



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

Issued by the Chief Inspector

Name of designated centre:	Cork City North 14
Name of provider:	Horizons
Address of centre:	Cork
Type of inspection:	Announced
Date of inspection:	16 June 2026
Centre ID:	OSV-0003293
Fieldwork ID:	MON-0042129

About the designated centre

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

Cork City North 14 is part of a purpose-built housing development located in an urban setting. It is located within walking distance of local shops and facilities. The service provides full-time residential support to eleven female adults with a diagnosis of intellectual disability or autism. The centre is comprised of three floors which are interconnected by stairs. Each resident has their own en-suite bedroom located throughout the designated centre on all floors. Each floor has a kitchen, dining area and living room. Laundry facilities, visiting rooms and staff offices are also available. Cork City North 14 can accommodate individuals with a range of medical and physical needs. Residents are supported by nursing and care staff during the day and there are a minimum of two staff on duty by night in the centre. The multi-disciplinary team are also available to further support residents when required. Residents are supported to access other services such as GP and chiropody as required.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	11
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How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Tuesday 16 June 2026	10:00hrs to 17:30hrs	Elaine McKeown	Lead
Wednesday 17 June 2026	09:00hrs to 17:15hrs	Elaine McKeown	Lead

What residents told us and what inspectors observed

This was an announced inspection to monitor the provider's compliance with the regulations and to inform the decision in relation to the renewing of the registration of the designated centre. The centre was previously inspected in October 2024 as part of the current registration cycle. The findings of that inspection found evidence of improvements for the residents engaging in meaningful activities, support being provided by a core staff team and improved governance and oversight. Protocols had also been put in place to support the safety and well being of the residents while awaiting structural changes to the premises. However, the inspector's findings during this announced inspection were that there were ongoing safeguarding concerns in this designated centre which continued to have adverse impacts on residents lived experiences.

The inspector met with all of the residents currently living in the designated centre over the two day inspection. Residents were supported to meet the inspector with staff present if they wished to do so or privately. The wishes of each resident were respected. Most of the residents were met with on both days as the inspection progressed. Residents spoke of positive aspects of their lives which included planning holidays, participating in the Special Olympics, setting up a community yoga class, enjoying paid employment and a range of other social activities. Residents also spoke of issues of concern on both days regarding the lived experience in the designated centre. Residents demonstrated how they were able to advocate for themselves and tell staff when they were not happy. This was observed by the inspector both in documentation such as logged complaints as well as being present when concerns were being voiced by residents in conversations with members of the staff team or directly in conversations held with the inspector.

Not all residents felt safe in their home and some residents personally experienced or were present when conflict situations occurred. The impact of adverse interactions with peers required residents to avoid communal areas or in the case of one resident spend most of their time in their bedroom as they did not wish to engage or be present when situations of conflict arose. Residents also referred to the term " conflict between the floors " in their resident meetings, logged complaints and verbally to staff as observed by the inspector during the inspection. The provider had engaged with all relevant parties since the previous Health Information and Quality Authority (HIQA) inspection in October 2024 to seek to separate the internal link between three floors in the designated centre. The purpose of the structural changes was to reduce the safeguarding concerns that were present in the designated centre. The inspector spoke with the provider's facilities manager on the phone during the inspection as they outlined the obstacles encountered with different parties outside of the provider's control to be able to complete the required structural works to remove the internal stairs that currently connects all three floors. The inspector was informed while some progress had been made in recent weeks it

would be another 12 to 18 months before the separation of the three floors would be completed.

The inspector was informed by some of the residents and the staff team that all of the residents had indicated they wished to remain living in the designated centre. Alternative living arrangements had been identified and offered to a number of residents who had chosen not to progress with reviewing the options being offered to them in other locations. On the first day of the inspection one resident did visit a property that was available and where they could live alone with staff support. The resident informed the inspector later in the afternoon they had a positive experience and may consider this as their new home. It was evident the staff team supporting the resident were aware of the preferences, anxieties and challenges that this resident faced when making such a big decision. There was also support available from a social worker who met with the resident on the second day of the inspection to advise and offer clarifications on questions the resident had. The inspector was informed if the resident chose to move to this new property they would be supported by a staff team which the resident would be consulted with and be actively involved in the interview process.

Ten of the residents required ongoing support with their mental health which added to the demands placed on the staff team. It was observed by the inspector extended periods of time was afforded to three residents during the inspection due to anxieties they were expressing. One of these residents required support on both days of the inspection and the other two residents on the second day. Staff were observed to listen to the residents, respectfully guide them through the issues they were talking about and seek to help each to engage in activities which they enjoyed. On two occasions two members of the staff team and the inspector were present to listen to one of the residents, on another occasion the person in charge and the inspector were present when two residents had issues of concern to discuss. All these interactions were un-rushed and residents were afforded the opportunity to make a complaint. However, on review of the complaints log since the previous inspection in October 2024 there had been 36 complaints made. While some complaints related to other matters, there was a re-occurring common complaint made by several of the residents regarding being in receipt of verbal aggression from a peer or being present during a conflict situation that was being directed towards others such as staff members. While the vulnerable person may have received an apology following an incident it was evident many of the complaints were closed out and the log recorded the complainant was not satisfied. Residents clearly voiced to the inspector the actions required to be taken to resolve the situation to their satisfaction, the staff team and provider were aware of these views.

The inspector was informed of the changing assessed needs of two residents in recent weeks prior to the inspection and the ongoing issues with staffing resources that had adversely impacted residents to attend social activities of their choice or their day service. During the inspection one resident who had been discharged from hospital a few days prior to the inspection required two staff to support them with transferring from their seated position and other activities of daily living. The provider had put an additional staff in place during night time to support this

resident's current assessed needs. Another resident living on the top floor had also been discharged from hospital in recent weeks, was using a mobility aid to assist them to mobilise safely and required increased staff supports to manage a health care condition.

The inspector was aware that residents had agreed to centre specific safeguarding protocols that had been put in place which included residents were to use the external stairs or the lift if moving between floors. Three residents informed the inspector they were not allowed to use the internal stairs and were observed to adhere to this "house rule". The stairs was being used by staff. There were agreements also in place regarding laundry, which could be adjusted if required once agreeable to all parties. These protocols had been put in place to support all of the residents while structural changes were awaited which all residents spoken too agreed would be a positive solution for some of the issues of concern in the designated centre. However, the compatibility/adverse interactions of some residents living together had been identified as an ongoing issue from previous HIQA inspections including December 2023. This was found to remain unresolved at the time of this inspection.

The inspector reviewed 11 questionnaires that had been given to residents to complete as part of this announced inspection. Three of the questionnaires were returned without being completed and five of the completed questionnaires had positive responses with no additional comments. Three other completed questionnaires had mostly positive responses but less than positive responses and additional comments related to "do you get on with people you live with". In addition, one resident would like more staff, another outlined how they were being supported to buy food items they preferred and another referred to the ongoing conflict in the designated centre and how they perceived the situation.

During the walk around of the designated centre it was evident residents were supported to decorate their own bedrooms with personal possessions. Communal areas were bright and well ventilated. There was evidence of regular cleaning taking place and there was a dedicated staff who attended to these duties each week as well as the night staff assisting and completing laundry tasks, if required. Exercise equipment was located in the sitting room on the middle floor and one resident spoke of how they liked to use it regularly. The atmosphere on the first day of the inspection was relaxed and residents were supported to complete planned activities such as attend their day service, go out with a staff member to meet a friend or to engage with staff in beauty treatments in the afternoon in the designated centre. In the evening residents spoke in relaxed tones to the staff about their day and plans for the evening. On the second morning the atmosphere was not as relaxed. Some residents were expressing anxieties and other residents were observed to avoid the communal areas as they later informed the inspector they did not want any engagement with peers who were anxious.

The inspector noted staff continuously provided re-assurance and tried to interject a jovial relaxed atmosphere where appropriate, but it was evident all present in the building were aware of the tension on the morning of the second day. In addition, the inspector observed two occasions where residents who required support did not

have staff available to support them. One resident was heard calling for assistance in low tones a number of times before the inspector advised staff of this and another resident came into the ground floor office where the inspector was reviewing documents and stated they could not find any staff to help them with their laundry. The inspector was aware that two staff were assisting one resident at that time and another staff was supporting a second resident who was upset. The inspector located a staff member on the third floor and advised them of the request for assistance.

In summary, while all residents voiced their preference to remain living in this designated centre and spoke positively about the supports being provided to them by the staff team, adverse interactions were having a negative impact on the well being and lived experience for some residents. Staffing resources available in the designated centre did not demonstrate effective support being provided to all of the residents in-line with their assessed needs. While residents were being supported to make a complaint about issues of concern repeated safeguarding incidents of similar circumstances continued to occur in the designated centre.

The next two sections of this report will 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 provided.

Capacity and capability

Overall, this inspection found that residents were in receipt of care and support from a dedicated core staff team. Some staff had worked in the designated centre for over ten years. The requirement for familiar staff to be on duty at all times was described as being essential for some of the residents. Adjustments to the staff rotas took place in the event of unplanned leave to ensure residents were being supported by at least one staff familiar to them. There had been some recent changes to the local management team. All residents were observed to be familiar with the person in charge and person participating in management during the inspection.

The inspector acknowledges there has been a rapid deterioration in the assessed needs of one resident in the days prior to the inspection and actions had been taken to provide additional staff resources at night time from Monday 15 June 2026. This required the use of agency staff. Prior to this agency staff would not have worked in the designated centre. There were regular relief staff available to support the core staff team. The inspector was given details by local management of the process in place by the provider to ensure the safety of residents while ensuring the agency staff had completed all the required training and a discussion was also held regarding how staff on duty ensured the identity of the person presenting for duty. In addition, a volunteer supported some of the residents in the designated centre to

attend yoga classes or avail of social outings in-line with expressed wishes. The inspector met this person during the inspection as they were supporting one resident to go out on a social outing in the afternoon of the second day.

The provider was aware of the regulatory requirements to complete an annual report and internal provider led audits every six months. The inspector reviewed the internal audits of February 2026 and August 2025 as well as the annual report for 2025. Ongoing issues relating to safeguarding, staff resources and negative interactions causing adverse impact on residents lived experiences were repeated findings in these reports. Some findings were documented as requiring immediate attention but remained an issue at the time of this inspection.

Registration Regulation 5: Application for registration or renewal of registration

The provider had ensured a complete application to renew the registration had been submitted as per regulatory requirements.

Judgment: Compliant

Regulation 14: Persons in charge

The registered provider had ensured that a person in charge had been appointed to work full-time and that they held the necessary skills and qualifications to carry out their role. The inspector acknowledges that the current person in charge had worked in the role with the provider in another designated centre prior to their appointment to this designated centre which had only occurred in the weeks prior to this inspection. Their remit was over this designated centre and they had received a detailed and ongoing handover from the previous person in charge to assist them in their role.

Judgment: Compliant

Regulation 15: Staffing

The registered provider had not ensured that the number and skill mix of the staff team was consistently appropriate to the number and assessed needs of all of the residents and layout of the designated centre.

- A selection of dates on the actual and planned rotas from 2 May 2026 until 22 June 2026 were reviewed by the inspector, seven weeks. On three of the dates reviewed there was no nurse on duty from 18:30 hrs until 20:00 hrs.

The current statement of purpose states the services provided to residents includes 12 hour nursing supports during the day, no nurse is rostered on duty at night time in the designated centre.

- On the actual rota of 4 June 2026 there were only two health care assistants rostered to be on duty between 18:30 hrs and 20:00 hrs with 11 residents documented as being present in the designated centre. This was not the minimum staffing levels as outlined by the provider in the statement of purpose of three staff and not in-line with the assessed needs of the residents being supported in the designated centre.
- Not all residents could attend their day service when they wished to do so due to lack of available staff resources, this included on the 27 April 2026 when a resident made a complaint about this issue. Another resident had also not been able to attend their day service on a few occasions including 17 September 2025 on which date they made a complaint. This resident has since being supported to visit alternative day services including on the day of the inspection to find a suitable alternative location for them.

Judgment: Not compliant

Regulation 16: Training and staff development

At the time of this inspection the staff team was comprised of 21 members, not all were in full time posts. This included the person in charge who worked full time in the designated centre, four nurses which was a whole time equivalent (WTE) of 2.7 positions, health care workers WTE of seven positions with 11 staff filling these roles. There were also five health care assistant relief staff but no relief nursing staff available to support the core staff team at the time of this inspection.

- The person in charge had ensured all of the staff team had completed a range of mandatory training courses to ensure they had the appropriate levels of knowledge and skills to best support residents. These included training in areas such as safeguarding, positive behaviour support and fire safety training. Additional bespoke training was planned to be provided for the staff team to support mental health and learn about supportive strategies.
- The person in charge ensured the training matrix was subject to regular review and updated as required. This included colour coding to alert for the need to book refresher training in advance of training expiring. For example, one staff had recently returned from extended planned leave and was scheduled to complete their training in safety intervention in the coming weeks. Another staff required refresher training in the safe administration of medications since March 2026 and this was booked to take place two weeks after this inspection. The staff member was not administering medications until the refresher training was successfully completed and was on duty with another staff member that could administer medications.

- Staff supervisions had taken place during 2025 with the person in charge who held the post at that time. Supervisions for 2026 with the newly appointed person in charge were scheduled to take place.

Judgment: Compliant

Regulation 23: Governance and management

The registered provider had a governance structure in place with staff members reporting to a person in charge. The person in charge had support from senior management within the organisation.

The annual review of the quality and safety of care and support in the designated centre was completed for 2025. This annual review contained information on what the residents were undertaking in the centre and identified due to lack of staff resources not all residents had been provided with opportunities to engage in activities of their choosing and one resident had been unable to attend their day service at times. The inspector was given an update by the person participating in management regarding links being made with the provider's sports and recreational manager to identify community groups and activities which the residents might like to engage with.

The report also referred to the high level of safeguarding concerns occurring in the designated centre.

The provider had completed internal six monthly audits in August 2025 and February 2026. Both internal audits identified the ongoing safeguarding concerns and the staff resources had not always been maintained to minimal staffing levels as outlined in the statement of purpose. This was also consistent with findings by the inspector during this inspection.

There were other repeat findings in both of the internal audits which included the compatibility of residents living together. There were a number of actions requiring immediate attention by the provider which included addressing the significant challenges concerning residents to be able exercise their rights and addressing the staffing levels in the designated centre. While details of progress being made on these matters was provided to the inspector during the inspection the issues remained at the time of this inspection.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The registered provider had ensured the statement of purpose was subject to regular review. It outlined the services and facilities provided at the centre. The document contained all the information required under Schedule 1 of the Regulations. The issues identified during the inspection regarding the skill mix and minimum staffing resources outlined in the current version of this document will be actioned under Regulation 15: Staffing

Judgment: Compliant

Regulation 31: Notification of incidents

The person in charge had ensured the Chief Inspector had been provided with notice in writing of adverse incidents occurring within the designated centre. There were a high level of adverse notifications impacting on residents lived experiences and safeguarding concerns submitted since the previous inspection in October 2024. During 2025, 53 such incidents were reported to the Chief Inspector, and up to the day prior to this inspection 17 incidents of a safeguarding nature had been reported. Measures outlined to the Chief Inspector since December 2024 to address the occurrence of such incidents included funding had been secured to separate the building into three floors with no internal stairs. As already outlined in this report this was not expected to be completed for another 12 -18 months and adverse incidents continued to occur, including during the evening of the first day of this inspection. This will be actioned under Regulation 8: Protection.

Judgment: Compliant

Regulation 34: Complaints procedure

The provider had ensured a policy was in place for the management of complaints.

- Details of who the complaint officer was were observed to be available within the designated centre. Easy-to-read information was available for residents to access.
- The inspector was informed there were no open complaints at the time of this inspection. The inspector reviewed the complaints log for the designated centre. There were 36 complaints documented since October 2024. Residents had been supported to make many of these complaints. Of these there were a large proportion relating to adverse interactions between peers, aggression being displayed and upset being caused. The records of all complaints included the outcome of the complaint and the satisfaction of the complainant. It was documented that many of the complaints had been closed but the complainant was not satisfied. Residents have spoken and documented ongoing concerns using the complaints process available to

them and indicated they are not happy with the "conflict between the floors", but the issue remains unresolved to the satisfaction of the affected residents. It was not evident if residents had been informed of the appeals process and effective measures required for the improvement in response to such complaints were put in place.

Judgment: Not compliant

Quality and safety

Overall, the inspector found that the quality and safety of care provided for residents required further review. Not all residents living in this designated centre were in receipt of safe services and support in-line with their assessed needs. Residents could not make choices at times regarding activities they would like to do due to lack of staffing resources. Residents had been unable to attend their day service as they wished to on occasions due to lack of staff. Residents reported they did not feel safe in their home, they avoided communal areas so as to not be present if conflict developed between peers. Residents voiced their concerns, logged complaints and verbalised their unhappiness but the issues of concern remained unresolved at the time of this inspection.

The premises had been identified to require internal structural works to provide an improved quality of life for residents who had chosen to remain living in the designated centre. This was outlined to the Chief Inspector following the October 2024 inspection. In December 2025 the inspector was informed following the submission of a notification regarding a safeguarding matter that funding had been approved for the works to be completed. The inspector acknowledges the provider is actively seeking to address this issue and barriers had been encountered since funding for the works had been approved. However, the inspector was also informed these works would take approximately 12-18 months to complete by the provider's facilities manager during the inspection.

Regulation 17: Premises

Overall, the designated centre was found to be clean, well maintained, ventilated and comfortable. The houses were located in a gated residential area in the city.

- Each resident had been supported to decorate their bedroom in-line with their preferences. There were personal possessions, photographs and other decor to create a homely atmosphere.
- The person in charge ensured any issues relating to the premises were addressed. This included during the inspection when a magnetic lock in place

to hold a door open in a visitors room was not working effectively on day one of the inspection. The issue was resolved during the second day by maintenance staff. This did not adversely impact on the effectiveness of the fire alarm function as the door remained closed until the mechanism was fixed.

- The inspector was provided with an update on the progression of planned structural works to separate the floors and remove the internal stairs that currently links the three floors by the provider's facilities manager. It has been identified by the provider the current layout is not conducive to the well being of residents and is having adverse impact on the lived experience for many of the residents living in the designated centre. The inspector acknowledges that issues to get these works completed had been encountered by the provider which were outside of their control since December 2025.

Judgment: Substantially compliant

Regulation 20: Information for residents

The registered provider had ensured residents were provided with a guide outlining the services and facilities provided in the designated centre in an appropriate easy to understand format.

Judgment: Compliant

Regulation 26: Risk management procedures

The risk register and individual residents' risk assessments had been subject to regular review with the most recent review taking place on 12 June 2026. A resident's individual risk assessment had been updated upon their discharge from hospital and reflected increased supports required which included two staff to support with transferring. The provider had approved an additional staff resource at night time since 15 June 2026 and this was subject to further review in mid- July 2026

There were nine risks rated as high at the time of the inspection. This included safeguarding of residents, service user experience, emotional disturbance, stress and emotional distress due to the working environment and skill mix of the staff team. The control measures in place included reference to the separation of the three floors with the removal of the internal stairs and a business case submitted to the funder seeking additional staff resources. While the provider was aware of these escalated risks, residents continued to be subject to adverse interactions causing them to be upset. This was evidenced during the inspection when two residents

reported an adverse interaction occurred on the evening of day one of this inspection.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The registered provider had ensured that appropriate fire management systems were in place. Fire safety equipment in the centre such as the emergency lighting and fire extinguishers had been checked and serviced in a timely manner. Staff were completing fire safety checks as required by the provider. Additional checks being completed by the landlord regarding the sounding of the fire alarm had been identified as not being completed in the most recent internal six monthly audit in February 2026. Agreement had been reached with the external contractor and the staff team for this testing to occur at a preferred time and day of the week to reduce adverse impact on the residents and training was being provided for the staff to be able to sound test the alarm to ensure compliance with fire safety checks as outlined by the provider.

No exits were observed to be obstructed during the inspection. Fire doors checked during the inspection by the inspector were found to be operating correctly. There was no adverse impact on the operation of the fire door in the visitors room when the magnetic door lock to keep the door open was not working, the door remained closed until the issue was resolved on day two of the inspection.

All residents had personal emergency evacuation plans in place which were subject to recent review and reflected changing needs of residents where required. Further review of one resident's plan was required and completed during the inspection as references to the staff supports documented in the plan were not reflective of the assessed needs as outlined to the inspector at the start of the inspection and in the residents personal plan.

Residents were provided with easy-to-understand information in relation to fire safety and evacuation. All residents were participating in the fire safety drills in the centre and minimum levels of staff were used for some of these drills. Details documented included the senario and the exits used by residents and staff. A minimal staffing drill had been completed on the evening prior to the inspection to assess the effectiveness of being able to support one the residents due to the recent change in their assessed needs. There were some details that were not reflective of another resident's current mobility as they required the use if a rollator and could not descend the stairs as outlined in the documented fire drill details. The person in charge spoke with the staff member who had carried out the drill and an updated record was provided to the inspector on day two of the inspection outlining the error and that the location of the resident had actually been on the ground floor visiting peers at the time of the alarm sounding.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The inspector reviewed personal plans of three residents during the inspection. Residents were asked for permission in advance of the inspector reviewing these files and this was given by each resident. The plans were found to be reflective of the individual about whom they were written. The staff team also had access to electronic formats of the residents personal plans which assisted with up-to-date information being available regarding each resident.

- Residents were provided with easy-to-understand formats of their personal plans and these were available in their bedrooms if they wished to have them there.
- Actions from the last two internal provider led audits regarding review of personal plans and health action plans had been completed in a timely manner and key workers were ensuring ongoing and regular review of personal plans were taking place with input from residents.
- Residents had been supported to identify personal goals such as plan a holiday, engage in social outings and attend concerts. Where progress with planning had been made this was documented, if a resident declined to progress with a goal this was also documented and alternatives reviewed or considered by the resident.
- The profiles were found to be person centred, reflective of changes that had occurred for residents and provided up-to date information on supports required with activities of daily living, likes and dislikes. The inspector did note two of the plans reviewed outlined the resident for whom they were written did not like loud noises and preferred a quieter environment. This was not consistently attainable with the current layout of the designated centre. The inspector acknowledges one of these residents had been offered the opportunity to move to another location but had declined as they wished to remain living in this designated centre.

Judgment: Compliant

Regulation 7: Positive behavioural support

The inspector was informed 10 of the current residents had positive behaviour support plans in place. The other resident no longer required such a plan and was being supported in-line with a diagnosis of dementia. Another resident had been discharged from psychiatric services and no longer required a mental health plan as they were reported to be doing very well. They were able to re-engage with the service if required in the future.

The inspector reviewed the behaviour support plans for three residents. All had been subject to recent review within the last few months. There were procedures to support the residents to manage behaviours of concern, which enabled them to live their lives as safely and independently as possible. The plans provided clear guidance to staff supporting each resident. For example, each plan was reflective of individual likes and dislikes, staffing resources required for community activities, possible triggers and how best to support each resident during different stages of their expressed behaviours. This included guidance for staff on how best to support each resident post an incident/challenging situation occurring.

The restrictive practice log for this designated centre was documented as being last reviewed in July 2025 with additional logs added where unplanned restrictions were implemented. The details included when residents were unable to attend their day service or yoga class due to staffing levels. For example, between April and June 2025, one resident had attended their day service 30 days out of a possible 58 days due to minimal staffing being in place and no resource available to support the resident to use public transport to get to their day service. The person in charge escalated this matter to senior management and the rights committee at that time due to impact on the resident's human rights. This will be actioned under Regulation 9: Residents rights

Judgment: Compliant

Regulation 8: Protection

Significant safeguarding concerns in the designated centre remained unresolved at the time of this inspection. While protocols and measures were put in place which included closing doors to communal areas on each floor and residents using the external stairs to access different floors in the designated centre to reduce the risk of negative interactions between some residents, this was not demonstrated as working effectively at the time of this inspection. The ongoing delay in progressing with planned internal structural works was an added issue as all of the residents spoken to outlined how they were of the opinion this would resolve many of the current safeguarding concerns.

An impact assessment psychology report was completed in August 2025 on four of the residents living on one of the floors. The psychologist identified the quality of life and impact on the mental health for three of the residents was being adversely affected by the current design and layout of their living accommodation and interpersonal clashes were occurring. The level of safeguarding concerns occurring in this designated centre were noted in the report to be the highest within the organisation and there was a requirement to maintain qualified staff to support the aging profile of the residents. The impact on the staff team was also documented with absenteeism indicating possible burnout and there had been significant staff turnover in the previous 12 months.

- At the time of this inspection there were three open safeguarding plans. All were subject to regular review. The details of the safeguarding concerns included for one resident 14 incidents with reasonable grounds for concern since January 2026 occurring in the designated centre.
- Some residents informed the inspector that they did not always feel safe or were happy in their home due to ongoing behaviours of others.

Judgment: Not compliant

Regulation 9: Residents' rights

The registered provider had not ensured the rights and diversity of all of the residents was being respected within the designated centre. While residents were being consulted, engaging in resident meetings, making complaints regarding issues of concern, the issues remained unresolved to the satisfaction of the residents.

- Residents were unable to make choices regarding their daily lives and activities if there were insufficient staffing resources available. This included attending day services or community classes where staff support was required.
- Residents privacy and dignity had been impacted adversely when subject to negative interactions with peers. While centre specific protocols had been put in place to promote each resident's right to privacy and be respected by their peers this was not always adhered to within the designated centre.

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	
Registration Regulation 5: Application for registration or renewal of registration	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Not compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 20: Information for residents	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Cork City North 14 OSV-0003293

Inspection ID: MON-0042129

Date of inspection: 17/06/2026

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	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing:	
• The PIC has completed a review of nursing hours and roster arrangements. A revised roster has been implemented to ensure nursing support is available in accordance with the Statement of Purpose and residents' assessed needs. Compliance with rostered nursing provision will be reviewed weekly and reported through local governance structures. • PIC to ensure staff nurse are rostered 75 hours per fortnight. The SOP will be reviewed and updated to reflect the contracted nursing hours. There is a CNM2 on site Monday to Friday to facilitate any additional supports. • The PIC will undertake a daily staffing review against residents' assessed support requirements. Where staffing deficits are identified, relief staff will be sourced, and where relief staff are unavailable, escalation to PPIM will occur on the same day to ensure minimum staffing requirements are maintained. • A formal escalation pathway has been established to access staffing support from link centres when minimum staffing levels cannot be met. Staffing escalations will be reviewed monthly for a six month period to understand staffing challenges and trends. This will be monitored through monthly PIC and PPIM supervision meetings. • A Business plan has been developed with the Executive Lead for Strategic Support and Oversight, PPIM and PIC which involves a skill mix review and will appropriately increase staffing resources. Pending approval of additional staffing resources, the PIC will prioritise staffing deployment to support residents' attendance at day services, social activities and community participation in line with assessed needs, will and preference and personal plans.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management:	

- An oversight working group has been established to monitor progress of this compliance plan. Progress updates, identified barriers, interim risk controls and action tracker will be reviewed monthly until the end of 2026 and reported directly to the Chief Operations Officer.
- A business plan has been developed by the Executive Lead for Strategic Support and Oversight, the PPIM, and the PIC, incorporating a skill mix review and proposals to increase staffing resources. An uplift in funding for the designated centre will support many areas in the designated centre including increase community participation and further mitigate safeguarding concerns. The plan has been submitted to the funder for approval. The timeframe for approval is outside the control of the provider. In the interim the provider continues to explore other options to support the designated centre.
- A community connector, through the sports and recreational department, is developing a community mapping exercise to find local community services that would suit the resident's needs.
- A monthly review of residents' access to activities, day services, and community participation will be completed over the next six months. This will enable the local team and oversight group to monitor residents access to community and choices in this regard. Any identified restrictions or barriers to participation will be escalated through the organisations governance structure.
- Centre Management continue to meet with the Designated Safeguarding Officer on a regular basis reviewing safeguarding plans and providing continued support to staff within the designated centre.
- The PIC will undertake a monthly governance review of safeguarding incidents, complaints, resident rights restrictions, staffing deficits and progress against this compliance plan. Actions will be recorded, assigned and monitored for completion.
- As part of the safeguarding reduction plan for the centre, the provider continues to engage with the Housing Provider regarding the proposed structural works to separate the floors within the designated centre. This is discussed under Regulation 17 Premises.
- One resident to continue to engage with Cork City Council regarding a new home. The Tenancy agreement is due to be discussed with resident for the new home the week commencing 28th July 2026. Social Work Department, PIC, PPIM and resident will continue to meet regularly with social housing agency to support resident. While housing options are being progressed, the resident will continue to receive individualised support and safeguarding reviews to minimise adverse impacts arising from compatibility issues within the designated centre.

Regulation 34: Complaints procedure

Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:

- The PIC will review all complaints received since October 2024 where the complainant expressed dissatisfaction with the outcome. Residents will be supported to access the appeals process and provided with accessible information on complaint and escalation procedures.
- Due to the high number of similar complaints within the designated centre, the PIC and Registered Provider will ensure that complaints remain open until the complainant has been consulted regarding the outcome and informed of their right to appeal. Where

dissatisfaction persists, the complaint will be escalated in line with organisational policy.	
Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: • The provider continues to engage with the Housing Provider regarding the proposed structural works to separate the floors within the designated centre. The projected completion date for this action is 30/06/2028, however, it is acknowledged that the completion of the structural works and associated timelines are outside the provider's control.	
Regulation 26: Risk management procedures	Substantially Compliant
Outline how you are going to come into compliance with Regulation 26: Risk management procedures: • Please see Regulation 17 regarding premises. • Please see regulation 23 regarding staffing resources and mitigation of safeguarding concerns. • One resident to continue to engage with Cork City Council regarding a new home. The Tenancy agreement is due to be discussed with resident for the new home the week commencing 28th July 2026. • High-rated risks relating to safeguarding, resident wellbeing, compatibility and staffing will be reviewed monthly by the PIC and PPIM. Existing control measures will be evaluated for effectiveness and additional measures introduced where risks continue to materialise.	
Regulation 8: Protection	Not Compliant
Outline how you are going to come into compliance with Regulation 8: Protection: • All safeguarding plans will be reviewed monthly by the safeguarding team, PIC and PPIM to evaluate effectiveness of current controls and identify additional protective measures where incidents continue to occur. • Please see regulation 17 Premises regarding the environmental and structural actions to support regulation 8 protection. • Enhanced supervision and monitoring arrangements have been implemented for residents impacted by repeated safeguarding concerns. All safeguarding incidents will be reviewed weekly by the PIC to identify patterns, triggers and preventative actions. • One resident to continue to engage with Cork City Council regarding a new home. Tenancy agreement due to be discussed with resident for the new home the week commencing 28th July 2026. Social worker department, PIC, PPIM and resident will continue to meet regularly with social housing agency to support resident. • Review the recommendations outlined within the impact assessments and ensure these are implemented in practice and reflected in support planning and daily service delivery. Any changes in circumstances, presentation, or effectiveness of the recommendations will be fed back to the author of the assessment for review and update as required. Progress against recommendations will be reviewed through monthly oversight meetings	

and monitored through safeguarding governance structures.	
Regulation 9: Residents' rights	Not Compliant
Outline how you are going to come into compliance with Regulation 9: Residents' rights: • Centre-specific protocols will be reviewed with residents and MDT members to ensure they remain proportionate, effective and supportive of residents' privacy, dignity and personal autonomy. Compliance with agreed protocols will be monitored through resident meetings and safeguarding reviews. • Please see regulation 23 for additional actions to support Regulation 9 Residents Rights.	

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	30/06/2027
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.	Substantially Compliant	Yellow	31/07/2026
Regulation 17(1)(a)	The registered provider shall ensure the premises of the designated centre are designed and laid out to meet	Substantially Compliant	Yellow	30/06/2028

	the aims and objectives of the service and the number and needs of residents.			
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.	Substantially Compliant	Yellow	30/06/2027
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	30/11/2026
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Substantially Compliant	Yellow	30/11/2026
Regulation 34(2)(d)	The registered provider shall ensure that the complainant is	Not Compliant	Orange	31/08/2026

	informed promptly of the outcome of his or her complaint and details of the appeals process.			
Regulation 34(2)(e)	The registered provider shall ensure that any measures required for improvement in response to a complaint are put in place.	Substantially Compliant	Yellow	31/08/2026
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	30/09/2026
Regulation 09(2)(b)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability has the freedom to exercise choice and control in his or her daily life.	Not Compliant	Orange	30/11/2026
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	Not Compliant	Orange	30/11/2026

	personal information.			
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