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:	Lios na Greine
Name of provider:	Health Service Executive
Address of centre:	Louth
Type of inspection:	Unannounced
Date of inspection:	04 June 2026
Centre ID:	OSV-0002566
Fieldwork ID:	MON-0050600

About the designated centre

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

The designated centre provides 24-hour nurse-led residential care and currently accommodates five adults, with intellectual disabilities. The building is a large detached bungalow on a private site. There is a lobby area and a spacious hallway on entering the house. There are five bedrooms, two of are en-suite bathroom. One resident has the exclusive use of a bathroom next to their bedroom, with two residents sharing a communal bathroom. There are two sitting rooms, one which includes a dining area. There is a kitchen and utility room and a staff office which is off the centres activity room. There is a large room for activities and just off this area is a storage room and a staff toilet. There is a large fenced garden to the back of the house with garden furniture. The centre also contains two outdoor spaces that house a generator and the centres heating boiler. The centre is located near a large town, and there are transport facilities for residents to access amenities in the town.

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 4 June 2026	09:30hrs to 18:30hrs	Brendan Kelly	Lead

What residents told us and what inspectors observed

This unannounced risk inspection was carried out following the receipt unsolicited information by the Chief Inspector of Social Services. The inspection also monitored the providers ongoing compliance with The Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

The unsolicited information received by the Chief Inspector detailed concerns in relation to Regulation 15: Staffing, Regulation 8: Protection, Regulation 13: General welfare and development and Regulation 18: Food and nutrition. Overall, the inspection showed that, in the main, residents are happy in their home and supported by a consistent staff team. Improvements, however, were required in relation to a number of regulations, namely, training and staff development, general welfare and development, individualised assessment and personal plans, risk assessments and, food and nutrition.

Lois na Greine is a large bungalow located in a rural setting outside a town in Co. Louth. This centre is currently registered for up to five residents with an intellectual disability and on the day of this inspection there were no resident vacancies. The centre consisted of five resident bedrooms, two of which were en-suite, one sitting room, one dining and sitting room space, a large kitchen, an activity room, a utility space and a staff office. A separate outside space was used for laundry purposes and one resident used a section of this room for their gardening.

On the day of this inspection, the centre's person in charge was on leave. The inspector had the opportunity to meet with and speak to two members of the provider's management team, one member of the front-line staff team and all five residents living in the centre. Judgements were also made by the inspector through observation of interactions throughout the day and the review of key documentation relating to the centre.

On arrival at the centre the inspector was greeted by a member of the front line staff team who was the senior staff member on duty for the day. The inspector completed a walk around of the centre. The inspector observed that the centre was homely, well maintained and laid out to suit the assessed needs of the residents. The inspector observed that resident bedrooms were decorated individually with evidence of family photographs and personal items.

The inspector spent some time observing the care and support provided to the five residents in the centre. All residents primarily used non-verbal means to communicate.The inspector observed that residents appeared happy and comfortable in the presence of the staff team. Staff working in the centre were observed to be responsive to the needs of the residents and engaged with residents in a positive manner throughout the inspection. Residents spent the day going in

and out of the centre with different staff members. The inspector observed residents in the communal spaces in the centre in each others company. While residents did not engage with each other they appeared happy and comfortable in each others presence.

The staff members who met with and spoke to the inspector were knowledgeable in terms of the assessed needs of the residents and the day to day operations of the centre.

The next two sections of this report will outline in greater detail the provider's capacity and capability to oversee the day-to-day management of the centre and the impacts these systems had on the quality and safety of the residents' lived experiences.

Capacity and capability

This inspection showed that the provider had the capacity and capability to manage the day-to-day operations of the centre. The centre had a management structure that included a full-time permanent person in charge who reported to the person participating in management. Improvements were required in staff training and aspects of oversight within the designated centre.

The provider had oversight and auditing systems in place that delivered actions aimed at service improvement in a timely manner. Improvements were required to ensure all identified actions were completed within the specified time frames.

The provider had recently reduced the staff on duty in the centre. The inspection identified that the provider had completed impact assessments for all residents in relation to this change in care and support.

The centre was staffed appropriately to meet the assessed needs of the residents. Staff were in receipt of regular supervision. However, improvements were required from the provider to ensure the staff team had the required training that allowed them to meet all of the assessed needs of the residents.

Regulation 15: Staffing

The provider had the appropriate number and skill mix of staff to ensure the assessed needs of the residents were met.

The provider had actual and planned rosters in place. Oversight of the rosters was part of the roles and responsibilities of the person in charge. The provider had recently reduced the number of staff working in the centre.

The inspector observed that the provider had completed a comprehensive assessment of needs on all residents in the centre prior to the planned reduction in staffing levels. The assessment of needs clearly outlined a rationale for the reduction in staffing and showed that there would not be a negative impact on the residents.

On the day of this inspection the inspector reviewed rosters from January to May 2026.

In reviewing the rosters the inspector observed the following:

- the agreed reduction in staffing was from two nurses on duty to one nurse on duty
- the staff team consisted of social care workers, care assistants and staff nurses
- shift patterns worked by staff were a mix of day duties of 07:45-20:00 and 08:00-20:00 and waking night duties from 19:45-08:00 and 20:00-08:00
- additional staff were used at times when residents had appointments or planned activities

The centre had two staff vacancies, one at care assistant grade and one at staff nurse grade. Contingency plans used by the provider in relation to the vacancy, planned and unplanned leave consisted of the use of regular agency staff. The inspector observed that the provider had used the same familiar agency staff to ensure consistent care for residents.

The provider also ensured that residents' needs and preferences were met accordingly. For example, a specific preference around staffing was outlined in a resident's care plan, as this was important to the resident. The inspector reviewed the care plan and the roster for the months of April and May 2026. It was found that the staffing requirements were in line with the resident's specific preference.

Judgment: Compliant

Regulation 16: Training and staff development

While the provider had ensured that actions from the centres previous compliance plan relating to staff training had been completed, additional improvements were required to ensure the staff team had the required training to meet the needs of the residents.

The provider had a training log in place that evidenced the mandatory and refresher training completed by the staff team. The training log was maintained and updated by the person in charge as part of their oversight responsibilities.

On reviewing the training log, the inspector observed that not all of the staff team had completed the required training for the centre and that on the day of inspection, there were no plans in place for the staff to attend the training. The inspector observed gaps in the training in the following areas:

- medication management
- food hygiene
- Lamh (a communication method used by persons with additional speech requirements)
- autism awareness

These trainings were of particular importance in this centre as residents' communication care plans outlined the importance of Lamh training and use of its symbols. All residents in the centre had a diagnosis of autism. Nurses in the centre were the only staff who could administer medications and the centre was non-compliant in Regulation 18: Food and nutrition.

Therefore, the providers training needs analysis and planning were not deemed as effective in ensuring staff were given the appropriate training specific to the needs of the residents.

Judgment: Not compliant

Regulation 23: Governance and management

The provider had ensured that there was a robust governance structure in place with clearly defined roles and responsibilities for each level of management in the centre. However, a number of oversight systems were found to require improvement from this inspection. Improvements were required in staff training, resident care plans, resident goals and, risk management.

The centre was managed day-to-day by a person in charge who had the required experience and qualifications to fulfil their role. The person in charge reported to the person participating in management. The provider also operated a buddy system with this centre linking in with a centre nearby on a daily basis. The buddy system was an important asset in circumstances such as staff shortages or in the event of additional transport needs.

The provider had systems in place to monitor and audit the centre. These systems included an annual review, provider-led unannounced audits every six months, governance meetings, local team meetings and local audits. On the day of this inspection, the inspector reviewed documentation from all of the aforementioned systems. The inspector observed that each meeting and audit had a corresponding

action plan that was time bound and identified the person responsible for completing.

The inspector observed consistent agenda items across all meetings such as:

- safeguarding
- risk management
- resident updates
- training
- incident reviews
- infection prevention and control

In reviewing the agreed actions across the documentation the inspector observed actions such as:

- improvements in the recording of spending of resident finances
- staff to ensure recommended communication devices are used
- resident prescriptions to be renewed as some where out of date
- policies to be reviewed and signed
- updates needed to care plans and risk assessments

The inspector observed that residents' finances were now subject to more robust scrutiny, with no gaps in staff double signatures for the month of May 2026. Residents' communication devices were being used by staff on the day of inspection. Additionally, the inspector observed that residents did have updated prescriptions.

As referenced earlier in the report, the provider has reduced staffing in the centre. The inspector observed further evidence from the provider to support the reduction. Before reducing staff numbers, the provider had completed a comprehensive impact assessment that demonstrated a reduction in the number of incidents in the centre from 2025 to 2026.

The inspector observed that while some of the actions were either completed or had an action plan in place to address the issue, a number of areas still required actions and relevant associated time lines. Most notably, in relation to staff training, care plans updates and evidence based risk assessments that were reviewed in a timely manner.

The evidence observed by the inspector showed that the governance systems were mostly effective in identifying issues in the centre. Additional work was required to ensure that all areas of improvements had actions that were identified through the providers own auditing systems.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

The provider had, in line with their regulatory requirements, notified the Chief Inspector of all incidents that had occurred in the centre.

Prior to this inspection the inspector carried out a review of the submitted incidents since the last inspection in the centre. On the day of this inspection the inspector reviewed the provider's incident log. The inspector observed that all incidents contained in the log had been appropriately notified.

Notifications had been submitted to the Chief Inspector outlining behavioural incidents, injuries and incidents of a safeguarding nature.

The inspector observed that the reporting systems in the centre were effective.

Judgment: Compliant

Quality and safety

The inspection showed that the provider was required to make significant improvements in ensuring all residents have days with access to a meaningful activities of their choosing. The setting and planning of meaningful resident goals also required significant improvement.

While there were systems in place regarding resident care plans and risk assessments, improvements were required to ensure these important documents were specific to the needs of each resident, signed by the persons completing the assessments and reviewed on a more regular basis.

The provider was required to review the processes around the storage and disposal of food items.

The provider had strong and robust systems that ensured residents were protected in their homes and the inspection identified strong systems in place for the provision of intimate care.

Regulation 13: General welfare and development

This inspection showed that not all residents living in the centre were being supported to have a meaningful day with activities of their choosing being provided to them.

Residents in the centre had monthly planners that outlined agreed activities for the month ahead. The inspector reviewed a sample of the residents' monthly planners

and observed that activities agreed upon were not always taking place and that activities planned were not always meaningful. For example, on the day of this inspection, one resident's planner stated that they were to go out for the day shopping. The inspector observed that the resident did not leave the centre until later in the afternoon and did not go shopping. The inspector observed that this was despite the centre being fully staffed on the day of the inspection.

Activities that were agreed upon in the planner were not always meaningful. For example, one residents plan stated that every afternoon for the month of May 2026, the resident had free-time in the garden.

The inspector observed that no resident left the centre in the evening after 17:00. The inspector did not observe any evidence that this was based on the residents will and preference.

When residents did engage in their local communities, the activities were limited. In the main, the inspector observed activities such as walks to the shop and drives.

The inspector observed that some resident goals were not observed to be person centred or meaningful. For example, one resident had a goal of going to the doctors surgery to have bloods taken. This goal had been in place since October 2025 and had not been updated.

Overall, resident activities were of limited quality and of a repetitive nature with no evidence observed by the inspector of the planning and development of meaningful person centred-goals.

Judgment: Not compliant

Regulation 18: Food and nutrition

The provider had adequate systems in place to ensure the centre had supplies of food. However, improvements were required in the identification of foods going out of date and when foods had been opened.

The inspector completed a walk around of the centre on arrival and reviewed the arrangements for grocery shopping and the storage of food items. The inspector observed that on the day of this inspection grocery shopping was planned and that this was carried out.

In reviewing the food items in the centre, the inspector observed an adequate supply of dairy products such as milks and cheeses. The inspector observed that meat for that days dinner had been left out by night staff and that it was the meat required by the weekly meal planner. The centre also had supplies of fruit, vegetables, bread, dried foods such as cereals, tinned foods, teas, coffees, juices and snacks.

However, the inspector did observe that the centre had multiple items stored both in the fridge, cupboards and fruit bowls that were either out of date or had visible mould. The inspector also observed multiple items that were open in the fridge that did not have labels informing staff of when they were opened or when they needed to be disposed of.

In addition, the provider's training log showed that 13 staff still remained outstanding in attending food safety training, with no plan in place for staff to attend.

The inspection showed that the provider is required to improve on the storage and disposal of food items and ensure that the staff team have the required training in ensuring food practices in the centre are safe.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

The provider had systems in place to identify, assess, mitigate and review risk management in the centre. However, the systems were not always effective in identifying all risks, not all risk control measures were being implemented, and some reviews were outstanding.

The provider had a risk management policy in place that guided staff practice in the area of risk management. The provider had risk registers in place for each individual resident and more centre-specific risks. These risk registers were maintained by the person in charge as part of their oversight responsibilities.

The inspector observed that the provider had identified risks in areas such as:

- manual handling
- slips, trips and falls
- fear of dogs
- unexplained absences
- aggression
- stress
- choking

In the main, risk assessments reviewed by the inspector were reviewed in line with the provider's policy or as specifically outlined in individual risk assessments. For example, centre-specific risks such as stress, aggression or manual handling were all reviewed by the person in charge in March 2026. Individual risk assessments, such as, choking and inappropriate behaviour in public, were reviewed between January and February 2026.

The inspector observed that not all assessed areas of concern for residents were appropriately risk assessed. For example, one resident in the centre had significant

levels of anxiety that impacted their daily lives; however, this was not subject to a corresponding risk assessment.

Another resident engaged in regular behaviours of concern, but there was no corresponding risk assessment. Centre management informed the inspector that care plans were in place for these identified areas. However, as discussed further in Regulation 5: Individualised assessments and personal plans, these plans were not updated on a regular basis to inform and guide staff on the level of risk.

The inspector also observed that not all control measures contained in risk assessments had been implemented effectively. For example, one resident's risk assessment regarding inappropriate behaviour in public outlined the need for staff to have completed Lamh training. As discussed earlier in this report, 11 staff had not yet completed the required training. The inspector also observed that this risk assessment was last reviewed in January 2025, which was outside of the providers recommended review period of at least 12 months.

The lack of appropriate identification, review and control measure implementation meant that staff were not always provided with accurate information regarding the management of risk management.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

While the provider had individual care plans in place for each resident in the centre, plans were not subject to regular review to ensure they were effectively meeting the needs of the residents and continually guiding staff practice.

The inspector reviewed a sample of care plans in place for residents including:

- communication
- behaviour support
- mobility
- mental health
- skin integrity
- bruising
- hay fever
- oral health
- hospital passport

In the main, plans reviewed by the inspector contained clear guidance for staff in meeting the assessed needs of the residents. For example, one residents behaviour support plan guided staff on the functions of behaviour, triggers, proactive and reactive strategies. However, the inspector observed that the plan had not been signed by any member of the team who completed the plan. The plan was also recommended to be reviewed in six months, but the inspector observed the last

review had been completed in February 2025. This meant that the provider could not assure themselves that the approaches taken by staff were still in line with the assessed needs of the resident.

The inspector reviewed one resident's hospital passport. This document guided staff and medical professionals in the event a resident needed to attend the hospital for treatment. The document contained important information on things you must know, things that are important and things that I would like to happen. However, the inspector again observed that the document was not signed by a staff member, and there was no review date to ensure that the information provided remained relevant to the resident. This meant that the provider could not be assured that if the resident was required to attend the hospital for treatment the staff or medical teams had the most up-to-date information.

The inspector also reviewed a number of care plans that were aimed at guiding staff practice in the day-to-day supports required by residents. While plans contained strong initial guidance in areas such as oral care, skin integrity and bruising they were not reviewed or updated on a regular basis. For example the last review of one resident's oral health care plan was July 2025 and the last review of a resident's skin integrity care plan was also July 2025.

Judgment: Substantially compliant

Regulation 8: Protection

The provider had effective systems in place that ensured residents were protected from all potential harm in their home.

The provider had submitted notifications to the Chief Inspector that were of a safeguarding nature. On the day of this inspection the inspector reviewed the systems the provider had in place to mitigate the ongoing risk to residents. The inspector observed that the provider had effective measures that reduced both the likelihood and impact of potential safeguarding incidents.

The measures observed included safeguarding plans, environmental changes and notifying the relevant bodies of any incidents.

The inspector also reviewed two residents' intimate care plans. The inspector observed that each plan gave staff specific guidance on resident preferences in areas such as showering, shaving, hair care, dressing and undressing. The inspector also observed that the provider had measures in place to respect the wishes of one resident in terms of the staff who supported the resident with their intimate care.

The inspector also observed that the provider had ensured the staff team had attended safeguarding, children's first, dignity at work and GDPR training.

The centre had appropriate signage throughout the centre identifying important people residents could contact if they felt unsafe and contact details for advocacy services. The inspector also observed that the provider had ensured safeguarding was a standing item at all centre meetings.
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	Not compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 13: General welfare and development	Not compliant
Regulation 18: Food and nutrition	Substantially compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 8: Protection	Compliant

Compliance Plan for Lios na Greine OSV-0002566

Inspection ID: MON-0050600

Date of inspection: 4/Jun/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 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
The electronic training log has been updated by the Person in Charge to reflect all staff training within the designated centre separating mandatory training and non-mandatory training.

Staff training is discussed by the Person in Charge at team meetings and timeframes for outstanding training is agreed with the staff member during their staff supervision meetings.

All registered nurses within the designated centre have completed their refresher training in medication management and the electronic training log has been updated by the Person in Charge to reflect this.

All staff within the designated centre have autism awareness training completed and the electronic training log has been updated by the Person in Charge to reflect this.

14 out of 15 staff have completed HACCP food hygiene level 2 training. Additional training has been sourced by the Person in Charge through the CNME department and a date for further training is confirmed for 2nd September 2026 for the staff member that still requires this training.

10 out of 15 staff have completed Lámh communication training. Additional Lámh communication training is scheduled by the Person in Charge for 3rd September 2026 for staff who still require this training.

The oversight and monitoring by the Director of Nursing (DON)/ Assistant Director of Nursing (ADON) of training and staff development will improve compliance.

Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The Person in Charge has developed and implemented a Quality Assurance tracker for the Designated Centre. This tracker records all actions arising from all audits carried out in the Designated Centre with each action is given a timeframe for which actions are to be completed.

The DON/ ADON have access to the Quality Assurance tracker on the shared drive system, and they are responsible for the oversight and monitoring of care delivery within the Designated Centre. The DON/ADON review the Quality Assurance tracker with the Person in Charge during weekly governance review meetings on site and via Microsoft teams as appropriate.

Actions from audits and their status for completion will be discussed by the Person in Charge with keyworkers at clinical support meetings and is also discussed by the Person in Charge at monthly staff team meetings to ensure that actions are being completed within the allocated timeframes.

Monthly feedback on the Quality Assurance Tracker is provided by the Person in Charge to the senior management team as part of senior management monthly governance arrangements.

The oversight and monitoring by the DON/ ADON of governance and management will improve compliance.

Regulation 13: General welfare and development	Not Compliant

Outline how you are going to come into compliance with Regulation 13: General welfare and development:
The Person in Charge has completed an audit on all residents' Person centred planning documentation. Actions identified are being implemented the nominated staff by the Person in Charge within an identified timeframe. This is closely monitored by the PIC and ADON to ensure compliance with agreed time frames.

All residents living in the centre have been supported to identify activities of choice to ensure they were experiencing a meaningful day of their choosing.
One resident who had previously completed an evening class in culinary baking has now commenced work experience in a local coffee shop. Another resident has commenced chair aerobics in their local Community Centre as part of their health lifestyle goal. Three residents are involved in growing vegetables and herbs in an allotment in their local community and four residents are participating in a local cycle group one evening per week.
Weekly activity planners have been put in place by the Person in Charge in the Designated Centre, and these outline all planned activities of choice for each resident. The daily shift leader ensures that all planned activities are carried out with the residents, and this is documented. In instances where a resident chooses not to take part in the planned activity, the resident is supported to partake in an alternative activity of choice and rationale is documented in relation to the change of plan on the day.

The Person in Charge has developed an audit tracker for reviewing of resident's activity schedules, plans of care, risk assessment, person centred goal setting plans and other healthcare assessments. This oversight and monitoring of all residents' documentation will ensure reviews and updates are carried out as per local policy.

Keyworkers provide monthly feedback to the Person in Charge regarding each resident's activity and goal progression at team meetings, and this is recorded in the team minutes.

The Person in Charge has developed a new suite of service documentation to support residents to develop an Individualised Person Centred Plan in line with HSE National Framework for Person-Centred Planning in Services for Persons with a Disability. This documentation is currently in the implementation phase of the process by the Person in Charge, and the plan is for full implementation by the end of Quarter 3 of 2026. Staff within the designated centre have received training in social goals as part of this new documentation implementation process. The Person in Charge and keyworkers are supporting residents to develop their Individualised Person Centered plan using the new documentation. Residents are being supported with the information gathering phase of this planning process at present, and this will be completed by 14/08/2026. All new goals identified will be reviewed by the Person in Charge and the key worker to ensure they are meaningful and achievable by 14/08/2026.

The oversight and monitoring by the DON/ ADON of general welfare and development will improve compliance.

Regulation 18: Food and nutrition	Substantially Compliant

Outline how you are going to come into compliance with Regulation 18: Food and nutrition:

14 out of 15 staff have completed HACCP food hygiene level 2 training. An additional training date is confirmed by the Person in Charge for 2nd September 2026 for the staff member that still requires this training.

The Person in Charge and/or shift leader is monitoring good food safety awareness on a daily basis, and the staff within the designated centre are promoting a culture of good food safety awareness by ensuring the following is implemented at all times:

- Daily and weekly menu planning
- Recording of known suppliers
- Appropriate use of PPE in the kitchen
- Preparation & Cooking of foods
- Safe storing of foods
- Labelling of foods to include dates cooked or opened in the fridge and food storage cupboards
- Temperature recording
- Disposing of foods which are out of date.

A member of the staff team is assigned by the Person in Charge and/or shift leader to kitchen duties each day & is responsible for ensuring all the above food safety measures are being followed. This is recorded on the daily allocations of duty form.

The Person in charge has develop a food safety awareness folder that includes food safety guidelines and all the necessary recording charts for food safety as well as kitchen cleaning schedules.

Weekly menu planning is discussed and agreed by the Person in Charge at the resident's meetings & is recorded in the communication diary for the week ahead. A daily menu is displayed within the kitchen. Appropriate signage to prompt food safety awareness is displayed within the kitchen area.

The Person in Charge will complete a monthly audit and carry out random weekly on the spot checks on all aspects of food safety hygiene.

The oversight and monitoring by the DON/ ADON of food and nutrition will improve compliance.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
All residents risk assessments and associated control measures have been reviewed and updated by the Person in Charge, and any areas of concern identified have

corresponding individualised risk assessments in place. This is in line with the service risk management policy.

10 of the 15 staff have completed Lámh communication training. Additional Lámh communication training is scheduled by the Person in Charge for 3rd September 2026 for the remaining staff who require this training.

Residents who exhibit behaviours of concern are supported by individualised positive behavioural support plans and plans of care. All behaviour support plans have been signed by the person who developed them, and this is being audited by the Person in Charge.

The Person in Charge has developed an audit tracker for reviewing of resident's plans of care, risk assessments, person centred goal setting plans and other healthcare assessments.

The oversight and monitoring by the DON/ ADON of risk management procedures will improve compliance.

Regulation 5: Individual assessment and personal plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
Each resident within the Designated Centre has three identified keyworkers, one of whom is a registered nurse and they are responsible for ensuring all residents information within the healthcare documentation is accurate and is reviewed as residents needs change or within recommended timelines as per the service policy on Person Centred Planning or in line with best practice.

Residents who exhibit behaviours of concern are supported by individualised positive behavioural support plans and plans of care. All positive behaviour support plans have been reviewed and signed by the person who developed them. Ongoing reviews will be assured with the implementation of the above audit tracker.

The person in charge has developed an audit tracker for reviewing of resident's plans of care, risk assessment, person centred goals setting plans and other healthcare assessments. This oversite and monitoring of all residents documentation will ensure reviews and updates are carried out as per local policy.

Any actions arising through the auditing process will be included in Designated Centre's Quality Assurance tracker.

The DON/ADON will review the Quality Assurance tracker with the Person in Charge at their weekly governance meetings. The oversight and monitoring by the DON and ADON of individualized assessment and person plans will improve compliance.

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 13(2)(a)	The registered provider shall provide the following for residents; access to facilities for occupation and recreation.	Not Compliant	Orange	30/Sep/2026
Regulation 13(2)(b)	The registered provider shall provide the following for residents; opportunities to participate in activities in accordance with their interests, capacities and developmental needs.	Not Compliant	Orange	31/Jul/2026
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	Not Compliant	Orange	3/Sep/2026

	development programme.			
Regulation 18(1)(b)	The person in charge shall, so far as reasonable and practicable, ensure that there is adequate provision for residents to store food in hygienic conditions.	Substantially Compliant	Yellow	8/Jun/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	12/Jun/2026
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Substantially Compliant	Yellow	12/Jun/2026
Regulation 05(6)(c)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in	Substantially Compliant	Yellow	31/Aug/2026

	needs or circumstances, which review shall assess the effectiveness of the plan.			