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:	East County Cork 1
Name of provider:	Horizons
Address of centre:	Cork
Type of inspection:	Announced
Date of inspection:	20 March 2025
Centre ID:	OSV-0003305
Fieldwork ID:	MON-0038406

About the designated centre

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

The designated centre provides full-time and shared residential care and support for up to 18 adult males and females with intellectual disability and / or autism. The centre is located within a large town. The centre is a single storey building, with residents having access to communal facilities such as a large sitting room, dining room, relaxation area and kitchen. There are 10 single occupancy and four shared (double occupancy) bedrooms in the centre. Some bedrooms have access to en-suite bathroom facilities. The centre further provides residents with bathroom and laundry facilities, visitors / quiet room and garden areas that were well maintained. In addition, the centre has a staff office and staff toilets. Residents are supported by both nursing and care staff at the centre. At night-time, residents are supported by two waking staff on duty. A day service is adjacent to the designated centre.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	18

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Thursday 20 March 2025	09:30hrs to 19:00hrs	Kerrie O'Halloran	Lead
Thursday 20 March 2025	09:30hrs to 19:00hrs	Robert Hennessy	Support

What residents told us and what inspectors observed

This was an announced inspection completed to inform the decision making with regard to the renewal of the centre's registration. The centre had been last inspected in February 2024. Since the last inspection, this inspection had some positive findings and significant improvements were found. Some improvements were still required which will be discussed in the body of the report.

From what the inspectors observed, residents enjoyed a good quality of life and were well supported and cared for in this designated centre. There were eighteen residents living in this centre at the time of this inspection. The inspector had the opportunity to meet with seventeen of the residents during the inspection.

The centre was a single-storey building on the outskirts of a large town in County Cork. A day service operated by the provider was located in the same building, adjacent to the designated centre.

The centre had a commercial kitchen and a chef was available part-time to provide meals to the residents Monday to Friday. At the weekends, the staff prepared the meals for the centre. There were ten single occupancy bedrooms in the centre and four shared bedrooms. Two single occupancy bedrooms had an ensuite bathroom. Some bedrooms had shared access to ensuite bathrooms. There were also two larger communal bathrooms. Other facilities available included two sitting rooms, a living and dining room and a laundry room. Residents had access to a garden area which included a patio area.

The centre was warm, clean and homely. Personalised pictures were displayed on the walls throughout the centre. Information on making complaints and safeguarding policy was available in communal areas. The centre had a number of communal spaces where residents could choose to spend time. The centre had painted the walls in a hallway two different colours to support a resident to identify or recognise where their bedroom and dining area was located.

On arrival to the centre the inspectors met with the person in charge. One of the inspectors met with a resident who was being supported by a staff member 1:1. The resident informed the inspector about their plans for the day and appeared happy with this. Both inspectors completed a walk-about of the centre with the person in charge. During this the inspectors had the opportunity to meet some of the residents. Residents were watching television, relaxing, looking at pictures, enjoying a cup of tea and listening to music. Other residents had left the centre to attend the day service, while some residents were being supported by staff for the day ahead.

All residents the inspectors met with during the day appeared very happy in their home. A resident spoke to the inspectors about attending a third level institution for an advocacy course they were completing and that they would be graduating this year. The resident spoke about how they like to advocate for the residents in the

centre. Another resident had also commenced this course and they were enjoying it.

During the course of the inspection one resident came to the inspectors to meet them. The resident showed one of the inspectors to their bedroom. The room was well decorated and had a relaxing chair in it which the resident liked to use. The resident said other areas of the centre could be loud at times and they like to come to their room as it was quiet.

Some residents living here were non-verbal and some interactions with the inspectors were limited. The inspectors therefore observed their activities and interactions with staff. Staff were very familiar with the residents communication needs. A staff member informed the inspector that one resident enjoyed looking at pictures and books and a particular chair in a communal living room.

The inspectors had the opportunity to meet staff members and the person in charge and the person participating in management. An inspector spoke to three staff members and found them to be knowledgeable about the residents' needs and could describe the rationale for the ways in which they were supporting residents. For example, one of the residents required one-to-one support. The staff spoke about how they manage this daily through the use of a visual planner for the resident.

As the inspection was announced, the residents' views had also been sought in advance of the inspector's arrival via the use of questionnaires. Seventeen residents had completed the questionnaires, some with support from staff. Residents indicated that they were happy in their home, with one resident saying 'I love it here'. Residents identified and some commented that they knew the staff team and the staff were very nice to them. Some residents shared bedrooms and all of these residents said they liked sharing a bedroom and were happy with this. Four residents indicated that they could not make a phone call in private. All residents were happy with the food in the centre, with a resident commenting that the liked the burgers.

The next two sections of the report present the findings of this inspection in relation to the overall management of the centre and how the arrangements in place impacted on the quality and safety of the service being delivered.

Capacity and capability

There was a clearly defined management structure in place, and lines of accountability were clear. The provider had various oversight strategies which were not always found to be effective in relation to monitoring practices and in quality improvement in various areas of care and support.

In recent weeks prior to the inspection the centre had appointed a new person in charge. They were seen to be knowledgeable in their role

There was a competent staff team who were seen on the day of the inspection to have kind and caring interaction with the residents. Staff demonstrated good knowledge of the support needs of residents.

The inspector reviewed a sample of rosters. They indicated that there were sufficient staff on duty to meet the needs of the residents.

The provider had suitable arrangements in place for the management of complaints. For example, there was an organisational complaints policy in place.

During this inspection the provider was requested to provide additional insurances in relation to Regulation 16, staff training and development. From a review of the training matrix not all staff had completed mandatory training identified by the provider. Training which was required to support the assessed needs of the residents was also not up to date.

The next section of the report will reflect how the management systems in place were contributing to the quality and safety of the service being provided in this designated centre.

Registration Regulation 5: Application for registration or renewal of registration

The application for the renewal of registration of this centre was received and contained all of the information as required by the regulations.

Judgment: Compliant

Regulation 14: Persons in charge

There was an appropriately qualified and experienced person in charge who demonstrated oversight of the designated centre and leadership of the staff team. The person in charge had commenced this position in recent weeks prior to the inspection. They outlined ways in which they were learning about the residents and the centre. They also described their role in quality improvement in the centre.

Judgment: Compliant

Regulation 15: Staffing

A planned and actual staffing roster was maintained as required by the regulations. There was a consistent staff team in place at the time of the inspection. Staff

spoken to on the day were knowledgeable in the residents care and support needs.

The inspectors spoke to three staff members. The inspectors found that they were knowledgeable about the support needs of residents and about their responsibilities in the care and support of residents. For example, they could describe the support required for a resident who had 1:1 staffing in place and knew about the specific communication needs of residents.

Judgment: Compliant

Regulation 16: Training and staff development

Staff received mandatory training in a number areas to ensure the safety and to meet the assessed needs of the residents in the centre. This training was identified in the centres statement of purpose. The inspectors reviewed the training matrix which identified 24 staff members. Not all staff had completed the required training courses. This included:

- Fire safety training, thirteen staff members required training.
- Safeguarding vulnerable persons at risk of abuse, six staff members required training.
- Manual handling, five staff members required training.
- Safety intervention training, 5 staff members required training.

As per the assessed needs of the residents living in the centre, four residents were prescribed emergency medication to be administered in the event of seizure activity. From a review of the training matrix a number of staff training had expired or they had not completed this training. From 13 March 2025 seven staff members training had expired, while nine staff members had no date identified of training being completed. From a review of the rosters, two nights in January 2025 and two nights in February 2025 had no staff on duty that were trained to support residents if an emergency had occurred. No incidents during this time were reported. The provider was asked to submit assurances to the office of the Chief Inspector to ensure this would not occur again. This was received on 25th March 2025. Additionally the inspectors had reviewed the rosters until April 1st which identified trained staff were on duty. The provider has a 24 hour on call governance system in place to provide support for staff.

The provider was not able to demonstrate on the day of the inspection if the staff team had been supported with supervision in line with the provider's own policy. Inspectors were unable to review a schedule of these supervisions for the staff team that had taken place in 2024 or that were due to take place in 2025.

Judgment: Not compliant

Regulation 22: Insurance

The registered provider had ensured that the designated centre was adequately insured and had provided a copy of the up-to-date insurance document as part of the registration renewal.

Judgment: Compliant

Regulation 23: Governance and management

The management structure defined in the statement of purpose was in line with what was in place during the inspection. Staff also clearly identified lines of authority and accountability amongst the team.

The provider's last two six-monthly unannounced reviews and the latest annual review were reviewed by the inspectors. The Annual Review of the care and support of residents which had been undertaken by the provider did not include consultation with residents or their representatives. The provider had completed six-monthly unannounced visits of the centre in November and June 2024. An action plan was in place with time lines. Some of these actions were seen to be completed within the required time frame, such as statement of purpose updated, inventory logs to be completed for each resident and staff skill mix to be considered.

The person in charge ensured a number of audits were being completed in the designated centre. An audit schedule was in place for 2025, which identified the responsible person to complete the audit. The inspector reviewed audits for complaints, staff training, risk register, rights restrictions, personal and intimate care and quality and safety audits. In general, these audits identified actions and time lines to be completed. For example, an automated external defibrillator (AED) audit identified a spare battery was required and this was documented as completed. For some audits however actions were not identified. For example in February 2025 a fire audit was completed. It was indicated that all staff had adequate fire training but from a review of these records a large number of staff had outstanding fire training.

The inspector reviewed the actions from the previous inspection and found that not all of these had been completed by the time of this inspection. For example, quarterly team meeting to take place with a structured agenda. However from a review of the staff team meeting minutes available it was not clear if this had taken place. For 2024 minutes were available for April, July and August. In 2025 monthly meetings had taken place, however both January and February team meetings only discussed one item relating to a new phone system in the centre. The March 2025 meeting reviewed did discuss a range of agenda items such as safeguarding, complaints, residents in the centre. This meeting had clear identified actions and

time lines in place.

The inspector requested further assurances be submitted to the office of the Chief Inspector regarding fire precautions in the centre and staff training. The assurances were received on the 25 March 2025 and identified actions the provider had taken to ensure a safe service was being provided to residents.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The provider had prepared a statement of purpose and function for the designated centre. This is an important governance document that details the care and support in place and the services to be provided to the residents in the centre. This included all the required information and adequately described the service.

An amendment was required on the statement of purpose due to an error in identifying the wrong person participating in management in one section of the document. This was identified to the person in charge and corrected on the day of the inspection.

Judgment: Compliant

Regulation 31: Notification of incidents

As part of the inspector's preparation for the inspection, they reviewed the notifications submitted by the provider. On the day of the inspection the inspector also reviewed the centres incident log. Two notifications had been received late by the provider in relation to the notification of alleged, suspected or confirmed, of abuse to a resident. As per the regulations, these notifications had not been received within the three days required by the Chief Inspector.

Judgment: Not compliant

Regulation 34: Complaints procedure

The provider had suitable arrangements in place for the management of complaints. There was a designated complaints officer nominated. There was no open complaints on the day of the inspection. The person in charge completed monthly complaints audits. There was evidence that complaints received were reviewed in a timely manner. For example, a complaint made by a resident in July 2024 identified

a potential safeguarding concern and this had been reported to the office of the Chief Inspector as per the regulations.

The service had also received compliments since the previous inspection. For example, family members complimented the care and support the residents received from the staff team.

Judgment: Compliant

Regulation 4: Written policies and procedures

The registered provider had schedule 5 policies in place. These policies were available to staff in an online format. Three of these policies had not been reviewed in the last three years as required by the regulation. These were Communication with residents, visitors, provision of information to residents.

Judgment: Substantially compliant

Quality and safety

The findings of this inspection indicated that residents were well-supported in area such as general welfare and development, positive behaviour support and protection. Since the previous inspection there had been improvement with compliance with the regulations. However, some areas required review, such as, fire precautions, risk management procedures, individual assessments and personal plans, residents' rights.

Staff in the centre discussed with the inspector about the development of an activity board that they are going to put in place in a communal area. This will display pictures and activities residents enjoy and have completed. Residents will be supported to take pictures and display them if they wish.

Residents had personal plans in place. The inspector reviewed five residents' personal plans. For the most part, these plans were seen to have been regularly reviewed. Some improvement was required which will be discussed under regulation 5, individual assessments and personal plans.

The provider was also asked to submit additional assurances to the office of the Chief Inspector in relation to Regulation 28, fire precautions. On review of the fire drills, the centre had not completed fire drills to reflect the minimum staffing levels in place at night. A number of the centres fire doors also required attention.

Regulation 13: General welfare and development

Residents were being supported to enjoy a good quality of life, and had access to numerous activities, both in their home and out in the community. The centre now had two vehicles to support activities. The staff members informed the inspectors of a third larger transport vehicle they also had available to them if they required.

Preferred activities were clearly outlined, and the likes and dislikes of each resident were recorded in resident's personal plans. One of the resident's plans indicated that they liked to visit a parent regularly. Residents enjoyed going to shops, cafes and restaurants. They also enjoyed planning overnight trips, going on train journeys, walks and going to the local pub. Residents also had the choice to attend the day service attached to the centre.

The records and the observations of the inspector throughout the inspection indicated that residents were supported to have a meaningful day and to be occupied in accordance with their preferences and abilities.

Judgment: Compliant

Regulation 17: Premises

The premises of this designated centre was comfortable, warm and well furnished. The house and grounds were clean and overall in a good state of repair. Some residents had their own bedroom, while a number of resident shared bedrooms. Residents had adequate storage space for their personal belongings and clothes. The houses had kitchen facilities, bathrooms, garden area and communal living space for the number and assessed needs of the residents.

Judgment: Compliant

Regulation 26: Risk management procedures

The provider had systems in place and processes in place for risk management at this centre. There was a policy in place for risk management. The centre had a risk register for the designated centre in place and these risks had been reviewed recently. Resident's had individual risk assessments in place, where risks to their well being and safety were identified, assessed and in general kept under ongoing review.

However the following required action;

Some controls required review to ensure they were consistent with the supports in place. For example, a risk assessment in place for environmental disturbances identified behaviour support training for all staff as a control measure. However, not all staff had received this training. Other risk assessments in place identified controls required which included the allocation of 1:1 staffing for a resident. However, this support measure was in place.
A resident in the centre required 1:1 staffing and this was in place. All staff had been requested to sign the lone working policy. A copy of this policy was kept in the resident behaviour support file. The centre had not identified a risk assessment in place for lone working. This required review.

Judgment: Substantially compliant

Regulation 28: Fire precautions

There was evidence of fire equipment being maintained and service as required by the regulations. There were fire maps and evacuation plans throughout the centre.

Residents had personal emergency evacuation plans in place.

On the day of the inspection, the inspectors requested assurances to be submitted in relation to the following areas of fire precautions. These assurances were received by the office of the chief inspector on the 25th March 2025 and outlined the measures that had been taken to address these issues. The assurance confirmed a fire drill with minimum staffing levels had taken place after the inspection on the 22nd March 2025 and a consultant would be visiting the centre to review the evacuation procedures in the centre.

- During a check of the fire doors, four fire doors were not working fully in the centre. Three of these were repaired on the day of inspection. The inspectors were informed a part was ordered to repair the fourth door.
- The inspectors reviewed the centres fire drills for the previous 12 months. There was no evidence of how residents may be evacuated when staffing is at night time levels.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

The person in charge had ensured that an assessment of need was completed for each resident, this informed the resident's personal plan. The plans in place were informative and contained good profile of the residents. The inspector viewed five of the residents' files.

Residents had been part of annual multi-disciplinary meetings. Where a support need was identified, care and support plans were developed. In general, these were seen to be kept under ongoing review and updated as required. However some review was required. One resident did not have their MUST (malnutrition universal screening tool) completed as indicated by their records.

Residents were supported to identify and set goals for the future in their yearly planning meetings. Residents were seen to be part of these meetings with the support of staff and management of the designated centre. It was seen for one resident that their goals had been reviewed and adapted to suit their needs and make them more achievable. Another resident had planned goals for the year which included going on an overnight trip and planning a spa day. However for another resident documentation reviewed was not clear if their goals had been completed and if one of the goals identified had any work undertaken to achieve them. This required review.

Judgment: Substantially compliant

Regulation 6: Health care

Judgment: Compliant

Regulation 7: Positive behavioural support

Some residents had positive behaviour support plans in place. The inspectors reviewed two of these behaviour support plans and saw that they were written in a person-centred manner. The plans identified triggers, proactive strategies and reactive strategies, a traffic light system was identified to support residents. These plans were seen to be reviewed annually.

The inspector spoke to three staff regarding the behaviour support plans in place. The staff were knowledgeable on the resident's behaviour support plans in place. For example staff spoke about different triggers or signs for a resident and how they support the resident through this. One resident had an easy-to-read anxiety plan in place.

Judgment: Compliant

Regulation 8: Protection

From a review of the training matrix not all staff had completed safeguarding training. This is identified under Regulation 16, staff training and development.

The inspector spoke with the person in charge and three staff members. They were each aware of their roles and responsibilities should there be an allegation or suspicion of abuse.

The provider had a safeguarding policy which was available and reviewed in the centre. Safeguarding plans were developed and reviewed as required. Each resident had an intimate care plan in their personal plan folder. There was easy-to-read information relating to safeguarding and protection available. Residents took part in regular residents meetings and safeguarding was a regular agenda item.

Safeguarding incidents are being identified and submitted to the chief inspectors office. The designated officer and the statutory bodies are being informed of safeguarding incidents. The provider had ensured 1:1 support was being maintained for a resident that required this. This was working well in the centre.

Judgment: Compliant

Regulation 9: Residents' rights

Residents took part in advocacy groups and a residents' forum on a weekly basis. These offered residents an opportunity to voice their opinion in how the service was run. Two residents were being supported to attend advocacy training with a third level institution. These residents were very proud about this training and were happy to be advocates in the centre.

There was information available to residents in the centre in relation to areas such as, complaints, safeguarding and advocacy. The centre had an advocacy folder in place, this held additional information on how residents are supported and how their voice is heard.

The staff members spoken with on the day told the inspectors of an upcoming plan they were developing with residents. An activity board was going to be displayed in one of the communal areas in the centre. This would display any upcoming events and outings being held in the centre and residents would also have the opportunity to display pictures of events or outing they had completed.

Resident also had pictures and visual aids to support them with their choice of meals and staff who would be on duty.

Resident's personal plans contained consent document which was in picture format. This identified if residents had consented to a number of things such as, access to personal information, medical needs and taking bloods.

A resident was being supported by the staff and management of the centre to seek

alternative housing. This was a long term goal for the resident and was in place since January 2024. Staff and management supported the resident weekly in checking the housing available.

Some consideration was required in relation to the use of shared en-suite bathrooms in the centre. The centre had six bedrooms that had adjoining shared bathrooms. On the day of the inspection these bathroom doors had been left open. When the inspector was speaking to one resident in their own bedroom, they could clearly see through into the adjoining bedroom. Not all of these shared bathrooms had signs in place to inform residents and staff if the bathrooms were in use. This required review to ensure residents privacy and dignity was respected.

Judgment: Substantially 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	Compliant
Regulation 16: Training and staff development	Not compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for East County Cork 1 OSV-0003305

Inspection ID: MON-0038406

Date of inspection: 20/03/2025

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: Training continues to be provided to staff to improve outcomes for people living in East County Cork 1. The PIC has a training matrix and schedule is in place for all staff for 2025. • 13 staff received Buccal midazolam training to support the needs of the residents, 2 relief staff remain outstanding and are scheduled for this training. The PIC will ensure that these staff will not be working alone or with a staff who does not have buccal midazolam training completed to support a resident with epilepsy. • 9 staff have completed fire training including 3 who participated in an additional fire warden training. 6 outstanding scheduled to be completed by end of Q2. • 4 staff outstanding for Manual handling and safety intervention training are scheduled throughout 2025. Staff supervisions had taken place in 2024 by the previous PIC. The PIC has scheduled reviews as needed for 2025.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The PIC will ensure that residents and families will be consulted and their voice expressed within the next annual review. The PIC has ensured that a training matrix and schedule is in place for all staff for 2025. Any outstanding training has been scheduled within the year.	

Additional fire warden training has been provided for staff with 3 having completed same. Night time simulated fire drill carried out in March identify improvements needed in evacuation times by night, learning outcomes have been reviewed by PIC and extra night time drills have been scheduled to try to further reduce evacuation times.
There are systems to ensure the service is safe, appropriate to person's needs, consistent & effectively monitored.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:

Effective immediately the person in charge will give the Chief Inspector notice in writing within 3 working days following adverse incidents occurring in the centre. The person in charge will ensure that a written report is provided to the Chief Inspector at the end of each quarter, of each calendar year, in relation to and of the following incidents occurring in the designated centre

Regulation 4: Written policies and procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:

3 policies remain in need of review, the provider is aware of same and has a schedule in place to review outdated policies by the end of May 2025.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:

The PIC has completed an assessment of risks (risk register) throughout the designated centre; controls, additional controls and risk rating has been amended where appropriate. A risk assessment is in place for a lone worker.
3 staff remain outstanding for behavior support training, they are included in the training schedule for 2025.

Regulation 28: Fire precautions	Substantially Compliant

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

The registered provider ensures that effective fire safety management systems and adequate means of escape, including emergency lighting are in place throughout the centre, all fire doors have now been repaired.

A fire audit has taken place in the centre by an external coordinator, once this report has been issued, the provider will assure that any matters of concern will be planned for in

collaboration with the facilities management and finance department.

A simulated night fire drill took place in November 2024 and again in March 2025, some improvements are needed to reduce evacuation times. Additional fire warden training has been provided with 3 staff having completed same. Fire drills are scheduled for day and night throughout the year as per regulation with the objective of consistently reducing evacuation times by night.

Regulation 5: Individual assessment and personal plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:

Each resident has a personal plan which details their needs and outlines the supports required to maximise their personal development and quality of life, in accordance with their wishes. Personal plans and goals are under review. MUST assessment is now complete. Plans reflect residents changing needs

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:

The registered provider ensures that each resident’s privacy and dignity is respected. In relation to the shared bedrooms and bathrooms, any resident sharing a bedroom has consented to same which is documented in their personal plan. Privacy and safety are discussed at residential forums, keeping bathroom doors closed has been discussed with regards to people’s privacy. Signs have been situated on the doors of shared bathrooms. Privacy and dignity has also been discussed at 2 staff meetings in April and May to ensure that all staff are aware of keeping bathroom doors closed at all times to ensure that the rights and dignity of each resident is respected.

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 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Not Compliant	Orange	31/12/2025
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	31/12/2025
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	31/12/2025
Regulation	The registered	Substantially	Yellow	31/12/2025

23(1)(e)	provider shall ensure that the review referred to in subparagraph (d) shall provide for consultation with residents and their representatives.	Compliant		
Regulation 26(1)(a)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: hazard identification and assessment of risks throughout the designated centre.	Substantially Compliant	Yellow	31/03/2025
Regulation 26(1)(e)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: arrangements to ensure that risk control measures are proportional to the risk identified, and that any adverse impact such measures might have on the resident's quality of life have been considered.	Substantially Compliant	Yellow	31/03/2025
Regulation 28(1)	The registered provider shall ensure that effective fire safety management	Substantially Compliant	Yellow	31/08/2025

	systems are in place.			
Regulation 28(4)(b)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Substantially Compliant	Yellow	31/08/2025
Regulation 31(1)(f)	The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: any allegation, suspected or confirmed, of abuse of any resident.	Not Compliant	Orange	20/03/2025
Regulation 04(3)	The registered provider shall review the policies and procedures referred to in paragraph (1) as often as the chief inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.	Substantially Compliant	Yellow	31/12/2025

Regulation 05(6)(c)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall assess the effectiveness of the plan.	Substantially Compliant	Yellow	31/08/2025
Regulation 09(3)	The registered provider shall ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.	Substantially Compliant	Yellow	31/05/2025