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:	Fernhill Respite House
Name of provider:	Health Service Executive
Address of centre:	Donegal
Type of inspection:	Unannounced
Date of inspection:	04 March 2026
Centre ID:	OSV-0003338
Fieldwork ID:	MON-0048988

About the designated centre

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

The provider describes the service offered as a four day and three night planned holiday respite break for male and female adults aged 18-65 years with a physical and/or sensory disability in a community setting. Fernhill Respite House is a bungalow situated in a residential housing development, in close proximity to the local town centre. Each resident has their own bedroom, and share the kitchen, main bathroom and sitting room facilities. Respite breaks are offered to over 30 service users, and up to three people can avail of a break at any one time. There are usually two staff on duty, this includes a sleepover arrangements. Staffing provision can be adjusted according to the needs of residents availing of respite.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	3

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 4 March 2026	10:00hrs to 14:30hrs	Úna McDermott	Lead

What residents told us and what inspectors observed

This was an unannounced risk inspection that took place over one day. It was a follow up inspection to one that took place on 5 November 2025 which found non-compliance in four regulations and substantial compliance in one.

This inspection identified two contrasting dimensions to the service. On the one hand, the quality of care and support provided to people attending the service continued to be of a high standard. On the other hand, the inspector was not assured by the provider's capacity to ensure that documentation governance was to the standard specified in their compliance plan response following the last inspection or in line with their organisational policies, procedures and guidelines. There was no improvement to the level of compliance found since the last inspection. Regulations relating to the statement of purpose, written policies and procedures, risk management and overall governance and management, remained not compliant. In addition, there was a non-compliant finding relating to staff training and development on this inspection. In light of the compliance response referred to above, this required significant improvement.

Fernhill Respite House provides planned respite breaks for adults with physical and sensory disabilities. There were three people at the centre on the morning of inspection. They sat at the table with the inspector having tea and chatting about their own homes, their daytime occupations and their experiences of attending respite which was very positive. This was similar to the findings of the last inspection. On this occasion, people told the inspector that they loved the service, that it was great craic and that the staff were fabulous. They said that they could choose what they liked to do and that this was supported. One person said that they felt like a 'normal person' when they were at Fernhill. This feedback was supported by the inspector's observations. For example, staff were noted planning a trip out with the people going, providing choices and seeking consent for decisions made.

Similar to the previous inspection, the inspector found that the positive feedback provided by residents, was attributed to the good practice, competence and commitment of the staff team who were providing the service with an absent person in charge and a lack of adequate leadership support.

The provider was aware of the failings relating to governance systems and how this could impact negatively on the safe and effective operation of the service. At the time of this repeat inspection, the service continued to operate without an effective framework for good practice, accountability and risk mitigation. In addition, commitments made by the provider to improve this, by the date specified in their compliance response plan (31 January 2025), were not achieved.

The next two sections of this report present the inspection findings in relation to the governance and management in the centre, and how governance and management affects the quality and safety of the service being delivered.

Capacity and capability

The inspector found little improvement in the capacity and capability of the registered provider to govern and manage the service. The support provided to residents was of a high standard, however, there was an absence of organisational structure and a lack of adequate governance systems to support the service

Examples are provided in the regulations below.

Regulation 16: Training and staff development

The inspector was not assured by arrangements for the training and supervision of staff at this centre. While staff had access to training, there continued to be little planning and organising of modules required, despite assurances provided following the November 2025 inspection.

For example, three staff were due annual refresher training in fire safety. Information on when this expired was not available for review and there were no plans in place for this to occur. In addition, three staff required refresher training in moving and handling. This was due since September 2025 and was yet to be arranged. The inspector saw that this was a requirement for the service due to the nature of support provided to physically disabled people. Furthermore, a commitment by the provider to provide training in positive behaviour support in December 2025 was not actioned due to issues with training staff. A further commitment to complete this by 31 January was not met.

A review of the arrangements to support staff through supervision and performance meetings found that these supports were not formally provided in line with the provider's policy. Such meetings would provide an opportunity to discuss training needs and ensure that modules were completed. This required review.

Judgment: Not compliant

Regulation 23: Governance and management

The person in charge continued to be absent from their role since May 2025. While a cover arrangement was in place, it was not effective. There continued to be a lack of clear and robust management support and poor oversight of the operational scaffold of the service. While a compliance plan response was submitted following the November 2025 inspection, not all actions planned were achieved and there was no improvement in compliance found on this inspection.

When gaps were identified at the service, there was no follow up to ensure that the matters identified were addressed. In their compliance response plan, the provider committed to the completion of audits on care planning, fire audit, documentation and policy sign off audit, complaints audit and incidents and accidents audit. The inspector found evidence of the completion of a personal care and support plan checklist tool dated 11 November 2026 which was completed for one resident only. Evidence of four other audits was not provided.

The annual review of care and support available at the centre was out of date since December 2024.

When requested, the six monthly provider-led audit was not available at the centre. It was provided by email toward the end of the inspection with a completion date of 11 December 2025 documented.

While a quality improvement plan was available dated 11 February 2026, it was incomplete. Actions had completion dates which expired in September 2025 and the comments section was not reviewed.

Staff meetings were not occurring in line with the provider's policy. The most recent staff meeting minutes available were for 9 March 2023.

The out of hour's arrangement for staff support remained unchanged. The inspector reviewed the protocol which named the person in charge and the house manager as the key contacts. As outlined, the person in charge was absent since May 2025 which meant that out of hours cover was provided by the house manager only. This required review.

Judgment: Not compliant

Regulation 3: Statement of purpose

The provider reviewed the statement of purpose dated 10 November 2025.

The inspector read the statement and found that improvements were required as follows;

The management and staffing requirements were not in line with the requirements of Schedule 2. The person in charge named was absent since May 2025.

Judgment: Not compliant

Regulation 4: Written policies and procedures

Following the last November 2025 inspection, the provider committed to reviewing and updating the policies, procedures and guidelines held at the centre to ensure that they met with the requirements of Schedule 5 of this regulation.

The inspector completed a review of the policies folder and found that two of four expired polices were updated. However, the policy on positive behaviour support was due for revision in October 2025. The policy on restrictive practices was due for revision in December 2025. This meant that clear up-to-date guidance for staff was not provided.

Judgment: Not compliant

Quality and safety

Under this dimension of the inspection, the inspector found no improvement in compliance relating to risk management systems and oversight. While the care and support of residents was of a good quality the systems and processes to sustain good practice were not adequate.

Further details are provided under the regulation below.

Regulation 26: Risk management procedures

The inspector found no improvement to the standard of risk management arrangements at the centre which in the main, remained unchanged and not compliant with the requirements of this regulation.

The inspector completed a review of the quality, safety and risk folder. The site specific safety statement was dated 1 December 2023.

The emergency plan for the centre was at provider level and specific to Fernhill Respite House. Its review date was March 2025.

The inspector reviewed the core risks for the service and found that there were sixteen risks documented. All had the name of the absent person in charge and while reviewed on 11 November 2025 gaps remained.

For example, control measures for fire risks were documented as fire training and mandatory discussions at team meeting. These control measures were not occurring in practice.

In addition, a risk assessment on risks relating to COVID-19 was reviewed on 11 November 2025. Control measures recommended included social distancing, twice daily resident temperature checks and interactions with the contract tracing team. This was obsolete at the time of inspection.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Not compliant
Regulation 4: Written policies and procedures	Not compliant
Quality and safety	
Regulation 26: Risk management procedures	Not compliant

Compliance Plan for Fernhill Respite House OSV-0003338

Inspection ID: MON-0048988

Date of inspection: 04/03/2026

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: To ensure compliance with Regulation 16, the following actions will be completed: • The Provider Representative and CNM3 have reviewed the Centre's training matrix and completed a training needs analysis. • A training plan has been developed and issued to each staff member. Completed 20.03.2026. • Mandatory HSEland Training has been completed by all staff on 30.03.2026. • Studia 3 Training: Training has been scheduled for 4 staff on 13.4.2026. • All Staff completed Fire Training on 23.03.2026. • All staff have been scheduled to complete Manual Handling Training on 07.05.2026. • The PIC has scheduled dates for all Performance Achievement Reviews to be completed by 30.05.2026. The PIC Performance Achievement Review completed 30.03.2026.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management:	

To ensure compliance with Regulation 23, the following actions will be implemented:

• The PIC commenced employment in the centre on 23.03.2026. The Statement of Purpose has been updated to reflect the PICs revised details. This update was completed on the 23.03.2026.

• A number of audits have been completed within the centre, Care Planning Audit, Fire Audit, Documentation and Policy Sign Off Audit, Complaints Audit, Incident Accident Audit. The PIC will ensure that all remaining audits are completed in-line with Donegal Disability Audit Schedule by 30.06.2026.

• Annual Review of Care and Support was completed on 20.03.2026 and is available on site. All staff have reviewed same.

• Clear governance arrangements are in place to support staff outside of normal working hours. An out-of-hours system for Fernhill Respite House is established to ensure that staff can access guidance and support in the event of an emergency.

• The Person in Charge (PIC) and House Manager provide out-of-hours cover, ensuring continuity of leadership, oversight, and decision-making when required.

• Up-to-date contact numbers for the PIC and House Manager are clearly displayed in the office to ensure staff have immediate and direct access to support in line with emergency response procedures.

Regulation 3: Statement of purpose	Not Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:

To ensure compliance with Regulation 3, the following actions will be implemented:

The PIC commenced employment in the centre on 23.03.2026. The Statement of Purpose has been updated to reflect the PICs revised details. This update was completed on the 23.03.2026.

Regulation 4: Written policies and procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:

To ensure compliance with Regulation 4, the following actions will be implemented:

• All Schedule five policies have been updated,

• All Staff have reviewed and signed on all policies. Completed 20.03.2026

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:

To ensure compliance with Regulation 26 Risk Management, the following actions will be implemented:

• The Provider Representative has reviewed and updated the Site-Specific Safety Statement, Donegal Disability Safety Statement and the HSE Corporate Safety Statement. Completed 20.03.2026.

• All Staff completed Fire Training on 24.03.2026

• Staff Meeting completed with all Staff and PIC 30.03.2026.

• The PIC has reviewed and updated all Risk Assessments within the Centre. Completed 26.03.2026.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 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	30/05/2026
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.	Not Compliant	Orange	23/03/2026
Regulation 23(1)(b)	The registered provider shall ensure that there is a clearly defined management structure in the designated centre that identifies the	Not Compliant	Orange	30/06/2026

	lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.			
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	23/03/2026
Regulation 23(1)(d)	The registered provider shall ensure that there is an annual review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards.	Not Compliant	Orange	20/03/2026
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Not Compliant	Orange	30/04/2026
Regulation 03(1)	The registered provider shall	Not Compliant	Orange	23/03/2026

	prepare in writing a statement of purpose containing the information set out in Schedule 1.			
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.	Not Compliant	Orange	20/03/2026