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:	Cork City North 5
Name of provider:	Horizons
Address of centre:	Cork
Type of inspection:	Unannounced
Date of inspection:	08 June 2026
Centre ID:	OSV-0003291
Fieldwork ID:	MON-0049188

About the designated centre

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

Cork City North 5 is a designated centre operated by Horizons. It provides a service to a maximum of twenty six adults with a disability. 25 places are offered to individuals on a residential basis and one respite bed was available to support seven individuals. The designated centre comprises of one large building made up of three interlinked units. Each unit comprises of a kitchen, dining room, sitting room, bathrooms, office and a number of resident bedrooms. The centre is located on a campus based setting in County Cork. The staff team consists of clinical nurse managers, staff nurses, care assistants and activation staff. The staff team are supported by the person in charge.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	23

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Monday 8 June 2026	11:45hrs to 19:00hrs	Conan O'Hara	Lead
Tuesday 9 June 2026	09:45hrs to 15:45hrs	Conan O'Hara	Lead
Monday 8 June 2026	11:45hrs to 19:00hrs	Mary Costelloe	Support
Tuesday 9 June 2026	09:10hrs to 15:45hrs	Mary Costelloe	Support

What residents told us and what inspectors observed

This was an unannounced inspection carried out to monitor compliance with the regulations and conditions of registration. The purpose of this inspection was to review actions taken by the provider, as outlined in their compliance plan to address areas of non compliance with the regulations and to inform a decision regarding the renewal of registration. The inspection was completed by two inspectors over two days.

The registration of the designated centre was renewed in January 2024 with a non-standard condition attached to the registration. This condition required the provider to address the regulatory non compliances as outlined in the plan dated 29/11/2023 to the satisfaction of the Office of the Chief Inspector no later than 31/12/2026.

The previous inspection in February 2025 found that there there continued to be areas that required improvement including staffing arrangements, training and development, governance and management, risk management and fire safety. The findings from this inspection found that the provider had made progress in implementing the compliance plan submitted and had implemented a number of the actions including:

- securing funding for additional 13.5 Whole Time Equivalent (WTE) staff which now formed part of the roster,
- ensuring all staff had up to date training,
- installing additional storage in the offices for files, equipment and Personal Protective Equipment (PPE), and
- a fire safety audit was completed by an external fire engineer and the identified fire safety issues had been addressed.

In addition, the provider had submitted an application to vary a condition of registration and had reduced the numbers of residents to be accommodated from 27 to 26.

Overall, while inspectors found that progress had been made, additional improvement works were still required in staffing, governance and management, fire safety, premises and general welfare and development in order to fully implement the agreed compliance plan. Improvements were also required to ensuring a more personalised approach to the provision of meals.

The inspectors had the opportunity to meet with the 23 residents living in the centre and one respite user over the course of this inspection. Many of the residents accommodated had complex and increasing health care support needs. The residents were of an aging profile, with many residents requiring support in relation to dementia, dysphagia, mobility and communication needs. The residents used both verbal and alternative methods of communication, such as vocalisations, facial

expressions and gestures to communicate their needs. Residents appeared well groomed, appropriately dressed and presented in a manner that reflected good standards of personal care.

On arrival on the first day of the inspection, following a meeting with the person in charge, the inspectors completed a walk around of the three units. The designated centre comprises of one large building made up of three interlinked units. Two units were located on the ground floor and one unit was located on the first floor. Overall, the inspectors found the premises to be clean, well maintained and decorated in a homely manner.

The first unit was home to eight residents. The unit comprised of an original property and modern extension. The original property contained a kitchen, dining room and sitting room and two offices upstairs. The more modern extension comprised of a seating area, office, nine bedrooms for residents and a number of shared bathrooms. The modern extension is laid out surrounding the courtyard an is specifically designed for people who may present with dementia. The inspectors found that residents' bedrooms were decorated in line with residents preferences with their preferred colour schemes, sporting and music interests, family photographs and other personal belongings of significance to them. There was an enclosed central courtyard with suitable garden furniture. There was also a Oratory available for all residents to use if they wished.

The inspectors met the residents while they were finishing lunch. Throughout the day the inspectors observed residents spending time in the sitting room watching TV and in the dining room. Later in the afternoon, the inspectors observed a number of residents arriving from the other two units to partake in a baking activity. A number of residents seemed to enjoy taking part, mixing ingredients and decorating the buns with icing. During the inspection, some residents were observed going for walks on the grounds with the support of staff, one resident spoke of how they had enjoyed going to the cafe located on campus, three others had enjoyed going to the local shops to buy their preferred food items. Residents were observed to be comfortable and content in their home. One resident spoken with said that they liked living in the house. The inspectors also spoke with one family member who spoke positively about the care and support provided to their family member.

The second unit was located through an interconnected corridor, on the first floor and was home to five residents. This unit comprised of kitchen, sitting room, office, seven bedrooms for residents use and a number of shared bathrooms. There was an outside veranda for residents to use if they wished.

The inspectors met with three residents spending time in the sitting room following their lunch. The residents appeared comfortable and relaxed in the sitting room listening to the radio. One of the residents showed the inspectors their teddies which was important to them. A fourth resident was in their bedroom when the inspectors arrived and met with inspectors in the sitting room on their way to have lunch. They told inspectors that they liked the service and their bedroom. The fifth resident was out in the community and inspectors briefly met the resident as they

were returning home. They said hello to the inspectors and appeared happy to be returning home.

The third unit is located on the ground floor and was home to eight residents. The third unit consisted of sitting room, dining room, kitchen, snug, eight resident bedrooms, office and a number shared bathrooms. Similarly, residents bedrooms reflected residents interests with posters of sport, art and photos of people important in their lives. The inspectors observed birthday balloons and a birthday banner in the dining room to celebrate one of the resident's birthday.

Residents were observed being supported in the sitting room watching TV and in the dining room with meals and snacks. One resident was observed spending time in the snug. The residents appeared comfortable in their home and in the presence of staff. Previously there was a shared bedroom in this unit. The inspectors were informed that this bedroom was now being used a a single bedroom and that there were no more shared rooms in this unit. The person in charge indicated that it has been a positive development for the residents.

On the second day of the inspection, the inspectors primarily spent time reviewing documentation and speaking with the person in charge and management. The inspectors noted some residents being supported to go to one of the units to take part in an art activity and residents appeared to enjoy taking part. The inspectors met with another resident being supported by staff as they were returning from a walk in the grounds, they appeared to be happy and showed the inspector some flowers they had picked along the way.

Inspectors also met with the activation staff member on duty who advised that they were planning to take two residents in the minibus to a swimming pool located close by. On enquiry, the inspector was informed that while a number of residents enjoyed going swimming, only two residents using wheelchairs could be accommodated in the minibus at any one time. This meant that residents were facilitated to go swimming on a rotational basis. The person in charge informed inspectors that they were trying to secure a second swimming slot each week in order to facilitate residents with more opportunities for swimming. They also advised that they had made a request for an additional transport vehicle.

Overall, the inspectors found that the provider had implemented a number of actions as outlined in their compliance plan. The inspectors observed the staff team supporting the residents in an appropriate and caring manner. However, continued work was required in relation to the staffing arrangements, governance and management, general welfare and development, premises and fire safety. In addition, improvement was required in providing a more personalised approach to the provision of meals.

The next two sections of the report present 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.

Capacity and capability

Overall, the inspectors found that the management systems in place were striving to ensure the provision of a good standard of care to residents and the provider had implemented a number of actions to come into compliance with the regulations. However, the staffing arrangements required continued attention.

There was a defined governance structure in place. The centre was managed by an appropriately qualified and experienced person in charge. Quality assurance audits were taking place to assess and monitor the service including the annual review and six-monthly provider audits. These audits identified areas for improvement and developed actions plans to address same. However, continued work was required to address a number of areas for improvement as outlined in this report.

Overall, the inspectors found that the staffing levels in the centre had improved since the last inspection. While the provider had secured funding for an additional 13.5 whole time equivalent staff posts, a large number of vacancies remained unfilled at the time of inspection. Consequently, the centre relied on agency staff to maintain the required staffing levels. The provider was actively in the process of recruiting to fill the vacancies.

The inspector reviewed a sample of training records which demonstrated that for the most part the staff team had up-to-date training. This meant that the staff team had the skills and knowledge to support residents. The provider had recently completed a training needs anaylsis and identified the requirement for additional training in dementia and deescalation and intervention techniques. There were plans in place to deliver this training.

Regulation 14: Persons in charge

The centre was managed by a full-time person in charge who was suitably qualified and experienced for the role. The person in charge was responsible for this designated centre only. The person in charge demonstrated a good knowledge of the residents and their assessed needs.

Judgment: Compliant

Regulation 15: Staffing

The 23 residents were supported by 12 staff during the day and six staff at night. In addition, residents were also supported by one or two activation staff during the daytime.

The inspectors found that the provider had made significant progress in addressing the non compliance with staffing levels to ensure that they were in line with the assessed needs of the residents. Since the last inspection, the provider had secured funding for the additional 13.5 whole time equivalent staff. On the day of the inspection, the additional staffing was reflected in the the staffing roster and vacancies were being filled by agency staff. The provider had also recruited a number of new staff including three nurses.

However, improvements were required to staffing arrangements in the centre, to reduce the centres reliance on agency staff in order to promote greater continuity and consistency of care for residents. At the time of the inspection the centre was operating with 13 vacancies which meant that there was a reliance on agency staff to maintain the roster. This at times impacted on continuity of care and activities. For example, two of the vacancies were for activation staff and it was reported that due to the staffing arrangements at times, activation staff may be redirected to provider direct care and support to residents. In addition, the inspectors were informed that reliance on agency also presented a challenge in releasing staff for training.

The reliance on agency staff to fill the expanded roster had been self-identified by the provider as an area for continued improvement. For example, in a risk assessment completed in March 2026 the staffing arrangements were identified as high risk. The inspectors were informed that the provider was actively recruiting to fill the vacant posts.

Judgment: Substantially compliant

Regulation 16: Training and staff development

There were systems in place for the training and development of the staff team. The previous inspection identified a number of training gaps in safeguarding, manual handling and positive behaviour support. This had been addressed.

From a review of a sample of training records, the majority of the staff team had up-to-date mandatory training completed including fire safety, safeguarding, positive behaviour support and manual handling and dysphagia. Where members of the staff team required refresher training, this had been self-identified and plans were in place to address same.

The provider had also completed a training needs review and identified the need for additional residents specific training in dementia and de escalation and intervention techniques. There were plans in place to deliver this training.

Judgment: Compliant

Regulation 23: Governance and management

There was a clearly defined management structure in place. the centre was managed by an appropriate qualified and experienced person in charge. The person in charge reported to a regional manager, who in turn reported to the Chief Operations Officer. The person in charge was responsible for this designated centre only. They were supported in their role by two Clinical Nurse Managers who also assisted with the oversight of the care and support provided.

There was evidence of quality assurance audits taking place to ensure the service provided was appropriate to the residents needs. The quality assurance audits included an annual review for 2025 and two six-monthly provider visits completed in October 2025 and February 2026. The audits identified a number of areas for improvement and there were plans in place to address same.

Overall, it was evident that the provider had made good progress in implementing the actions as outlined in their compliance plan submitted and in responding to the restrictive condition attached to the registration of the centre. However, continued work was required to address areas for improvement such as staffing arrangements, general welfare and development and food and nutrition.

Judgment: Substantially compliant

Quality and safety

Overall, the inspectors found that the service was striving to provide person centred care and support to the residents in a homely environment. However, continued improvement was required in the general welfare and development, fire safety and premises. In addition, improvement was required in the provision of meals.

The inspectors reviewed a sample of the residents' personal files which comprised of an comprehensive assessment of the residents' personal, social and health needs. Personal support plans reviewed were in place and guided the staff team. The inspectors reviewed activation records and found that continued improvement was required to ensure that residents had regular opportunities for meaningful occupation. At the time of the inspection, the person in charge was in the process of reviewing the templates and systems in place regarding goals and activation.

There were appropriate systems in place to keep the residents safe. For example, a review of incidents and accidents demonstrated that the were appropriately

managed and responded to. Some residents communicated with the inspectors that they liked living in the designated centre and others appeared comfortable and content in their home. This inspection found that improvement was required to ensure that residents were offered a varied and nutritious diet and that meaningful choice was available in accordance with resident's individual preferences and needs. This is detailed further under Regulation 18: Food and Nutrition.

The previous inspections identified significant concerns in relation to fire safety. This had been addressed. However, further work was required to strengthen the providers' fire drill arrangements.

The inspectors found that the premises was clean, generally well maintained and presented in a homely manner. There were some aspects of the premises required attention. This had been self-identified by the provider and plans were in place to address same.

Regulation 13: General welfare and development

Improvements were required to ensure that residents had regular opportunities for meaningful occupation and recreation. At the time of inspection, there were two activation staff vacancies in the centre. On the days of the inspection, one activation member was on duty who was responsible for delivering the activity programme across the three units. At times, the activation staff may be redirected to provide direct care and support.

Many residents were of an older age profile and a large number had dementia related support needs. Staff outlined that many of these residents preferred sensory type in-house activities. While activities such as music therapy, yoga, reiki and massage therapy were available on some days, a review of residents' records indicated that residents did not consistently participate in meaningful activities. Records often documented that residents spent their day watching television or chatting with peers as the primary activity undertaken during the day. While these activities may reflect residents choices at times, inspectors found that records did not consistently demonstrate that residents were supported to participate in a range of meaningful activities in line with their assessed needs, interests and preferences.

Improvements were also required to ensure residents had access to adequate transport arrangements to support their participation in community life and activities of their choice. The centre had access to one mini bus to support the transport needs of 23 residents. Inspectors were informed that priority for use of the vehicle was generally given to residents attending medical appointments. In addition, the vehicle could only accommodate one or two residents using large wheelchairs at any one time. As a result, transport was not always available to facilitate residents to attend community-based activities in accordance with their preferences. Staff informed inspectors that due to the limited availability of transport, residents were facilitated to attend some activities on a rotational basis to ensure equitable access

for all. The person in charge had raised this as an issue and the provider had indicated that an additional vehicle was due to be provided by September 2026.

On the day of the inspection, the templates and systems regarding personal care plans and goals were under review to ensure that personal care plans were available to residents in an accessible and easy read version. Plans were being enhanced through the inclusion of photographs and other visual supports to promote residents understanding and engagement with their care. The use of the photographs was also intended to support reminiscence and meaningful conversations with residents, particularly those with cognitive and communication support needs.

Judgment: Substantially compliant

Regulation 17: Premises

The premises was designed, laid out to meet the aims and objectives of the service and the number and needs of residents, however, some improvements were still required to providing adequate storage for equipment. The centre consisted of one large building made up of three interlinked units. Two units were located on the ground floor and one unit was located on the first floor. A lift was provided between floors. The inspectors found that the designated centre was decorated in a homely manner, clean and, for the most part, well maintained.

Each unit in the centre contained a kitchen, communal dining and sitting rooms for residents use. All residents now had their own bedrooms with two previously occupied twin bedrooms now allocated for single use. Bedrooms were found to be bright, spacious and comfortably decorated. All bedrooms were personalised in line with resident's preferences and interests including their preferred colour schemes, sporting and music interests, family photographs and other personal belongings of significance to them. Residents had access to enclosed garden areas which were provided with suitable outdoor furniture and a variety of potted plants. Residents could also visit or spend quiet reflective time in the oratory available in the centre.

There were some areas in need of attention including:

- areas of lifting floors,
- internal areas in need of painting,
- external works to address moss and weeds,
- the modernising of some bathroom areas where the current flooring was lifting in places, broken tiles and a malodor was observed in one bathroom on inspection.

The inspectors were informed that the local management team had recently completed a review of the building and had identified some areas that required refurbishment and repairs, including shower rooms and flooring in some areas of the centre. These identified works had been escalated to the facilities department and a

plan of works was being put in place to address the issues. On the days of inspection, general maintenance works and cleaning was taking place to the external areas of the centre.

The centre was well equipped with aids and appliances to support and meet the assessed needs of the residents living there including overhead ceiling hoists, specialised equipment including beds, mattresses, showering equipment and a variety of specialised individual chairs. Records reviewed demonstrated that all equipment had been regularly serviced.

The storage of equipment continued to present a challenge in the centre. Since the last inspection, the provider installed additional storage in the main office for files, equipment and PPE. However, due to the support needs of many residents, resulting in the assessment and provision of a significant amount of large specialised equipment, including specialised seating and showering equipment. While this equipment needed to remain readily accessible to support residents safely, storage options were limited. As a result, equipment was often stored in shower rooms which impacted upon the availability of space when not in use.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

This inspection found that improvements were required to ensure that residents were offered a varied and nutritious diet and that meaningful choice was available in accordance with resident's individual preferences and needs.

The centre operated a catering model whereby the main meals were prepared and cooked in a central kitchen before being distributed to the three kitchens in the centre. The main meals consisting of two options were delivered hot during the weekdays and a chilled meal was delivered on Fridays which could be reheated and served over the weekends. This limited opportunities for residents to be involved in meal planning, as well as impacting negatively on individual choice, personal preferences and the overall dining experience. A review of complaints indicated that three recent complaints had been received from residents regarding dissatisfaction with the quality of the food and choice options. They had expressed a wish for more choices and variety of foods. Staff spoken with also raised concerns regarding the quality of food at times and that reheating of meals at weekends negatively impacted upon the overall standard of meals served.

Breakfasts and evening meals were prepared and served from the kitchens in each unit. During the two days of inspection, the inspectors noted that there were limited options available to residents for the evening meal. Many of the residents required modified diets in line with their assessed swallowing needs as recommended by the SLT (speech and language therapist). Some staff spoken acknowledged challenges in providing a varied menu for residents requiring modified diets while also ensuring

meals remained nutritionally balanced and appealing. On the first evening of inspection, staff on duty had concerns regarding the meal option which had been left prepared for some residents in one of the units, advising that it was unsuitable in texture and consistency and not nutritionally balanced. Staff informed inspectors that they had not served this meal due to the choking risk to residents and had obtained an alternative option for residents from the local shop.

These findings were discussed with the local management team during the inspection. In response, arrangements were made for the dietitian and speech and language therapist to attend the centre on the second day of inspection to provide additional guidance and support to staff. This was intended to assist staff in developing varied menu options for residents requiring modified diets and to ensure that meals were nutritionally adequate, appropriately prepared and reflective of residents assessed needs and preferences. The local management team also spoke of how the current arrangements were being reviewed with the aim of enhancing the quality, variety and improved choices for residents.

Judgment: Not compliant

Regulation 26: Risk management procedures

The registered provider ensured that there were systems for the assessment, management and ongoing review of risk. The inspector reviewed the risk register and found that general and individual risk assessments were in place. The risk assessments were up to date and reflected the risks and control measures in place. For example, the risk register had identified the current staffing arrangements as a key risk risk in the centre. The inspectors also reviewed risk assessments in place for rights, safeguarding, behaviours and feeding, eating and drinking.

Judgment: Compliant

Regulation 28: Fire precautions

The provider had completed a significant works to address the fire safety management concerns identified during the previous inspections. However, some improvements were still required to strengthen the providers' fire drill arrangements.

An urgent action was issued around fire safety at the time of the last inspection regarding the fire alarm system and staff training. This had been addressed, the inspectors reviewed evidence demonstrating that the required fire safety works had been completed. For example, new fire alarm panels had been installed in each of the three units, fire doors had been upgraded and replaced, the staff team had up-to-date training and the appointment of designated fire wardens on all shifts. In

addition, following the last inspection a fire safety audit was completed by an external fire engineer of the centre. Post inspection, the provider submitted assurances from a suitably qualified and competent fire safety professional confirming that the identified fire safety works had been satisfactorily completed.

There was a schedule of fire drills in place and fire drills had recently taken place in all three units. In response to extended evacuation times that required further review, alternative evacuation methods had been identified for some residents and incorporated into their personal emergency evacuation plans (PEEP'S). However, a review of fire drill records did not consistently provide assurances that all residents could be safely and promptly evacuated in the event of fire particularly during the night-time when staffing levels were at their lowest. Improvements were required to ensure that fire drill records provided clarity of information, adequately reflected the centres maximum occupancy, night-time scenarios and clearly demonstrated the effectiveness of evacuation procedures for all residents.

Judgment: Substantially compliant

Regulation 8: Protection

The registered provider and person in charge had systems to keep the residents in the centre safe. The inspectors reviewed incidents and accidents records for the period January 2026 to June 2026. There was evidence that incidents were appropriately managed and responded to. In addition, a quarterly triangulation audit completed by the person in charge to ensure that all incidents have been reviewed, responded to and reported as required.

All staff had received training in safeguarding vulnerable adults. Staff were found to be knowledgeable in relation to keeping the residents safe and on how to report allegations of abuse. A number of residents told the inspectors that they liked their home and all residents were observed to appear relaxed and content in their home.

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 14: Persons in charge	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Substantially compliant
Quality and safety	
Regulation 13: General welfare and development	Substantially compliant
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Not compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 8: Protection	Compliant

Compliance Plan for Cork City North 5 OSV-0003291

Inspection ID: MON-0049188

Date of inspection: 09/06/2026

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	Substantially Compliant

Outline how you are going to come into compliance with Regulation 15: Staffing:

• Additional funding of 13.5 WTE has been secured to ensure that the designated centre has sufficient suitably qualified, competent and experienced staff, supported by an effective governance structure. The HR team are actively recruiting to fill current vacancies. A significant recruitment drive including a recruitment day is open to new applicants on 15.07.2026.

• CCN5 is a prioritised location for recruitment and allocation of new recruits within the organisation.

• The management team will continue to monitor agency usage on a monthly basis with a target reduction of agency hours by 30% by end December 2026

• A permanent relief panel is available to the centre. Relief staff are prioritised over agency staffing usage in the designated centre.

• Since the inspection date, two new recruits (2 WTE) have commenced and are supported by a senior staff member to ensure appropriate mentorship. The centres roster is reviewed to ensure its efficiency.

• Progress will be monitored through a monthly vacancy and agency-usage report reviewed by management. The report will record current vacancies, recruitment progress, agency hours used, relief panel usage, and any impact on activation, training release or continuity of care.

Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:

• The provider will implement an integrated governance tracker to ensure that actions arising under Regulations 13, 15, 17, 18 and 28 are monitored, progressed, evidenced and escalated where required.

• The PIC and PPIM will meet monthly to ensure robust oversight, monitoring, audit and analysis which will identify areas of improvement which can be escalated through the risk management escalation process if required.

• A review process has been completed to enhance personal plans ensuring there is a detailed likes and dislikes for each resident. A focal point has also been placed on PCPs/GOALS/ACTIVITIES ensuring they are meaningful, person-centred, in line with the residents assessed needs and reflective of residents' wishes and preferences.

• The centre has a robust auditing process in place. To strengthen this further, a tracker will be implemented by 31/07/26 for personal plans, PCPs, goals and all personal information in relation to the resident. The management team will review this tracker quarterly and discuss with the broader team areas of improvement which will incorporate progress of personal goals and activities. The management team will delegate actions to be completed.

• A personal plan committee has been developed which will meet quarterly to discuss progress and areas of improvement

Regulation 13: General welfare and development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 13: General welfare and development:
• All residents have had comprehensive PCP, goal progress and activation folders updated. The folders have been created by the activation staff team in collaboration with the resident, their families and key workers. This folder identifies the persons interests and hobbies, their assessed needs, whilst also taking into consideration their own individual choice of partaking in simpler activities.
• A weekly timetable has been developed to reflect in-house activities that are of the resident’s preferences.
• Activation records will be audited monthly to demonstrate residents are offered

opportunities for meaningful activities in line with assessed needs, interests and preferences.
• A musician attends weekly to perform music sessions and resident participation indicates positive engagement and enjoyment, the swimming sessions have also increased to twice weekly, allowing for more residents to attend each week.
• Residents are also provided the opportunity to participate in religious services, cooking experiences, as evening meals are being prepared and cooked in the centre, social outings to the local hairdressers, shops to buy some groceries and even their local take away. Long term goals are in progress. One resident wished to attend the Galway-Cork match recently and enjoyed same.
• A referral was also sent to SLT for a PWS to enhance communication via an assistive device, to improve the resident's communication of particular likes and dislikes.
• Residents will be afforded the opportunity to avail of taxis as an additional source of transport should they wish
• Resident feedback will be obtained through residential meetings, keyworker meetings and surveys.
• Oversight through PIC and PPIM governance meeting and six-monthly audits visits. Further to this, a monthly review of participation rates and resident feedback will be undertaken. The monthly audit will confirm whether each resident has been offered and supported to engage in meaningful activities in line with their assessed needs, interests and preferences, and will identify any barriers such as staffing, transport or communication supports.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
The Facilities Department and the management team had prior to the visit walked the designated centre identifying maintenance which were later priortised at executive level. The PIC has received a comprehensive plan of works from the Facilities Department.

• Areas of lifting floors. Two-bedroom flooring replacements have been approved by the Executive Team.
• Internal areas in need of painting – this has been Completed.
• External works to address moss and weeds. To be completed by 31.07.2026
• The modernising of some bathroom has been approved by the Executive Team
• The equipment such as shower chairs and specialised seating are now under an auditing process and form part of our monthly environmental audit, from this audit we ensure that equipment is kept to a minimum to ensure the safe storage of same, any equipment not being used is returned to the OT department immediately or collected by the HSE. This equipment is not kept in corridors, exits or communal areas.

Regulation 18: Food and nutrition	Not Compliant

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

• The Person in Charge has completed a review of the current food provision arrangements to ensure residents are provided with a varied, nutritious diet and meaningful choice at all mealtimes.

• Weekend meal arrangements have been reviewed to improve the quality, presentation and choice of meals available. The chill option at weekends remains in place however the PIC has, in conjunction with the staff team rotated across the roster identified staff who have begun to cook varied meals onsite at the weekend as an additional option. This change to the meal plan will be captured in the residential forum.

• A chef will be recruited to support meal preparation within the Designated Centre
In conjunction with the new post of chef, catering department, Dietitian and Speech and Language Therapist will revise the menu plan which will be developed to increase variety, improve food quality and ensure meals meet residents' nutritional and assessed swallowing needs.

• Slow cookers have been purchased for the 3 areas.

• An easy read menu is available to the residents that consists of breakfast options, lunch, dinner and dessert.

• As part of a quality improvement plan, SLT's and dieticians have been involved with the service and have provided several menus that are suitable for modification to adhere to FEDs recommendations, ensuring adequate calorie, nutrient and vitamin intake and this is currently being adhered to by the staff in the centre.

• On the first day of the inspection the heads of departments from Speech and Language and Dietician came onsite and spoke with the staff team regarding options of evening meals which can be offered to residents. As a number of the residents need modified diets this supported the introduction of new meal choices. Numerous menus and directions regarding preparing and modifying meals were also disseminated to the team.

• As part of a pilot scheme, the service will benefit from an outsourced service who specialises in dysphagia friendly food items and allows for the PWS to experience other food items that would not be routinely available/suitable.

• As part of a wider governance and oversight the PIC will monitor residents' feedback through a monthly resident meal satisfaction review.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:

The provider had completed significant works to address the fire safety management concerns identified during the previous inspections. Further enhancement of fire drill processes is required to provide assurance that all residents can be safely and promptly evacuated under all foreseeable circumstances, including night-time conditions.
• The Person in Charge will review and strengthen the centre's fire drill programme to ensure fire evacuation drills reflect the centre's maximum occupancy, dependency levels of residents, and realistic day and night-time scenarios.
• Additional simulated night-time evacuation drills will be completed across all units to assess the effectiveness of current evacuation arrangements and Personal Emergency Evacuation Plans (PEEPs). Where improvements are identified, residents' PEEPs will be reviewed and updated accordingly. A process will be implemented to ensure learning from fire drills is communicated to staff and incorporated into practice.
• New fire drill record forms have been implemented in the centre, which prompts the staff to document factual information about the safely evacuation of residents.
• General evacuation plan allows for horizontal evacuation; therefore, residents move from compartment A to compartment B before the need to evacuate the building. This is now detailed in fire drill records. Compartmentalising the building provides the centre with multiple refuge areas to ensure the safety of residents, reducing the need for a specific safe evacuation time.
• The management team will review fire records monthly, 6 monthly auditing of PEEPs
• Fire drill outcomes will be regularly reviewed by the Person in Charge and PPIM as part of the centre's governance and oversight and fire safety monitoring arrangements to ensure ongoing compliance and continuous improvement.

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)(b)	The registered provider shall provide the following for residents; opportunities to participate in activities in accordance with their interests, capacities and developmental needs.	Substantially Compliant	Yellow	30/09/2026
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Substantially Compliant	Yellow	31/12/2026
Regulation 17(1)(b)	The registered provider shall ensure the premises of the	Substantially Compliant	Yellow	31/12/2026

	designated centre are of sound construction and kept in a good state of repair externally and internally.			
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Substantially Compliant	Yellow	31/12/2026
Regulation 18(2)(b)	The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which are wholesome and nutritious.	Not Compliant	Orange	31/08/2026
Regulation 18(2)(c)	The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which offers choice at mealtimes.	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.	Substantially Compliant	Yellow	31/07/2026
Regulation 28(3)(d)	The registered provider shall make adequate	Substantially Compliant	Yellow	31/07/2026

	arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.			