



Report of an inspection of a Designated Centre for Disabilities (Adults).

Issued by the Chief Inspector

Name of designated centre:	The Willows
Name of provider:	Autism Initiatives Ireland Company Limited By Guarantee
Address of centre:	Wexford
Type of inspection:	Unannounced
Date of inspection:	08 July 2025
Centre ID:	OSV-0005792
Fieldwork ID:	MON-0047651

About the designated centre

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

The Willows is located in a rural area of Co. Wexford, close to a small village. A large town, which has all services and amenities, is a short commute away. The house comprises of a three bedroom bungalow and a separate one bedroom apartment is on the same site. Both the bungalow and the apartment have their own private garden spaces and there is ample parking. The provider's stated objective is to provide 24 hour care to persons diagnosed with autism spectrum condition. This centre is registered to provide care to four residents, full time care is provided to one adult, who lives in the self-contained apartment and respite care for up to a maximum of three residents in the main house at any one time. The aim of care, as set out in the centre's statement of purpose, is to provide person centred, tailored service appropriate to residents individual needs, wants and dreams. Increasing independence in skills for daily living is a core objective and staff actively encourage and promote social inclusion. Residents have access to daily activities and transport is available to facilitate such activities. Residents present with a broad range of needs in the context of their disability and the service aims to meet these requirements with physical, mobility and sensory support. The model of care is social and the staff team is comprised of a senior social care worker, social care workers and support workers, under the guidance and direction of the person in charge.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	3
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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
Tuesday 8 July 2025	09:00hrs to 17:00hrs	Linda Dowling	Lead

What residents told us and what inspectors observed

This unannounced risk-based inspection was completed following receipt of information to the Chief Inspector of Social Services. The provider was issued a provider assurance report which they completed and returned to the Chief Inspector. This inspection was to determine the ongoing compliance of the designated centre, with relevant regulations and standards. An inspection of this centre took place in December 2024, where it was found that the centre required improvements in areas such as food and nutrition, fire and governance and management. This inspection evidenced some progress made in relation to these findings, although further improvements were required in relation to fire precautions.

Overall, findings of the current inspection indicated that, although residents were afforded good quality of care in relation to their assessed needs, improvements were still required in staffing, training and development and fire. This will be detailed further throughout the report.

The inspection was facilitated by a supervisor who was present in the centre while the current person in charge was on statutory leave, an area manager was also present later in the day. In addition to a review of documents, interaction with the resident of the apartment and two respite users, staff and management, a walk around of the premises and observation of daily practice were utilised to determine residents' lived experiences in the designated centre. This centre is registered to provide a full time residential placement to one resident who occupies a single apartment and it also provides respite support to four regular respite users in the main house.

The centre was found to be clean and in good state of repair, residents were seen to be comfortable in their environment and were observed to seek out what they wanted. For example, one respite user was seen to get a cup and request a drink using non-verbal prompts, another respite user was seen to choose a film they wanted to watch.

Upon arrival, the inspector was greeted by a staff and one respite user. On introduction the inspector met with the supervisor who facilitated the opening meeting. The inspector had opportunities to engage with one respite user who came in and out of the office getting his mobile phone and i pad on a number of occasions. They were supported by their assigned staff at all times to ensure they were able to access what they required.

Later in the morning, the second respite user arrived to the centre, they had been collected from home by two staff, they were shown their plan for the day in a visual format, they had a hot drink and watched a film with staff. They were observed to engage on several occasions with staff in relation to the film and seek assurance in

relation to their planned activities. Staff were responsive on all occasions and were observed to offer reassurance when required.

In the afternoon the inspector met with the resident in their apartment, they were observed to communicate with their staff enquiring about what was for dinner, the staff responded as per the residents assessed needs and the residents appeared content with the response. The apartment was clean and well maintained. The apartment had been decorated in line with the residents support plans and risk assessments with some restrictive practices observed such as their TV in a perspex cabinet. The staff had supported the resident to decorate the apartments with paintings on the walls of their music preferences and familiar words and pictures displayed on the windows. The staff member supporting the resident was very familiar with their needs and preferences and spoke of the resident in a respectful manner.

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

Capacity and capability

The findings from this inspection highlighted that while improvements were required to ensure residents receive continuity of care and support. And staff receive appropriate development, support and performance management in line with the providers policy, residents were receiving good quality care and support.

Residents were observed to be comfortable in the presence of each other, their staffing supports and management. As previously mentioned while the provider had made some progress in the actions set out in their compliance plan from their previous inspection in Regulation 28: Fire precautions, further work was required to ensure they were fully compliant with the regulation.

Regulation 15: Staffing

The inspector found that the staff team were striving to provide care in line with the residents' assessed needs. However, the staffing arrangements required improvement.

The inspector reviewed three staff files and found them to contain the relevant documentation as set out in schedule 2 of the regulations.

There was a roster in place that was maintained in terms of the core staff team, although at times the agency staff were difficult to track due to use of initials, and in

some cases the agency was referenced not the staffs name. The rosters were keep up-to-date and reflective of annual leave, sick leave and training. Core staff were identified by their full name and their grade listed on a cover sheet the roster reflected the main house and the residential apartment. The inspector reviewed a sample of rosters covering May and June 2025. For the most part, there were three staff on duty by day and one waking night shift in the main house. The staffing levels in the main house can vary at times depending on the number of respite users scheduled to attend and their assessed needs. In the apartments one staff was on duty by day and one waking night shift with support from a second staff in the main house when the resident wishes to leave the centre.

However, the inspector found there was a significant reliance on agency staffing to maintain the staffing complement. For example, in May 2025, 27 shifts were covered by five different agency staff and in June 2025, 19 shifts were covered by three different agency staff. While the provider was engaging in ongoing recruitment for the three vacancies, this required further review to ensure the continuity of care for the respite users.

Judgment: Substantially compliant

Regulation 16: Training and staff development

The inspector found improvements were required in the area of staff training and development, some residents had behaviour support plans on file and five staff members were outstanding training in positive behaviour support. One staff also required medication administration refresher training.

From review of three staff members performance reviews and practice supports meetings, it was evident this was an area for improvement. The purpose of performance review meetings is to set goals for the employee to achieve. For the most part, staff members were in receipt of these meetings. Where the gap was evident was in the practice support meetings, in these meetings employees has an opportunity to seek support in achieving their goals. As per the providers policy staff members should have four practice support meetings per year. From review of staff files there was evident some staff were overdue their practice support meetings for 2025.

Judgment: Substantially compliant

Regulation 23: Governance and management

Overall, there were good systems in place for the oversight of residents well-being. A monthly practice report was sent to the area manager with an overview of the

service for the previous month, this covered information and statistics on, incidents and accidents, medication administration, errors and use of as required medication (PRN) and a health and well being update on the resident and respite users who had attended.

The reporting structure for the centre had recently changed due to statutory leave of the person in charge, the provider ensured there was managerial presence in the centre regularly. There was a managerial cover roster in place for the month of July which identified who would be present in the centre each day. Staff were aware of this and the out of hours on-call service. The provider had submitted a notification to register one of their flexi supervisors to cover the role of person in charge for the period of leave as per the regulations.

There was a series of audits both at local and provider level in place. For example, the provider completed two six-monthly unannounced audits of the quality and safety of care completed in April and May 2024. One annual service review was completed to cover January to December 2024. On review of these audits they were found to be action-focused and, for the most part marked as completed.

Judgment: Compliant

Quality and safety

From what the inspector observed, speaking with the resident, respite users, staff and management and from review of documentation, it was clear that good efforts were being made by the provider and management and the staff members to ensure that residents were receiving good quality and safe services.

There was a range of systems in place to keep residents and respite users safe, including risk assessments and safeguarding procedures. While some improvements were still required in fire precautions the provider had taken steps to come into compliance since the last inspection.

Regulation 26: Risk management procedures

The inspector reviewed the centre's risk register and individual risk registers for a sample of respite users.

All risks had been identified and control measures were put in place to reduce their impact. Respite users had risk assessments in place for topics such as behaviour management, medication administration, personal care and absconding. The centre specific risk assessments covered topics such as vehicles, lone working, infection control, behaviour and slips, trips and falls. All risk assessments reviewed by the

inspector were found to be in date and reflective of the presenting risk with appropriate control measures in place.

From discussion with staff on duty on the day of the inspection, they demonstrated a knowledge of residents risks and were aware of the control measures in place to mitigate this risk and how to support the residents if they engaged in high risk behaviours such as absconding.

From review of the managers monthly practice report, it was evident that managers were reviewed incidents happening in the centre on a regular basis and this review of incidents was further reviewed by the area manager.

Judgment: Compliant

Regulation 28: Fire precautions

In previous inspection completed in December 2024, Regulation 28: Fire Precautions was found non compliant. There was evidence the provider was taking steps to come into compliance with the introduction of enhanced personal emergency evacuation protocol (PEEP). The provider had also rolled out new classroom based fire warden training that includes both theoretical and practical training in one session, however there were still some staff awaiting this training on the day of inspection.

The inspector noted while fire drills were being completed on a regular basis, the information in relation to the simulated night drill was unclear, the inspector was unable to identify if residents were in their bedroom at the time and while it was completed with minimum staffing levels and maximum number of residents present, it was held during the day and did not assure the inspector that all residents could be safely evacuated in all eventualities.

Judgment: Substantially compliant

Regulation 8: Protection

There were systems in place to keep the residents safe. All staff had basic safeguarding training completed with additional training scheduled by the provider in supporting a positive Safeguarding culture to enhance staffs knowledge and understanding of safeguarding. Staff demonstrated a knowledge of the residents' needs and what to do in the event of a concern. The inspector reviewed an overview of incidents from the previous three months and found that they were appropriately reviewed and managed. The resident and respite users appeared

content and comfortable in the centre and in their interactions with staff supporting them.

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	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Compliant
Quality and safety	
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 8: Protection	Compliant

Compliance Plan for The Willows OSV-0005792

Inspection ID: MON-0047651

Date of inspection: 08/07/2025

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 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: Due to a planned change to the service (impacting the number of staff needed) that were initially due to take effect in July 2025 the staffing vacancies have reduced to one specific purpose support worker vacancy, Vacancies will continue to be covered wherever possible by the designated centers own panel of flexi part time workers, Agency staff full names will be added to the Rota cover page and manager weekly checklist and 6 monthly provider audit template will be updated to reflect reviewing that this is complete, Implementation of the section 39 pay increase will be implemented as soon as the funding becomes available to support recruitment and retention,	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: Performance review and practice support schedules to be saved to the organisations service compliance folder and to be reviewed as part of the 6 monthly provider audit, the provider audit template will be updated to reflect this review, this service compliance folder is accessible to the PPIM and can be reviewed if there is any concern or identification during monthly manager reports regarding outstanding performance reviews and practice supports.	

A standardised practice support and performance review schedule will be completed by PPIM and rolled out through the organisations continuous quality improvement committee. In the interim a service specific schedule is in place in the designated Centre that accurately reflects all recent meetings that have taken place and upcoming meetings due, all staff within the designated centre will have a performance review taking place in August and September 2025.

The implementation of an additional practice support tool will be completed to ensure the capturing of all unplanned practice support that takes place regularly in the service.

The monthly managers' report that is sent to PPIM requests information regarding any outstanding performance reviews, this has been updated to reflect practice support as well as performance reviews.

The weekly managers' checklist has been updated to reflect the updating of Performance review and practice support schedule that is saved in the service compliance folder on the T-drive.

All staff outstanding mandatory training including PBS refresher have since completed or have been scheduled to complete a refresher within the coming weeks

Managers weekly checklist and the 6 monthly provider audit will be updated to review and ensure that staff outstanding mandatory training are not lone working.

Regulation 28: Fire precautions	Substantially Compliant
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Outline how you are going to come into compliance with Regulation 28: Fire precautions: Fire Warden practical and theory has been merged into one classroom-based training module from April 2025, new staff complete this training on induction week, and existing staff will complete this training at refresher to replace the previous fire warden theory and fire extinguisher practical training.

Any staff member outstanding practical fire training directed to refrain from lone working until practical fire training completed,

Fire drill template will be updated to reflect where the residents were at the time of the drill and guidance will include completing the fire drill at different times of the day (including during darkness) the provider assurance audit will also be updated to reflect this change and ensure its completion,

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 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Substantially Compliant	Yellow	22/09/2025
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	20/10/2025
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	20/10/2025

Regulation 28(4)(a)	The registered provider shall make arrangements for staff to receive suitable training in fire prevention, emergency procedures, building layout and escape routes, location of fire alarm call points and first aid fire fighting equipment, fire control techniques and arrangements for the evacuation of residents.	Substantially Compliant	Yellow	20/10/2025
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