



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

Issued by the Chief Inspector

Name of designated centre:	Good Counsel Services
Name of provider:	Health Service Executive
Address of centre:	Dublin 16
Type of inspection:	Unannounced
Date of inspection:	01 July 2026
Centre ID:	OSV-0002586
Fieldwork ID:	MON-0050903

About the designated centre

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

Good Counsel Services provides a residential service for up to 22 adults with an intellectual disability and acquired brain injuries who may present with additional complex needs. There are four premises which make up the centre, which are located in different south Dublin suburbs, and are within a short distance from each other. One unit is a five-bedroomed house, which is home to five residents. The second is an eight-bedded unit which is based on the first floor of a building on a shared campus with HSE Offices and a nursing home. This provides 24 hour nursing care to residents who have high support needs. The third location consists of two houses. One house is subdivided into three apartments, while the other is a four bedroomed house. Residents use a combination of public transport, and transport provided to them. Residents are supported 24 hours a day, seven days a week by a staff team consisting of a person in charge, clinical nurse managers, staff nurses, health care assistants and catering staff.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	19
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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
Wednesday 1 July 2026	10:00hrs to 19:30hrs	Karen Leen	Lead
Wednesday 1 July 2026	10:00hrs to 19:30hrs	Karen McLaughlin	Lead

What residents told us and what inspectors observed

This inspection outlines the findings of an unannounced risk inspection, completed to assess the provider's regulatory compliance in relation to the care and welfare of residents who were living in the centre.

Inspectors used observations, in addition to a review of documentation, and conversations with staff and residents to form judgements on the residents' quality of life. At the time of this inspection the person in charge was on planned leave. The inspection was conducted over a single day and was facilitated by staff on duty.

Good counsel services is registered for 22 residents, at the time of the inspection there was 19 residents living in the centre with three vacancies. The designated centre comprises of two houses, three apartments and an area on the first floor of a large building. The locations within the designated centre are approximately 15 - 20 minute drive from each other.

The inspection found high levels of non compliance with the regulations, resulting in the issuing of an immediate action in the designated centre in order for the provider to address an immediate risk identified by the inspectors under Regulation 8: Protection. On the day of the inspection, the provider put in place a number of actions to protect residents in the centre and subsequently submitted a detail response to the immediate action.

Additionally, this inspection found there were also improvements required to Regulation 15: Staffing, Regulation 23: Governance and Management, Regulation 24: Admissions and contract for the provision of services, Regulation 17: Premises, Regulation 7: Positive Behavioural Support and Regulation 9: Residents' rights. This is further discussed in the main body of the report.

The first premises was a nine-bed unit on the first floor of a large building which contains office spaces on the ground floor. Each resident has their own bedroom with an en-suite, five resident bedrooms have access to their own personal balcony. The premises has an industrial kitchen and dining area and a smaller kitchen with dining room where residents can chose to eat their meals. This house had catering staff who were available to residents seven days a week. The inspectors found that there was an issue with access to appropriate storage in the premises. On review of the laundry room the inspectors found inappropriate storage of laundry and medical supplies. This will be discussed further under Regulation 17: Premises.

The second area visited by the inspectors consisted of a four bed house and three apartments (two one-bed apartments and one two-bed apartment). Each apartment has an open plan kitchen/dining/sitting room and bedroom with separate bathroom. The house has a kitchen come dining room, two sitting rooms, three ground floor bedrooms with ensuite bathrooms, an upstairs office and a resident bedroom with

ensuite facilities. There was a paved patio area with raised beds at the front of the house and the back of the apartments. There was an additional garden area to the back of the two story house, which residents could access through their home but there was also a door from an external service that had access to the shared garden. This will be discussed further under Regulation 8: Protection.

The third premises was a three storey house, close to local amenities. There were two sitting rooms, a staff office, kitchen come dining room, a utility room, five resident bedrooms, three of which have en suite bathrooms. There was also a main bathroom on the third floor.

Inspectors had the opportunity to meet with 16 residents, 14 staff, clinical nurse manager grade two, assistant director of nursing and the director of nursing. The inspectors found that all staff spoken to were knowledgeable of residents assessed needs, however, inspectors found that for some residents activities within the community were limited or dependent on staff availability. For example, one resident required a staff nurse to be present when accessing their community. On review of rosters and from discussion with staff members this was not always available to the resident.

The inspectors had the opportunity to meet with one resident on arrival to one house in the designated centre. They told the inspectors that they were going out for the morning to their local day service and that they would like to meet with the inspectors when they returned. In the afternoon of the inspection, the resident returned to their home and came to speak to the inspectors.

On return to the centre, the resident came and met with the inspectors. Staff remained for a short period while the resident discussed what they had cooked during their time at the day service. The staff member then left the resident to sit and talk to the inspectors. The resident asked the inspectors if they were looking at their files. The inspectors discussed that they had not reviewed their file but asked would it be okay to review it later. The resident responded that they were happy for the inspectors to look at their file. They requested that the staff put more pictures in their file.

The resident told the inspectors that they did not like living in their home and that they were moving to a new home. During this interaction the inspectors were made aware of a response to be given to the resident around moving house. Inspectors observed a staff member inform the resident that they would be moving to their new home soon. The inspectors asked the senior manager supporting the inspection, as the manager was covering for the day of the inspection was there a plan in place to move the resident. They informed the inspectors that they were not aware of any proposed move. This will be discussed further under Regulation 7: Positive Behaviour Support.

During the afternoon of the inspection, the inspectors went separately to the two other locations that make up the designated centre. On arrival to one of the premises, one inspector met with two residents. One resident was sitting in a large

comfort chair and was listening to music. The resident greeted the inspector and returned to their music.

The second resident was enjoying their dinner, they greeted the inspector and told them about their interest in construction, building works and cranes. The resident then proceeded to tell the inspector about the large crane across the road from their house and how they had set up the small sitting room so that they could watch the crane and the crane driver during the day. The inspector viewed the residents' bedroom and found that it replicated their love of machinery and construction.

The inspector had the opportunity to meet with one resident on their return from an appointment. The inspector greeted the resident with staff once they had settled following their return. Support staff discussed that the resident was feeling very tired after their appointment so the inspector spent a small amount of time with the resident. The inspector observed one staff member kneeling down beside the resident and discussing what they would like to eat and telling them they could relax for the remainder of the day.

On arrival to the third house, the inspector was greeted by a staff member who informed the inspector that the residents would be returning home shortly. When residents started to return, one resident showed the inspector around the house and the back garden. They showed the inspector their bedroom and chatted for a while about their plans for the evening. Another resident also spoke to the inspector and told her that they had recently moved to the house and were very happy with the move. They also showed the inspector their bedroom and around the downstairs of the house.

The next two sections of the report presents the findings of this inspection in relation to the governance and management arrangements in place in the centre and how these arrangements impacted on the quality and safety of the service being delivered to each resident living in the centre.

Capacity and capability

The purpose of this inspection was to monitor ongoing levels of compliance with the regulations. This section of the report sets out the findings of the inspection in relation to the leadership and management of the service, and how effective it was in ensuring that a good quality and safe service was being provided.

The inspectors were not assured on the day of inspection that there were appropriate management systems in place to ensure that the service provided was safe, consistent and appropriate to residents' needs. Furthermore, there was a lack of oversight of the centre as demonstrated by the high levels of non compliance found on this inspection.

This inspection found repeat findings from a previous inspection in the designated centre completed in August 2024 in relation to Regulation 15: Staffing. The inspectors reviewed the planned and actual rosters in place in the designated centre from May to July 2026 and found a continued reliance on agency staff in order to support residents in the centre and as a result there was insufficient staffing resources to meet residents assessed needs.

Additionally, inspectors found that despite the identified changing needs of residents in the designated centre, the provider had not implemented adequate supports for residents.

The inspectors found that the provider had identified an admission date for one resident to the centre in July 2026. The inspectors found that appropriate supports were not in place for the proposed residents or for peer members in the designated centre. For example, compatibility assessments had not been completed, with transition plans identifying that restrictive practices would be required in order to maintain the resident's safety in the home. This would have an impact on all residents in the house.

In addition, they had not identified the risk associated to possible admissions to the centre where resources were depleted, such as appropriate staffing levels.

Regulation 15: Staffing

This inspection found repeat findings from previous inspection in the designated centre completed in August 2024 in relation to Regulation 15: Staffing. The inspectors reviewed the planned and actual rosters in place in the designated centre from May to July 2026 and found a continued reliance on agency staff in order to support residents in the centre and insufficient resources to meet residents assessed needs.

The inspectors found that for one house in the centre which was home to eight residents with complex needs, staffing levels throughout the night did not provide adequate levels of support. The night time staffing ratio for the house was five staff at night with two of the staff required to be nursing staff. From the eight residents living in this house, three residents required one to one staffing to support their assessed needs over a 24 hour period, with two residents requiring staff to sit outside their bedroom in order to support them during the night.

Furthermore, one staff from the complement of five was also required to leave the house twice nightly to support a resident with personal care in a second location which was 15 minutes away by car and then return to the house to ensure safe staffing levels. This will be discussed further in Regulation 23: Governance and Management and Regulation 9: Residents' Rights.

On review of rosters inspectors found that while the provider was attempting to use regular agency staff multiple shifts were covered across the roster by different

agency nurses or health care assistants. For example, the inspectors reviewed rosters for one house in the centre from 29 June 2026 to 01 July 2026 a three day period 24 agency shifts were required using eight different agency staff.

The inspectors found that on average across a one week period in one of the houses of the actual roster demonstrated a reliance of three agency staff per day and four agency staff at night to support residents.

In addition, inspectors reviewed five days on the roster from May to July 2026 where the roster stated staff nurse support required. The roster did not reflect if nursing support or cover had been identified and put in place for the shifts.

The inspectors found that this lack of continuity was having a negative effect on residents who presented with complex medical needs such as Alzheimer's diagnosis and behaviours of concern. These residents require familiar and consistent staffing support to ensure their needs are met in a holistic manner. Furthermore some residents required one to one or three to one staff support to meet their assessed needs and inspectors found that these resources were not always available.

In addition, despite the heavy reliance on agency staff and lack of staffing resource to deliver safe care to the residents living in the centre at the time of the inspection, inspectors found that the provider had identified a transfer date for a new resident with complex medical needs to be admitted to the centre. This new resident required additional staff support and there were no arrangements to ensure this additional staff support was in place.

The provider had completed a business case in relation to this planned transition which identified and risk assessed the requirement of an additional 2.24 staff nurse and 2.2 health care staff in order for the resident to be supported in the designated centre. The inspectors reviewed the planned roster for the proposed move in date and the roster for the following week. This roster did not have the additional staffing requirement in place to support this resident, who as previously discussed presented with high support needs.

In addition, inspectors found that the rosters reviewed for one house in the designated centre did not demonstrate the full name or grade of staff working in the centre.

Judgment: Not compliant

Regulation 23: Governance and management

This inspection found that while there was clearly defined management structure in place the provider had failed to ensure that the centre was resourced to ensure the effective delivery of care and support in accordance with the statement of purpose and assessed needs of residents.

On the day of the inspection, management could not detail the current whole time equivalent vacancies in the centre. Following the inspection, the provider submitted a breakdown of staff vacancies in the centre which documented six nursing vacancies and 18.05 care staff vacancies. The provider had 11 of the vacancies in the final stages of the recruitment process.

Furthermore, the inspection found that the systems in place for the oversight and monitoring of care and support had not identified the levels of non compliance with the regulation highlighted during the inspection process. For example, the provider had completed a six-monthly unannounced audit in January 2026 which resulted in an action plan with four actions to be completed. These included recruitment, advocacy for non-verbal residents, cleaning of external pathways to the centre and overflowing bins. However, the providers' six-monthly audit had not identified a number of issues in relation to the premises in one house in the designated centre.

The inspectors found during the course of the inspection that a number of documents in relation to residents care were not readily available for review and documents reviewed contained outdated information. For example, one resident who had experienced changing needs, had a behaviour support plan in place which documented that the resident required a different environment to support the identified changing needs. Inspectors found no further review in relation to any planned moves or transitions and staff spoken with were not aware of any transition plan.

Staff meetings were occurring in the designated centre, the meetings were occurring in each of the three houses in the centre. However, the inspectors reviewed eight staff meetings held from January to June 2026 and found low attendance levels at each staff meeting.

The inspectors found that the clinical nurse manager grade two was present at six meetings with a maximum of two to four staff present and the person in charge had attended two. In addition, the inspectors found that for two of the houses in the designated centre, staff had not signed that they had read the minutes of the meetings held to ensure that they had been updated to the risks or updated supports for residents.

On review of a staff meeting held on 03 April 2026, staff raised concerns to the person in charge in relation to facilitating night time and early morning supports for one resident in a second house in the centre. As part of the concern raised, staff requested that the provider review an additional twilight staff to support residents. An action following on from the staff meeting documented that staffs concerns would be brought to the next senior governance and management meeting. Inspectors reviewed the governance meetings held in June 2026 which did not present or document staff concerns raised in the April meeting. Furthermore, inspectors were presented with no evidence to document that staffs concerns were escalated to the provider. The inspectors found that the meetings did not give staff an appropriate opportunity to raise concerns and did not have sufficient management attendance.

Findings on inspection did not provide assurances that the oversight and management systems were effective in ensuring a safe quality service to residents.

Judgment: Not compliant

Regulation 24: Admissions and contract for the provision of services

The inspectors found that there was an ongoing transition plan in place for one resident who had an identified planned admission date to one house in the designated centre in July 2026. The inspectors reviewed the transition plan in place for the resident and found that the provider had failed to implement the proposed safe staffing levels required in order to ensure that the residents' admission to the centre would be safe and in line with their assessed needs.

As part of the resident's transition plan, the resident had completed a one night stay and a consecutive two night stay in the centre. Following the two night stay on the 18 June 2026 and 19 June 2026, staff documented their concerns in relation to the residents complex health needs and co-morbidities and requested that further consultation with staff should happen to review the proposed move. The staff identified that further review was required in order to support the residents transition and to record and assess the residents physical and emotional wellbeing. Support staff recommended additional overnight stays in order to appropriately monitor and support the resident.

The inspectors reviewed nursing case notes of a meeting held with the project lead and staff nurse on 30 June 2026, documented concerns raised by staff following the overnight stay of the resident were not discussed at this meeting. Instead, the nursing case notes documented that the resident was moving to the centre on the identified date in July, with no additional overnight stays put in place for the resident as part of their transition plan.

The inspectors requested to review the resident's personal emergency evacuation plan (PEEP) for the three nights that they had stayed in the centre and for their admission in July 2026. The PEEP was not readily available in the centre and had to be emailed to the assistant director of nursing. The inspectors found that the PEEP did not give adequate detail to guide staff to support the resident to evacuate in the event of a fire. The PEEP in place highlighted the residents' dietary requirements and supports required when eating or drinking. In addition, the PEEP did not document the fire evacuation aids the resident required in order to safely evacuate the premises. These evacuation aids are required to support staff or the emergency services and as they were not in place when the resident was in the centre this put the resident at risk.

Inspectors met and chatted to one resident who had recently moved to one of the houses in the centre by way of transfer from another designated centre. The

resident expressed that they were very happy with their new home and showed the inspector around.

Support staff discussed that the resident had one to one support in place as they greatly enjoyed accessing a number of local activities but required staffing support in order to fully participate in certain activities and to maintain a safe environment.

The inspectors reviewed four contracts of care and found that they were up to date and where possible had been signed by residents.

Judgment: Not compliant

Quality and safety

This section of the report describes the quality of the service and how safe it was for the residents. Overall, the inspection findings identified concerns in relation to the providers' oversight of safeguarding measures in place, residents rights and the storage of medical equipment and laundry management.

Some residents required support with communication. The inspectors saw that staff members were familiar with residents' communications and could support residents to engage in conversations with the inspector.

The designated centre comprised of a number of premises across three locations. The houses were generally homely, nicely decorated, and met the needs of the residents, however, in one location improvements were required in relation to storage and safe procedures regarding laundry management.

While positive behaviour support plans were in place for residents, inspectors found that guidance in place to support staff when assisting residents with behaviours of concern required review. For one resident, inspectors found supports in place on the day of the inspection was increasing their levels of anxiety. Furthermore, there were a number of restrictive practices in place that had not been notified to the Office of the Chief Inspector (Chief Inspector).

The inspection found that while the provider had completed appropriate safeguarding reviews in line with policy and procedure, they had failed to identify all safeguarding concerns as highlighted under Regulation 8: Protection. This failure to identify possible safeguarding risks to residents demonstrated that the provider did not have sufficient oversight and detection systems in place. The level of non compliance found under this regulation led to inspectors issuing an immediate action to the provider during the course of inspection and requesting assurances that the risk identified was immediately addressed on the day of the inspection in order to safeguard residents.

The registered provider had not ensured that all residents human rights were upheld particularly in relation to their intimate and healthcare needs.

Furthermore, some residents had limited opportunity access to recreation and activities in accordance with their interests, capacities and developmental needs.

Regulation 10: Communication

There were comprehensive communication plans in place that gave clear guidance and set out how each person communicated their needs and preferences.

Residents' files contained communication care plans where required, and a communication profile which detailed how best to support the resident. Throughout the duration of the inspection, inspectors observed residents receiving information and being communicated with in a way that met their assessed needs. Staff were observed to be respectful of the individual communication style and preferences of the residents.

Some residents required support to engage in conversations with the inspectors. Inspectors saw that staff members clearly understood residents' communications and were able to support conversations.

Communication aids, including visual supports, had been implemented in line with residents' needs and were readily available in the centre. Additionally, important information, such as the schedule for the day were displayed in an easy to read format. Inspectors observed a lot of the signage in the centre was in easy-to-read, such as menu planner, daily and weekly planners and local community activities and events. This supported residents to understand and engage with the information provided.

Residents had access to relevant communication media including personal mobile phones, televisions and streaming services.

Judgment: Compliant

Regulation 17: Premises

The inspectors completed a walk through of three of the premises in the designated centre. During the walk through of one premises, the inspectors found a number of concerns in relation to laundry management and the storage of medical supplies.

In one of the houses in the designated centre, residents' laundry was sent to an external laundry service. If residents wished for certain items to be washed at home this was facilitated by support staff. On review of the laundry room, inspectors

found multiple netted laundry bags piled on top of each other and sitting on top of an unused commode. Inspectors were informed by staff that laundry was collected on Monday, Wednesday and Friday each week. Staff confirmed that the laundry awaiting collection would be items from Monday night and Tuesday. Inspectors observed that each netted bag had individual residents labels to identify personal clothing, however, each bag was piled on top of other residents bags of clothing.

Furthermore, the laundry room was also used for storage of multiple items including three residents' wheelchairs, incontinence wear, catheter bags and catheter leg straps. The inspectors found that boxes containing the medical items were stocked on the floor of the laundry. The laundry also had a hand sink, washer and drier which exposed the area to heat and moisture, which could compromise the structural integrity of the catheter bag, tubing or seals.

The laundry room was fitted with a small sink, during the walk through inspectors observed kitchen cloths and tea towels soaking in a large basin beside the sink. Inspectors spoke to two staff in relation to soiled items, staff discussed that they would use alginate bags and place soiled clothing on the appropriate wash setting. On the day of the inspection there was no alginate bags available in the designated centre. This presented as a infection prevention and control (IPC) risk.

In the same house, the inspectors reviewed the staff room. This room was found to have items stored including sharps boxes, archiving and medical supplies. On review of the oxygen masks stored in the staff room, the inspectors found an open oxygen mask lying on the inside of the box. The inspectors also found a closed sharp box, which had been closed on the 28 May 2026 sitting on top of multiple items. The oxygen mask and sharps box was brought to the attention of senior management when observed by the inspectors.

In addition, inspectors found that the ceiling tiles in four en-suite residents' bathrooms were lifting away from the ceiling.

The inspectors found that in each of the premises residents bedrooms were decorated in line with their personal tastes and interests. Later in the inspection, the inspectors visited two houses and one apartment in the designated centre. These premises were found to be well maintained and comfortable environment for residents.

In one house, the inspector found accessible call buttons for residents to seek assistance when required. These buttons assisted residents to increase their independence within their home with supports available when required during personal care.

Judgment: Not compliant

Regulation 7: Positive behavioural support

Staff spoken with informed the inspectors that four residents, in one house required support in promoting positive behaviour. Inspectors reviewed all four plans. However, following review of one resident's positive behaviour support plan, inspectors noted that the plan had insufficient information detailing required supports and the rationale to support these strategies.

As previously discussed, while meeting with one resident in the designated centre, they informed the inspectors that they did not like living in their home. They told the inspectors that they were moving to a new home. The inspectors informed the resident that they did not know about their planned move. The resident repeated to the inspectors that they were moving and if the inspectors where in their home to ask about their move.

As the resident was displaying signs of upset, the inspectors asked the support staff to provide assistance to the resident. The support staff advised the resident that they would be moving to their new home soon. The inspectors observed that each time the support staff reassured the resident that they would be moving home soon the resident became more upset.

The inspectors reviewed the residents support plan and found that the resident had a behaviour support plan in place which highlighted that a move was not happening for the person but that staff should respond by telling the resident they would be moving soon.

A clear script was in place for the resident, who would ask when they were moving to their new home. On further analysis of the script, the response to the resident when they asked about when move would take place was to say 'after your birthday'.

Inspectors found that there was no clear rational for the script and inspectors observed when staff were supporting the resident they were increasing their anxiety. Furthermore, inspectors found that due to the high reliance on agency staff, the provider could not be assured that the script, if suitable, was being implemented to support the resident.

In addition to this, staff were unsure whether the possibility that the resident did not want to reside in the house had been explored. When inspectors asked management was the resident moving, they were told no that there was no plan to move the resident.

This meant that information to adequately guide and support staff to manage behaviours of concern, in a consistent way, was insufficient and therefore impacting on the quality of care the resident was receiving. The inspectors were not assured that the systems in place to support residents with behaviours of concern were effective.

Where therapeutic interventions had been recommended, not all plans clearly demonstrated at what stage the intervention should be implemented. In addition,

the use of the intervention had not been adequately risk assessed and guidance available to staff as to how to administer the intervention was not clear.

Some restrictive practices that were in place for example, nightly checks for two residents, had not received a restrictive practice review and in addition had not been notified to the Chief Inspector on a quarterly basis, as required.

One of the night time checks outlined that the resident was to be checked regularly and the other resident's support plan stated hourly. This plan was not signed and the inspectors were not assured that consent had been obtained and less intrusive options explored.

Improvement was required to ensure all restrictive practices had been suitably reviewed to ensure they were the least restrictive and used for the shortest duration possible.

Judgment: Not compliant

Regulation 8: Protection

During the inspection, one inspector conducted a walkthrough of one premises within the designated centre, accompanied by a staff member. In order to gain entrance or exit of the premises residents and staff were required to use a magnetic fob system. While the inspector was reviewing the rear garden of the designated centre with staff, they observed an agency cleaner exit the centre and walk through a communal garden leading to a second house that was not part of the designated centre. The inspector saw the cleaner leave the designated centre and open the back door of the second premises.

The inspector then asked staff whether this second house formed part of the designated centre. Staff informed the inspector that the second house was not included in the designated centre, it was part of the providers' wider remit and was home to individuals without disabilities who required support staff.

The inspector spoke to the assistant director of nursing and the clinical nurse manager grade two following the observation. Senior management and staff could not confirm if the magnetic fob in place for all staff would access both the designated centre and the premises located next door to the centre.

An immediate action was issued to the provider as inspectors were not assured that the provider could protect residents from all forms of abuse in one premises of the designated centre. The use of a fob for the designated centre which could allow an external support service to access the designated centre posed a potential risk for all residents in the centre. The provider could not be assured that no unauthorised persons or visitors could enter the residents home without permission or without Garda vetting where appropriate. The inspectors found that the cleaning staff

moving between two premises could lead to the fob not being appropriately secured or left behind.

In addition, the provider could not be assured that infection protection and control (IPC) measures could be adhered to with cleaning staff working between two alternative centres one under the providers disability remit and a secondary provision of care with no formal lines of communication to notify the provider of possible IPC concerns.

On the day of the inspection the provider put a number of local control measures in place to enhance protection measures for residents and subsequently submitted a compliance plan response. The provider gave assurances in relation to actions undertaken to ensure that no unauthorised persons could access the centre. A risk assessment was put in place in relation to IPC measures.

All staff had received up-to-date training in the safeguarding and protection of vulnerable adults. Staff spoken with were familiar with reporting systems in place, should a safeguarding concern arise.

Judgment: Not compliant

Regulation 9: Residents' rights

As previously discussed, support was required for one resident night time support by three staff in order to provide intimate care. The inspectors reviewed daily night time reports and night time global reports which demonstrated a number of times where support staff from another house in the designated centre could not come to the residents home to provide support for personal care. This would then result in the residents' personal care being provided by two staff and in their bed instead of the bathroom.

The inspectors reviewed six separate entries on 31 May, 02 June, 11 June, 15 June, 21 June, 24 June 2026, where no second staff was available to support the resident, despite documentation that the resident had been "heavily incontinent". On review of global and nursing reports from May 2026 to June 2026 the noted time for staff to attend the centre were set at between 21:30 and 22:30 and 06:00 and 06:30. Inspectors found that details around that resident's personal care were not clearly documented by all staff. It was not always clearly documented if a third staff was present for personal care.

Inspectors found further documentation in the residents support plan which detailed that the resident is susceptible to urinary tract infections. The inspectors found that the practice in relation to a resident requiring to wait for staff to come to their home in order to provider personal care during the night was not in line with best practice and did not promote their basic rights.

In addition, the inspectors reviewed the residents assessment of need and relevant support document and found that there was no risk assessment in place for the requirement of three to one staffing and the supports to be provided if this could not be facilitated. The inspectors found that the residents manual handling risk assessment on file was dated 2024 with no history of review in 2025 or 2026. On request support staff could not find a recent review in line with the residents changing needs.

Residents had limited opportunity access to recreation and activities in accordance with their interests, capacities and developmental needs.

In one house, the meaningful activity record for two residents was reviewed over a five week period and inspectors noted that outside of attending day services, one resident had gone out once to attend a medical appointment and the other resident visited a family member twice and attended the hairdresser. Other activities listed on the record included in house activities such as 'personal space', 'relaxation' and 'individual interests'.

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 15: Staffing	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Admissions and contract for the provision of services	Not compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 17: Premises	Not compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Good Counsel Services OSV-0002586

Inspection ID: MON-0050903

Date of inspection: 01/07/2026

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 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: 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. Regulation 15(1) • Continuous rolling campaigns to recruit all grades of staff, care assistants, health care assistants and staff nurses. Since the inspection 5 Health Care Assistant and 1 catering officer and 1 nurse have either commenced employment or received start date Ongoing • Recruitment for CNM1 for part of the Designated Center will be processed • The statement of purpose and function has been reviewed and has an up-to-date WTE of staffing level required to provide 24-hour support and care of the residents within the Designated Centre. Completed • . • Admissions are currently on hold as per discussion with HIQA Inspector and HIQA Regional Manager. • The Person in Charge will review agency utilisation on a regular basis. Trends and staffing deficits will be reported to the Director of Nursing and PPIM through normal governance processes The registered provider shall ensure that where nursing care is required, subject to the statement of purpose and the assessed needs of residents, it is provided. Regulation 15(2) • Any resident that requires additional staff support over the 24hour period will have a staff member allocated so there is appropriate care in accordance with the individuals care plan Completed • Night staffing resources allocated to support residents with assessed 1:1 and 3:1 supports remain available at all times. Staff will no longer be redeployed from one location to another where this reduces staffing levels below assessed need Completed • The registered provider shall ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time	

basis. Regulation 15(3) • The rostering of the staff team (HSE and agency) in each location of the Designated Centre will be consistent and limited crossover between the individual homes. The roster contains additional information such as complete name of staff agency name Completed • Campaign to convert Agency staff to HSE contracts this is at offer of contract stage ongoing Ongoing • Banking system for HSE staff is in the early stages of being introduced to limit the amount of agency staff being used Ongoing	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose. Regulation 23(1)(a) • WTE have been identified and this has been amended in the Statement of Purpose and Function this will be reviewed when there is any admissions to the DC Completed • Audit of all documents contained in the care plan has commenced to ensure there is current and accurate information contained for each resident Ongoing • All residents' PEEPs have been reviewed within the Designated Centre a new format has been used to guide the staff for safe evacuation plans for each resident. Completed 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. Regulation 23(1)(c) • The Person in Charge will be present for majority staff meetings held throughout the Designated Centre meetings will occur on both shifts to ensure the adequate staff presence and input Commenced • Alls staff including agency will receive the minutes of staff meetings. • Local Quality and safety meetings occur monthly where the action plans from inspections and audits are discussed also included is trends in submitted notifications, restrictive practices, incident management, training requirements, safeguarding and residents/representative feedback. • Any restrictive practices within the DC are returned in line with regulations the PIC audits this on a monthly basis • All minutes of staff meetings will be sent to the ADON's and DON's and any actions are documented with clear timelines and ownership of such actions. • 2 monthly senior management meeting will occur to discuss any outstanding issues are tracked and there are agreed actions timelines and responsible person is assigned to these actions. • All staff including regular agency staff are required to sign the minutes of meetings this	

has been included in the Person in Charges & CNM2 weekly /monthly checklist
Commenced

The registered provider shall ensure that effective arrangements are in place to facilitate staff to raise concerns about the quality and safety of the care and support provided to residents. Regulation 23(3)(b)

- The PIC will communicate with PPIM/Senior managers any issues raised at staff meetings so any matters raised can be dealt with in a timely manner the minutes will be signed with any actions which are noted and completed or resolved. Commenced
- Senior managers whilst doing rounds will note any concerns that are raised by staff and address them as soon as possible and bring them to the attention of the PIC /PPIM/DON or escalate if needed. Commenced

Regulation 24: Admissions and contract for the provision of services

Not Compliant

Outline how you are going to come into compliance with Regulation 24: Admissions and contract for the provision of services:

- Any new admissions to the centre will have a transition plan in place that supports the move any areas identified through assessment of need will be addressed prior to admission. Ongoing
- Staffing levels will be reviewed with any admission to the Designated Centre and any additional support over the 24 hours will be provided and post admission this is reviewed to ensure adequate staffing to support the resident. Ongoing
- During the transition period a fire evacuation plan PEEP will accompany the residents and amended appropriately for the new home to ensure the supports are present to aid a safe evacuation in an emergency. Ongoing
- A checklist will be developed to ensure a smooth and safe transition this will ensure that all residents are supported during the process appropriately and confirms the following is included compatibility assessment, staffing resources, Risk Assessment, environmental suitability, personal emergency evacuation plans the PIC will review the plan continuously Ongoing
- Where a staffing deficit is identified this is clearly noted in the transition plans risk assessed with a plan to address the have the appropriate resources in place to allow the admission to take place. Ongoing

Regulation 17: Premises	Not Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally. Regulation 17(1)(b) • The maintenance have been, notified of the repairs that are required to the Designated centre. Completed • A weekly list is comprised for repairs and anything urgent is requested immediately Ongoing The registered provider shall make provision for the matters set out in Schedule 6. Regulation 17(7) • The HSE property and estates team are in discussions with the landlord to have increased access for storage DON & PIC will continue to pursue this with the estates team. Ongoing • There has been an Increase in laundry collection to 5 days per week (Monday to Friday) Completed • There has been change of usage for the staff room to provide additional storage for one of the homes in the Designated Centre medical supplies will no longer being stored in laundry areas a checklist of what is stored in room in place. • with alternative arrangements for staff in the office areas. Application to vary will be submitted to change the floor plans in line with regulations Ongoing • There are clear guidelines and policies in place for IPC practices and the disposal of IPC waste. The IPC link practitioner nurses are given protected time and will carry out an audit of IPC waste disposal and laundry management within the Designated Centre. Ongoing	
Regulation 7: Positive behavioural support	Not Compliant
Outline how you are going to come into compliance with Regulation 7: Positive behavioural support: The registered provider shall ensure that where required, therapeutic interventions are implemented with the informed consent of each resident, or his or her representative, and are reviewed as part of the personal planning process Regulation 7(3) • Residents' Will and Preference regarding where they live and who they live with will be supported through decision making by having support from the National Advocacy Service and referred to HSE social work department. Completed • Families as resident representatives are involved in the care planning process.	

Functional capacity assessments will be carried out in line with the decision-making capacity act when required. Ongoing The registered provider shall ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information. Regulation 7(4) The person in charge shall ensure that, where necessitates intervention under this Regulation every effort is made to identify and alleviate the cause of the resident's challenging behaviour. Regulation 7(5)(a) The PIC engages the CNS in Positive Behaviour Support when needed in order to support the residents and the staff with communicative behaviour following a functional analysis, the behaviour support plan will contain • Proactive strategies are clearly outlined in the stress management plan to help prevent residents from becoming upset when they do not receive the response they expect. The plan also clearly states that the "script" is an intentional and consistent response, used as part of the agreed support strategy. Completed • The PIC ensures all staff are made aware of Stress Management Plans/Behaviour support plans and any changes made by noting this on the safety pause board in the staff office Ongoing • Residents Positive Behaviour Support Plans are under review with the Advanced Nurse Practitioner in Positive Behaviour Support and Autism and the CNS in Positive Behaviour Support this is to ensure all reactive strategies that are in place are clear and the intention of any strategy is clearly documented Ongoing • Any resident who requires MDT supports when behaviour supports are not effective will have an MDT review. • Bespoke training for staff to support the staff team to be skilled in managing Challenging behaviour includes Studio 3 , Positive Behaviour support, goal setting , trauma informed care approaches	
Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection: The registered provider shall protect residents from all forms of abuse. Regulation 8(2) 8(3) • Only staff working within the Designated Centre who are authorised to access the fob for residents' homes they alone will only be permitted to enter without prior announcement, the PIC will review fob access monthly. All other visitors must announce themselves sign in the visitors book and enter the premises in accordance with the Designated Centre's Visitors Policy. Completed • Any safeguarding issues will be brought to the attention of the designated officer immediately and will be discussed with the PIC/PPIM whereby a safeguarding action plan is agreed and actioned • Any suspicion of an abusive incident or a resident coming to harm will be investigated	
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acted upon and reported in line with Regulations HSE Incident Management Framework Policy and HSE Safeguarding Policy Completed

- A formal arrangement is in place with the neighbouring HSE service and the contracted cleaning company to ensure that staff within the Designated Centre are immediately informed of any outbreak of an infectious illness. Upon notification, appropriate infection prevention and control (IPC) measures are implemented immediately. A corresponding risk assessment is also in place to identify, assess, and manage any associated risks.

Completed

Regulation 9: Residents' rights

Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights: The registered provider shall ensure that each resident, in 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 9(2)(a)

All residents have checklist of activities documented every day in care plan , choices are offered to residents for activities both internally and external to their home such as attending mass, going for lunch dinner, day services, day trips, local pub, and visiting friends it is now captured what activities are offered to residents. When a resident chooses not to participate in activities this is clearly documented in the care plan. Any activities the residents would like can be discussed at the residents weekly meeting in their home Completed

All residents have SMART goals that are discussed at the monthly meeting held with the resident and their keyworker. To ensure oversight by the PIC they will monitor and sign these meetings. A review of each person's activities will include what is described as an "Individual interest" for each resident. Ongoing

Some residents who require specific supports in relation to night- time have had a social story in accessible format introduced to them, this was done in order to gain their preference for night time checks. Resident's preferences have been noted and consent obtained. Any resident with medical risks acute or ongoing has a health management plan and risk assessment in place to support the night- time checks. Completed

Any occasion whereby the resident has to be checked outside of the norm this will be documented and recorded as a restrictive practice. Ongoing

Restrictive practices are an agenda item on the local Quality and Safety meetings this is also noted at the human rights committee meeting which has internal and external representatives including safeguarding social -worker and advocacy facilitator. The PIC will increase audits on restrictive practices from 3 monthly to monthly Ongoing

The registered provider shall ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and

personal information. Regulation 9(3)

All residents have an intimate care plan which describes any supports needed to provide personal care and the approaches that is most preferred by the resident. This has been reviewed for the residents in the home and includes Specific Health Management Plan and manual handling Risk Assessment. Staffing levels have been changed accordingly so personal care can be provided on a 24 hour basis as documented in the identified residents care plan. Completed

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.	Not Compliant	Orange	01/10/2026
Regulation 15(2)	The registered provider shall ensure that where nursing care is required, subject to the statement of purpose and the assessed needs of residents, it is provided.	Not Compliant	Orange	06/08/2026
Regulation 15(3)	The registered provider shall ensure that residents receive continuity of care and support, particularly in	Not Compliant	Orange	01/10/2026

	circumstances where staff are employed on a less than full-time basis.			
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Not Compliant	Orange	31/08/2026
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Not Compliant	Orange	01/10/2026
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.	Not Compliant	Orange	31/08/2026
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.	Not Compliant	Orange	06/08/2026
Regulation 23(3)(b)	The registered provider shall	Not Compliant	Orange	06/08/2026

	ensure that effective arrangements are in place to facilitate staff to raise concerns about the quality and safety of the care and support provided to residents.			
Regulation 24(1)(a)	The registered provider shall ensure that each application for admission to the designated centre is determined on the basis of transparent criteria in accordance with the statement of purpose.	Not Compliant	Orange	01/10/2026
Regulation 07(3)	The registered provider shall ensure that where required, therapeutic interventions are implemented with the informed consent of each resident, or his or her representative, and are reviewed as part of the personal planning process.	Not Compliant	Orange	01/10/2026
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in	Not Compliant	Orange	01/10/2026

	accordance with national policy and evidence based practice.			
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	03/07/2026
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	03/07/2026
Regulation 08(3)	The person in charge shall initiate and put in place an Investigation in relation to any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.	Not Compliant	Red	03/07/2026
Regulation 09(2)(a)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability participates in and consents, with supports where	Not Compliant	Orange	01/09/2026

	necessary, to decisions about his or her care and support.			
Regulation 09(3)	The registered provider shall ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.	Not Compliant	Orange	01/09/2026