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:	05 November 2025
Centre ID:	OSV-0003338
Fieldwork ID:	MON-0048799

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. There are usually two staff on duty, this includes a sleepover arrangement. 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:	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
Wednesday 5 November 2025	10:15hrs to 16:30hrs	Úna McDermott	Lead

What residents told us and what inspectors observed

Fernhill Respite House provides planned respite breaks for adults with physical and/or sensory disabilities. At centre level, a high standard of person centred care and support was provided by a dedicated staff team who were familiar with each person's individual needs. However, the inspector found that the governance and management arrangements were inadequate. This impacted on the long term safety of the service. There was poor oversight of the systems and processes used at the centre and a lack of regular review. The inspector found non-compliance in three regulations and substantial compliance in one. An immediate action was issued under Regulation 23: Governance and Management which the provider rectified prior to the end of the inspection. These matters will be expanded on later in this report.

There were two residents staying at Fernhill at the time of inspection. Both held conversations with the inspector. They spoke highly of their experience while on respite breaks. They said that they were very much enjoyed them and that it was a like a 'home from home'. They said that they decided what to do while on respite which meant that their human rights were respected. Also, that they were supported by kind and caring staff.

At the time of this inspection, the person in charge was on leave since May 2025. On arrival, the inspector met with the house manager, who facilitated the inspection. The provider representative attended in the afternoon. In addition, the inspector met with two staff members who were observed supporting residents as required throughout the day. The atmosphere was and companionable and relaxed, and interactions between staff and residents were warm and respectful. The inspector spoke with all staff members who told the inspector that they enjoyed their work. In particular, they said that they liked the fact that they reported for duty at the beginning of the respite break and stayed until the end. They could provide consistent care for residents staying and could participate in a range of different activities in line with resident's preferences For example; a trip to the hospital for a medical appointment or a social night out. All staff told the inspector that they would like to provide additional respite breaks if possible and while they understood that they were restricted to the provision of services to people under the age of 65 years, they found it difficult when residents had to leave the service as they aged.

The centre consisted of a single story building in a residential area close to a large town. It was registered to provide overnight accommodation for up to three residents. Each person had their own bedroom and one had an en-suite bathroom. The centre also had a shared bathroom with level access shower. The kitchen and sitting rooms were open plan and there was an additional room for relaxation provided. The centre was clean, warm and comfortable. The hard and soft furnishings were of good standard and the rooms were nicely decorated with homely touches throughout. Information for staff and residents was displayed on

notice boards, however, the house manager told the inspector that they preferred to keep this to a minimum in order to maintain a homely environment. All bedrooms had a comprehensive information booklet for those staying.

The next two sections of this report present the inspection findings in relation to the governance and management in the centre and how this impacts the quality and safety of the service provided.

Capacity and capability

The inspector found that while the service provided at centre level was of a high standard, there was an absence of effective support at service level. At the time of the inspection, the inspector found that this did not pose a high risk to the residents as they were well cared for, however, it posed a risk which the provider was aware of, which was not addressed at the time of inspection and was not sustainable the in the long term.

Significant work was required to improve the standard of the statement of purpose and action was required on the day of inspection to ensure that the service was offered in line with the conditions of registration. A review of the policies, procedures and guidelines at the centre as also required.

Staffing arrangements at the centre were working well and were offered on a person-centred and consistent basis. Some improvement to the arrangements for staff training were required. There were no open complaints the time of inspection and where required, information was submitted to the Chief Inspector of Social Services in line with the requirements.

Regulation 15: Staffing

There were two staff on duty on the day of inspection which meant that individual support was provided to each person availing of a respite break. They had appropriate skills, qualifications and experience to meet with the residents' care and support needs.

The inspector reviewed the roster from 1 October to the day of inspection. It provided an accurate account of the staff on duty and was well maintained. Staff were consistently employed which meant that they were familiar with residents' assessed needs and residents described their competence in the care they provided.

Judgment: Compliant

Regulation 16: Training and staff development

Staff had access to training, including refresher training, as part of a continuous professional development programme. The sample reviewed found that most training modules were up to date, however, some mandatory refresher modules required completion. For example; three staff required refresher training in cardiac pulmonary resuscitation (CPR) and one staff required part of their medicines administration training.

Judgment: Substantially compliant

Regulation 23: Governance and management

As outlined, the person in charge was absent from their role since May 2025. The inspector found that at centre level, a house manager was employed. This person was a member of the core staff team who typically supported the person in charge while also working with residents on respite breaks. They, along with the staff team were maintaining the service to the best of their ability, however, at service level, there was a lack of clear and robust management support and poor oversight of the service. An immediate action was issued on the day of inspection which will be expanded on below.

For example; the service was operating outside of the requirements of condition 1 of the registration conditions of the centre and not in line with the statement of purpose. This related to the use of a registered bed which was used to accommodate a staff sleepover arrangement. An immediate action was issued to the provider representative by telephone. This prompted a review of the staffing arrangements. As the residents did not require two sleep-over staff, one staff member was removed from the sleep over shift.

There was a lack of a defined management structures at service level, which impacted on the governance systems and decision making process at centre level. The house manager told the inspector that they reported to the acting service manager in relation to some matters and to the general manager for others. For example, the acting service manager was provided with written updates after each respite break was complete, while the general manager was contacted in relation to operational decisions such as planned trips. When asked, they said that this resulted in uncertainty and delays in response times.

Centre level audits were last completed in May 2025. This was not in line with the provider's audit schedule dated 12 February 2025 which required the completion of weekly, monthly and quarterly audits. In addition, the most recent six monthly provider-led audit at the centre was completed 17 months ago on 26 May 2024. An

annual review of care and support was not available for review at the centre on the day of inspection.

The out of hours arrangements required review to ensure that they were effective, sustainable and in line with the guidance provided. At the time of inspection, an informal arrangement was in place which meant that the staff team contacted the house manager or each other in the evenings or at weekends in order to address gaps in staffing or concerns relating to the service. This meant that the house manager was always on call and this was not sustainable.

Overall, the inspector found that there was a lack of robust governance and support. This was due to the fact that there were role vacancies which impacted on the monitoring and oversight of the service. This was not in line with the requirements of this regulation and was not sustainable.

Judgment: Not compliant

Regulation 3: Statement of purpose

The registered provider had prepared a statement of purpose dated 10 December 2025 which was reviewed by the inspector. The inspector found that it did not meet with the requirements of Schedule 1 of this regulation and considerable action was required to return to compliance.

For example;

The staffing structure had changed as the person in charge was absent and the house manager was covering their role. In addition, the overall reporting organisational structure had changed as the senior manager role was vacant. This was not updated.

The description of the rooms in the designated centre required review to ensure that the primary purpose of each room was clearly defined and correct. Bedroom 4 was a registered bedroom and not a staff bedroom as described. Bedroom 1 was a registered bedroom for respite residents. It was used as a staff sleepover room on the day of inspection.

Judgment: Not compliant

Regulation 31: Notification of incidents

The people attending this respite service had low support needs, had good levels of capacity and independence and were compatible with each other. A review of the incidents recorded at the centre since 1 January 2025 found that there were not

matters which required notification to the Chief Inspector of Social Services under the three day monitoring arrangements. Quarterly notifications were notified as required.

Judgment: Compliant

Regulation 34: Complaints procedure

There were no open complaints at this centre and no recent complaints for review. The inspector spoke with a resident who said that they had access to the complaints policy and were aware of how to make a compliant. They said that they had done so in the distant past, that they felt listened to and that the matter was addressed promptly and to their satisfaction.

While the complaints policy held at the centre required review, this matter is addressed under Regulation 4; Written policies and procedures in this report.

Judgment: Compliant

Regulation 4: Written policies and procedures

The registered provider had prepared a policy and procedures folder with written policies which were available to guide staff. This was reviewed by the inspector who found that it did not meet with the requirements of Schedule 5 of this regulation.

For example; four policies were out of date and required review. These included the policy on behaviour support, the use of restrictive procedures, the monitoring of nutritional intake and the investigation of complaints.

Judgment: Not compliant

Quality and safety

As outlined the quality of care and support provided was of good quality. However, significant improvements were required with risk management systems which were not compliant at the time of this inspection.

The ethos of promoting the rights of residents was apparent in the day-to-day running of the centre. Residents were supported to engage in activities that they enjoyed and that were important to them. Residents were involved in the running of

the centre. They told the inspector that they were happy with the quality of the service they received.

The premises met with requirements and was kept clean and tidy and in good repair. Fire safety and management systems were regularly reviewed by a staff member and all staff had training fire safety completed.

Regulation 13: General welfare and development

People attending respite care received person-centred care which had regard for the nature and extent of their disability and their assessed needs and wishes. They were provided with opportunities to take part in activities or events which matched their individual or group interests.

Judgment: Compliant

Regulation 17: Premises

The long term suitability of the premises was under review by the provider's maintenance and infection prevention and controls teams. This matter is reported on under Regulation 26; Risk management procedures in this report.

The inspector found that the premises provided was suitable in meeting with the assessed needs of the residents with in line with Schedule 6 of this regulation. Adequate private and communal accommodation was provided for those staying overnight. Rooms were of a good size and typical to that of a typical home. The premises was kept well and was clean and tidy.

Judgment: Compliant

Regulation 26: Risk management procedures

The registered provider had some systems in place for the assessment and management of risk, however, these were not subject to regular review and this required improvement. In addition, where the provider was aware of risks posed to the service, not all recommendations were reviewed and actioned if required.

While a list of core centre level risks was available, the risk register to guide mitigation and control was not available for review. In addition, the risk list

documented risks such as self-harm which may not be relevant to the risks present and this required update.

Where required, individual risk assessments were completed. For example, a resident that enjoyed smoking had a risk assessment with associated control measures (03 April 2023). This was due for review on 03 April 2024. There was no evidence of review and the risk assessment was closed.

The provider was aware of risks identified by a joint infection prevention and control and maintenance assessment on 16 April 2024. However, the matters raised in the report (23 April 2024) required further exploration and review to ensure that they aligned with the requirements Care and Support of Residents in Designated Centres for Persons with Disabilities Regulations (2013) and were completed in full if required.

Judgment: Not compliant

Regulation 28: Fire precautions

The provider had fire safety management systems in place including arrangements to detect, contain and extinguish fires and to evacuate the premises.

The inspector met a staff member who had acted as safety officer for the service. They were competent in their role and provided an overview of the actions taken to plan for and mitigate against fire risks. Residents had individual personal emergency evacuation plans and fire drills were taking place on a regular basis. All staff had access to fire training and this was in date.

Judgment: Compliant

Regulation 9: Residents' rights

The rights of residents were respected at this centre and they were actively involved in directing their care and support while using this respite service. The service provided was person-centred and adapted to accommodate each person's preferences. Opinions were sought and listened to and their views helped to guide decisions made. Information on human rights and advocacy supports were readily available and residents were aware of how to request additional support to access these services if they wished to do so.

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	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Not compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Not compliant
Quality and safety	
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 28: Fire precautions	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Fernhill Respite House OSV-0003338

Inspection ID: MON-0048799

Date of inspection: 05/11/2025

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 16: Training and staff development	Substantially 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 implemented:

- The Provider Representative and House Manager has 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 11.11.2025
- Mandatory HSEland training will be completed by all staff by 30th January 2026.
- Studio 3 Training: Training was scheduled for December 3rd but was rescheduled by Studio 3 trainers. Training re-scheduled for January 2026 for the staff members requiring this module.
- CPR Training: One staff member completed CPR Refresher Training on the 11.11.2025. The remaining staff will complete CPR Refresher Training on 15th December 2025.
- All staff have completed medication management training, one staff requires competency review on this. Date scheduled for competency review 5th December 2025.

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 Person in Charge (PIC) will review the centre's roster on an ongoing basis to ensure staffing levels meet residents' needs and comply with the centre's Statement of Purpose.
- Donegal Disability Service HR Department are currently coordinating the recruitment of a PIC for Fernhill. Appointment of a PIC is anticipated by 31 January 2026.
- Interim Governance and management arrangements for this centre have been confirmed and communicated to all staff. The House manager reports to the A/Service manager to the General Manager Completed 10th November 2025.
- Governance structure has been clearly identified within the centre outlining reporting lines (House Manager → Acting Service Manager → General Manager) by 20 November 2025.
- A number of Audits have been commenced within the centre, Care Planning Audit, Fire Audit, Documentation and Policy sign off Audit, Complaints Audit, Incident and Accident Audit. All remaining audits to be completed by 30.12.2025
- Provider-led six-monthly audit to be completed by 15 December 2025. Completed 3rd December 2025.
- The annual review of care and support for this centre was completed in February 2025 this is now available on site.
- An updated Statement of Purpose was submitted to the Regulator on 14th November 2025 inclusive of current use of rooms within the centre.
- Weekly updates on compliance are provided to General Manager.
- Monthly governance review meetings commencing in December 2025.
- Fernhill Respite House does not operate an Out of Hours Cover arrangement. In the event of an emergency staff will contact Now Doc/Emergency Services or An Garda Síochana for advice. These arrangements have been set out in the Site-Specific Statement.

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:

- An updated Statement of Purpose was submitted to the Regulator on 14th November 2025 inclusive of current use of rooms within the centre.

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 5 Policies & Procedures have been updated on 10th & 11th November.
- All staff to review, read and sign policies by 31.12.2025.

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 and House Manager has reviewed and updated the centre's risks and risk ratings. Completed on 11th November 2025.
- The Provider Representative and House Manager has reviewed and updated the centre's Risk Register and is now available on site. Completed 11th November 2025.
- The Provider Representative and House Manager will ensure the centre's risk assessments and Risk Registered are reviewed and updated on a quarterly basis.
- All works included in the IPC report of 16.04.2025 have been completed

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.	Substantially Compliant	Yellow	31.01.2026
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	31.01.2026
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	11.11.2025

	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	11.11.2025
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	Completed Feb 2025 Available on Site 14.11.2025
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	Completed 11.11.2025
Regulation 03(1)	The registered provider shall	Not Compliant	Orange	Completed 14.11.2025

	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	Completed 14.11.2025