Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	Dunmanway Residential
Name of provider:	CoAction West Cork CLG
Address of centre:	Cork
Type of inspection:	Announced
Date of inspection:	12 February 2026
Centre ID:	OSV-0002110
Fieldwork ID:	MON-0040947

About the designated centre

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

Dunmanway Residential consists of a large purpose built single storey building located in a town. The centre provides a respite service for up to six residents of both genders primarily for those between the ages of 6 and 18 although it can support those up to the age of 20 if they are still in their final year of education. The centre supports those with intellectual disabilities. Support to residents is provided by the person in charge, nurses, social care workers and health care assistants. Individual bedrooms are available for residents and other facilities in the centre include bathrooms, a dining area, a kitchen, a living room, a sunroom and staff rooms.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	2

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 12 February 2026	09:30hrs to 18:15hrs	Deirdre Duggan	Lead

What residents told us and what inspectors observed

From what the inspector observed and from speaking to staff and management, residents who received respite supports in this centre were overall offered a service tailored to their individual needs and preferences. The provider had identified that improvements were required in relation to a number of areas and was working towards addressing these with ongoing improvements required. Non compliance was found in relation to personal planning, notification of incidents, staffing and positive behaviour support.

Dunmanway Residential comprises a large purpose-built bungalow located on the outskirts of a rural town. The centre is located next to admin buildings and a playground also operated by the provider. Residents have access to a secure outdoor area and the adjoining playground and the outdoor area was seen to have garden furniture and a small trampoline for the use of residents. One bedroom was in use as a sensory room at the time of the inspection.

The inspector saw that the centre was well maintained and appropriate to the needs of the children and young people that availed of respite breaks. As noted on previous inspections, the centre was warm, bright and homely and decorated in line with the age profile and needs of residents that used the service. Some enhancements had been made since the previous inspection to the décor including brightly coloured hanging lanterns and new sensory and relaxation equipment in the conservatory area.

The centre is registered to provide respite accommodation for up to six residents at any one time and at the time of this inspection generally provided short break services four nights and five days per week. Some day respite was also offered in the centre and this provided the children and young people using this service with an opportunity to become familiar with the service prior to commencing overnight breaks if required.

This was an announced inspection and was scheduled to take place when residents would be present in the centre. As part of this inspection, the inspector met with residents, staff and a family member and reviewed centre specific documentation. Two residents were availing of respite services on the day of the inspection and arrived to the centre after school. A third resident was unable to attend as planned on the day of the inspection. Both residents interacted briefly with the inspector and appeared to be comfortable with the presence of the inspector. Both residents did not use verbal communication but communicated in their own unique styles and the familiar staff member present was seen to be very familiar with how these residents communicated.

The inspector spent the majority of time that residents were present in the centre reviewing documentation and observing practice in the communal areas of the

centre. Overall, residents were seen to be cared for by a kind and attentive staff team and residents were seen to enjoy their evening while the inspector was present. Two staff of the three present were not very familiar with these residents and this meant that one staff member was under additional pressure to ensure that both residents' needs were appropriately identified and met.

Residents were observed to be offered snacks and drinks regularly and had a home-cooked dinner provided also. Both residents were provided with opportunities to leave the centre for walks and to go to the playground and spend time in the outdoor area if desired. Individuals spent a brief time watching preferred television programmes and the interactions between the children and staff supporting them were seen to be kind, caring, and attentive. While there were some restrictions in place in this centre for health and safety reasons, these were seen to be considered and were overall in line with the type of service provided in the centre and the age profile of residents and did not appear to be negatively impacting on the service provided to residents during this inspection.

A family member of a young person that was in receipt of respite services in the centre called to the centre to meet with the inspector. They told the inspector that they were very happy with the service provided to their child and that their child was very happy to attend respite and enjoyed their time there, including accessing community activities. They also reported good communication with the management and staff team and that they were very satisfied with the staffing, food and accommodation provided while their child accessed the service. Some other information from another family member was also received that indicated that they were not satisfied with some aspects of the service. The inspector was told by the management of the centre about efforts the provider was making to improve communication and share important information with family members.

This inspection found that there while there was evidence that residents received a good service overall, some improvements were required to ensure that the plans in place for residents were fully reflective of the care provided and to fully ensure that residents were being afforded safe and person centred services that met their assessed needs. The next two sections of the report present the findings of this inspection in relation to the governance and management arrangements in place in the centre, and how these arrangements impacted on the quality and safety of the service being delivered.

Capacity and capability

This inspection found that there were local management systems were in place that were appropriate to ensure that the services provided within the centre were overall safe and appropriate to residents' needs. Improvements were required in relation to the personal plans, notification of incidents, positive behaviour support,training and staffing in the centre. Some of these issues will be further discussed in the quality

and safety section of this report. The providers audit systems were identifying issues and actions were being taken to address these.

An application to renew the registration of this centre had been received by the Chief Inspector. At the time of this inspection a bedroom was in use as a sensory room and another bedroom was identified as a second staff room but the inspector was told that this room was not in use. The provider was requested to submit some updated information to ensure that the arrangements in place were accurately reflected under the statement of purpose, floor plans and registration conditions of the centre.This announced inspection was carried out to inform the decision to renew the registration of the centre. Some information had also received by the Chief Inspector prior to this inspection and this was used to direct some of the lines of enquiry for the inspection.

The Chief Inspector had previously been informed of a number of vacancies in the providers' senior management team. At the time of this inspection, a number of these vacancies had been filled, including the human resource manager position and a quality, safety and risk manager. This meant that the governance arrangements in place had been enhanced since the previous inspection and the inspector was told that this was impacting positively in areas such as staff recruitment and the speed of on-boarding new staff. A new person in charge had also commenced in the centre since the previous inspection. For an interim period the assistant director of services (ADOS) had stepped into the person in charge role while recruitment was underway.

The person in charge (PIC) reported to an Assistant Director of Services (ADOS), who in turn reported to the Director of Services (DOS), who reported to the Chief Executive Officer/Board of Management. Both the recently incoming person in charge and ADOS who was also a person participating in the management (PPIM) of the centre were present on the day of the inspection. The person in charge also had other duties with this provider but was based in an administration building beside the centre and maintained a presence in the centre. The inspector had an opportunity to speak with both these individual throughout the day. The management team was seen to have good oversight of the centre and were knowledgeable in relation to any issues.

This inspection found that some improvements were required in relation to staff training and consistency of staffing. Also, although incidents were seen to be reported and responded to and this meant that measures were in place to keep residents safe, some incidents had not been reported to the Chief Inspector in line with the regulations.

Although some issues were identified during the inspection, the management team spoke about the efforts they were making to enhance and improve the documentation systems in place in the centre and presented as committed to ensuring that the service provided in the centre was meeting the needs of the children and young people that used it. For example, recruitment efforts were ongoing, with some new staff identified in the period prior to the inspection.

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

Registration Regulation 5: Application for registration or renewal of registration

The provider had submitted an application to renew the registration of this centre and this was submitted within the required time frame. This information was reviewed by the inspector. However, some of the information provided was not fully accurate. While some information was received by the provider following the inspection, further information was required to ensure the details provided in respect of the application were fully accurate progress and this had not been received at the time of this report.

- Following the change of use of a room in the centre, the most recent application for the renewal of registration did not accurately reflect the capacity and facilities available in the centre.

Judgment: Substantially compliant

Regulation 14: Persons in charge

The registered provider had appointed a suitable person in charge. This individual possessed the required qualifications, experience and skills and at the time of the inspection was seen to have the capacity to maintain oversight of the centre. Evidence of the person's qualifications, experience and skills was submitted as part of the application to renew the registration of the centre and was reviewed by the inspector.

Judgment: Compliant

Regulation 15: Staffing

The registered provider was continuing to make efforts to ensure that the staffing arrangements in place were appropriate to the number and assessed needs of the residents when they received a service in this respite centre. The skill mix of staff was good with nursing staff, social care workers and support workers employed. Staffing levels were overall maintained in line with the statement of purpose in the centre and the inspector was told that planned respite had not been cancelled due

to staff shortages since the previous inspection. However, continuity of care was not always fully provided for.

The inspector viewed the planned and actual staff rotas in place around in respect of a three month period. While these did refer to some core staff by first names only, the inspector was told that staff log-in records were held that showed when staff were on duty in the centre for traceability purposes. Generally two to three staff were on duty by day and a sleepover staff was on duty by night, usually with the support of a waking night staff member also. Records reviewed showed that the staffing arrangements were based on the number and assessed needs of residents. For example, on occasions where children with complex medical needs were attending respite two staff nurses would be on duty day and night.

A regular core staff team worked in the centre but there were some longstanding vacancies and this was impacting on the continuity of care provided to residents, particularly midweek. The management and staff team reported that vacancies would be filled by relief or home support staff members. While this meant that staffing levels were sufficient to meet the basic care, support and supervision of residents, it did not always provide for full continuity of care for residents and could impact on the service provided on occasion, such as limiting access to activities.

Recruitment drives were ongoing and the provider had put in place additional initiatives in an effort to recruit staff. A new staff member was completing shadow shifts as part of their induction to the centre during this inspection.

Judgment: Substantially compliant

Regulation 16: Training and staff development

The inspector viewed a training matrix for 22 staff that were also named on the centre roster, although rosters indicated that at least two of these did not regularly work in the centre. This matrix showed that while the person in charge had oversight of the training needs of staff, a number of staff had not received mandatory training that had been identified as required for their roles. For example18 staff had either not completed or were overdue refresher training in the area of safety intervention, although this was seen to be scheduled for the following month. Also six staff did not have up-to-date fire safety training completed. This meant that all staff might not have the required skills to safely support residents at all times.

Judgment: Not compliant

Regulation 22: Insurance

The provider had submitted evidence as part of the application to renew the registration of the centre that showed they had in place insurance in respect of the designated centre as appropriate.

Judgment: Compliant

Regulation 23: Governance and management

Management systems were in place that for the most part contributed to ensuring that the service provided was safe and suited to the residents that accessed respite supports. However, non compliance with the regulations was found that indicated that ongoing improvements were required to ensure that this was always the case. The management of the centre were aware of and taking action in relation to a number of the issues identified and were upfront with the inspector about these throughout the inspection.

There was a clear governance structure in place that set out the lines of accountability within the service and the providers' governance structures had been improved with the recruitment of key personnel. Good facilities and resources were provided in the centre including a suitable premises and staffing levels that were in line with the statement of purpose and transport.

An annual review dated September 2025 was reviewed by the inspector and this provided evidence of consultation with residents' representatives. Other documentation reviewed by the inspector during the inspection included provider audits, team meeting minutes, the provider's report of the most recent six monthly unannounced inspection and action plans in place as well as documentation held in the centre in respect of residents' care and support. The inspector also spoke with a number of staff and management. Overall, the evidence reviewed showed that the provider was maintaining oversight of the service provided in this centre and the providers' systems were identifying issues. Action plans arising from audit systems in place were seen to be in place and monitored. While some actions that would contribute to bringing the centre into compliance with the regulations were underway at the time of the inspection, these issues were not yet fully addressed at the time of this inspection. Actions being taken included ongoing staff recruitment, review of positive behaviour support plans and personal plans and scheduling training.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The registered provider had in place a statement of purpose that contained all of the information as specified in the regulations. This was submitted as part of the application to renew the registration of the centre and was also available in the centre. Some amendments were required to ensure that all of the information was fully accurate in relation to the intended purpose of each room in the centre and the provider committed to ensuring that this was submitted to the Chief Inspector. This is covered under Registration Regulation 5.

Judgment: Compliant

Regulation 31: Notification of incidents

Not all incidents had been reported to the Chief Inspector as required and some quarterly notifications were submitted outside the specified time-frame. For example, a review of incidents showed that four incidents of a safeguarding nature were identified as having occurred and these had not been notified. Also the Chief Inspector had not been informed as required by the regulations of an unplanned occasion that the fire alarm equipment had been activated. These were submitted by the person in charge following the inspection.

Judgment: Not compliant

Regulation 34: Complaints procedure

The registered provider had in place a complaints policy and procedure and this was viewed on display in the hallway of the centre. This had been reviewed within the previous 3 years but was identified as being due for review in April 2025. This is covered under Regulation 4. Easy-to-read guidance in relation to how to make a complaint was available to the residents and their representatives and was viewed by the inspector in the foyer of the centre. A staff member spoken with was familiar with the complaints procedures in place. There was evidence that where residents might not be able to independently make a complaint their representatives were provided with opportunities to raise issues or concerns and that these concerns and that these would be taken seriously and used to inform ongoing practice in the centre.

The complaints log was reviewed by the inspector in the centre and some complaints had been documented since the previous inspection. It was seen that complaints were recorded as appropriate in this log, including any actions taken on foot of the complaint, the outcome of the complaint, and the satisfaction of the complainant. The person in charge spoke about the complaints that had been received in the designated centre and how these were responded to and this was in

line with the documentation reviewed and information received by the Chief Inspector about the centre.

Judgment: Compliant

Regulation 4: Written policies and procedures

The registered provider had in place written policies and procedures in relation to the matter set out in Schedule 5. The inspector was provided with a folder containing the centres' policies and procedures during the inspection and was told that some policies were out of date due in part to governance team vacancies in the preceding years. On reviewing the policies in place, some had recently been reviewed and a number of policies had been identified as overdue review. These were indicated to have reviews underway or completed and awaiting sign-off. These included policies and procedures related to:

- Admissions, transfers and discharges (centre based respite policy)
- Provision of behavioural support
- Visitors
- Complaints

Judgment: Substantially compliant

Quality and safety

This inspection found that overall safe and good quality services were provided to the children and young people that accessed respite in this centre. Improvements were required in relation to personal planning and positive behaviour support for residents and some work had commenced on this. The findings of the inspection indicated that overall, the day-to-day care and support provided was good and that the provider was taking action to address any identified improvements required to ensure that all residents' assessed needs could be fully met.

A number of documents were reviewed throughout the day of the inspection, including a sample of residents' personal plans, respite records, fire safety documentation and medication records. Resident documentation reviewed during the inspection was overall seen to provide guidance to staff about the supports residents required to meet their healthcare, social and personal needs. Some documentation was seen to require updating to ensure it was fully reflective of any changes that had occurred and provided the most up-to-date guidance for staff supporting residents or for new staff who might not be fully familiar with residents' changing needs. There was evidence that efforts were being made to obtain up-to-

date information and consent from the parents and guardians of residents in relation to the care and supports provided to them.

Overall, documentation reviewed showed that residents were seen to be provided with opportunities to participate in a wide variety of community based activities if desired, although consistency of staff was seen to impact on this on occasion as previously referenced.

Referrals in relation to positive behaviour support had been made if required. However, at the time of this inspection, staff did not have fully up-to-date and relevant guidance to support a resident with changing needs in this area. Also, some practices had not been identified as restrictive and there was no evidence of appropriate guidance available to support staff when managing peer-to-peer interactions in the centre.

It is acknowledged that there was some good practice observed in the centre in relation to staff supporting a resident in line with the guidance available to them. Also, where restrictions were identified these were recorded and reviewed regularly, with risk assessments in place to support their implementation and it was evident that some work had been completed in this area since the previous inspection.

An issue identified during the previous inspection in relation to the fire precautions had been addressed. The provider had taken action to review the fire safety precautions in the centre and a report from a competent individual was in progress at the time of this inspection. Some actions had already been taken by the provider to rectify any issues this had identified and some further works were planned. Some issues in relation to automatic door closures were observed during this inspection.

There was evidence that residents had good access to healthcare supports, including nursing support if required during respite stays in line with their assessed needs and as identified on the previous inspection, there were systems in place to manage risk in the centre. Staff spoke about residents in a respectful person focused manner. Staff told the inspector that they felt residents were safe and well cared for in this centre and the evidence found during this inspection indicated that for the most part residents were being provided with good quality, person centred services but that deficits in personal planning and positive behaviour support were impacting on a small number of children that used the service.

Regulation 11: Visits

Generally, due to the nature of the service provided, residents in this centre did not receive visitors. However,the person in charge had ensured that, as far as reasonably practicable, residents are free to receive visitors without restriction and that suitable communal facilities are available to receive visitors, and, a suitable private area, which is not the resident's room, is available to a resident in which to receive a visitor if required. The inspector saw that the centre had a number of communal areas, including some that could be used for private visits if required,

without impacting on other residents. These were appropriately furnished with seating and was a comfortable space for residents to receive visitors. The communal areas of the centre were spacious and homely and would also provide for visits if residents desired. The residents' guide and statement of purpose set out the visiting arrangements for the centre.

Judgment: Compliant

Regulation 13: General welfare and development

Overall, it was seen that residents were offered a good standard of care and support while attending for respite in this centre. Goals in place in residents' plans included goals to assist residents with developing daily living skills. Residents observed on the day of the inspection were seen to be relaxed and content in the centre and with the staff that supported them and were seen to be comfortable to move around the centre and make use of the facilities available to them. Residents had access to appropriate facilities and equipment for play and relaxation during their respite stays, including a playground located next the centre operated by the provider. This was usually available for the sole use of residents in the evening and weekends. A bedroom was in use as a sensory room and was seen to be a quiet and welcoming space with a variety of equipment available to residents. Also, the communal areas of the centre were equipped with games, sensory equipment, TV's, video games and bean bags and couches for residents to relax and play. Respite records reviewed showed that residents accessed a variety of activities during their stays including day trips, cinema, walks, movies, games, puzzles, playgrounds, beaches, shopping, eating out and baking.

Judgment: Compliant

Regulation 17: Premises

The premises was suitably designed and laid out to meet the aims and objectives of the service. Residents have the use of single bedrooms, some en-suite, and ample shower, bath and toilet facilities and a number of spacious communal areas. The centre was seen is accessible to residents who use mobility equipment and facilities included two bedrooms and bathrooms with overhead hoist facilities and a hydrotherapy bath.

The inspector completed a walk-around and saw that the centre was well maintained and appropriate to the needs of the children and young people that availed of respite breaks. As noted on previous inspections, the centre was warm, bright and homely and decorated in line with the age profile and needs of residents that used the service. Some enhancements had been made since the previous

inspection to the décor including brightly coloured hanging lanterns and new sensory and relaxation equipment in the conservatory area.

Judgment: Compliant

Regulation 20: Information for residents

The registered provider had ensured that there was an appropriate resident's guide was in place that set out the information as required in the regulations. This document was submitted and reviewed as part of the application for the registration f the centre and was also present in the centre on the day of the inspection and a required amendment was made on the day of the inspection.

Judgment: Compliant

Regulation 28: Fire precautions

The fire precautions in place in the centre were reviewed by the inspector through a walk-around and visual inspection and reviewing the fire folder maintained in the centre. An issue identified in the previous inspection had been addressed. However, the registered provider had not ensured that the local fire safety systems in place were fully effective in identifying issues and that fully sufficient containment measures were in place in the centre. However, the impact of this was reduced due to the high staff to resident ratio and other measures in place such as fire-fighting equipment, emergency lighting, an alarm panel, weekly evacuation drills and having a member of the familiar core staff team present on every shift. The provider had taken recent steps to identify address issues and the inspector was told that a recent review of fire precautions in the centre had been completed by a competent professional and that pending a complete report, actions were being taken to address the main issues identified. These issues did not present a high risk to residents at the time of this inspection. Some improvements were also required in relation to staff training and the documentation in place around evacuation and fire checks in the centre.

-As mentioned under Regulation 16, all staff did not have up-to-date fire training completed at the time of the inspection.

-A personal emergency evacuation plan (PEEP) in place for one resident was overdue for review

-The provider had identified that there was some works required to fire doors in the centre and at the time of the inspection this remained outstanding. Some issues

were identified with the automatic closures on one fire door. Weekly checks completed by staff had not identified/documented this.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

The inspector reviewed the management of medications in the centre, including the records kept in respect of medications administered and stored in the centre for five residents. A medication policy was in place and had been reviewed in January 2026.

PRN (medication given as required) protocols were viewed to be in place in residents' medication folders. These provided guidance to staff about the indications for use for these medications, the maximum dosage to be administered, the minimum interval between doses and administration instructions. The sample of these reviewed were seen to provide clear guidance to staff. Specific, detailed protocols were viewed to be in place in relation to the very specific needs of one resident.

The storage of medications in the centre was reviewed and it was seen that medications were stored separately in a locked press designated for this use. Residents medications were provided from home. Medications were signed into and out of the centre by staff and family members. Prescription and administration records were seen to be generally up-to-date and most of the sample reviewed had recently been reviewed by the residents' general practitioner. One was not available at the time of the inspection as the provider was awaiting some changes to ensure it was in line with their medication policy.

Quarterly medication audits were being completed, with the most recent of these occurring in December 2025 and also an audit regarding the management of enteral tubes had been completed in respect of two residents who had their medications administered in this way. Actions identified were mostly documentation related and included some actions regarding improving compliance with the medication policy in relation to the prescription charts and medications provided by family/guardians to ensure that all medications administered were clearly identified and administered as prescribed to each resident. There was evidence of ongoing communication with families and guardians in relation to this issue. During the introduction meeting the management of the centre also told the inspector about recent actions taken to address some issues identified with the documentation in place in respect of controlled medications.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The person in charge had not fully ensured that all personal plans were the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances that takes into account changes in circumstances and new developments.

Personal plans were in place for residents and a sample of 5 residents plans were reviewed by the inspector. The inspector also observed staff practice during the inspection. Some ongoing work was being completed in relation to personal planning and some plans were seen to be up-to-date and have been recently reviewed. However, in some plans reviewed some of the documentation in place in relation to personal planning required updating and not all plans were followed in line with residents' assessed needs:

- Some personal plans reviewed had not yet been subject to an annual review.
- Goals were not always updated to reflect changes or in line with the ongoing development of residents. For example, one resident had a recurring goal for a number of years that was noted to have been achieved numerous times since it had commenced. No changes had been made to reflect the residents' progress and ongoing development
- A plan had not been updated to reflect the most up-to-date information and learning from incidents that had been discussed by the management team.
- Observations on the day of the inspection indicated that not all of the guidance in plans was fully adhered to at all times. For example, the guidance in relation to a residents' assessed needs around eating had not been fully adhered to.

Judgment: Not compliant

Regulation 7: Positive behavioural support

The person in charge had not yet fully ensured that staff had up to date knowledge and skills to respond to behaviours of concern and support residents to manage their behaviour. Positive behaviour support plans were in place for some residents and two of these were reviewed by the inspector.

- A positive behaviour support plan in place for a resident that required substantial supports in this area did not provide specific guidance to staff about assisting this resident to manage responsive behaviours in the respite setting and did not take into account recent changes in the presentation of a resident. From speaking with staff, reviewing incident notes and observations in the centre, it was not demonstrated that this guidance was sufficient to fully guide staff at the time of the inspection. A referral had been made in respect of this plan but in the interim staff did not have access to up-to-date guidance or information to support them in their roles and ensure that the

care and support provided fully met the needs of the resident and that other residents were not impacted by these responsive behaviours.

- A second positive behaviour support plan on file dated July 2023 was identified as a "draft".
- Some practices, such as observed by the inspector in the centre on the day of the inspection had not been identified as restrictive in nature. This included staff keeping residents separate by using their bodies to block movement. This was discussed with the management team during the feedback meeting. This meant that these practices were not subject to full oversight or review to ensure that they were carried out appropriately in line with best practice. It is acknowledged that these were used to ensure the safety of all residents. As referenced above, the guidance in place for staff did not take into account recent changes and developments for residents. While there was some consideration into resident groupings in the centre there was insufficient guidance for staff in relation to managing peer-to-peer interactions when a young person who presented with responsive behaviours shared with other residents who might be impacted by this.

Judgment: Not compliant

Regulation 8: Protection

The registered provider was ensuring that residents were protected from abuse in the centre and had received appropriate training in this area. The inspector spoke with centre management, a staff member and observed practice in the centre and also reviewed documentation including incident records, risk assessments, and respite records.

Staff and management spoken to were clear on their responsibilities in relation to safeguarding in this centre and all staff had completed training in Children's First. Observations in the centre indicated that staff were committed to ensuring that residents were safeguarded from abuse and protected in the centre. Where incidents had occurred between residents, action was taken to ensure that residents were protected and that reduce the likelihood of re-occurrence. Where concerns had been raised in relation to practices in the centre, these were seen to be taken seriously, investigated and learning documented. Incidents were documented as discussed with the designated liaison person and reviewed as part of the providers' incident management system. Although action was taken in response to any concerns, some incidents had not been identified as requiring reporting to the Chief Inspector and this is addressed under Regulation 31. The inspector was told that resident compatibility was reviewed and considered when allocating resident groups for specific respite periods.

Records provided indicated that the provider had in place Garda Vetting disclosures in respect of the staff working in the centre. Some of these were in the process of being renewed at the time of the inspection.

Judgment: Compliant

Regulation 9: Residents' rights

Overall, the documentation reviewed and the observations of the inspector in the centre indicated that residents' rights were respected in this centre. The young people that used this service while the inspection was underway were seen to be treated with kindness and provided with some choices in relation to snacks, meals and activity. House meetings that residents had opportunities to attend were documented also and evidenced consultation with residents in relation to what they would like to do and achieve during their breaks in the centre. These recorded residents' choices in relation to the menu and the activities they would like to partake in during their respite stay.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 5: Application for registration or renewal of registration	Substantially compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Not compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Compliant
Regulation 20: Information for residents	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Dunmanway Residential OSV-0002110

Inspection ID: MON-0040947

Date of inspection: 12/02/2026

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
Registration Regulation 5: Application for registration or renewal of registration	Substantially Compliant
Outline how you are going to come into compliance with Registration Regulation 5: Application for registration or renewal of registration: An updated Statement of Purpose and Floor plan has been submitted to the inspectorate on the 19th of March 2026.	
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: The person in charge will develop and implement a targeted recruitment and retention plan to address all outstanding staffing vacancies within the centre in conjunction with the HR Department. To ensure continuity of care, each individual resident's file is reviewed and updated accordingly to ensure current information for the individual's care. The person in charge will ensure that all staff coming into the designated centre are provided with the appropriate handover and information pertaining to the residents. The person in charge will work identifying core relief staff to strengthen the continuity of care provided when relief staff are used within the designated centre. Team Meetings are held every two months within the designated centre. Core relief staff and staff that have completed several shifts within the centre are invited to attend. During this, residents are discussed including any updates and plans. The Person in Charge will ensure that a standard agenda item includes continuity of care, care	

planning/updates and shift planning.

The Person in Charge will ensure that the lead staff on shift is provided with time to plan each shift to ensure that when relief staff are in situ, that they are able to assess and plan the shift in accordance with the needs of the residents in attendance.

Regulation 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
The Person in Charge will complete a full review of the training matrix and identify gaps in training. A scheduled plan will be developed to ensure that all trainings are completed in line with the Statement of Purpose and assessed needs of the residents. Area of non compliance will be identified and the appropriate training sourced for the staff.

Scheduled Safety Intervention Training 31st of March 2026 and Refresher 22nd of April 2026 has been completed.

Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
CoAction will strengthen governance and oversight systems to ensure that all actions arising from audits, reviews, and inspections are completed within agreed timeframes and that the Action Tracker is updated regularly and identifies all progresses on actions.

CoAction will ensure that there is active monitoring of the designated centre through the 6 Monthly Audits, Action Trackers, Person in Charge Monthly Meetings and data reporting mechanism which identifies gaps in documentation. This will ensure that there is ongoing monitoring and oversight of the centre's non-compliance and provide for proactive management of same.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
All incidents now have been reported via notifications to the Chief inspector as of 17th of February 2026. All incidents had been reported in line with CoAction's policies and procedures and reported to the Designated Liaison Person. All actions of the incidents had been followed to completion.

Following receipt of updated guidance, CoAction will ensure that all allegations, suspected and confirmed cases of abuse are notified to the Chief Inspector and have updated its procedures to align with this.

Regulation 4: Written policies and procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
CoAction is committed to ensure that all organisational Schedule 5 Policies are prioritised and reviewed to ensure compliance with regulation within a twelve-month deadline. This is being processed through the 4 PG Review Committee chaired by the organisations Quality, Safety and Risk Manager.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
The Person in Charge will complete a full review of the training matrix and identify gaps in training. A scheduled plan will be developed to ensure that all trainings are completed in line with the Statement of Purpose and assessed needs of the residents.

One PEEP had been updated and was with the individual's parents for review and was due for return prior to that individual's next respite visit. The Person in Charge will ensure timely follow up.

A full fire door assessment has been completed, and a report has been issued to CoAction for the completion of works. A scheduled plan of works will be completed and processed accordingly to ensure each fire door meets regulation.

Regulation 5: Individual assessment and personal plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
CoAction is committed to reviewing and updating personal plans in line with the assessed needs of individuals attending respite. The Person in Charge will ensure that annual reviews are scheduled and seek updates from the relevant professionals as appropriate. This review will include explicit information is provider for individuals care plans. A schedule of review will be devised within the designated centre to ensure that timely and effective updates are completed yearly. A file review system will be implemented that will highlight areas that are compliant, will be due a review shortly or are requiring urgent review.

The Person in Charge is developing new systems around the development of goals and plans that are SMART and relevant to the current needs of the individuals. A standard item on Team Meeting will be the review and update of current goals and plans.

Following a serious incident or series of incidents, CoAction is committed to reviewing the individuals risk profile and care plans to accurately reflect the individuals needs and provide the guidance to staff. The Person in Charge will ensure that in the event that this is required, they will engage the relevant professionals and/or other stakeholders in case meetings and provide updates to the risk assessment and care plans.

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
CoAction is committed to reviewing and updating personal plans in line with the assessed needs of individuals attending respite. Following a serious incident or series of incidents, the Person in Charge will ensure that when required, they will engage the relevant professionals and/or other stakeholders in case meetings and provide updates to the risk

assessment and care plans inclusive of the Behavioural Support Plans.

The Person in Charge will review all current Behavioural Support Plans in place with respect to the designated centre and as appropriate will request more specific respite focused behavioural support plans from the relevant professional and/or stakeholder.

Scheduled Safety Intervention Training 31st of March 2026 and Refresher 22nd of April 2026 has been completed. The Person in Charge will refer the use of body blocking to CoAction's Restrictive Practice Committee in quarter 2 of 2026 for review which will inform the organisational practices.

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
Registration Regulation 5(3)(h)	In addition to the requirements set out in section 48(2) of the Act, an application for the registration or the renewal of registration of a designated centre shall be accompanied by a statement of the maximum number of residents who will be accommodated at the designated centre at any one time during the period of registration, and for which the registered provider is requesting approval by the chief inspector in the application for the registration or the renewal of registration of the designated centre.	Substantially Compliant	Yellow	19/03/2026

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	30/09/2026
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Not Compliant	Orange	01/07/2026
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.	Substantially Compliant	Yellow	01/07/2026
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	30/09/2026
Regulation 28(4)(a)	The registered provider shall make arrangements for	Substantially Compliant	Yellow	01/07/2026

	staff to receive suitable training in fire prevention, emergency procedures, building layout and escape routes, location of fire alarm call points and first aid fire fighting equipment, fire control techniques and arrangements for the evacuation of residents.			
Regulation 31(1)(f)	The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: any allegation, suspected or confirmed, of abuse of any resident.	Not Compliant	Orange	17/02/2026
Regulation 31(3)(b)	The person in charge shall ensure that a written report is provided to the chief inspector at the end of each quarter of each calendar year in relation to and of the following incidents occurring in the designated centre: any occasion on which the fire alarm equipment was operated other	Not Compliant	Orange	17/02/2026

	than for the purpose of fire practice, drill or test of equipment.			
Regulation 04(3)	The registered provider shall review the policies and procedures referred to in paragraph (1) as often as the chief inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.	Substantially Compliant	Yellow	26/03/2027
Regulation 05(2)	The registered provider shall ensure, insofar as is reasonably practicable, that arrangements are in place to meet the needs of each resident, as assessed in accordance with paragraph (1).	Not Compliant	Orange	30/08/2026
Regulation 05(6)(c)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall assess the effectiveness of the plan.	Not Compliant	Orange	01/07/2026
Regulation 05(6)(d)	The person in charge shall	Not Compliant	Orange	30/09/2026

	ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall take into account changes in circumstances and new developments.			
Regulation 07(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.	Not Compliant	Orange	22/04/2026
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.	Substantially Compliant	Yellow	01/05/2026