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:	St Rita's Residential Service
Name of provider:	Western Care Association
Address of centre:	Mayo
Type of inspection:	Unannounced
Date of inspection:	16 February 2026
Centre ID:	OSV-0003915
Fieldwork ID:	MON-0048572

About the designated centre

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

St Rita's Residential Service can support four male and female adults, with intellectual disability and or autism as well as additional physical and or sensory disability. Residents supported at the service range in age from 18 years upwards. The centre comprises of a purpose built house in a rural town. Residents are supported by a staff team that includes the person in charge, social care workers and social care assistants. Staff are based in the centre when residents are present, including at night.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	4

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
Monday 16 February 2026	11:30hrs to 16:40hrs	Alanna Ní Mhíocháin	Lead

What residents told us and what inspectors observed

This inspection was to review the effectiveness of the actions taken by the provider to improve the quality of the service and to determine the impact on the residents' quality of life. This was a focused inspection to follow-up on the actions taken by the provider since the last inspection of this centre on 16 June 2025. There were improved oversight arrangements in relation to staff training and the provider had commenced regular local management and senior management meetings to review service improvement actions. Members of the multidisciplinary team had completed assessments with residents and had provided training to staff. However, though some actions had commenced in the service, additional time was required to determine their effectiveness at improving the quality of the service. In addition, additional time was needed to complete planned projects; for example, sessions with the provider's behaviour support practitioner. Significant improvement was required to ensure that residents received appropriate supports relating to their behaviour, that all restrictive practices were fully assessed and reviewed, and that the rights of residents were promoted.

This was an unannounced inspection. It was facilitated by the person in charge and the area manager. As this was a focused inspection, the entire premises were not inspected on this occasion. However, the inspector noted that the centre was clean, tidy and in a good state of repair. It was warm and nicely decorated. One resident had a sitting area and kitchenette separate to the main kitchen in the house. On the previous inspection of this centre, two cupboards in this kitchenette were locked. On this occasion, one cupboard was locked. The resident's risk assessment outlined that this contained food items and cleaning products. The fridge in the kitchenette contained a small bottle of milk.

The centre was home to four residents. All residents had lived in the centre for a number of years. Two residents attended day services five days per week in another location, while two residents were supported by staff within the designated centre throughout the day. Residents required varying levels of support in relation to their mobility, personal care and daily activities. Some residents required full support from staff with all of these needs. Other residents mobilised independently through the centre. All residents required support from staff in relation to their communication and to access the community.

The inspector met with all four residents on the day of inspection. The inspector met the residents as they returned to the centre from a walk in the community and from their day services. Residents spent time relaxing in the living room. The inspector was present in the kitchen while two residents were having their lunch. The inspector observed staff supporting residents throughout the day.

In addition to the person in charge and the area manager, the inspector had the opportunity to meet with another member of staff. This staff member had worked in

the centre for a number of years. They spoke about the care and support needs of the residents. The staff member was knowledgeable about the change in restrictive practices in the centre in recent months. They spoke about some practices that had been eliminated from use and the positive impact that this had on one resident in particular. The staff member spoke about the current focus within the centre on offering choices to residents in relation to their activities. They spoke about the changes to staffing allocations for one resident who could now access the local community with the support of one staff member rather than two. This meant that the residents did not need to go on outings together at all times and that one resident could stay at home, if they wanted.

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

Capacity and capability

The provider had systems for the oversight and governance of this centre. These included regular meetings with local management and meetings with senior managers. The provider completed an unannounced visit to the service since its last inspection. The quality of the service had improved since the previous inspection of this centre through these governance systems. However, further improvement was required. Meetings were not always completed in line with the provider's target timelines. The provider had not implemented a new finance audit in line with their target timelines. Further, not all issues identified on inspection were highlighted and addressed through the provider's governance systems.

Record keeping in relation to staff training had improved since the last inspection. The person in charge had an effective system to monitor the training needs of all staff working in the centre. Staff training was largely up to date.

Regulation 16: Training and staff development

The provider identified the training required by staff to meet the needs of residents in this centre. Staff had largely up-to-date training. This meant that residents were supported by staff who had the necessary knowledge and skills to meet the needs of the residents.

The person in charge completed a training needs analysis every three months. The most recent of these was completed on 18 December 2025 and it was reviewed by the inspector. This analysis identified the mandatory training modules required by staff in this centre. It identified the number of staff who required refresher training

in these areas. The analysis included staff who were rostered to work in the centre and those who provided cover to planned and unplanned leave.

In addition, the person in charge had access to a computer system with the most current information relating to staff training. This information related to staff who were rostered specifically to this centre. The inspector reviewed these records and found that staff had largely up-to-date training in the modules that the provider had identified as mandatory. These modules included supporting residents with behaviour that is challenging, safeguarding vulnerable adults, the administration of emergency medication in the event of a seizure, and guidelines relating to feeding, eating, drinking and swallowing.

Judgment: Compliant

Regulation 23: Governance and management

The provider had implemented oversight arrangements and was in the process of introducing a new action tracking document. However, further improvement was required to ensure that the provider implemented actions in line with their own timelines.

The provider had implemented a number of regular meetings to maintain oversight of service improvement actions. The person in charge and their line manager were due to meet every six weeks. The area manager reported that these meetings commenced in July 2025. The most recent meeting had taken place on 21 November 2025 and the next was due to occur on 24 February 2026. This meant that these meetings had not taken place in line with the provider's timelines. The inspector reviewed the minutes from the meeting that had taken place on 1 July 2025 and the most recent meeting in November 2025. The meetings covered areas relating to the implementation of the centre's compliance plan from previous inspections of the centre. It also covered areas relating to complaints, risk management, safeguarding, incident reviews and restrictive practices. An action plan was generated from these meetings to address any service improvement issues that were identified. The person responsible for completing the action and the target date for completion was recorded. However, not all issues identified by the inspector were identified through this process; for example, the absence of protocols for all restrictive practices in the centre had not been highlighted through this process.

The person in charge and the area manager also met with senior managers within the organisation every two months. The inspector reviewed the minutes from the meetings of August, October and December 2025. These covered issues relating to the implementation of service improvement actions in the centre.

The provider had completed an unannounced visit to the centre on 15 October 2025. The report following this visit was reviewed by the inspector. It was comprehensive and included a review of the incidents that had occurred in the

centre. An action plan to address service improvement issues was devised as part of the report.

The quality of the information obtained through routine audits in this centre had been highlighted as an issue in previous inspections of this centre. The inspector found that the same audits were in use in the centre as previous inspections. Through its compliance plan following the last inspection of this centre in June 2025, the provider had committed to reviewing the finance audit used in the centre and to have a new version implemented by 31 July 2025. On the day of inspection, this had not yet been introduced to the centre. This meant that the provider had not adhered to its own timelines in relation to service improvement actions. The area manager reported that a new action tracker was going to be introduced in the centre that would record any actions needed to address issues identified through routine monthly and quarterly audits. The inspector reviewed the template for this action tracker. It recorded the necessary actions, the person responsible and the timeline for its completion. As the use of this document had not yet commenced in the centre, its effectiveness could not be determined on this inspection.

Judgment: Substantially compliant

Quality and safety

The provider had completed actions to address the issues found on the last inspection regarding the quality of the service. Members of the multidisciplinary team had completed assessments of the residents needs and completed training with staff. While there had been an improvement to the quality of the service, additional time was required for new systems to be established and to determine if they were effective. This included new communication supports for residents and identifying activities that were in line with the resident's interests. Significant improvement was required to ensure that residents received appropriate supports relating to their behaviour, that all restrictive practices were fully assessed and reviewed, and that the rights of residents were promoted.

The provider had arrangements for the assessment of risks to residents. The risk assessments were comprehensive and control measures to reduce risks to residents were recorded.

Regulation 10: Communication

The provider developed new systems to support residents with their communication. While these systems had commenced, on the day of inspection they were not yet

fully implemented and additional time was required to ensure that they met the needs of the residents.

The provider had arranged for a speech and language therapist to provide training to staff. The training was based on the speech and language therapy reports that had been developed for each resident prior to the last inspection of this centre. The training occurred in November 2025. It covered the development of communication passports for residents and the use of some Lámh signs. The inspector reviewed the communication passports that were developed for two residents. These had been commenced and contained some information about the residents' communication strategies. However, the communication passports had not yet been fully completed with some sections remaining blank. The person in charge reported that this would be completed following input from the provider's behaviour support practitioner.

The provider had commenced the use of objects of reference as a communication system in the centre. The inspector noted that there was a box in the kitchen for each resident. These contained the objects of reference and information that explained the significance of each object. All objects were present and the inspector noted one resident holding one object in line with this system. The person in charge reported that this system had been newly commenced and would be expanded in time in line with the residents' interests and preferences.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

The provider had systems in place for the identification and assessment of risk in the centre. This meant that risks to residents were identified and that staff were given information on how to reduce the risk and promote residents' safety.

The inspector reviewed the individual risk assessments that had been developed for all four residents. These were recently updated by the person in charge. They were comprehensive and appropriately risk rated. The risk to residents was described and they gave guidance to staff on how to reduce risks. Further information about the supports that should be offered to residents to manage anxiety was required but this will be addressed under Regulation 7: positive behavioural support.

A risk register had been developed for the centre. These risks related to the service as a whole rather than an individual resident. The risks were relevant to the centre and were appropriately risk rated. The risk assessments signposted staff to relevant documents to ensure that they were aware of the measures that should be taken to reduce risks to residents, staff and visitors to the centre.

Judgment: Compliant

Regulation 7: Positive behavioural support

Significant improvement was needed to ensure that residents received the supports they required in relation to their behaviour. Significant improvement was also required to ensure that all restrictive practices in the centre were recorded and were the least restrictive option in use for the shortest duration of time. The provider was found to be not compliant in relation to this regulation on the last two inspections of this centre.

The inspector noted that the provider's behaviour support service had completed a review of one resident's behaviour support plan. The plan gave very clear guidance to staff on how to support the resident. However, not all residents had behaviour support plans in place despite identified needs in this area. For example, one resident's risk assessments identified that they may engage in behaviour that could result in an injury. The control measures stated that staff should support the resident to manage their anxiety should this behaviour occur. However, it was not clear how staff should do this and what specific steps should be taken to support the resident. Without detailed documentation, staff did not have the necessary information to guide their practice and this placed the resident at risk if they were not adequately and appropriately supported. In addition, without specific guidance, the provider did not have a point of reference to monitor that the resident was receiving the appropriate supports in line with their needs.

The provider had taken steps to review and reduce the restrictive practices in the centre. The inspector noted that, since the last inspection, a number of restrictive practices had been removed in the service. For example, multiple routine checks on residents at night were no longer occurring. Risk assessments had been developed that outlined how residents could alert staff if they needed assistance at night. The provider was in the process of evaluating some restrictive practices in the service relating to holds during medical procedures and these too had been eliminated. However, some practices remained in the centre without adequate documentation or review to ensure that they were the least restrictive option in use for the shortest duration of time. For example, the centre's kitchen was locked to prevent a resident from accessing it when staff were unavailable to supervise the resident. This occurred at times when staff were supporting other residents with personal care. The provider's most recent unannounced visit to the centre highlighted that the resident had been locked out of the kitchen for over 40 minutes on one occasion. The person in charge reported that this was not the only incident of its kind but that it did not happen frequently. The inspector requested documentation relating to the protocol that governed this practice but none was available. Therefore, the purpose of this practice was not clear and there was no information to guide staff on when or how to implement this practice. Further, without clear guidance, the practice could not be subject to adequate review and scrutiny to ensure that it was a necessary practice, the least restrictive, and in use for the shortest possible duration of time. Of concern, the provider's human rights committee had attended the centre on 18 June 2025 to review restrictive practices in the centre. The inspector reviewed the report of this visit that was recorded in the residents' rights review checklists.

This report did not identify that there were restrictive practices in use in the centre without adequate protocols.

Judgment: Not compliant

Regulation 9: Residents' rights

Significant improvement was needed to ensure that the rights of residents were promoted in this centre. The provider was found to be not compliant in relation to this regulation on the last two inspections of this centre.

The inspector noted that the provider had sourced support from members of the multidisciplinary team to guide practice in relation to the promotion of the rights of the residents. The provider's behaviour support practitioner planned to complete four sessions with staff to promote more opportunities for residents' to have choice and control in their lives. The plan was also to develop more leisure opportunities for residents. On the day of inspection, only the first of four sessions had been completed. Therefore, while some recommendations had been commenced in the centre, further improvement was needed to ensure that the recommendations resulted in an improved service to residents that respected their rights.

The inspector reviewed the daily notes recorded for two residents from 1 February 2026 to the day of inspection. These documents contained sections for staff to record the choices that were offered to residents during the day. The inspector's review found that these documents did not demonstrate that residents were offered choices or, in some cases, the choices recorded were not meaningful. For example, it was recorded that residents were offered to choose what colour clothes protector they wore at mealtimes and that they chose the room in which they spent their time. It was not recorded if residents had been offered choices in relation to their meals, activities in the centre or in the wider community.

Further, the notes demonstrated that the lack of guidance to staff in relation to residents' behaviour and restrictive practices may be negatively impacting on residents rights. For example, in one case, it was recorded that a resident had attempted to access the fridge in the kitchen but was redirected away from it. It was unclear why the resident had not been supported to access the fridge in line with their wishes.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Substantially compliant
Quality and safety	
Regulation 10: Communication	Substantially compliant
Regulation 26: Risk management procedures	Compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for St Rita's Residential Service OSV-0003915

Inspection ID: MON-0048572

Date of inspection: 16/02/2026

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The business meetings have now have been scheduled every six weeks. The PPIM and Person in Charge will review restrictive practices in the centre. Restrictive practices will be added as a standing item on the agenda for business meetings. The Governance and Oversight meetings continue on a monthly basis. The last meeting took place on 18/02/26. The next Governance and Oversight meeting will take place on 26/03/26. The provider will introduce the revised financial audit once feedback from the pilot group is received on 31/03/26. An Audit Findings Action Plan has commenced in the service. This will identify all actions from audits that need to be completed in the service.	
Regulation 10: Communication	Substantially Compliant
Outline how you are going to come into compliance with Regulation 10: Communication: All communication passports have been reviewed and updated by the Person in Charge. The Person in Charge shared the communication passports with the staff team at team meeting on 10/03/26.	

There are two focus workshops currently in process with the staff team; "Rights and Positive Risk Taking" facilitated by QSSI and "A Day in the Lives" facilitated by Behaviour Support and Psychology. The function of the Rights and Positive Risk Taking workshop was to determine the will and preference of each person and facilitate an understanding of each person through a rights-based lens. Three workshops have taken place and the final workshop will take place on 02/04/26. The final workshop will assess the daily routines of each person supported and focus on proactive risk management to ensure the will and preference of each person is reflected in their routines and encourage new opportunities in their lives.

The function of "A day in the lives" workshop is to look at each person individually and focus on enrichment, wellbeing and enhancement of each person's life. Two workshops have taken place. The remaining workshops will focus on developing and expanding on promoting more opportunities for choice, control, leisure and living for each person and will take place on 16/03/26 and 30/03/26.

Following the completion of workshops with the staff team, Rights and Positive Risk Taking by provided by QSSI and "A Day in the Lives" by Behaviour Support and Psychology, all communication passports will be reviewed and updated by 24/04/26 to reflect learning and routines of each person supported.

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
PRMP's for all people supported have been updated by Person in Charge 09/03/26 to reflect specific steps that should be taken by staff to support the residents.

A positive behavior support plan will be completed for one resident by the Psychology Department and Behaviour Support by 30/04/26. Referrals entered for two residents on 12/03/26 for positive behavior support plans.

Restrictive practices reviewed in the service by the Person in Charge and protocols will be developed for PRN restrictions in the service 12/03/26. Referrals were entered on 04/02/26 on behalf of each person supported for MDT input in reviewing restrictive practices, proactive strategies and reduction of same in the service.
A further update will be sent to rights review committee by Person in Charge on 19/03/26 following development of protocols for further input/review of restrictive practices in the service.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
There are two focus workshops currently in process with the staff team; "Rights and Positive Risk Taking" facilitated by QSSI and "A Day in the Lives" facilitated by Behaviour Support and Psychology. The function of the Rights and Positive Risk Taking workshop was to determine the will and preference of each person and facilitate an understanding of each person through a rights-based lens. Three workshops have taken place and the final workshop will take place on 02/04/26. The final workshop will assess the daily routines of each person supported and focus on proactive risk management to ensure the will and preference of each person is reflected in their routines and encourage new opportunities in their lives.

The function of "A day in the lives" workshop is to look at each person individually and focus on enrichment, wellbeing and enhancement of each person's life. Two workshops have taken place. The remaining workshops will take place on 16/03/26 and 30/03/26 and will focus on developing and expanding on promoting more opportunities for choice, control, leisure and living for each person.
Following the workshops, and with further support from Speech and Language Therapist, each person's communication systems will be expanded to reflect preferred activities and offer further opportunities for choice in their daily lives. The initial phase of this work will be completed by 26/06/26.

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 10(1)	The registered provider shall ensure that each resident is assisted and supported at all times to communicate in accordance with the residents' needs and wishes.	Substantially Compliant	Yellow	24/04/2026
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Substantially Compliant	Yellow	31/03/2026
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	Not Compliant	Orange	30/04/2026

	behaviour that is challenging and to support residents to manage their behaviour.			
Regulation 7(5)(a)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation every effort is made to identify and alleviate the cause of the resident's challenging behaviour.	Not Compliant	Orange	30/04/2026
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.	Not Compliant	Orange	30/04/2026
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.	Not Compliant	Orange	30/04/2026
Regulation 09(2)(a)	The registered provider shall ensure that each resident, in	Not Compliant	Orange	26/06/2026

	accordance with his or her wishes, age and the nature of his or her disability participates in and consents, with supports where necessary, to decisions about his or her care and support.			
Regulation 09(2)(b)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability has the freedom to exercise choice and control in his or her daily life.	Not Compliant	Orange	26/06/2026