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:	Listowel Residential Services
Name of provider:	Kerry Parents and Friends Association
Address of centre:	Kerry
Type of inspection:	Unannounced
Date of inspection:	03 September 2025
Centre ID:	OSV-0003429
Fieldwork ID:	MON-0047711

About the designated centre

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

Listowel Residential Services consists of one detached two-storey house located on the outskirts of a town and a second detached two-storey house located a short distance away outside the town. One house can provide full-time residential support for up to six residents. The other house can provide full-time residential support for four residents and five day residential support for a fifth resident. In total the centre can support a maximum of eleven residents of both genders over the age of 18 with intellectual disabilities. Each resident has their own bedroom and other rooms in the two houses include kitchens, sitting rooms, utility rooms and bathrooms. Residents are supported by the person in charge, social care workers and support workers.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	10

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 3 September 2025	09:40hrs to 16:45hrs	Robert Hennessy	Lead

What residents told us and what inspectors observed

This was an unannounced inspection of the designated centre which focused on regulations in relation to the safeguarding of residents. The feedback from residents spoken with in the designated centre was positive, with the residents explaining how proud they were with their homes. The designated centre is compromised of two houses in a large town which are a short drive apart. The designated can accommodate 11 residents and there were ten residents residing in the designated centre on the day of the inspection. Residents met during the inspection indicated they were happy and comfortable living in the centre.

The inspector was met by staff in the first home of the designated centre visited. Most of the residents were away from the centre at their day service and staff were assisting one resident that remained in the centre with their morning routine. Staff members spoken with during the inspection were aware of safeguarding concerns in the designated centre and how they may be dealt with. The inspector undertook a walk around of this part of the designated centre. It was well maintained and had adequate spaces in the centre for residents to utilise. The residents bedrooms that were viewed were personalised. There was adequate storage space for the residents in their bedrooms. A resident had moved to a downstairs bedroom recently and this was more suitable to their needs and working well for the resident according to staff. The resident that did not attend day service was met later in the day and they briefly interacted with the inspector. They were working on their laptop in kitchen of the centre and staff were chatting with them in a kind and relaxed manner.

The inspector reviewed documentation in the staff office in the centre. Documents were provided by the management in the centre as required by the inspector.

The inspector then visited the second house in the centre which was a short drive away. One resident in this house showed the inspector around their house and informed the inspector that they were very happy in their home. They said that they liked to stay at home independently during the week. They told the inspector about the job they had which they enjoyed. The resident also showed the inspector the garden and the work they liked to undertake to maintain this. The inspector briefly met with three other residents in this part of the centre when they had returned to their home following their day service. The staff at this time were providing the residents with a meal and were interacting with the residents in a kind and respectful manner.

This interior and the outdoor area of this part of the designated centre were well maintained. Areas throughout the house were personalised and meaningful for the residents. Concerns regarding this part of the premises are discussed under regulation 17 in the report.

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

A new system of auditing was being introduced by the person in charge to ensure the quality of service in the designated centre was being effectively monitored. This inspection found that the management and staff team in place in the centre were familiar with the residents living in the centre and were committed to providing an effective service that met their assessed needs. There was a clear management structure present and overall there was evidence that the management of this centre were maintaining oversight and that these individuals maintained a strong presence in the centre. Some resources identified in line with the residents needs were not available in the designated centre this is discussed under regulation 23.

Staffing levels were maintained in the centre to ensure the residents could be supported to undertake the activities they wanted. Residents said they received good support from the staff. The staff team were knowledgeable of the residents' needs when they spoke with the inspector.

The person in charge had ensured that the staff team had received appropriate training to meet the needs of the residents. There was evidence of the training programme being monitored to ensure that the staff team remained up to date with their training. There was a supervision schedule in place for staff.

Regulation 15: Staffing

Staffing levels were maintained at appropriate level to the number and the assessed needs of the residents and the layout of the centre. The staffing levels also corresponded to the staffing levels described in the statement of purpose. A planned and actual staffing rota was available on the day of the inspection. Staff spoken with on the day were very familiar with the residents' needs and spoke about them in a respectful manner. Residents were seen to be comfortable spending time with staff. One to one supports required by residents were in place and maintained.

Judgment: Compliant

Regulation 16: Training and staff development

Training was being undertaken by staff in the centre that was required for the

residents' needs. The inspector viewed the training matrix for the designated centre which tracked the training undertaken by the staff. It was evident from this training matrix that the person in charge had maintained oversight of the training needs of the staff. Training provided included safeguarding training, training in relation to managing behaviours that challenge and training for staff to support residents safely with their medication needs.

A schedule for staff supervision was maintained and this was provided to the inspector. The schedule showed that supervision had begun for the year and that there was a schedule to complete regular staff supervision sessions throughout the year.

Judgment: Compliant

Regulation 23: Governance and management

The annual review of the quality and safety of care and support in the designated centre had been completed for 2024. This report was made available to the inspector. The review contained residents' views on how the service was run. The unannounced registered provider visits were completed every six months. These unannounced provider visits were identifying actions for the designated centre under the regulations.

The designated centre had staff meetings once a month which discussed the safeguarding of the residents. Residents' meetings were taking place in the designated centre on a weekly basis. These meetings included discussions around such issues as fire safety and safeguarding.

A new schedule of auditing was being put in place by the person in charge to monitor the service locally and a schedule was being put in place for these audits to be completed.

Some resources to meet residents' needs were not being provided by the registered provider. The premises in one part of the designated centre was not meeting the resident's need for a low stimulus environment, which was identified on the previous inspection. This meant that the resident involved had to travel to a day centre hub in the nearby town to access a quieter environment when required. Resources available in relation to positive behaviour support were inconsistent and not delivered in a timely manner. Staff identified that a resident currently required support in this area but this was not currently provided.

Judgment: Substantially compliant

Quality and safety

The person in charge had ensured there were relevant assessments undertaken and personal plans in place for the residents. These were reviewed in a timely manner. These plans contained information on residents' needs in relation to health care and also on how they communicate and how they liked to be communicated with.

Residents' rights were respected and upheld in the designated centre and the centre was resident led in the way it was run. Residents had goals for the year created and these goals were realistic and reviewed. Residents had positive behaviour support plans in place when they required support in this area.

Safeguarding issues were identified and reported in the designated centre. Staff had received training in relation to safeguarding. Staff spoken with during the inspection were aware of how to deal with safeguarding concerns in the designated centre.

The premises while well maintained in the designated centre, was not meeting the needs of some of the residents in one part. Concerns regarding the premises is discussed further in the report under Regulation 17.

Regulation 10: Communication

Residents' personal plans contained information on how the residents communicated. These plans also contained information on how residents liked to be communicated with.

Residents had access and were using smart devices on the day of the inspection such as tablet devices, speakers and televisions. One resident was observed to be carrying out research on their laptop during the inspection.

Residents were given easy to read information to access and was available when required in the centre.

Judgment: Compliant

Regulation 17: Premises

The two homes in the centre were well maintained and met the needs of most of the residents living there. Residents had bedrooms that were personalised and one resident in particular spoke about how proud they were of their home.

The previous inspection completed in December 2023 highlighted that a resident required a low stimulus environment that was not always available to them due to the current layout of the centre. Currently the resident had access to a day centre

but this required a drive into the town nearby. The management team in the centre discussed the plan of purchasing an outdoor cabin to go into the garden of the centre as a short term plan. There was a longer term plan for this particular resident to have their own self contained apartment with an extension being built onto the existing centre to create this. The registered provider had committed to these works in the previous inspection compliance plan and committed to have these works completed by June 2025. These works had yet to begin and the registered provider was unable to provide a time frame for them to be completed.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

Assessments and personal plans were viewed for three of the residents. Review of the personal plans had taken place in the last 12 months. There was evidence in the personal plans of multidisciplinary team involvement in supporting the residents throughout the year. The residents social and health care needs were well met and documented.

Residents goals for the year were well planned, well documented and being monitored. Pictures of residents undertaking activities provided evidence of the residents completing their goals. An example of this would be the residents attending the local horse racing event and attending a wildlife park. The residents were clearly to enjoy these occasions from the pictures and one resident told the inspector how much they liked going to the local horse racing event.

Judgment: Compliant

Regulation 7: Positive behavioural support

Some residents had behaviour support plans in place when required. The plans reviewed had information to guide staff on how to work with the residents in this area. Staff spoken with were knowledgeable of these plans. Restrictive practices were logged and were submitted to the Chief Inspector on a quarterly basis.

The management in the centre identified during the inspection that they did not currently have access to a positive behaviour specialist and were referring to an outside organisation. The management team had flagged a resident was currently requiring behavioural support input but was unable to provide this resource for the resident at this time.

Judgment: Substantially compliant

Regulation 8: Protection

Safeguarding concerns in the centre were dealt with in line with the registered provider's policy. Incidents that required notification to the Chief Inspector's office were done so appropriately. All staff had received training in the area of safeguarding. The staff spoken with during the inspection were aware of abuses that may occur and how this should be dealt with. The organisations policy in relation to safeguarding was provided in an easy to read format.

Residents had intimate care plans to identify the supports the residents required in this area and guided staff on how to provide these supports.

Staff members were seen to speak with residents in a kind and respectful manner. Staff were seen to be respectful of the residents' privacy and sought permission from residents when providing support to them.

Judgment: Compliant

Regulation 9: Residents' rights

Residents meetings were occurring regularly in the centre. These meetings discussed relevant topics for the residents ranging from planning for the weekend and fire safety.

Residents had a choice of activities available to them. One resident was seen carrying out tasks during the day with support from staff. Another resident spoke with the inspector about the employment they had and how they enjoyed maintaining the garden in the centre.

Residents had financial accounts in their own name. One resident consented to have their family manage their finances. Residents were supported to have their financial accounts in an institution of their choosing, with residents having financial accounts in different institutions.

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	Compliant
Regulation 23: Governance and management	Substantially compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 17: Premises	Not compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Listowel Residential Services OSV-0003429

Inspection ID: MON-0047711

Date of inspection: 03/09/2025

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 23: Governance and management	Substantially Compliant

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

Governance and Oversight

A Team Lead is in place to strengthen local oversight and communication within the residence. The Person in Charge (PIC) now receives daily reports on both residents to monitor support consistency, incidents, and wellbeing trends. Weekly PIC-ADOS tracker is completed by the PIC and reviewed by the ADOS, providing real-time visibility of operational issues, staffing levels, and resident outcomes. Monthly staff meetings continue to review safeguarding, health and safety, and residents' rights.

Resourcing and Quality Monitoring

To meet the assessed needs of residents, the PIC has submitted a business case to the funder to secure permanent rostered hours and enhance staffing levels within the designated centre. A CAS Funding Form for environmental works has been formally submitted to the relevant local government agency. In the interim, a Log Cabin has been purchased to provide a low-stimulus space as planning approval and site works are progressed. The new local audit schedule has been implemented by the PIC to monitor key regulatory areas, including safeguarding, health and safety, personal planning, communication supports, and medication management. Audit findings are reviewed through weekly governance meetings and inform the service's Quality Improvement Plan (QIP). In addition, unannounced provider visits continue to occur every six months, ensuring independent oversight and action tracking.

Positive Behaviour Support (PBS) Governance.

We acknowledge that access to psychology and PBS input has been inconsistent due to the retirement of the Clinical Psychologist and the funder paused the recruitment of a replacement. The funder has directed KPFA to access MDT through a regional multidisciplinary agency and primary care services to access MDT supports. This unmet need has been formally recorded on our Service Gap Tracker and is escalated during regular governance meetings with KPFA's funder. To strengthen internal capacity, a staff member has completed accredited Positive Behaviour Support training. Work is underway to determine how this internal resource can be used effectively, with a funding

application in progress to support implementation.
Summary of Assurance
• Clear governance structure with daily, weekly, and monthly reporting in place.
• Oversight strengthened through local audit schedule, unannounced visits, and QIP monitoring.
• Business case and funding application submitted to the relevant local government body to ensure resourcing and environmental suitability.
• Identified gaps in psychology/PBS supports tracked and escalated through governance channels.
• Continuous improvement actions implemented to maintain quality and safety of care.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
The provider acknowledges that the environmental works identified during the previous inspection have not yet commenced due to external factors related to funding and planning processes. There has been ongoing correspondence and revision of costings with the relevant local government body to progress the Capital Assistance Scheme (CAS) funding application for the approved extension. The final revised application was formally submitted to local government body on 7 October 2025 for consideration.
Pending the completion of this extension, the provider has implemented interim environmental measures to ensure that the resident's sensory and behavioural support needs are met:
• A Log Cabin has been purchased to serve as a low-stimulus space within the garden area of the residence.
• The cabin will provide a quiet, self-regulated environment for residents requiring reduced stimulation and space for calm engagement.
• Planning permission and site works are currently in progress, with installation targeted for completion by end of Quarter 1, 2026.
• The resident continues to have access to a Day Service Hub, which provides an alternative low-stimulus environment with full bathroom and kitchen facilities as required.
• Staff continue to implement a contingency plan that ensures choice, comfort, and safety, and report that the resident is content with this arrangement.
The provider will continue to monitor progress through weekly PIC-ADOS tracker & Monthly PIC-ADOS meetings, ensuring that all environmental milestones are tracked and reported until full compliance is achieved.
Expected Outcome:
The resident will have access to a purpose-designed, low-stimulus environment both in the short term (via the Log Cabin) and long term (via the self-contained extension). The final works are expected to be fully complete and operational by November, 2026, subject to planning and pending funding approval timelines.

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
The provider acknowledges that access to a qualified Positive Behaviour Support (PBS) specialist has been limited and that this has affected the timeliness of behavioural assessments for some residents. The service has been proactive in identifying this as a risk and has implemented a series of interim and strategic actions to ensure continuity of

behavioural support and compliance with Regulation 7.
1. Interim Measures and Current Supports
• Behaviour Support Plans (PBSPs) are in place for all residents who require them and are implemented by trained staff.
• All restrictive practices are logged and reviewed monthly, and notifications to the Chief Inspector are submitted quarterly in line with Regulation 7(5).
• Staff demonstrate good knowledge of existing PBSPs and use proactive and least-restrictive strategies to support residents.
• Resident 135 currently requiring specialist behavioural input is being supported through the contingency plan, and the regional multi-disciplinary mental health support team.
• Resident 64 has received support from regional multi-disciplinary service provider, an interdisciplinary geriatric medicine/ neurology clinical service, GP and specialist adult mental health service.
• Staff are receiving direct coaching and oversight from the Team Lead and Person in Charge (PIC) to maintain consistent approaches and reduce triggers.
2. Capacity Building and Sustainability
• The service has identified the absence of internal PBS or Psychology support capacity as a key gap and has recorded this on the Service Gap Tracker, which is reviewed regularly and escalated at meetings with KPFA's funders.
• A staff member, has successfully completed Positive Behaviour Support training.
• The provider is finalising a funding application to enable the development and utilisation of this internal PBS resource to support the service on an ongoing basis.
• Staff are scheduled to complete Positive Behaviour Support and Mental Health First Aid training by the end of 2025, enhancing team competence and consistency of practice.
• Input from KPFA CPI Instructors regarding reviews of appropriate response strategies.
3. Governance and Monitoring
• PBS planning and restrictive practice reviews form part of the centre's monthly team meetings.
• The PIC ensures all PBSPs are reviewed regularly and updated in consultation with the MDT and the resident, where possible.
Summary of Assurance
• Interim PBS supports are in place and guided by external professionals (regional mdt service provider and specialist adult mental health service).
• Gaps in formal PBS resources are tracked and escalated through governance structures.
• Internal capacity-building and training plans are underway.
The provider remains committed to advocating for all residents to have timely access to consistent, person-centred behavioural support.

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 17(1)(a)	The registered provider shall ensure the premises of the designated centre are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.	Not Compliant	Orange	30/11/2026
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.	Substantially Compliant	Yellow	30/11/2026
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	Substantially Compliant	Yellow	31/12/2025

	behaviour that is challenging and to support residents to manage their behaviour.			