviewed by the inspector and found to be complete.

Judgment: Compliant

Regulation 15: Staffing

On the day of inspection, the number and skill-mix of staff on duty was in line with the needs of the residents. However, improvement was required to ensure that the number of staff on duty met the needs of residents at all times. Improvement was also required to ensure that staff were consistent and familiar to the residents.

One the day of inspection, there were three residents in the centre. The necessary number of staff required to support these residents was on duty. One resident was supported by two staff to attend a medical appointment. Another was supported by the provider's activation coordinator to go shopping. This left a member of staff in the centre to support the remaining resident. However, the person in charge reported that there was no additional staffing resource in the centre should the fourth resident be there. This presented a risk as some residents required the supervision of a staff member at certain times. For example, one residents' risk assessment noted that they required supervision when mobilising in the hallway. In addition, the activation coordinator was available to support residents four mornings per week. This meant that three days every week, one resident was supported to leave the centre from within the centre's staffing arrangements. Again, this was suited to the needs of three residents but additional support would be required to support the fourth resident.

The person in charge reported that there was one staff vacancy in the centre. On the day of inspection, there was no definite plan for this role to be filled. The inspector reviewed the rosters for the centre from 1 April 2026 to the day of inspection and the planned roster until 26 July 2026. This showed that there was a significant reliance on agency staff to cover all staff leave. Staff rosters were planned in two-week blocks. The inspector noted that at least six agency staff were required for each two-week block since April and, for some two-week blocks, up to nine agency staff were required in the centre. Though some of these staff members

worked in the centre regularly and were familiar to the residents, the inspector noted that there was some change over of staff or that some agency staff worked in the centre infrequently. The importance of consistent, familiar staff was highlighted in the behaviour support plans and risk assessments that had been developed for some residents. This will be discussed under Regulation 7: Positive behavioural support and Regulation 26: Risk management.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Staff training in this centre was up to date. This meant that staff had been given the opportunity to develop the necessary skills and knowledge to ensure that residents received the supports required to meet their needs.

The inspector reviewed the training records in the centre. This showed that staff had up-to-date training in the modules that the provider had identified as mandatory.

Judgment: Compliant

Regulation 22: Insurance

The provider had submitted details of their insurance arrangements as part of the application to renew the registration of the centre. This was reviewed by the inspector and found to include all the details required under the regulations.

Judgment: Compliant

Regulation 23: Governance and management

Significant improvement was required to ensure that there was effective oversight of the service. Improvement was also needed to ensure that the centre was adequately resourced to meet the residents' needs.

The provider maintained oversight of the service through routine audits. The provider had a schedule of audits that outlined when certain audits should be completed in the centre. The inspector reviewed the audits that had been completed in the centre since the beginning of 2026. This showed that not all audits were completed in line with the provider's schedule. For example, the provider had

identified that audits of residents' finances should be completed monthly. However, there was no audit on file for April, May or June 2026.

The provider had not completed six-monthly unannounced audits in the centre as required under the regulations. The most recent unannounced audit was completed on 11 and 17 June 2026. However, prior to that, the most recent audit was completed 11 months previously in July 2025. Further, the most recent provider-led audit had been completed by the area manager for the centre. This was not in keeping with best practice of an external auditor reviewing the quality and safety of care and support. The most recent audit had not identified areas that were noted during the inspection. For example, the audit had not identified that audits of residents' finances had not been completed in line with the provider's schedule.

It was not clear that all service improvement actions identified by the provider were completed in line with their timelines. For example, a review of a safeguarding incident in the centre identified that a staff member required refresher training in safeguarding. The provider had set a target date for completion of this training but, the staff member's training record indicated that this refresher had not taken place in line with this timeline.

Improvement was required to ensure that the centre was adequately resourced to meet the needs of the residents. This was reflected in the staffing arrangements as outlined under Regulation 15: Staffing. In addition, the centre had one vehicle for use by the residents. This meant that when one resident was out of the centre, the other residents were unable to leave the centre. As noted in the opening section of the report, one resident's behaviour support plan highlighted that they should be supported to leave the centre in the mornings. Further, due to safeguarding measures, residents could not always travel together in the same vehicle. The person in charge reported that an additional vehicle was occasionally available from the activation coordinator when they were on leave. However, for three days per week, residents only had access to one vehicle, and this was not in keeping with their assessed needs.

Judgment: Not compliant

Regulation 3: Statement of purpose

The provider had submitted their statement of purpose as part of the documentation required to renew the registration of the centre. This was reviewed by the inspector and found to contain the information outlined in the regulations.

Judgment: Compliant

Quality and safety

Improvements were required to the risk management procedures in the centre. Not all risks to the service and the impact on residents had been identified. This meant that control measures and contingency plans to support residents had not been identified. The risk of the provider's policies relating to procurement on the rights of the residents had not been assessed and measures put in place to mitigate this risk.

The health, social and personal care needs of residents had been assessed. There was guidance for staff in residents' positive behaviour support plans and risk assessments to reduce the likelihood of negative interactions between residents. The premises were also laid out to suit the needs of the residents and to reduce the likelihood of safeguarding incidents. However, the documentation relating to safeguarding plans required improvement to ensure that staff were given adequate information to ensure a consistent approach between staff.

The provider had systems in place to protect residents from the risk of fire. Staff knew the supports required by residents to evacuate in the event of an emergency. However, improvement was required to the recording of fire drills and fire door checks so that the provider could be assured that these systems were functioning appropriately.

Regulation 10: Communication

The provider had arrangements to ensure that staff knew how to support the residents to communicate their needs and wishes.

The inspector reviewed the communication passports that were developed for two residents. This gave clear information to staff on the residents' background, interests and hobbies. The documents outlined how to present information to residents in a way that was accessible to them. It also outlined how residents expressed their wishes and needs. These documents had been reviewed within the previous 12 months.

Judgment: Compliant

Regulation 17: Premises

The premises were suited to the needs of the residents.

As outlined in the opening section of the report, the house was clean, tidy and in a good state of repair. It was nicely decorated. There was adequate space in the house for residents to spend time together or alone, as they wished. The changes

made to the lay-out of the centre since the last inspection resulted in more space for residents and had reduced negative interactions between residents. The centre had the appropriate equipment needed by residents to complete their activities of daily living. Residents had ample space to store their personal belongings.

Judgment: Compliant

Regulation 20: Information for residents

The provider had developed a guide for the residents. This was reviewed by the inspector and found to contain the information set out in the regulations.

Judgment: Compliant

Regulation 26: Risk management procedures

Improvement was required to ensure that all risks to residents were identified, assessed and that control measures were implemented to reduce the risks.

The inspector reviewed the risk assessments developed for two residents. These were in line with the residents' assessment of their health, social and personal care needs. They gave guidance to staff on how to reduce risks to residents.

The person in charge maintained a risk register of risks to the service. However, significant risks to the service, as noted on inspection, were not recorded on this register. Namely, there was no risk assessment in place in relation to the staffing levels in the centre. It had been identified that some residents required the support of two staff when in the community. For example, on the day of inspection, two staff were required to support a resident to attend a medical appointment. Should all four residents be in the centre, this would mean that one staff member would be in the centre to support three residents. This risk had not been assessed or control measures specified to reduce the risk to residents. This was despite known compatibility issues and risks relating to falls where staff supervision was required.

Further, a risk assessment relating to the resourcing of the centre had not been developed. The risk regarding the dependency on agency and unfamiliar staff, and access to one vehicle only had not been assessed. Also, the risk to the rights of the residents due to the provider's policies relating to procurement had not been identified. This will be discussed further under Regulation 9: Residents' rights.

Judgment: Not compliant

Regulation 28: Fire precautions

The provider had systems in place to ensure that residents were protected from the risk of fire. However, some improvement was required in relation to the documentation of fire drills and fire safety checks.

The provider had arrangements for the detection, containment and extinguishing of fires. The centre was equipped with a fire detection and alarm system that was checked routinely by an external fire company. The company also checked the centre's emergency lighting. The inspector viewed the most recent records of these checks. The inspector noted that fire extinguishers in the centre had been serviced by an external company within the previous 12 months.

There were guidance documents on the supports that residents required to evacuate the centre in the event of a fire. These had been recently reviewed and gave clear information. In speaking with the inspector, staff demonstrated good knowledge of these plans.

Improvement was required in relation to the recording of fire drills and fire safety checks. The inspector reviewed the three most recent fire drill records. These simulated differing staffing levels and day or nighttime scenarios. However, the specifics of the scenario were not recorded in relation to the location of the fire and the evacuation method used. This meant that the provider could not be assured that the correct evacuation procedures were being used during these drills. Furthermore, although the person in charge reported that staff completed weekly checks of fire doors, records were not consistently completed six-monthly in accordance with the provider's requirements.

Judgment: Substantially 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. The residents' files contained plans that guided staff on how to offer support to residents to meet their assessed needs. These plans were regularly reviewed and updated.

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 had arrangements to ensure that residents received positive behaviour support.

The inspector reviewed the behaviour support plans that were developed for two residents. The plans had been recently reviewed and completed by an appropriately qualified professional. The behaviour support plans outlined steps that should be taken so that negative interactions between residents were minimised. This included providing one resident with opportunities to access the community daily, as discussed previously. The plans also highlighted that some residents required one-to-one time with staff members during the day to support their behaviour. The importance of residents being supported by familiar and consistent staff was also highlighted in these plans. When speaking with the inspector, staff gave examples of how they implemented these plans.

Staff had completed training in positive behaviour support. This training was up to date.

Judgment: Compliant

Regulation 8: Protection

The provider had measures in place to protect residents from the risk of abuse. Improvement was required to ensure that clear documentation was available to staff in safeguarding plans. Improvement was also required to ensure that information from the National Safeguarding and Protection Team was available in the centre.

On the day of inspection, there were a number of open safeguarding plans in the centre. Two open plans were reviewed by the inspector. The inspector reviewed the correspondence between the provider's designated officer and the National Safeguarding and Protection Team. This showed that the provider was responsive when incidents occurred and that measures were put in place to reduce the recurrence of incidents. The inspector noted that the number of negative interactions between residents had reduced in recent months. The person in charge and staff reported that this was, in part, due to the relocation of one resident's bedroom to upstairs and the reduction in resident numbers in the centre in recent months. However, it was unclear if these plans remained open with the National Safeguarding and Protection Team. This was the case for a number of safeguarding incidents that had been reported. The person in charge said that the designated officer assigned to the centre was on extended leave. The contingency plan was for the person in charge to report incidents to the designated officer's line manager. As

a result, incidents could be reported to the National Safeguarding and Protection Team but return correspondence from that team to the centre was not communicated to the person in charge. This was a significant gap in the oversight of the safeguarding plans in the centre.

Further, improvement was required so that staff had access to clear safeguarding plans to ensure that all staff used a consistent approach in supporting residents. Staff were not able to access the full safeguarding plans that were in the centre and the correspondence with the National Safeguarding and Protection Team. These were only made available to the person in charge. The rationale for this practice was unclear. Summary documents were made available to staff. These summaries outlined the actions that the provider had taken to support the residents. For example, the summaries stated that behaviour support plans would be reviewed, referrals made to the multidisciplinary team and that the safeguarding plans were updated. However, the specific actions that staff should take to protect residents and to avoid a recurrence of the incident were not clearly specified. It should be noted, that risk assessments and behaviour support plans included guidance to staff on how to avoid safeguarding incidents but these were not clearly documented in the residents' safeguarding plans.

Judgment: Substantially compliant

Regulation 9: Residents' rights

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

The residents' ability to make choices in their daily lives was impacted by the resourcing of the centre. As there was only one vehicle in the centre, the known compatibility issues between residents and the requirement of one resident to access the community as part of their behaviour support plan, the availability of transport for residents to leave the centre when they wished was impacted. Staffing arrangements, where residents required two staff to support them in the community, could also potentially impact on the residents.

In addition, as mentioned in the opening section of the report, one resident said that they wanted to go on a holiday to Spain. A staff member informed the inspector that the resident had made this known to staff. However, this goal was not recorded for the resident, and plans had not been put in place to investigate and progress this goal with the resident. Further, residents' choices of trips to hotels and events were potentially impacted by the provider's procurement policies. For example, the person in charge reported that a predetermined selection of hotels was presented to residents as choices for nights away. This was a selection of hotels with existing procurement arrangements with the provider. It meant that residents did not have free choice to pick where they wanted to go on their holiday.

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	
Registration Regulation 5: Application for registration or renewal of registration	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 17: Premises	Compliant
Regulation 20: Information for residents	Compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Ait Aoibhinn Service OSV-0008660

Inspection ID: MON-0042319

Date of inspection: 14/07/2026

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: • A review of the staffing arrangements within Ait Aoibhinn Service has been completed to ensure staffing levels are responsive to the assessed needs of all four residents. Residents' needs are assessed at least annually and the roster is mapped in response to these needs. Staffing requirements have been reviewed in consideration of residents' mobility needs, supervision requirements, safeguarding arrangements, positive behaviour support plans and community access needs. • The vacant post has been prioritised through the HSE recruitment process and recruitment efforts continue. Pending recruitment, a core group of regular agency staff has been identified and are rostered on an ongoing basis to maximise continuity of care and ensure familiarity with residents' support needs. • A review of the roster has been completed to ensure staffing resources are available when all four residents are present in the centre and where residents require two staff to support for appointments and community activities. This includes the PIC being present to support the service to facilitate planned appointments, the resource of activation coordinator already supporting Ait Aoibhinn has the availability to expand hours of support when a need is identified such as appointments requiring 2 staff support to any one resident. The Community Nursing Team are also an available support to the service to assist with appointments and managing the diary of events at Ait Aoibhinn. • Agency utilisation is continually monitored by the Person in Charge with the objective of reducing reliance on unfamiliar agency personnel. Staff induction records, resident safeguarding plans and behavioural support plans are reviewed with all agency staff as part of induction prior to commencing duty to ensure they know how to support residents and their preferences. • Risk assessments have been completed in relation to the services use of agency staff, and the support required by residents should there be appointments/activities requiring 2	

staff to support 1 resident.

Date for completion: 31 August 2026

Regulation 23: Governance and management

Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:

- The governance and oversight systems within the designated centre have been reviewed following inspection.
- The annual audit schedule has been reviewed, identifying all required audits, responsible persons and completion dates. The Person in Charge will monitor completion monthly and report progress through formal governance meetings.
- The quality improvement plan (QIP) for the service has been reviewed and revised so that it is now a live document which requires regular timely updates and allows easier tracking of timelines, actions required and work completed to date. This document will be maintained by the PIC. The PIC will update and submit a copy to the Director of Service monthly so that there is governance and oversight of actions, and any outstanding actions.
- Monthly operational meetings have been scheduled and commenced for the PIC and Director of Service to ensure oversight of the service and ongoing review of systems.
- Outstanding audits, including residents' finance audits, have been completed and these have been added to the QIP as a means of tracking and monitoring same. This has been developed to ensure audits are completed within required timeframes. Audit findings and associated actions will be reviewed monthly to ensure actions are completed within agreed timelines.
- All actions arising from audits, incidents, safeguarding reviews and inspections will be assigned to a responsible person, monitored monthly through the QIP and escalated where target dates are not achieved.
- The six-monthly provider-led unannounced visit programme has been revised to ensure compliance with Regulation 23(2)(a). Future unannounced visits will be completed within the required timeframe by a suitably senior manager independent of the day-to-day operation of the service. A revised schedule for all services in Mayo Community living has been completed and commenced for the remainder of 2026.
- To address resource deficits identified during inspection, a review of transport resources has been completed. A additional vehicle has been supplied to Ait Aoibhinn to ensure residents can access same when they wish and as needed.
- The vacant area manager position for Ait Aoibhinn has been recruited and a start date agreed.

Date for completion: 31 August 2026

Regulation 26: Risk management procedures	Not Compliant
Outline how you are going to come into compliance with Regulation 26: Risk management procedures: • The centres risk register has been comprehensively reviewed and updated. Specific risk assessments have been developed regarding: - Staffing levels when all four residents are present in the centre. - Reliance on agency staff and associated impact on continuity of care. - Access to transport and community participation opportunities. - Resident compatibility and safeguarding arrangements. - Residents' rights in relation to procurement and choice. - Emergency contingencies where staffing deficits arise. • Each risk assessment identifies risk controls, responsible persons, escalation processes and contingency measures. • The risk register will be reviewed monthly by the Person in Charge as part of the services QIP and discussed through governance meetings with Director of Service to ensure risks remain current and control measures remain effective. Risk assessments will be updated following incidents, changes in residents' assessed needs or changes to service delivery arrangements. Date for completion: 31 August 2026	
Regulation 28: Fire precautions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: • The template for recording fire drills will now record and capture: • Location of simulated fire & exit route used. • Day time/night drill. • Method of evacuation utilised. • Learning identified and actions required. • Fire drills will continue to be completed at regular intervals and under varying conditions to ensure residents and staff can evacuate safely. • All staff have been reminded of documentation requirements and records of completed drills will be reviewed by the Person in Charge.	

- A documented weekly fire door inspection is used in the service. Fire door checks are recorded and monitored as part of these environmental safety checks. The monthly fire audit will verify completion of these checks. The 6 monthly recording of fire door checks has been added to the centres diary of scheduled events to ensure it is completed within correct time frames.

Date for completion: 31 August 2026.

Regulation 8: Protection

Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:

- All safeguarding documentation within the centre has been reviewed.
- All safeguarding plans have been reviewed to identify current safeguarding status and ensure up-to-date correspondence from the National Safeguarding Office/Protection Team is available within the service.
- All open safeguarding plans will continue to be reviewed regularly and updated and a safeguarding care plan will be available to clearly identify:
 - The nature of the safeguarding concern.
 - Control measures in place.
 - Staff responsibilities.
 - Required supervision arrangements.
 - Links to associated behaviour support and risk management plans.
- Safeguarding within Ait Aoibhinn will be tracked and monitored as part of the revised QIP in the service.
- Appropriate safeguarding information will be made available to staff while maintaining confidentiality requirements.

Date for completion: 31 August 2026

Regulation 9: Residents' rights

Not Compliant

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

- Residents' rights and choices have been reviewed following inspection.
- A review of transport resources has been completed to improve residents' opportunities to access the community in line with their wishes, assessed needs and behaviour support plans. An additional vehicle has now been supplied to Ait Aoibhinn.
- Residents' goals and aspirations will be formally discussed during resident meetings, key worker sessions and personal planning reviews. Individual goals, including expressed wishes regarding holidays and travel, will be documented, progressed and reviewed

regularly with residents and their representatives. The Person in Charge and staff team will support residents to explore holiday and social activity options based on their individual preferences.

- A risk assessment has been completed in relation to residents' rights and choices in relation to financing options for same.
- Residents' access to meaningful activities, holidays and community participation will be reviewed monthly as part of the centre's quality Improvement plans. The QIP will be discussed at PIC & Director of Services monthly operational meetings

Date for completion: 31 August 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 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Substantially Compliant	Yellow	31/08/2026
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	31/08/2026
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to	Not Compliant	Orange	31/08/2026

	ensure the effective delivery of care and support in accordance with the statement of purpose.			
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	31/08/2026
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 put a plan in place to address any concerns regarding the standard of care and support.	Not Compliant	Orange	31/08/2026
Regulation 26(2)	The registered provider shall ensure that there	Not Compliant	Orange	31/08/2026

	are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.			
Regulation 28(1)	The registered provider shall ensure that effective fire safety management systems are in place.	Substantially Compliant	Yellow	31/08/2026
Regulation 28(4)(b)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Substantially Compliant	Yellow	31/08/2026
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Substantially Compliant	Yellow	31/08/2026
Regulation 09(2)(b)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability has the freedom to	Not Compliant	Orange	31/08/2026

	exercise choice and control in his or her daily life.			
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