Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	Cork City South 1
Name of provider:	Horizons
Address of centre:	Cork
Type of inspection:	Unannounced
Date of inspection:	14 August 2025
Centre ID:	OSV-0003695
Fieldwork ID:	MON-0047773

About the designated centre

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

Cork City South 1 consisted of three large detached two-storey houses located on the outskirts of a city. Combined the three houses can support up to 25 residents. The houses mainly provide a full-time residential support for residents with intellectual disabilities and autism of both genders, over the age of 18 but can also provide some respite. Individual bedrooms are available for all residents in each house and other facilities in the houses include bathrooms, sitting rooms, dining rooms and kitchens. Support to residents is provided by the person in charge, care assistants and staff nurses.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	20

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 14 August 2025	12:35hrs to 18:30hrs	Conor Dennehy	Lead
Thursday 14 August 2025	12:35hrs to 18:30hrs	Elaine McKeown	Support

What residents told us and what inspectors observed

Only one house of this centre was visited during this inspection. While residents in that house were away from the house for part of the inspection, they did return before the inspection ended. This gave inspectors some time to meet with residents and observe interactions which were noted to be very positive. However, a number of regulatory actions were identified during this inspection, some of which impacted residents.

This centre was made up of three different houses all of which mainly provided residential care but also some respite care. On the day of inspection 20 residents were present across all three houses but inspectors only visited one of these houses. This was done specifically to follow up on some unsolicited information of concern that had been received related to medicines management practices in this house. This will be outlined in more detail in the next section of the report. This house operated on a Monday to Friday basis and had a capacity for eights residents. The inspectors were aware from previous inspections that this house was typically unoccupied during the day-time with residents attending day services. As such, to maximise time in the house and ensure no delays in accessing the house, the provider was given one hour's notice that inspectors would be inspecting this house.

When inspectors arrived at this house, management of the centre and the provider were present to enable the inspection to begin. During an introduction meeting with the person in charge (PIC), it was indicated that seven residents were availing of the house that day, all of whom were due to return to the house later in the afternoon. Six of these residents were residential residents while a seventh was a respite resident. Another residential resident, who would normally have been staying in this house during the week was staying with their family on the day of inspection.

Given that no residents were present during the initial hours of the inspection, inspectors focused on reviewing documentation and speaking with management present during this period. As the inspection progressed, a staff member came on duty to commence their shift shortly before residents arrived back to the centre. As an inspector was speaking with this staff member in the house's kitchen-dining room, all seven residents returned to the house from their day service. Five of these residents briefly passed through the kitchen-dining room with all greeting the inspector and the staff member. In doing so one of these residents hugged the staff member and shook the inspector's hand. Such residents also welcomed the other inspector to the house.

Soon after an inspector sat with six of the residents present in the house's larger sitting room. The atmosphere at this time was very relaxed and jovial with residents seeming comfortable in each other's presence. The inspector directed his conversation and queries to the residents as a group but noted that some of the residents present engaged more than others. It was particularly noticeable that two of the residents mostly responded to comments or queries made by the inspector at

this time but none of the other residents appeared fazed by this.

During this period of interactions with the residents, one of the residents asked the inspector where he was from. When the inspector said he was from Kerry, two of the residents asked the inspector to leave the house but did so in a humorous way which other residents present found funny. A resident then spoke of going to Kerry recently for a holiday but commented that it had been expensive before then asking if the inspector had been on holidays yet. When the inspector responded by saying that he had not, some residents gave suggestions on where the inspector could go for a holiday. These suggestions included Baltimore, Kinsale and Rome.

After this interaction, another inspector saw that this resident went to a private area to take another phone call on their mobile phone while the seventh resident present joined the resident group in the larger sitting room after they had completed their usual routine. These residents were then supported to make a choice for their tea which the staff member on duty facilitated. The inspectors were informed that residents had their own routines for helping out during meal times such as putting items in the dishwasher.

Once residents had their tea, four of the residents were observed to relax in the larger sitting room to watch television. None of the residents spoken to at this time had plans for the evening but two residents spoke of their plans for the coming weekend. One was looking forward to be going for a weekend break to another designated centre which was located near a beach. The other resident was going to their family home with a sibling. Another resident spoke of their large extended family and how much they enjoyed spending time with them at weekends.

While residents were present in the house, there was banter and conversations observed and overheard between the residents, the staff member and management present. This included residents enquiring about activities and plans for the up-coming weekend. One member of management was also overheard to be asked by a resident about their family with the manager pleasantly responding to the questions asked. Such observations indicated that all present were familiar and comfortable with each other. At the end of inspection, residents were relaxing the larger sitting room with one resident shaking an inspector's hand before inspectors departed.

Although the residents met on the day of inspection seemed content overall and positive interactions were observed, some of the findings during inspection indicated some negative impacts on these residents. For example, staffing arrangements in the house visited limited residents' abilities to pursue activities away from the house. This was despite residents having complained about such matters previously. As such regulatory actions were identified in staffing and complaints, along with medicines management and governance. These will be discussed in greater detail in the following sections of the report.

In summary, all seven residents present in the house visited during this inspection were met by inspectors. A relaxed and jovial atmosphere was encountered during this time with residents appearing comfortable together as a group but also with

staff and management present. Such residents were very welcoming to the inspectors. Despite, such findings, a number of regulatory actions were identified during this inspection related to areas such as medicines management, staffing and governance.

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

Capacity and capability

During the previous inspection of this centre in April 2025 regulatory actions were found related to governance, staffing and complaints. On the current inspection a number of regulatory actions were found in similar areas as well as other areas such as medicines management.

This designated centre was registered until March 2027 with a restrictive condition attached that required compliance with a specific plan by 31 December 2026. Progress with this plan was assessed at the previous inspection of this centre in April 2025 where all three houses of the centre were visited. The April 2025 inspection did identify some changes that had taken place since an earlier inspection in December 2023. However, a number of regulatory actions were found during the April 2025 inspection. This included areas such as resourcing of the centre, oversight of the centre, staffing, complaints, fire doors and the premises provided. In response to that inspection the provider submitted a compliance plan outlining the measures they could take to come back into compliance. This included a commitment that one house of the centre would be vacated by December 2025 with the residents living there planned to move elsewhere.

Since receipt of that compliance plan response, the Chief Inspector of Social Services had received some unsolicited information relating to another house of this centre. This information raised concerns, particularly relating to medicines management practices. As a result, the provider was issued with a provider assurance report (PAR) by the Chief Inspector during July 2025. This PAR sought assurance in certain regulations and also asked a number of specific questions related to the house in question. The provider's response to this PAR indicated that quality improvement was needed in this house while also highlighting some medicine errors that had not been previously identified as such. However, while the PAR response did contain a lot of information, some of the specific questions asked were not fully answered so this response did not provide assurances to the Chief Inspector.

For example, the PAR questions related to all residents living in the house inspected. However, much of the PAR response focused on a single resident. Taking this into account, the decision was made to conduct the current inspection, which was

focused on one house only, to assess the information provided in the PAR and to follow up on some of the outstanding matters not fully addressed in the PAR response. Overall, the inspection findings raised concerns around medicine practices and oversight in the house inspected. While inspectors were not focused on following up actions from the April 2025 inspection, it was also clear that some actions arising from that inspection had not been addressed while issues in areas such as staffing and complaints remained. Consequently, as had been the case with the April 2025 inspection, a number of regulatory actions were found on the current inspection.

Regulation 15: Staffing

Under this regulation the provider is required to ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents. During the April 2025 inspection, it had been identified that there were times in the house inspected where only one staff member could be on duty supporting up to eight residents after they returned to the house following day services. This limited residents' abilities to pursue activities away from the house. Based on discussions with management and staff along with staff rotas reviewed from 30 June 2025 on, it was clear that this remained the case at the time of this inspection. This continued to limit residents' ability to pursue activities away from the house. For example, a staff member highlighted that on account of such staffing arrangements only in-house activities could be pursued. It was also highlighted how, in the absence, of a second staff member working in the house, a vehicle for the house that all residents could travel on, could not be accessed. As a result, the finding from the April 2025 inspection regarding this house remained unchanged.

In addition, when reviewing records related to one resident living in this house, it was highlighted how a need had been identified for this resident to have additional staff provided for them during the day in their residential setting. Such staffing was not in place at the time of this inspection. As had been the case at the time of the April 2025 inspection, inspectors were also informed that there were staffing vacancies in the centre overall and that a risk related to staffing had been escalated internally within the provider also. Given that such a risk had been escalated at the time of the April 2025 inspection also, this indicated that the provider had yet to mitigate this risk and provide appropriate staffing resources for the centre.

Despite this, it was acknowledged that to support one resident with a particular prescribed medicine, the provider had put in place an additional waking night staff member in the house visited during this inspection. This had been in place since June 2025 but, as outlined in the PAR response, there had been two nights in that month where this waking night staff had not been in place. This had resulted in the resident not being able to be administered the particular medicine on those two nights. Discussions during this inspection and rotas reviewed indicated that the waking night staff had been in place since then. It was noted though that the staff rotas reviewed, did not indicate the actual hours that such waking night staff

worked in the centre.

Judgment: Not compliant

Regulation 23: Governance and management

In keeping with this regulation, the provider must ensure that management systems are in place to ensure that the services provided are safe, appropriate to residents' needs, consistent and effectively monitored. In the PAR issued to the provider in July 2025, the provider was requested to provide assurances on how it was in compliance with Regulation 23 Governance and management. In the PAR response submitted, the provider outlined the measures in place and actions to be taken in this area in the context of the governance and management of the centre and the house that was the subject of the PAR. These measures and actions included:

- Staff team meetings being conducted as per a schedule in the house visited on this inspection.
- The PIC conducting staff supervision as per a schedule.
- All audits being conducted as scheduled.
- A review of medicine recording being completed in the house visited on this inspection.
- A review meeting that took place in April 2025 related to a medicines issue raised at that time.
- A risk assessment for medicines management for the house visited being completed.
- A person participating in management (PPIM) for the centre to have scheduled supervision meetings with the PIC in relation to medicines management and other health needs of the residents within the house visited on this inspection.
- An assistant director of nursing (ADON) to have scheduled supervision meetings with the PIC in relation to medicines management and other health needs of the residents within the house visited on this inspection. A time frame for such meetings was given as 31 July 2025 in the PAR response.

On the current inspection, based on discussions and documentation provided to inspectors, the following was found regarding the above stated measures and actions:

- Staff team meetings in this house were to be conducted quarterly but only two had been conducted in 2025, these had taken place in February and August.
- No formal supervision process was followed in this centre although the PIC did indicate that they visited the house and did performance development reviews with staff.
- The provider had a schedule for monthly audits in place and inspectors were initially informed that all audits were up-to-date. While some records of

completed audits were seen from recent months in areas such as rights restrictions and protected meal times, upon further queries, it was then confirmed that no audits for July 2025 had been completed at the time of this inspection.

- Inspectors were informed that a review of medicines recording had taken place for one resident in the house inspected but not all residents of that house. This was despite, the PAR raising queries about residents rather that a single resident.
- A review meeting had taken place in April 2025 related to an identified medicines issue with a note of this meeting provided. The note indicated some actions that were to be done including that all staff in the house inspected were to read the provider's medicine management policy and sign off that they have read same. When an inspector requested to see to evidence of this action being completed, they were informed that no such records to confirm this action being done were in place.
- A risk assessment for medicines management for the house visited had been completed based on documentation provided.
- Meetings between the PIC and a PPIM were scheduled for the rest of the year based on documentation provided. Records of similar meetings from June 2025 and July 2025 were also provided during this inspection. The PIC informed the inspectors that they reported to this PPIM for operational issues. This was in keeping with the outlined organisational structure for the centre in the centre's statement of purpose which had been reviewed in August 2025.
- Supervision meetings between an ADON and the PIC had yet to take place. It was indicated to inspectors that this was contributed to by annual leave but that the ADON had been invited to attend the scheduled meeting between the PIC and the PPIM. It was later clarified that the PIC would not meet with the PPIM and the ADON at the same time. Inspectors were also informed that the PIC reported clinically to the ADON. This was not reflected in the outlined organisational structure for the centre in the centre's statement of purpose.

In the PAR response, the provider had indicated that they would arrange for twice yearly medicines audits in the house visited to be conducted. Such an audit had yet to take place although inspectors were informed that this was due to take place the week after this inspection. Communication following the inspection indicated that it would be completed by 26 August 2025 while the PIC and ADON would be conducting a review of medicines before 26 August 2025. During the inspection it was indicated to the inspectors that a medicines audit had not taken place in the house since the beginning of 2024. Given the findings of this inspection regarding Regulation 29 Medicines and pharmaceutical services, this indicated that there had not been appropriate oversight of medicines management practices in the centre. Communication received on 18 August 2025 indicated that the provider's audit schedule was to include twice yearly medicines audits but that due to an error such audits had been taken out of the schedule. This indication of twice yearly medicines audits was not consistent with the provider's medicines administration policy which provided for medicines audits to be carried out "at least quarterly".

Furthermore, as highlighted earlier in this report, a number of regulatory actions

were identified by the April 2025 inspection with the provider's compliance plan response outlining the actions they would take to come back into compliance. While following up on progress on these actions was not focus of the current inspection, it was apparent that some actions had not been completed. For example, the compliance plan for the April 2025 inspection indicated that weekly resident forums would take place and that a hole a kitchen-dining room wall would be addressed by 1 July 2025. On the current inspection it was seen that only monthly resident forums were taking place in the house visited while the same hole that was seen during the April 2025 inspection remained. Such observations raised concerns around the oversight measures being followed for this centre.

Given some of the inspections findings, some specific information and documents were requested during the feedback meeting for the inspection to be provided to inspectors following the inspection. Communication received on 18 August 2025 provided most of the specific information or documents that had been requested by inspectors. However, when reading notes of a staff team meeting from February 2025 on the day of inspection, reference was made to one resident's money being managed by others. The notes indicated that this has resulted in the resident being provided with limited money when they came to stay at the house visited during this inspection. Reference was also made to additional money for the resident not being readily supplied. An action identified from the staff team meeting was to request support from social work for this matter. When queried on the day of inspection, the management in the centre were unsure as to what the extent of social work involvement had taken place since the meeting. As such inspectors requested confirmation of the extent of social worker involvement to be provided by 18 August 2025 but no information on this was provided. As such, it was unclear if this matter had been referred for social work support.

Inspectors were informed on the day of inspection though that a business case relating to the potential move elsewhere of residents from another of the centre's houses had been approved. This was a positive development. However, based on documents reviewed and discussions on the inspection, it was also highlighted that a number of risks in the centre had been identified as high risks and escalated internally within the provider. Such risks were relevant to the quality and safety of care and support provided to residents and covered areas such as residents' rights, residents' experience, staffing, effective governance, premises and fire safety. Such issues had also been highlighted during the April 2025 inspection and it was acknowledged that the provider's time frames for addressing such matters from their previous compliance plan had yet to pass. It was noted though that the staffing risk in the centre had been escalated multiples times previously and the amount of escalated risks for the centre had increased since the April 2025 inspection.

Judgment: Not compliant

Regulation 31: Notification of incidents

Under this regulation, the Chief Inspector must be notified in writing within three working days of any allegation of misconduct by the registered provider or by staff. In the PAR issued to the provider in July 2025, the provider was asked if there had been any instance identified or alleged of a staff member administering medicines but signing the name of a different staff member. The PAR response submitted indicated that no clear evidence had been found to suggest that an instance of this had occurred but the PAR response did not address if any instance had been alleged.

In light of this, it was queried during the inspection if there was any allegation of a staff member administering medicines but signing the name of a different staff member. On the inspection day and during communication received on 15 August 2025, it was suggested that there had been no such allegation. However, when confirmation of this was requested in writing, communication was received on 18 August 2025 which confirmed that there had been three such allegations raised between September 2024 and August 2025. All of these allegations were raised before this inspection but none of them had been notified to the Chief Inspector via the required notification.

Judgment: Not compliant

Regulation 34: Complaints procedure

The provider has specific responsibilities under this regulation related to having an effective complaints procedure and in ensuring how complaints are responded to and recorded. The April 2025 inspection found that complaints raised by residents during resident forums in one house were not being documented in the complaints log. This meant that it was not recorded what the outcome of these complaints were, what action had been taken and whether complainants had been satisfied or not. Such findings did not provide assurances that residents were being made fully aware of and assisted to understand the provider's complaints processes. In response to this the provider indicated in their compliance plan response for the April 2025 inspection that retrospective complaint forms had been completed in relation all complaints raised in resident forums. It was also stated that the complaints process would be discussed at weekly residents' forums.

As part of the current inspection, which focused on the same house, inspectors specifically requested records of all complaints in relation to the house. An inspector was subsequently provided with a complaints folder and was explicitly informed that this contained records of all complaints that had been made or logged since the April 2025 inspection. When reviewing this it was seen that there were some retrospective complaints logged related to the resident forums that had been identified during the previous inspection. These retrospective complaints records covered issues such as staffing and transport, and while these complaints were marked as resolved to residents' satisfaction, issues remained with both of these as

referenced under Regulation 15 Staffing.

When reviewing the complaints records provided on the day of inspection, the retrospective complaints recorded from past residents' forums referenced such forums as occurring in December 2024. However, the April 2025 inspection had identified complaints that had been made during a March 2025 residents' forum also. These were not directly referenced in the complaints records seen on the day of inspection which did not provide assurances all complaints had been appropriately logged. In addition, as referenced earlier, residents' forums were only taking place monthly rather that weekly as confirmed by documentation reviewed and discussions with the PIC. While notes of these monthly resident forums did include a section on complaints, they were not occurring at the frequency previously suggested by the provider.

In addition, to the retrospective complaints that were recorded arising from previous resident forums, two further complaints had been recently logged retrospectively. Both of these complaints related to aspects of medicines management and had been initially raised in July 2024 and April 2025 respectively. These had not been regarded as complaints at the time they arose and were only logged as complaints retrospectively following the queries raised in the PAR issued to the provider in July 2025. It was noted that both of these complaints were marked as resolved to the satisfaction of the complainant. However, information received during the inspection day was not consistent with this and it was indicated that the complainant's satisfaction level had not been confirmed before the complaints were marked as resolved. It was also noted that one of these complaints related to aspect of medicine recording but, as mentioned under Regulation 29 Medicines and pharmaceutical services, a similar issue was identified during this inspection. This did not provide assurance that there had been sufficient learning from the complaint.

As mentioned earlier in this regulation, inspectors had requested records of all complaints in relation to the house and were informed on the day that they had been given records of all complaints that had been made or logged since the April 2025 inspection. Despite this, communication the day following this inspection confirmed that a further complaint had been made in May 2025 related to the house inspected. A record of this had not been made available to inspectors on the day of inspection but was subsequently provided the day after the inspection. In light of this, the provider was requested to provide confirmation that all complaints records had been made available to inspectors. Communication received on 18 August 2025 repeated much of the information that had already been provided on 15 August 2025 and did not explicitly provide the confirmation requested.

Judgment: Not compliant

Quality and safety

Based on the findings of this inspection, improvement was needed regarding medicines management. The premises currently provided for two of the residents in the house visited during this inspection was not in keeping with recommendations made for their home.

In the PAR response submitted in July 2025, the provider had identified a number of medicine errors. These errors had not been recognised or recorded as such at the time they occurred but were subsequently recorded retrospectively. This was seen on the current inspection based on documentation provided but some additional medicines management issues were identified during the course of this inspection. This raised concerns around medicines management practices in the house visited during this inspection. It was also noted that this house did not provide two residents with a level access home as had been recommended for them by the provider's dementia care team. A similar finding had also been raised during the April 2025 inspection of this centre. These residents' personal plans were also reviewed during this inspection. This personal plans had evidence of review but some areas for improvement were identified.

Regulation 17: Premises

Under this regulation, the provider is required to ensure that the premises of a designated centre is designed and laid out to meet the needs of residents. The April 2025 inspection highlighted that on account of a resident's dementia diagnosis in the house visited during the current inspection, this resident was being discussed by the provider's admissions, discharge and transitions committee. This was with a view to finding the resident a more suitable premises to live in with such findings contributing to a judgement of Not Compliant under this regulation. This resident's bedroom was on the first floor of the house visited, as were all eight resident bedrooms in this house. In the PAR response it was indicated that the provider's dementia care team had recommended that this resident needed a level access home. On the current inspection, it was also indicated that the same team had recently made the same recommendation for another resident with dementia who availed of the same house.

In the current premises layout provided by the house visited during this inspection, neither resident had a level access home. Documentation reviewed also referenced one resident as having expressed their will and preference to move to another designated centre which could provide level access. Taking into account that the number of residents in this house who needed a level access home had increased since the April 2025 inspection along with the escalated risk related to premises, the judgement under this regulation remained unchanged. It was acknowledged though that since the April 2025 inspection, the provider had completed a proposal for modifications to this house that outlined a plan to create two downstairs bedrooms and en-suite bathrooms to accommodate residents with aging needs. It was unknown at the time of the current inspection if this plan would proceed.

Aside from this issue, the house visited during this inspection was generally seen to be presented in a clean, homely and well-furnished manner on the day of inspection. Some maintenance issues were seen though in the house visited during this inspection. This included a hole in a wall of the kitchen-dining room which had not been addressed by 1 July 2025 as previously suggested by the provider. The ceiling in the same kitchen-dining room was also seen to need repainting. Following the April 2025 inspection, the provider had committed to completing painting of all rooms in this house during October 2025.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

Responsibilities under this regulation include having appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines. As highlighted earlier in this report the provider was issued with a PAR in July 2025 primarily related to medicines management practices. In the response submitted by the provider, it was identified that a number of medicine errors had been identified for one resident as part of a review conducted for this resident following the issuing of the PAR. These errors, which had occurred in 2024 and 2025, included:

- An incorrect medicines administration recording document being used.
- The resident receiving one particular prescribed medicine from staff who were not trained to administer this medicine.
- The resident not receiving one particular prescribed medicine.

There was no indication that such errors had adversely impacted the resident involved but these errors had not been recorded as medicines errors at the time they occurred contrary to the provider's medicines policy. Following such matters being recognised by the provider on account of the PAR issued, these incidents were recorded as medicine errors retrospectively with documentation reviewed during the current inspection confirming this. The PAR response also indicated that in response to such errors, a specific protocol in relation to medicines administration for the resident involved had been introduced. A copy of this protocol was provided during this inspection with a staff member spoken with demonstrating an awareness of this.

While this follow up action was noted, as referenced under Regulation 23 Governance and management, in responding to the PAR the provider had only reviewed the medicine records of one resident from this house while a medicine audit had not been conducted in the house for some time. As such an inspector reviewed further aspects of medicines management practices during this inspection and identified the following areas that needed improvement:

- A medicine that had expired in April 2025 was still being administered to a

resident. This medicine was administered to the resident once daily while present in the house since April 2025 including on the day of this inspection.
- Another resident's PRN medicines had been updated/re-written on 14 January 2025 and indicated a weekly administration of a medicine. This was not in line with the provider's medicine policy as this was a regular medicine given to the resident each week. In addition, an inspector was informed this medicine was usually given to the resident while at home with relatives but the recording of this was not in line with the provider's policy in this area. As such, there was no record documented of the prescribed medicine being administered weekly to support the resident's health management plan relating to their bone health. This was despite a complaint about a similar matter for a different resident having been previously raised.

Ultimately, the findings of the current inspection coupled with the content of the PAR response raised concerns around aspects of medicines management practices in the house visited during this inspection.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

Residents having personal plans in place is a key requirement under this regulation. During the course of this inspection selected documentation from personal plans of three residents was reviewed by an inspector. There was evidence of review of such documentation which included input from health and social care professionals while multidisciplinary reviews were also taking place. During one multidisciplinary meeting in December 2024 for one resident, a review by the positive behaviour support (PBS) team had been requested. A co-ordinated support meeting was held regarding the resident in June 2025 which included a member of the PBS team. The inspectors were informed that a behaviour support plan was to be developed by the PBS team by September 2025 for this resident.

For the same resident, the PAR response had indicated that a specific chart to record any behavioural incidents was to be introduced in both the house visited during inspection and the resident's day services. During the inspection, it was indicated that this chart was available in electronic version and was to be completed by the staff working in the house if required. The PIC also indicated that they had sent a copy of the chart to the day service staff on 9 June 2025 so that relevant information would be recorded. The inspectors were informed that no incidents had occurred since the chart had commenced although it was indicated that this had not been checked with day services to confirm this.

Aside from this, some areas for improvement were identified regarding the personal plan documents reviewed during this inspection. These were:

- One resident had been subject to regular reviews by their psychiatrist with

three such reviews taking place in June and July 2025 due to the resident's presentation and altered sleep pattern. Some medication changes had taken place during these consultations. On the most recent review on 7 July 2025 there was also a recommendation that staff were to record the sleep pattern of the resident. While the inspectors were informed that the sleep pattern for the resident was being recorded in their daily communication notes in a narrative format, this was found to not have been consistently or appropriately recorded. For example, on the communication notes written between the 13 and 16 July 2025 no reference was made to how the resident had slept.

- Another resident had a dental health review schedule documented in one section of their personal plan which indicated they required cleaning to be completed every three months by a dental hygienist. However, the same resident's current dental health management plan reviewed by an inspector documented dental review as required. The inspector was informed by the PIC that three monthly visits to the dental hygienist were not taking place.
- Not all personal goals were evidenced to be progressing for some residents. For example, in May 2025 one resident had identified a goal to play snooker or darts with peers locally. This had not been progressed at the time of this inspection. Another resident in January 2025 had identified goals which included joining a local community group, go on holidays with peers and attend a sporting fixture of a specific team they liked. There was no progress or updates documented for this resident's goals.

While such areas did need improvement, it was acknowledged by inspectors that the residents present during this inspection, presented as comfortable and content on the day of inspection. Observations of residents in this regard are outlined in the opening section of this report.

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	
Regulation 15: Staffing	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Not compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant

Compliance Plan for Cork City South 1 OSV-0003695

Inspection ID: MON-0047773

Date of inspection: 14/08/2025

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 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • All posts which comprise the staffing skill mix and complement for the centre are in place since 29th September 2025. The registered provider will ensure that the centre continues to be resourced appropriately. • The staff rota has been reviewed to ensure it meets the requirements of the regulations and measures implemented to ensure ongoing compliance. **The compliance plan response from the registered provider does not adequately assure the Chief Inspector that the action will result in compliance with the regulations.**	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • The registered provider has implemented additional oversight of the centre while the systems analysis is taking place. This is being carried out by members of the Management Team. Detail related to different aspects is included under the relevant regulation in this compliance plan response. • A systems analysis of Governance and Management of CCS1 will be conducted by the provider. The systems analysis will identify the measures required to ensure the service meets the requirements of the Regulations. This will be completed by 31/01/2026.	

• The issue referred to in the report relating to the management of a resident's finances is a historical issue whereby members of the resident's natural support network support them to manage their finances. The organization is working with the person and their natural supports in respect of this. All appropriate support, including social work and any other MDT required, is being provided to ensure that the resident's will and preference in relation to the management of their finances is fully respected.
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Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
The registered provider is carrying out a review to ensure that the systems failure that lead to the inadvertent non-submission of required notifications is addressed. This will include a review to ensure that all notifications have been made and that the issues relating to inaccurate information provided to the regulator is addressed. This review will be completed as part of the systems analysis outlined in the response to Regulation 23. In the interim retrospective notifications will be submitted.

The compliance plan response from the registered provider does not adequately assure the Chief Inspector that the action will result in compliance with the regulations.

Regulation 34: Complaints procedure	Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
• The provider will carry out a systems analysis of CCS1. This review will include complaints procedures. This will be completed by 31/01/2025.
• In the interim residents are being supported by the person in charge and staff team to understand the complaints procedure, submit complaints and have their complaints responded to. This is monitored via the governance structure by the PPIM and auditing.
• Learning from complaints will be monitored and actions identified as required.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• One person has transferred to more suitable accommodation to meet their needs and 4 further people have received the keys to their new home with the plan (on the basis of it meeting the residents' assessed needs and the timeframe for the regulator to register the centre) for the residents to move by the end of 2025. One other person is planning to move to another centre in a number of weeks.
At that stage the registered provider will reassess the suitability of the centre for the remaining people and will ensure a plan which meets residents' needs is devised and implemented.
• In regard to maintenance issues, the provider acknowledges there are challenges in the availability of trades people at the moment. The provider is working on addressing this challenge. The hole referred to in the report has been addressed.

Regulation 29: Medicines and pharmaceutical services	Not Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
• The medicine referred to in the report as being out of date since April 2025 was a multivitamin. It had been received from the person's family members and was transferred from the packet received into the old container which resulted in the inspector misunderstanding that the multivitamin had expired when this was not the case. The registered provider has carried out a review and amendment to the process to ensure this does not reoccur. Timeframe: Completed
• The issue related to a medicine for a resident noted as 'PRN' on the prescription sheet did not adversely impact the resident as the resident was receiving the medicine as prescribed when they were at their family home. The documentation error has been resolved and the registered provider has carried out a review of all residents' prescription sheets to ensure that there are no other issues relating to this and practice is consistent with the registered provider's policy. Timeframe: Completed
• The medicine policy is being reviewed to ensure it accurately reflects practice. Training and support is being provided to staff to ensure they adhere to the policy. Timeframe: 31/10/2025
• The registered provider is carrying out a review of all medicines management in the centre. To date the medicines audit has been completed and actions arising are being addressed. All actions and measures will be implemented to prevent any reoccurrence of issues raised. Timeframe for completion: 31/01/2026

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:

• A sleep chart has been implemented to replace the documenting of the resident's sleep cycle in the narrative notes. Timeframe for completion: Completed.

• A positive behavior support plan is being developed for one person to incorporate all care needs including the person's structured sleep hygiene support plan. Timeframe for completion: 31/12/2025

• All residents' health action plans are being reviewed to ensure all required healthcare is provided as per the residents' plans. This includes oral hygiene. Timeframe for completion: 30/11/2025

• A review of personal plans will form part of the systems analysis. Timeframe for completion: 31/01/2026

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	29/09/2025
Regulation 15(4)	The person in charge shall ensure that there is a planned and actual staff rota, showing staff on duty during the day and night and that it is properly maintained.	Substantially Compliant	Yellow	29/09/2025
Regulation 17(1)(a)	The registered provider shall ensure the premises of the designated centre are designed and laid out to meet	Not Compliant	Orange	30/06/2026

	the aims and objectives of the service and the number and needs of residents.			
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Substantially Compliant	Yellow	10/10/2025
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.	Not Compliant	Orange	31/01/2026
Regulation 29(4)(b)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine which is prescribed is administered as prescribed to the resident for whom	Not Compliant	Orange	31/01/2026

	it is prescribed and to no other resident.			
Regulation 29(4)(c)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that out of date or returned medicines are stored in a secure manner that is segregated from other medicinal products, and are disposed of and not further used as medicinal products in accordance with any relevant national legislation or guidance.	Not Compliant	Orange	31/01/2026
Regulation 31(1)(g)	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 of misconduct by the registered provider or by staff.	Not Compliant	Orange	21/10/2026
Regulation 34(2)(c)	The registered provider shall ensure that complainants are	Substantially Compliant	Yellow	31/01/2026

	assisted to understand the complaints procedure.			
Regulation 34(2)(e)	The registered provider shall ensure that any measures required for improvement in response to a complaint are put in place.	Not Compliant	Orange	31/01/2026
Regulation 34(2)(f)	The registered provider shall ensure that the nominated person maintains a record of all complaints including details of any investigation into a complaint, outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.	Not Compliant	Orange	31/01/2026
Regulation 05(6)(c)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall assess the effectiveness of the plan.	Substantially Compliant	Yellow	31/01/2026
Regulation 05(6)(d)	The person in charge shall ensure that the personal plan is the subject of a review, carried out	Substantially Compliant	Yellow	31/01/2026

	annually or more frequently if there is a change in needs or circumstances, which review shall take into account changes in circumstances and new developments.			