



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

Issued by the Chief Inspector

Name of designated centre:	Cork City North 3
Name of provider:	Horizons
Address of centre:	Cork
Type of inspection:	Unannounced
Date of inspection:	03 June 2026
Centre ID:	OSV-0003697
Fieldwork ID:	MON-0049335

About the designated centre

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

The designated centre was purpose built to provide a home to 20 adult residents with complex care needs, behaviours that challenge and mental health difficulties. The centre comprises of three purpose-built inter-linked units (bungalows) on a campus style setting on the outskirts of a city. These units have a shared paved area to the rear, garden and ground area to the front and was located adjacent to a dedicated day centre / day service for residents. The units each have a kitchen and dining area, a sitting room, single bedrooms accommodating each resident and bathroom facilities.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	17
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How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 3 June 2026	08:45hrs to 18:10hrs	Deirdre Duggan	Lead
Wednesday 3 June 2026	08:45hrs to 18:10hrs	Conan O'Hara	Support
Wednesday 3 June 2026	08:45hrs to 18:10hrs	Louise O'Sullivan	Support

What residents told us and what inspectors observed

This inspection was an unannounced risk-based inspection carried out to assess compliance with the regulations and to monitor the providers' progress in meeting a restrictive condition attached to the registration of the centre as part of the renewal of the registration of the centre in March 2024.

From what inspectors observed, the day-to-day care needs of residents in this centre continued to be met at the time of this inspection and inspectors saw that since the previous inspection a number of actions had been taken by the provider to bring about improvements in the centre. However, some residents lived experience continued to be impacted by ongoing incompatibility within resident cohorts, and some staffing issues in the centre. This meant that the provider had not yet fully ensured that a safe and effective service was being provided for all residents living in this centre.

The centre comprises three purpose built interconnected single-storey units located in a gated campus setting. A day service and administration building is located on the same grounds and residents have access to this building also. There were 17 residents living in the centre at time of this inspection. Each bungalow accommodated between four and seven residents. Inspectors had an opportunity to meet with 16 residents during this inspection. One resident was in bed on the morning of the inspection and went for an appointment in the afternoon and inspectors did not have an opportunity to meet with them. Residents each have their own bedrooms and each bungalow has kitchen, laundry and bathroom facilities.

Inspectors visited all three houses and met with residents and the staff supporting them, reviewed documentation and observed interactions and practices in each unit. Inspectors spent a number of hours in the individual units of the centre. Some documentation was reviewed in the residents' homes and some was reviewed in an office area in the day service building made available to inspectors. Inspectors also had an opportunity to meet with the management team in the centre. Residents were met together or in the company of staff and some residents were also met individually where possible. Some residents chose not to interact at length with inspectors and this wish was respected.

Some residents were up when inspectors arrived and others were observed to get up at a time of their own choosing during the morning. Generally residents' told the inspectors that they were happy living in the centre and liked their homes. In one house, positive interactions between residents and the staff team was observed as residents had breakfast and prepared for the day. Residents confirmed that the staff that supported them were good to them and some spoke about recent events in their lives including parties, family visits and shopping. One resident stated that staff were good to them. Some residents showed inspectors their bedrooms and things

that were important to them such as pictures, medals, art-work and music collections. Residents were all seen to be nicely dressed and some residents confirmed that they enjoyed shopping for their own shoes and clothes and had picked these out themselves. One resident spoken with highlighted that at times there was not enough staff at weekends.

Throughout the day some residents moved between their homes and the on-site day services. Some residents were observed to depart for planned activities, external day service and appointments. An inspector was told that one resident was gone to Fota Island for the day but afterwards staff told the inspector that this had been changed to facilitate other residents' appointments in the afternoon and the resident had went out locally instead. Residents returned to their respective houses for lunch. Midday hot meals were provided from the providers' central kitchen located external to this campus and other meals were prepared on site by staff or residents themselves if they chose. Residents told inspectors that they liked the meals provided and were observed to enjoy meals, drinks and snacks throughout the inspection and receive support in this area if required. Overall, residents presented as content during the inspection.

Since the previous inspection, one resident had moved out of the centre to their own community based home in line with their wishes. In addition, another resident had moved from one bungalow to a different bungalow in response to safeguarding concerns. It was clear that this was having a positive impact for residents overall. However, two residents that lived in the same house told inspectors that they did not always get along with one another and one resident became upset for a time when speaking about this. It was evident during the time spent in this house that staff were vigilant in relation to this matter but that this was having an ongoing impact on the everyday lived experiences of the residents living in the part of the centre. Also, a second unit was seen to be very busy and space was limited when all staff and residents were present and there was some ongoing safeguarding and incompatibility concerns reported from this unit also.

Inspectors saw that some areas of the centre were well maintained, bright and homely and resident bedrooms and communal areas were nicely personalised and decorated. However, some areas, in particular a number of bathrooms, kitchens and some areas of flooring in the centre were seen to be in a poor state of repair and in need of attention.

Overall, this inspection found that although improvements were ongoing, continued work was required to effectively address areas of non-compliance. This meant that residents were still not at all times being afforded fully safe and person centred services that met their assessed needs.

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

While it was evident that some further improvements had occurred in this centre since the previous inspection, inspectors found that the governance and management systems in place had not yet fully ensured that the services provided within the centre were safe, consistent, and appropriate to all residents' needs. Issues were identified in relation to staffing and staff training.

This centre was registered until March 2027 with a restrictive condition. This was applied to the registration of the centre in March 2024 due to ongoing non-compliance with the regulations. A risk-based inspection completed in December 2024 found evidence of some improvements and some progress with the providers' plan to bring the centre into compliance but ongoing non compliance across a number of areas remained.

At the time of this inspection there was a clear governance structure in place in the centre and some management changes had recently occurred. The provider had appointed a new person in charge in the two months prior to the inspection. This individual was supported in their role by a Clinical Nurse Manager 1 (CNM1) and both of these individuals were based on the campus grounds where the centre was located. The person in charge reported to a person participating in the management of the centre, a regional manager. The person in charge had remit over this designated centre only but also maintained temporary oversight of a community based service for one individual who had transitioned from the service. This was to support the transition of the resident and there were plans for the responsibility for this service to transfer to another individual once the initial transition period had concluded. The person in charge and regional manager made themselves available on the day of the inspection and other members of the providers senior management team also made themselves available for feedback at the end of the inspection. There was good indications that the incoming management team were making significant efforts to identify and address ongoing and previously identified issues in the centre but not all issues had been fully addressed at the time of this inspection.

Ongoing issues were identified in relation to staffing, and this was compounded by some specific factors including the transition plan for one resident who had moved out of the centre and safeguarding measures in place for some residents that necessitated additional staff for community based activities. Nursing care continued to be provided to residents and overall it was seen that efforts were made to provide residents with a consistent core staff team. However, there was an ongoing reliance on agency staff to supplement the staffing levels in the centre due to vacancies on the staff team and residents' individual needs. There was ongoing interaction between the provider and the funder in relation to the additional resources required in the centre and the provider had completed a staffing and skill mix review to support this.

The records reviewed indicated that while issues remained in relation to the training of staff, the person in charge had oversight of this and good efforts were being made to bring this regulation into compliance with recent improvements noted.

In summary, while the provider was making efforts to bring this centre into compliance with the regulations and recent changes had brought about some improvements for residents, further work was required to bring the centre into compliance with the regulations. 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.

Regulation 15: Staffing

The registered provider had not fully ensured that the number of staff was appropriate to the number and assessed needs of the residents. Staff rosters, interviews with staff, feedback from residents' families and other documentation reviewed demonstrated that the staff levels in place did not always fully provide for a high quality and effective service to residents.

- There were six vacancies reported on the staff team at the time of this inspection. These were being covered by relief and agency staff while recruitment efforts were ongoing.
- A skill mix review completed by the provider had identified a need to enhance the skill mix and staffing levels in the centre to meet the ongoing and changing needs of residents.
- The provider had self-assessed compromised staffing levels as being a high risk which had been escalated to the regional manager.
- Family feedback in the most recent six monthly audit noted some additional staffing would be helpful
- A resident had one-to-one staffing in place and this was being provided by agency staff. However, a risk assessment in place outlined that this resident required two-to-one supports to leave the centre and staff highlighted that safeguarding plans and positive behaviour support plans in place stressed the need for this resident to be occupied and take part in external activities. A case conference held in November 2025 also highlighted the need for 2:1 staffing for this resident until a planned transition took place. While efforts were made to allocate two staff to this resident when required, this had a knock-on impact on the staffing resources available to other residents.
- Inspectors found examples of residents' planned activities being cancelled due to reduced staffing or to facilitate the care and support needs of other residents, such as for medical or dental appointments.
- Regular staff in the centre were also being diverted to support the recent transition of a resident from the centre and this was reducing the number of familiar core staff available in the centre and impacting on the service provided to other residents.

The inspectors were informed that that one new staff member was due to start the week following the inspection.

Judgment: Not compliant

Regulation 16: Training and staff development

A training matrix was in place to oversee staff training and this was reviewed. The person in charge had not yet fully ensured that all staff had access to appropriate training, as part of a continuous professional development programme. This provided details relating to 46 staff working in the centre and this was cross referenced against staff training records kept in the centre. The matrix showed that a number of staff were overdue training and refresher training across some areas.

For example, the training matrix and staff records on file showed that:

- Six new staff had not yet completed fire safety training and a number of staff were due refresher training.
- 13 staff did not have positive behaviour support training completed. Seven staff did not have safety intervention training completed.
- Three staff had not completed manual handling training and a number of staff were overdue refresher training.

It is acknowledged there was a plan in place to address these issues and some progress was identified.

Judgment: Not compliant

Regulation 23: Governance and management

There was a clearly defined management structure in the designated centre. However, management systems in place had not yet fully ensured that service provided was safe and appropriate to all residents' needs.

At the time of the inspection, an establishing management team was in place and were taking action to identify and address issues. For example, it was evident that some recent action had been taken to address staff training issues identified in the centre. Notwithstanding this, fully effective action had not been taken in a timely manner since the previous inspection to address this ongoing issue. Similarly, there was evidence of some work taken by the provider to address premises issues and to improve the overall homeliness of the centre but this had not been fully completed and since the previous inspection the condition of some areas of the centre had deteriorated further.

This inspection found that the provider had enhanced their monitoring systems in place since the previous inspection and that issues in the centre were being identified and developed plans were in place. However, there was ongoing non compliance found under the regulations concerning staffing, general welfare and development and safeguarding. In addition, a number of the timelines outlined in the providers' plan referred to in the restrictive condition on the registration of the centre had passed and further work was required to ensure that this is effectively addressed.

The registered provider had not yet fully ensured that the designated centre was resourced to ensure the effective delivery of service in accordance with the statement of purpose. The provider had self-identified that staffing resources were an issue in the centre. Inspectors were told during the feedback meeting at the end of the inspection about current efforts the provider was making to work with the funder in relation to this but at the time of this inspection these additional resources were not in place.

Judgment: Not compliant

Quality and safety

Overall, residents presented as happy and content in their homes and told inspectors they were happy living in the centre. Residents were seen to be overall well cared for and most residents were enjoying a good life in the centre. Some positive change had taken place since the previous inspection and there were indications that the provider was committed to continuing to effect change in this centre. However, as discussed in the previous sections of this report, ongoing incompatibility in two houses and staff resources continued to impact on residents at the time of this inspection. Issues were identified in relation to general welfare and development, protection, positive behavioural support and premises.

The core staff team supporting residents were seen to be committed and knowledgeable about the individuals living in the centre. Throughout the inspection staff presented as committed to ensuring that residents were provided with good quality care and support. Plans were in place to guide staff about how best to support residents and improvements were noted in the oversight of these and also positive behaviour support plans.

While there had been a reduction in the number of safeguarding concerns being reported to the chief inspector in respect of this centre, peer-to-peer safeguarding incidents continued to occur regularly and some residents continued to impact on the lived experiences of the people that they shared their homes with. Inspection findings indicated that recent changes in the centre had brought about some very positive changes and overall this had improved the lives of the people living in the

centre but that some challenges remained in relation to staffing and compatibility concerns.

The previous inspection had identified that some residents were regularly offered and took part in opportunities to leave the centre for planned activities, personal development and leisure but that improvements were required to ensure that all residents were consistently and regularly provided with adequate opportunities to participate in activities in accordance with their interests, capacities and developmental needs. This inspection found that while there was an improved focus on offering residents activities, all residents were still not being afforded regular opportunities to leave the centre and take part in meaningful occupation in line with their own interests and capabilities. From speaking with staff and residents, it appeared that this was directly related to staffing levels in the centre, rather than staff culture or attitudes and it was seen that when staffing levels allowed, that efforts were made to offer options that residents might enjoy, such as shopping for specific preferred items, going for meals, or attending sporting events or local places of interest.

Overall, residents were accommodated in nice homes that were personalised and homely. However, while some areas of the centre were seen to have been upgraded and decorated to a good standard, some maintenance issues were found during the inspection including some sections of flooring, some bathrooms and kitchen units.

In summary, this centre offered a good standard of care to most of the residents living there. However, some residents continued to be impacted by the people that they lived with and staff resources available to them and continued and sustained improvement was required.

Regulation 13: General welfare and development

The registered provider had not ensured that all residents were consistently and regularly provided with adequate opportunities to participate in activities in accordance with their interests, capacities and developmental needs. Five residents' activity records and a sample of daily notes were reviewed alongside other resident information, including positive behaviour support plans in place for three residents.

These records did not demonstrate that all residents were regularly offered or took part in activities off-campus and this was also observed on the day of the inspection. While some access to the community and on-site activity was observed and reported, records reviewed showed that some residents were not offered regular meaningful occupation on a consistent basis. For example:

- One resident had two "spins" and three walks documented in the month of May.
- Another had only one external activity, a trip to mass, documented for a two week period in May.

- As part of the safeguarding and positive behaviour support measures in place in the centre staff told the inspector that it was important for a resident to leave the centre daily to provide them with meaningful occupation and reduce the impact of their responsive behaviours on themselves and other residents. While this resident was seen to be offered more activity than some other residents, this tended to consist of "spins" with no purpose identified and some meals out and it was not evident that this resident was enjoying meaningful occupation in line with their interests and capacities. This had been identified during the previous inspection also.
- Also, some residents had documented goals in place that did not have any evidence of progression.

Judgment: Not compliant

Regulation 17: Premises

Overall, the premises was laid out and suitable to meet the needs of the residents. The centre was accessible to the residents that lived there. Efforts were being made to ensure that the centre was homely and provided a nice living environment for residents and inspectors saw that overall residents bedrooms and communal areas were nicely decorated and furnished. A large amount of the flooring had been replaced or maintained within the previous couple of years but some areas had not yet been completed. The registered provider had not fully ensured that all areas of the premises of the designated centre was kept in a good state of repair and this meant that residents were exposed to the risk of falls and infection prevention and control risks. For example:

- Areas of some bathrooms had missing tiles, some toilets were extremely stained with a build up of limescale and a cover for pipework was noted to be missing also in a bathroom. One small toilet area was seen to be locked in one unit and when the inspector viewed this, this was seen to be in poor condition.
- Flooring in a number of areas of the centre was worn and marked. Some holes and gaps in flooring were noted. Flooring in a laundry room was observed to be cracked and lifting. Complaints records reviewed during the inspection showed that a resident had made a complaint about tripping over this flooring.
- Kitchen units had signs of wear and tear and damaged surfaces.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Plans were in place for residents and a review of a sample of these showed that there was ongoing efforts to keep these up-to-date and reflective of residents' current needs. There was evidence of oversight and review of these and they included support plans that reflected the health, social and emotional needs of residents. Annual multidisciplinary (MDT) meetings were documented and it was seen that actions arising from these were completed. For example, an MDT meeting completed in February 2026 had identified a referral to the positive behaviour support team was required in relation to progressing an interim plan in place. This had been completed.

Since the previous inspection one resident had transitioned out of the centre and there were advanced plans for another resident to transition to a community based home that would better suit their needs also. The provider was making efforts to ensure that these transitions occurred in a planned manner and that appropriate arrangements were in place for residents to support successful transitions. These transitions would also positively impact on other residents' lived experiences and provide greater capacity for this designated centre to fully meet the needs of the remaining residents. This demonstrated the provider were making ongoing and sustained efforts to meet the assessed needs of the residents living in this centre. Some findings in relation to specific residents are covered under Regulation 8 and Regulation 13.

Judgment: Compliant

Regulation 7: Positive behavioural support

Positive behaviour support plans were in place to provide guidance to staff about how best to support residents to manage their behaviour, including how to respond to and support residents with responsive behaviours that could impact themselves and others. Three of these were reviewed by an inspector. It was noted that a resident who presented with self-injurious behaviours had a positive behaviour support plan in place that provided good guidance to staff in relation to this. There was also evidence that a residents' positive behaviour support plan had been recently reviewed and updated by the positive behaviour support team. Residents had mental health support plans in place if required and had access to allied health professionals including a positive behaviour support team and a psychiatrist. Staff were seen to respond to and interact with residents in line with the plans in place.

However, plans and recommendations in place for residents were not always fully adhered to. For example, two residents were not partaking in structured regular planned activities that were in line with the recommendations outlined in their positive behaviour support plan and this meant that the potential for them to engage in responsive behaviours that impacted on themselves and others was increased. One resident did not have a visual schedule in place that was recommended in their plan. Notifications received from this centre and

documentation reviewed indicated that these residents were often involved in safeguarding related incidents in the centre.

A small number of staff had not received training in the area of positive behaviour support-this is covered under Regulation 16: Staff training and development.

Judgment: Substantially compliant

Regulation 8: Protection

The registered provider was not yet fully protecting all residents from all forms of abuse. Some changes in resident cohorts since the previous inspection had made a positive impact in reducing the impact of safeguarding concerns in the centre. One resident had moved out and another resident had moved within the centre to another house. However, some ongoing incompatibility of residents remained and safeguarding plans in place to prevent peer-to-peer abuse were not fully effective in protecting residents in two houses in particular. 12 safeguarding related notifications had been received in the three month period prior to this inspection and since a resident had transitioned out of the centre.

Another transition was planned that was likely to address the compatibility issues in one house and was anticipated to better meet the needs of that resident. However, at the time of this inspection this resident did continue to impact on their peers regularly despite controls in place that included 1:1 staffing. Also some other peer-to-peer issues remained that were not yet addressed.

Some of the planned measures that might reduce the impact that residents had on one another were not seen to be fully implemented. For example, as detailed under Regulation 7: Positive behavioural support, one resident did not have a weekly schedule in place as recommended in their positive behaviour support plan. Two residents told inspectors that they did not get along with each other and the impact that this had on them sometimes, including examples of safeguarding incidents. Inspectors were told that there were no plans to alter the living arrangements of these residents at the time of this inspection.

Safeguarding documentation was reviewed that showed that the provider was linking with the appropriate statutory bodies in relation to most safeguarding incidents reported. However, from a sample of records reviewed there were four occasions in January 2026 where the provider had not reported these incidents as required. This had been self-identified by the provider in the month prior to the inspection and it is acknowledged steps had been taken to enhance the triangulation of safeguarding documentation in the centre. Where incidents of a safeguarding nature were identified and reported, safeguarding plans were in place and staff had access to safeguarding training.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 13: General welfare and development	Not compliant
Regulation 17: Premises	Substantially compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Not compliant

Compliance Plan for Cork City North 3 OSV-0003697

Inspection ID: MON-0049335

Date of inspection: 3/Jun/2026

Introduction and instruction

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

This document is divided into two sections:

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

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

A finding of:

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: Since the inspection, a regular relief staff member has commenced employment. In addition, one permanent staff member has been recruited and is scheduled to commence employment on 10 August 2026. Four of the six vacant posts are currently being covered by regular relief staff who work both day and night duty, providing continuity and consistency of care for residents. Active recruitment remains ongoing to fill the remaining vacant post. The Person in Charge reviews staffing levels weekly against residents' assessed support needs, safeguarding requirements, healthcare appointments, positive behaviour support plans and planned community activities. Rosters are adjusted proactively to ensure staffing resources are allocated in a manner that supports residents to access meaningful activities, attend appointments and receive supports in accordance with their individual assessments and personal plans. Where agency staff are required, the designated centre utilises agency personnel familiar with the residents, their support needs and safeguarding arrangements. This measure is maintained as an interim control to ensure safe staffing levels are sustained while recruitment is ongoing The staffing and skill-mix review completed by the provider continues to inform workforce planning and resource allocation within the designated centre. Progress against recruitment, vacancy management, staffing levels and the impact on residents' quality of life is reviewed through the centre's governance structure and escalated to senior management as required. The Person in Charge reviews cancelled or postponed activities, staffing deficits and unmet support requirements as part of weekly governance review to ensure residents continue to receive supports in accordance with their assessed needs.	

Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: A review of all mandatory and role-specific training has been completed and a training action plan has been implemented to address outstanding training requirements. Since the inspection, 10 staff members have successfully completed fire safety training. All newly recruited staff are required to complete mandatory training as part of the induction process before commencing their duties within the designated Centre these details were missing for six new staff on the day of inspection- this has now been rectified by the PIC. The Person in Charge has implemented enhanced oversight of training compliance through monthly review of the training matrix, with any outstanding training requirements escalated and addressed promptly. This process will ensure staff have access to appropriate mandatory and refresher training as part of a continuous professional development programme and that training arrangements are responsive to the changing needs of residents and the service Positive Behaviour Support, manual handling and safety intervention training has been scheduled with staff allocated to upcoming training sessions. Training compliance is monitored by the person in charge through the Centre's training matrix.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: Governance and management arrangements within the designated Centre has been strengthened to provide greater oversight of quality, safety and regulatory compliance. The person in charge has enhanced the Centre's governance systems through regular governance meetings, scheduled audits, the implementation of safeguarding triangulation matrix, a training matrix and an action tracker to ensure that identified actions are progressed and monitored to completion.	

The safeguarding triangulation matrix has strengthened governance oversight by enabling cross- reference of safeguarding documentation, incidents and notifications. The PSF1s identified before the inspection were completed retrospectively and referred to the HSE safeguarding and protection team in accordance with organisational safeguarding procedures. Safeguarding measures remain in place and continue to be monitored through the Centre’s safeguarding governance processes. Since the inspection, governance oversight has also supported improvements across the designated Centre, including the completion of fire safety training for ten staff members, ongoing monitoring of mandatory training matrix, active recruitment to vacant posts with regular relief staff maintaining continuity of care, the appointment of a permanent staff member commencing in August 2026, the installation of hydro bath in House 2, and the implementation of a schedule for pending environmental improvement works. Progress against the actions associated with the restrictive registration condition is reviewed monthly by the Person in Charge and Regional Manager. Outstanding actions are tracked through the centre action tracker, with progress monitored to completion and escalated through the provider's governance structures where required.	
Regulation 13: General welfare and development	Not Compliant
Outline how you are going to come into compliance with Regulation 13: General welfare and development: Residents individual activity schedules have been reviewed to ensure they are person-centred and reflect each resident’s assessed needs, interests, preferences & personal goals. Structured weekly activity schedules are now in place to support purposeful, meaningful engagement, community participation and opportunities for social inclusion in accordance with residents' will and preference. Residents' personal goals are reviewed through the personal planning process and at multidisciplinary review meetings. Progress towards identified goals is documented, monitored and evaluated to ensure residents are supported to develop skills, maintain community links and achieve outcomes of importance to them. Increased staffing resources since the inspection has supported improved access to community-based activities, appointments and meaningful occupation.	

Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: A schedule of maintenance and refurbishment works has been developed to address the premises issues identified during the inspection, including flooring, bathrooms and kitchen units. Since the inspection, a new hydro bath has been installed to enhance residents' comfort and wellbeing. Outstanding works will be completed in accordance with the agreed maintenance programme and monitored through the providers arrangements and governance. Residents will be consulted and involved, where appropriate, in decisions relating to environmental improvements to ensure the Centre continues to provide a safe, homely and person-centred living environment.	
Regulation 7: Positive behavioural support	Substantially Compliant
Outline how you are going to come into compliance with Regulation 7: Positive behavioural support: Positive behavioural support plans have been reviewed to ensure that recommendations are implemented consistently in practice. Staff have been advised and reminded of the requirement to implement all recommendations contained within residents PBS plans, including structured activities and communication support where identified. A review of all residents PBS has been undertaken to ensure that all recommendations including the provision of visual schedules where required are identified, implemented and monitored. Staff who have not yet completed PBS training have been identified and will attend the next available training sessions in line with the organisation's mandatory training programme. Training compliance and implementation of behavioural support interventions will be monitored through the centre's governance and quality assurance processes to ensure residents are supported in a consistent manner and that every effort is made to identify, alleviate and respond appropriately to behaviours requiring support.	

Regulation 8: Protection	Not Compliant
Outline how you are going to come into compliance with Regulation 8: Protection: The provider has reviewed all safeguarding arrangements within the designated centre to ensure residents are protected from all forms of abuse and that safeguarding measures are responsive to residents' current assessed needs. Individual safeguarding plans have been reviewed and updated to ensure control measures are clearly defined, proportionate and implemented consistently in practice. Residents who are impacted by peer-to-peer safeguarding concerns are subject to enhanced compatibility reviews. Safeguarding incidents are reviewed weekly by the Person in Charge and CNM1 to evaluate the effectiveness of existing safeguarding controls and to ensure additional measures are implemented where required. A safeguarding triangulation matrix has strengthened governance oversight by enabling cross- reference of safeguarding documentation, incidents and notifications. This process supports timely identification, escalation and management of safeguarding concerns and provides assurance that safeguarding procedures are followed consistently.	

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 13(2)(b)	The registered provider shall provide the following for residents; opportunities to participate in activities in accordance with their interests, capacities and developmental needs.	Not Compliant	Orange	31/Dec/2026
Regulation 13(2)(c)	The registered provider shall provide the following for residents; supports to develop and maintain personal relationships and links with the wider community in accordance with their wishes.	Not Compliant	Orange	31/Dec/2026
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the	Not Compliant	Orange	30/Apr/2027

	number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.			
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/Dec/2026
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Not Compliant	Orange	31/Mar/2027
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.	Not Compliant	Orange	31/Oct/2026
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the	Not Compliant	Orange	31/Oct/2026

	designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.			
Regulation 7(5)(a)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation every effort is made to identify and alleviate the cause of the resident's challenging behaviour.	Substantially Compliant	Yellow	30/Sep/2026
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	30/Sep/2026