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:	Acorn Respite & Residential Services
Name of provider:	Western Care Association
Address of centre:	Mayo
Type of inspection:	Unannounced
Date of inspection:	02 October 2025
Centre ID:	OSV-0003914
Fieldwork ID:	MON-0047934

About the designated centre

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

Acorn Residential Services is a centre operated by Western Care Association. The centre provides residential care for up to nine male and female residents, who are over the age of 18 years and who have an intellectual disability. The centre comprises of two houses located on the outskirts of a town in Co. Mayo, situated within close proximity to each other. Residents have their own bedroom, en-suite facilities, shared bathrooms, kitchen and dining areas, sitting rooms, staff office, utility and garden area. Staff are on duty both day and night to support the residents who live here.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	5

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Thursday 2 October 2025	10:00hrs to 17:00hrs	Catherine Glynn	Lead
Friday 3 October 2025	09:00hrs to 10:05hrs	Catherine Glynn	Lead
Thursday 2 October 2025	10:00hrs to 17:00hrs	Marie Byrne	Support
Friday 3 October 2025	09:00hrs to 10:05hrs	Marie Byrne	Support

What residents told us and what inspectors observed

Overall, the inspectors noted that significant improvements across the regulations reviewed previously had occurred. The management team were now established, aware and had a range of documentation supporting the steps taken to meet compliance in the centre. The inspectors noted that the governance and management oversight was very effective and had commenced robust systems to promote and maintain an effective oversight of the centre.

This was an unannounced inspection to monitor the provider's arrangements in response to a targeted inspection completed in May 2025, when inspectors found six regulations not compliant. Inspectors found from a review of documentation, observation and meeting with the person in charge and the person participating in management that significant improvements had occurred following the warning meeting completed in July 2025. Minor improvements were required following the inspection and the provider was fully aware of further improvements required, and this is discussed under regulations eight and seven in the report.

On arrival at the centre at 10:00am it was evident that one house was unoccupied, so inspectors contacted the numbers listed in the statement of purpose and found that the person in charge was present in the second house. Inspectors attended this house and met the person in charge, and the person participating in management arrived shortly after. Overall, inspectors met five residents, three staff, the person in charge and the person participating in management for Acorn services over the two days of the inspection.

From speaking with the management team and staff it was clear that many measures were in place to care and support residents as per their assessed needs, while also ensuring that all residents benefited from a good quality of life. It was very evident that the person in charge and staff team were now ensuring that the residents were engaging in their local community. Examples of community based activities that residents were engaging in included attending, line dancing, bingo, active 55 retirement group, a local knitting club, bowling, advocacy group, the sensory cinema, and attending a local pet farm. Some residents were in the process of sampling different activities to find which ones they find meaningful. In addition, some residents had a planned day off from day services during the week where they were supported by staff on a 1:1 basis to engage in activities of their choice. Furthermore, one resident had participated in a local and national advocacy group and had completed a film about advocacy and this resident was looking forward to attending a planned event in Brussels for the premier of the film following a closed screening in the Dail. The resident also spoke about meeting representatives in the Dail and was glad to have participated and spoke about the support they had received.

The centre was comfortable, suitably decorated and very spacious throughout for all of the residents. There was evidence of resident's personal items and objects of

interest through the centre. Inspectors noted that the centre was well kept, clean and visibly tidy throughout.

It was very clear to the inspectors that staff were very familiar with the residents' needs, and their various forms of communicating and interacting. For example, one resident liked to tap each hand of the person they met and as a way of saying good bye also. Staff could interpret the behaviours of the residents at all times and were noted to be very responsive to any changes in presentation at all times. Initially on day two, residents were enjoying home based activities in one house and staff suggested that the presence of the inspectors may cause a change in presentation for one resident. However, the resident sate in the office throughout the inspectors time and sat between a manager and an inspector. It was noted that the resident was very relaxed and enjoyed the interactions of everyone present.

Overall, significant improvements had occurred in the centre following the inspection completed in May 2025, with two minor actions remaining in positive behaviour support and safeguarding, which is discussed under each regulation.

The next two sections of the report outline 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 delivered to residents living in this centre.

Capacity and capability

The outcomes of this inspection found that the provider had strengthened and improved arrangements in place for management and monitoring of the service, to ensure that residents' rights were being supported, and that they were protected from harm. Inspectors found that of the six regulations found not compliant previously four were satisfactorily addressed with two minor actions remaining in regulations seven and eight, which are discussed later in the report.

There was a clear governance structure with defined roles and responsibilities identified to manage the centre. Residents were safeguarded through consistent care and support, which was provided by a suitably trained and knowledgeable staff team. The management systems ensured that the provider's commitment to safeguarding was appropriate and had a positive impact on the lives of residents. There was a suitably qualified and experienced person in charge who was also responsible for other services in the organisation. The person participating in management spoke about plans for recruiting an assistant manager after a recruitment campaign that was occurring at the time of the inspection. This was to ensure that effective governance and management were in place at all times in the centre.

The management team were very familiar with the support needs of residents who lived and attended for respite in the centre and focused on ensuring that residents

would receive a high quality care and support service in Acorn respite and residential services. The management structures were now established and focused on providing a person centred service for the residents.

Governance and oversight arrangements at the centre ensured that the needs and preferences of residents were now paramount at the centre in day to day operations at Acorn respite and residential services.

Regulation 23: Governance and management

There was effective leadership and management arrangements in place to govern the centre and to ensure the provision of a good quality and safe service to residents living and attending for respite in the centre. The monitoring had strengthened since the last inspection, resulting in improved support and monitoring for all residents living and attending Acorn services for respite and residential support.

Inspectors found that the provider had addressed all of the actions identified during the previous inspection, completed in May 2025 during a risk inspection, which had significantly improved the quality and safety of care in the centre. For example, a revision of personal plans, safeguarding, risk management, positive behaviour support, and complaints management in the centre.

Minor actions remained on this inspection in safeguarding and positive behaviour support, which are further discussed under each regulation. Gaps noted included the lack of oversight on financial management of residents finances and recognition of all restrictive practices in place in the centre.

There were clear lines of accountability in the centre. Staff knew who to contact should any issues arise. Information was shared at regular team meetings, completed monthly and the inspector reviewed minutes of the meetings from June to September 2025. Meeting records showed discussions on specific issues relating to the residents' care such as review of staff roster, resident's activities and weekly activity planning.

Judgment: Compliant

Regulation 34: Complaints procedure

The provider had ensured, following the previous inspection in May, that all of the nominated person's shown in the service user guide for complaints were now correct and matched the management structure in place in the centre.

Judgment: Compliant

Quality and safety

Overall, inspectors found that residents were in receipt of a good quality of care and support in the centre. They had opportunities to take part in both home and community based activities in line with their wishes and preferences. However, inspectors found that some improvements were required in relation to recognising and reporting restrictive practices. In addition, action was required to ensure full oversight of one residents' finances.

During this unannounced inspection, inspectors found that both houses were warm, clean and homely. The provider was in the process of reviewing the suitability of one premises to ensure its suitability to meet residents' needs and their aging profile. Inspectors reviewed a recent occupational therapy report which found that residents' needs could be met at the time of the report. However, they recognised that the upstairs living would not be suitable in the long-term. On the day of the inspection the occupational therapist and a member of the provider's property team were onsite to review the environment and discuss options.

Inspectors reviewed a sample of four resident's assessments and personal plans. These documents were detailed in nature and guiding staff to support residents in line with their support needs, likes, dislikes and preferences. Residents had access to allied health professionals in line with their assessed needs. One resident had a positive behaviour support plan and this was found to clearly guide staff practice. There were a number of restrictive practices in place and these were being regularly reviewed to ensure they were the least restrictive for the shortest duration. However, inspectors observed a number of restrictions which had not been notified to the Chief Inspector of Social Services. This will be discussed further under Regulation 7: Positive Behavioural Support.

Residents staff and visitors were protected by the risk management procedures and practices in the centre. There was a system for responding to emergencies and to ensure the vehicles were serviced and maintained.

Inspectors also found that there were systems in place to safeguard residents and ensure they were safe. This included a safeguarding policy and detailed procedures for staff to follow should there be an allegation or suspicion of abuse. In addition, staff had completed training to ensure they were aware of their roles and responsibilities. However, at the time of the inspection the provider did not have full oversight of one residents' account in a financial institution. Therefore, they could not demonstrate that their finances were safeguarded. This will be discussed further under Regulation 8: Protection.

Regulation 26: Risk management procedures

The provider had ensured that systems were in place for effective risk management in this designated centre.

Inspectors reviewed the provider's systems for the identification, assessment and management of risks in the centre. They had policies and procedures for responding to emergencies and systems were in place to ensure the vehicles were roadworthy and suitably equipped.

Inspectors reviewed the risk register and a sample of four residents' risk management plans and found that they were reflective of presenting risks and incidents in the centre. For example, for a resident who had experienced a number of non-serious injuries around their home and environmental and falls assessments had been completed and additional control measures had been implemented to reduce the presenting risks.

Inspectors reviewed the provider's updated risk management policy and found that it met regulatory requirements.

There were effective systems to record incidents and accidents in the centre. A sample of seven incident reports between May and September 2025 were reviewed. These were detailed in nature and had been reviewed by the relevant parties. For example, each one was reviewed by the person in change and PPIM, and those which required review by the provider's designated officer were sent to them for their review in line with the provider's policy. In addition, inspectors reviewed the quarterly incident review for quarter two 2025. This contained a breakdown of the number and type of incidents and any trends which were occurring. Inspectors reviewed a sample of three staff meetings from 2025 and found that incident review formed part of discussions held.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

Overall, inspectors found that residents had up-to-date assessments of need and personal plans in this centre, in line with the provider's policy and procedures.

Inspectors reviewed a sample of four residents' assessment of need and personal plans and found that there the information in each residents' plan reviewed was consistent across all documents reviewed. They contained the most up-to-date guidance and were sufficiently detailed to guide staff practice. They identified residents' strengths and talents, their care and support needs, their communication preferences and how they make choices and decisions in their day-to-day lives.

Residents' health and wellbeing was being supported through diet, nutrition and recreation. They had their healthcare needs assessed and health actions plans were developed an reviewed as required. Residents were being supported to understand their healthcare conditions with information available to them on each healthcare condition. Where applicable, this information was also available in an easy-to-ready format.

Overall, inspectors found that a number of improvements had been made since the last inspection. For example:

- Each residents assessment of need had been updated.
- One residents' outstanding annual review had been completed.
- Residents were supported to access a number of allied health professionals in line with their assessed needs.
- Monthly keyworker reports were being completed.
- A community mapping meeting had occurred with the provider's community inclusion office and residents now had detailed goals in place.

Judgment: Compliant

Regulation 7: Positive behavioural support

Inspectors found that responsive behaviours were managed in a way which kept everybody safe. Restrictive practices were recorded and being reviewed by the provider's rights committee; however, inspectors observed a number of restrictive practices which had not been recorded as such or notified to the Chief Inspector of Social Services.

There were a number of restrictions in the centre such as lap belts, motion sensors and bed rails. A restrictive practice register was developed by the local management team and it was being regularly reviewed. Each resident had a rights checklist in place which detailed the restrictive practices in place. Inspectors were informed that the rights checklists for each resident and respite user had been reviewed by the provider's rights committee since the last inspection. Inspectors reviewed a sample of four of these checklists and found that they had been recently reviewed by the rights committee.

As previously mentioned, over the course of the inspection, inspectors observed some restrictive practices had not been reported to the Chief Inspector. For example, they found that;

- There were four locked presses in the kitchen in one house.
- There was a keypad lock on the front door of one house.
- There were 15 minute visual night checks for one resident.
- Residents' finances were in locked presses in both houses.

Inspectors acknowledge that the 15 minute visual night checks were recently

reviewed by the provider's rights committee. They recognised that the rationale for the restriction in line with presenting risks and that the residents' right to privacy may be restricted. However, they requested that the local management team review this restriction to consider a less restrictive alternative. This review was in progress at the time of the inspection as the resident was due to be discharge from the service.

Inspectors were informed that residents could access the support of the behaviour support service or psychology, if required. One resident was accessing the support of the behaviour support service at the time of the inspection and they had a positive behaviour support plan in place. This plan was reviewed by inspectors and found to be detailed in nature. It contained proactive and reactive support strategies.

Judgment: Substantially compliant

Regulation 8: Protection

Inspectors found that residents were protected by the safeguarding policies and procedures and procedures in the centre. Residents told inspectors they were happy and felt safe living in the centre. However, as previously mentioned, improvements were required to ensure that the provider's oversight systems were effective in safeguarding one residents' finances.

100% of staff had completed online safeguarding training and two staff who were due to complete in-person training were booked on. The provider had a safeguarding policy which was available and reviewed in the centre. There had been no safeguarding concerns notified to the Chief Inspector since the last inspection. However, inspectors reviewed the systems in place to ensure that safeguarding plans were developed and reviewed, if required. Each resident had a detailed intimate care plan in their personal plan folder. Inspectors reviewed a sample of four of these and found that they detailed residents' support needs and their preferences.

Inspectors reviewed financial records for four residents. Each resident had a financial support risk assessment in place in line with the provider's policy. This detailed the supports they require, if any, to manage their finances. For three of the four residents' records reviewed, there were effective systems to ensure that their finances were safeguarded. This included records of their income and expenditure which was being regularly reviewed and audited by staff. It also included records of money withdrawn, money spent and receipts for each purchase. In addition, a review of account statements from financial institutions was being completed. However, the provider did not have full oversight of a resident's account in a financial institution. As a result it could not be demonstrated that the residents' finances were safeguarded. The provider was aware of this and had supported the resident to get the required documentation ready to open an another account in a

financial institution. Residents had a personal property register in place. However, inspectors found that some of these were not sufficiently detailed. For example, one residents register had estimated value of €800 for clothes. Inspectors reviewed the receipts for some of their purchases in 2025 and found that they had spent more on clothes during this period.
Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 23: Governance and management	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 26: Risk management procedures	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Substantially compliant

Compliance Plan for Acorn Respite & Residential Services OSV-0003914

Inspection ID: MON-0047934

Date of inspection: 03/10/2025

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 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
PIC has begun the process of reviewing and removing restrictions in services. All restrictions noted on day of inspection were noted in quarterly returns. Keypad has now been replaced with a thumb lock and staff and persons supported have access to keys. Quarterly uploaded to portal 30/10/2025
Keypad removed 20/10/25.

Removal of two locked presses has taken place the remaining locked press will stay in place as it is to safeguard person supported for cleaning products. This will be reflected in quarterly returns going forward. Completed 08/10/25.

Consultation has taken place around use of an audio-visual monitor with person supported, family and staff team. All alternative options have been explored and not deemed suitable given the residents' needs. Audio-visual monitor will be sourced in the coming weeks and removal of physical 15 minute visual checks will commence once monitor is in place. 15 minute checks will take place via the audio-video monitor and it will be turned off outside these times and stored in a kitchen press to prevent any other resident accessing same and viewing the resident while they are sleeping.

A protocol has been developed around use of the audio-video monitor (12/11/2025 completed). A nightly log will be compiled for staff to complete when using the monitor for night time checks.

Discussions had with residents' parent on the 20/10/25 and 12/11/2025. PPIM met with the Rights Review Committee on 12/11/2025 (completed) and presented the updates regarding the night time checks. The committee upheld the use of the audio-video monitor and will review in 3 months time. Audio-video monitor will be sourced by staff team week ending 16/11/2025.

PIC has reviewed all Rights restrictions and ensure they are reflective of all rights restrictions in place.

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
PIC and named staff alongside person supported have arranged a date with banking institution 03/11/2025 to further proceed with opening of bank account to ensure safeguarding of all expenses. Bank of Ireland account opened for person supported.

PIC, and named staff will support the resident to keep a more detailed account of all possessions, this will be reflected in the residents property register.

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 07(5)(b)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation all alternative measures are considered before a restrictive procedure is used.	Substantially Compliant	Yellow	31/12/2025
Regulation 07(5)(c)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation the least restrictive procedure, for the shortest duration necessary, is used.	Substantially Compliant	Yellow	31/12/2025
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Substantially Compliant	Yellow	31/12/2025