Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	Tigh an Oileain
Name of provider:	Kerry Parents and Friends Association
Address of centre:	Kerry
Type of inspection:	Unannounced
Date of inspection:	17 July 2025
Centre ID:	OSV-0001970
Fieldwork ID:	MON-0047602

About the designated centre

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

Tigh an Oileain is a large detached purpose built one-storey building located on the outskirts of a village that can provide full time residential care for a maximum of five male residents over the age of 18 with intellectual disabilities. The centre also has one bedroom that can be used for respite by a male or female adult so in total the centre has a maximum capacity of six. Each resident has their own en suite bedroom and other rooms in the centre include a kitchen-dining room, a sun room, a sitting room, a music room, a games room and a utility room. Residents are supported by the person in charge, social care workers and support workers.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	5

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
Thursday 17 July 2025	09:00hrs to 16:30hrs	Deirdre Duggan	Lead
Thursday 17 July 2025	09:00hrs to 16:30hrs	Lucia Power	Support
Wednesday 23 July 2025	10:00hrs to 14:15hrs	Lucia Power	Support

What residents told us and what inspectors observed

From what inspectors observed residents in this centre were receiving a good quality person-centred service and were happy in their home. The findings of this inspection indicated that there was good knowledge among the staff team and the centre was seen to be well run with the input of staff even though the management team was depleted at the time of the inspection and no management were present for the majority of the inspection.

This was an unannounced risk inspection and was carried out to assess ongoing compliance with the regulations. Some solicited information had been received from the provider in the period prior to this inspection and the provider's response to adverse incidents and governance and management arrangements were reviewed during the inspection.

The centre was home to five residents at the time of this inspection, with one vacancy. As outlined in their statement of purpose, one individual who was not a resident accessed day services in the building. The respite bed was not in use at the time of the inspection. The centre comprised of a large purpose built bungalow located on the outskirts of a rural village. Residents all had their own bedrooms. There were numerous communal spaces available to residents including a dining area, a large sitting room and a large conservatory area with seating and dining facilities along with a sea view. Residents had access to a large activity room with ample art and crafts supplies and inspectors saw numerous large canvas artworks completed and in progress by residents.

On arrival to the centre, the inspectors met with a number of staff and residents. Night staff were getting ready to depart the centre at the end of their shift and the day staff had commenced and were completing a handover. A senior social care worker who was due to depart the centre following a sleepover shift communicated that they would remain on duty for a period to assist inspectors as they were very familiar with the centre.

On the day of the inspection two support workers were on duty to support the residents by day and a sleepover staff member was rostered by night. During the inspection, residents gave both inspectors a tour of their home and also invited the inspectors to join them for their tea break and chatted with residents about the things that they enjoyed and important people and events in their lives.

Residents were seen to contribute to their home. For example, residents unpacked and put away a grocery delivery and were involved in growing vegetables. One resident walked to the local shop daily to buy newspapers for residents. A resident showed inspectors a large poly-tunnel that was on the grounds of the centre and included a seating area and an array of plants. They also introduced the inspectors to the resident hen.

Inspectors heard about a recent visit to a large town to see a popular country singer perform. This artist's music DVD was playing on the TV during the inspection and residents told the inspectors that they had enjoyed this concert. Residents also told inspectors about an overnight trip they had taken and also about taking part in the local St. Patrick's Day Parade. Residents and staff had dressed up as characters from a popular comedy show and they showed inspectors pictures of them participating in the parade and told inspectors about the plans they had to take part next year. This was reflected in some of the goals viewed in residents' files and it was clear that residents had been very active in the planning of this event. It was clear from speaking with residents that they were very involved and connected to their local community and their families while living in the centre.

Residents were seen relaxing in their home and some were completing craft activities in an activity room. Residents and staff showed inspectors the artwork that residents made, including a painting that was being completed for submission to a major art exhibition. A notice board in the kitchen showed planned and recently completed activities including a beach visit, trips to local attractions, golfing and a visit to a pet farm. There were numerous pictures of residents enjoying days out and other activities on display.

Overall, this inspection found that there was evidence of good compliance with the regulations concerning the care and support of residents and that this meant that residents were being afforded good quality services that met their assessed needs. However, some issues in relation to staffing, rights in relation to finances, and the containment of fire were identified. The next two sections of the report present the findings of this inspection in relation to the governance and management arrangements in place in the centre, and how these arrangements impacted on the quality and safety of the service being delivered.

Capacity and capability

This unannounced inspection found that the arrangements for oversight and governance put in place by the provider were impacted by a number of unplanned absences within the provider's management team. However, a strong local staff and management team meant that there was limited evidence to show that this was impacting on the day-to-day operations and services being provided in this designated centre. The staff team present on the day of inspection were very knowledgeable about the day-to-day running of the centre and were seen to be very familiar with the assessed needs of the residents living there and the plans in place to meet those needs. Some issues were identified in relation to the staffing arrangements also.

There were arrangements put in place by the provider to maintain oversight in this centre, such as reporting and auditing structures. However, due to a number of absences on the provider's senior management team, these arrangements were not

fully effective at the time of this inspection and depended very heavily on oversight by a small number of individuals with a large remit. All of the members of the direct management team for the centre were absent on the day of this inspection. However, the provider's director of services visited the centre in the afternoon to speak with the inspectors and receive feedback at the end of the inspection.

The person in charge was not present on the day of this unannounced inspection. The person in charge had a significant remit and responsibilities within their role, with responsibility over a number of areas of service provision, including day services. The director of services told inspectors that a business case had been submitted to the funder that, if approved, would lead to a reduction in the remit of the person in charge. They also told the inspectors that due to unexpected absences across the assistant director of services team, the person in charge had been directed to report directly to the director of services as an interim measure. The provider was making efforts to recruit a director of nursing to assist in maintaining oversight of designated centres to mitigate against the impact of these unexpected absences.

Despite the governance challenges identified above, this inspection found that a committed local management and staff team in place in this centre was ensuring that overall the services being provided were safe and appropriate to residents' needs. Staff spoken with during the inspection presented as committed to providing a very good quality service to residents and were found to be competent and knowledgeable in their roles. Staff spoken with reported that they were very well supported by the person in charge and reported that they received adequate training from the provider to equip them in their roles.

The centre was overall well resourced. The premises were designed and laid out to meet the needs of residents and a bath had been installed for one resident since the previous inspection. Residents had access to transport and staffing levels were generally adequate to meet the needs of residents, although staff recruitment challenges were ongoing and this meant that sometimes sanctioned additional staffing to meet one resident's needs were not always in place. Staff were seen to be well informed. For example, staff team meetings generally took place on a monthly basis and documentation reviewed showed that learning from a May 2025 medicines audit had been shared with the team, alongside other pertinent information including safeguarding and governance arrangements and challenges.

Following an adverse incident in the centre that had resulted in an injury to a resident, the provider had taken steps to learn from the incident and had disseminated this learning to staff across the organisation by way of a memorandum. A provider assurance report had been submitted to the Chief Inspector of Social Services following this incident and documentation in the centre that incorporated the findings and quality improvement plans as part of a provider assurance response plan was reviewed during this inspection. There was evidence that actions were being completed such as review and updating of support plans and health assessments. Time-lines in place took account of the body of work that was to be completed to ensure that all actions could be completed thoroughly. However, as will be outlined under Regulation 23: Governance and Management, a

separate provider assurance report had also been submitted in relation to the governance and management arrangements for the designated centres under the providers' remit, and some of the actions outlined in that were not completed in line with the time-lines provided.

The next section of the report will reflect how the management systems in place were contributing to the quality and safety of the service provided in this designated centre.

Regulation 15: Staffing

The number, qualifications and skill mix of staff in the centre was for the most part seen to be appropriate to the assessed needs and size and layout of the centre. Staff supports were provided by social care workers and support workers. There were planned and actual rotas maintained in the centre and continuity of care and support was provided to the residents.

The planned and actual rotas available in the designated centre from January 2025 were requested by an inspector, with a sample of dates reviewed in full. These showed that generally staffing levels in the centre were consistent with the statement of purpose. The rota in place identified key information but it did not include staff designations. It was noted that the rota did rely on relief staff on occasions, although there was evidence that consistency of care was provided and the overall staff team was small and familiar to residents.

Staff numbers were allocated to support the needs of the residents. Generally two staff members were on duty by day and a sleepover staff was present at night. At weekends, one staff member provided supports. However, at the time of this inspection, an additional staff member had been allocated by the provider in the evening until 10pm and for a period each day at weekends due to the changing needs of one resident. This meant that this resident could, for example, remain at home while the other residents went out, if they wished, and also that they could be offered more 1:1 supports if required. While these additional staff had been sanctioned to support residents' changing needs, some issues were reported in the recruitment of new staff and staff spoken with reported that at times staffing levels could be impacted by leave or lack of availability of staff to cover these additional hours. For example, on the three evenings before the inspection, these hours had not been filled in full due to staff leave. One resident was assessed as requiring 2:1 supports for some aspects of intimate care such as showering and staff told inspectors that this would be completed while two staff were present in the centre and how this resident would be supported in the event that staffing levels were reduced. While it was also mentioned to inspectors that staffing did occasionally impact on planned activities and an example provided, there was evidence to show that a planned trip had been rescheduled and this had been discussed with residents.

A sample of staff files was reviewed by an inspector in the providers' administration

offices in the week following this inspection. These were seen to contain all of the appropriate information as set out in Schedule 2 of the regulations.

Judgment: Substantially compliant

Regulation 21: Records

An inspector reviewed the provider's staffing files for their eight registered centres in the week following this inspection taking place. This was to ensure the provider was compliant with Regulation 21(1)(a) - records of information and documents in relation to staff specified under schedule 2.

The inspector reviewed these files at the provider's main office as all the files were stored in the central office. The provider had given permission to the inspector by prior arrangement.

The inspector reviewed a sample of forty eight files over the eight designated centres, these included staffing roles such as person in charge, care assistants, nursing and social care staff. The inspector also reviewed staff who had permanent and relief contracts of employment.

All staff files reviewed had up to date Garda Síochána (police) vetting which was furnished within a three year period. All other information as outlined under schedule 2 was in the staff files. For example contracts of employment, references, evidence of staff identities and employment histories were all present.

Judgment: Compliant

Regulation 23: Governance and management

Governance and management systems in place at the time of this inspection were not effective to ensure that provider oversight was being fully maintained at all times. The provider had systems in place to maintain oversight of the service provided in this centre. However, at the time of this inspection, management systems in place did not fully account for an over-reliance on specific individuals to ensure that full oversight of certain aspects of the designated centre was maintained.

Challenges to maintaining oversight at the time of the inspection due to unexpected management absences had been recognised by the provider. The provider had submitted a provider assurance report relating to governance and management of the designated centres under their remit to the Chief Inspector prior to this inspection. Some of the actions outlined in this had not been completed within the time-lines provided. For example, the statement of purpose had not been updated,

there were no contingency plans in place in relation to providing oversight during periods when the person in charge was absent. Some notifications had not been submitted within the time-frame required by the regulations and some gaps were noted in documentation to reflect how the centre was responding to the changing needs of residents.

However, it was seen that local staff and management team in place were committed to ensuring that the day-to-day service provided was appropriate to the residents' needs, and the care provided to residents by the staff team was seen to be good, with limited evidence to suggest that the current governance challenges were impacting directly on the residents' living in this centre at the time of this inspection.

An annual review had been completed and this was reviewed by an inspector and seen to include feedback from residents and family members. It was noted that the Chief Executive Officer (CEO) had visited the centre the week before this inspection. Documentation reviewed by an inspector during the inspection such as provider audits, team meeting minutes, the risk register and incident reports showed that the provider and person in charge were recognising and taking action to address any issues that arose in the centre. Six monthly unannounced visits by the provider were occurring. An inspector had sight of a report on one of these dated January 2025 and was told that the most recent unannounced audit had been completed but the report was in draft at the time of the inspection. An action plan identified how identified issues were addressed.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The registered provider had a statement of purpose in place which was present in the centre. This was reviewed by an inspector and was seen to contain the information as specified in the regulations. The inspector reviewed a copy of this document in the centre dated February 2025. The statement of purpose for all of the provider's designated centres were due to be updated by 27 June 2025 as per previous assurances provided in relation to overall governance and management. These updates had not yet been completed and this is covered under Regulation 23 Governance and management.

Judgment: Compliant

Quality and safety

The wellbeing and welfare of residents in this centre was maintained by a high standard of evidence-based care and support. Overall safe and good quality services were provided to the five residents that lived in this centre. Some issues in relation to fire doors were identified.

Residents were supported by a familiar and consistent staff team in the centre and there was overall a low turnover of staff reported. Staff working with residents on the day of the inspection were observed to be very familiar with residents and their preferences and support needs. Staff in the centre presented as having a strong awareness of residents' assessed needs, safeguarding plans and support plans.

Documentation in place about residents was seen to provide good guidance to staff about the supports residents required to meet their healthcare, social and personal needs. This inspection found that there was ongoing consideration of the future needs of residents. Inspectors viewed a number of documents throughout the day of the inspection, including four residents' personal plans, support plans, healthcare plans, safeguarding plans, risk assessments and communication guidance. The documentation viewed was seen to be well maintained, and information about residents was for the most part up-to-date and person-focused. The provider had identified that some resident information required updating and there was evidence that this was in progress at the time of this inspection. There was clear evidence that efforts were being made to obtain consent from residents in relation to the care and supports provided to them and to involve residents in decisions about their day-to-day life.

Individualised personal plans were in place that contained detailed information to guide staff and ensure consistency of support for residents and that was evidence that residents had good access to specific healthcare supports, including access to health and social professionals as required. Staff spoke about residents in a respectful person focused manner. Staff told an inspector that they felt residents were safe and well cared for in this centre.

Inspectors were told about the supports that one resident was receiving around some memory decline that had been noted, and how this resident's family were involved and consulted with about this. Residents took part in regular resident meetings and were able to tell inspectors about these and about how they were consulted with about the running of their home.

Regulation 26: Risk management procedures

The registered provider had a risk management policy in place that provided for the identification, assessment and review of risk in the centre. The same policy also outlined control measures for specific risks as required including self-harm and accidental injury.

Overall, risk was seen to be well managed. Individual risks such as the risk of choking had been considered. The director of services provided access to the

provider's incident recording system for the centre and these were reviewed by inspectors. A risk register was reviewed that showed that risk assessments had been updated to reflect incidents that occurred and that these were reflective of the risks identified in the centre. One risk assessment reviewed did not fully reflect the supports required for one resident following a change in needs, despite a support plan indicating that this has been risk assessed. However, the support plans in place did provide very good guidance to staff about the safest way to support this resident. The risk of staff shortages was identified and some controls put in place such as the use of agency staff if required.

Judgment: Compliant

Regulation 28: Fire precautions

The registered provider had ensured there were fire safety systems in place in this centre such as a fire alarm system, appropriate fire-fighting equipment and fire doors. Although overall, these were well managed, some issues were identified in relation to the fire doors present. These were:

- Gaps were noted in fire doors in the hallway and laundry and in a fire door between the sitting room and kitchen.
- One fire door was seen to be blocked by a television.

Personal emergency evacuation procedures were in place for residents and regular safety checks were being completed. A resident was involved in completing checks and told an inspector about this. Staff were aware of the evacuation procedures in place.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Personal plans were in place as required for residents and the person in charge was ensuring that overall the centre was suitable to meet the needs of the residents living there. Individualised plans were seen to be in place that reflected residents' assessed needs and a sample of four of these were reviewed by the inspectors. Support plans were in place that provided good guidance to staff about the supports residents required to meet their healthcare, social and personal needs. Changing needs had been identified. For example, support plans were in place around a diagnosis of dementia received by a resident. There was evidence of input and supports provided to the resident from health and social care professionals viewed in residents' files. For example, there was evidence of residents receiving general practitioner (GP), dietitian and psychiatry review, among others. Following an

adverse incident that resulted in a minor injury to a resident, support plans had been updated to reflect specific strategies that staff should use to support the resident. Similarly, following a fall, a resident had an exercise plan put in place and staff were observed completing this on the day of the inspection. Daily logs were seen to be detailed and provided good information to incoming staff. Communication plans were viewed in residents' files.

The person-centred plans in place were seen to be prepared in an accessible and reader friendly format and there was ample evidence of residents' input into their own plans. The inspectors saw that goal planning was documented in the centre and that residents were being afforded opportunities to set and achieve goals. Inspectors saw evidence in the personal plans that the residents had been supported to take part in a planning meetings and that goals were being updated as circumstances changed. Goals were set that reflected the particular interests, capacities and personalities of the residents. Some of the goals viewed to be in place included a trip to London, responsibility for fire checks, a meditation class, horse riding and concerts. There was clear evidence of progression and ongoing review of goals. For example, there were numerous photographs that documented various activities that residents had participated that were in line with goals that they had set. One resident had a previous goal for celebrity to visit the house and showed inspectors the pictures of this event on display in the hallway of the centre.

Judgment: Compliant

Regulation 6: Health care

The registered provider was ensuring that residents were provided with appropriate healthcare, having regard to the personal plans in place. Residents were supported to make and attend healthcare appointments as required and where a healthcare need was identified, there were appropriate support plans in place to provide guidance to staff.

There were good health support plans in place, including plans to support residents through difficult periods in their lives. Mental health support plans were viewed that included coping strategies. A sample of healthcare records were reviewed during the inspection. There was detailed information recorded in each residents' personal file about their healthcare needs and how these were supported in the designated centre. OK Health checks were viewed in residents' files and there was evidence that residents' attended annual health checks. Support plans were in place around allergies and in relation to medicines, with clear prescription sheets in use.

Judgment: Compliant

Regulation 8: Protection

The findings of this inspection indicated that the registered provider had the necessary measures in place to protect the resident from abuse and were responsive and supportive to residents in relation to allegations of abuse. An inspector viewed records that showed that staff working in the centre had received appropriate Garda vetting disclosures. The topic of safeguarding was seen to be discussed regularly at team meetings.

The provider was making active efforts to safeguard residents while also respecting residents' rights to independence and autonomy. Where specific risks had been identified, the provider had taken steps to support a resident in a manner that promoted their safety and good efforts had been made to educate residents in relation to self-care and protection and about protocols that were in place to protect them from abuse.

One resident spoke to an inspector about the supports that they had received from the provider following a disclosure they had made. It was clear that this resident was assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection. Formal safeguarding plans were in place if required and there were clear efforts to balance risk with the rights of the resident and to put in place controls to mitigate against identified risks. Safeguarding plans were updated regularly and there was very good oversight of these. Following an incident that was recognised as a safeguarding concern, the provider put in place clear plans and took action to identify any actions that could be put in place to prevent reoccurrence. Staff spoken with on the day of the inspection demonstrated a good understanding of how to safeguard residents and one staff member told an inspector that the staff team were very focused on safeguarding. Residents also indicated to inspectors that they felt safe and well protected in the centre.

Intimate care plans were seen in residents' files and were seen to be reflective of the changing needs of one resident.

Judgment: Compliant

Regulation 9: Residents' rights

The provider had identified some institutional practices in relation to how residents' money was managed. The director of services told inspectors about the actions the provider was taking to try to address this issue.

Residents rights were respected in this centre and it was evident that there was ongoing and meaningful consultation with residents about matters that were important to them. Staff and resident interactions were seen to be respectful and dignified. Residents were seen to be very involved and participate in the day-to-day running of their own household. For example, residents chose the menu in the

centre each week and were observed to take an active role in putting away groceries delivered on the day of the inspection. A resident had the job of going to the shop for the papers. Residents told the inspectors about choosing their own activities, clothes and footwear. Information and general written consent form covering aspects of care and support received by residents was viewed in residents' files.

Weekly resident meetings took place every Thursday and records of these were seen to include lots of consultation with residents about various topics. Residents used a decision making document to inform their decisions in relation to activities or plans during these meetings. For example, prior to taking part in the St. Patrick's Day parade, residents had considered their roles, the benefits of taking part, why it was important to them etc.

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	
Regulation 15: Staffing	Substantially compliant
Regulation 21: Records	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Quality and safety	
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Tigh an Oileain OSV-0001970

Inspection ID: MON-0047602

Date of inspection: 17/07/2025

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: The organisation continues to recruit for additional staff, one candidate is currently being processed to fill the evening hours in Tigh an Oileain. Another staff who has been redeployed to the local day service will return to his post when a newly recruited staff commences her post in the day service. This will fill the current gaps in the DC.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: All ADOS`S have returned from leave to their posts. Funding for additional ADOS and clerical grade 4 has been secured for a period of 12 months. These posts are currently advertised. The ADOS department has a reporting structure in place to escalate if actions are not going to be completed in time through Monthly Action Tracker Meetings with the Compliance Lead and PICs - which have just started to roll out. They occur monthly on an individual level, and focus on any actions for the residence from either HIQA or our own internal audits/inspections. We will also discuss the medium and green risks in the centre. The aim is to keep on track and support with reaching our goals and timelines - pushing forward with progress and quality improvement.	
Regulation 28: Fire precautions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: Laundry room door has been fixed by a competent person. KPFA will engage a company to complete a Fire Door Inspection to identify the remedial works or replacement of doors with gaps.	

KPFA will secure a Fire Engineer Report for the designated centre, to identify works that need to be actioned to come into compliance with Fire Regulations, submit a Business Case to the HSE and create an action plan for completion of same.

Regulation 9: Residents' rights	Substantially Compliant

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

An Easy Read Money Management Guide has been developed and implemented. It covers items such as where my money comes from and how it's used to rights under the ADM and practical tools for budgeting, shopping and planning. This universal support is being rolled out across services to facilitate financial discussions at keyworker meetings, resident forums and as part of the care planning in my assessment of need.

A best practice example of an easy read support plan is in place and has been shared across all centres for supporting residents with their individual banking and money management. It supports a template for an accessible personalised support plan detailing how a resident can be supported to know and understand their personal financial situation thus improving autonomy and decision making. The Personalised support plans for finances now include a Consent Journey — a practical tool that maps how information is introduced, supported, and revisited over time, ensuring the person is meaningfully involved in financial decisions at a pace that suits them. This approach affirms each person's right to be supported in all decisions about their life, including how their money is managed.

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	28/02/2026
Regulation 23(1)(b)	The registered provider shall ensure that there is a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.	Substantially Compliant	Yellow	28/02/2026
Regulation 23(1)(c)	The registered provider shall	Substantially Compliant	Yellow	28/02/2026

	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.			
Regulation 28(1)	The registered provider shall ensure that effective fire safety management systems are in place.	Substantially Compliant	Yellow	31/10/2026
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	31/10/2026
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 exercise choice and control in his or her daily life.	Substantially Compliant	Yellow	28/11/2025