



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

## Issued by the Chief Inspector

|                            |                     |
|----------------------------|---------------------|
| Name of designated centre: | North County Cork 2 |
| Name of provider:          | Horizons            |
| Address of centre:         | Cork                |
| Type of inspection:        | Unannounced         |
| Date of inspection:        | 31 July 2025        |
| Centre ID:                 | OSV-0003707         |
| Fieldwork ID:              | MON-0047835         |

## About the designated centre

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

North County Cork 2 is comprised of three separate buildings, located within the environs of a large town. The largest building has a capacity for 16 residents, three of whom can live in a self-contained apartment unit that is part of this building. This building mainly provides a full-time residential service but there is one bedroom that is used for respite. The remainder of the designated centre is located in another residential area of the town is comprised of two semi-detached houses which have been joined internally to make one building and a two storey semi-detached house located next door. The larger house can provide residential support for up to eight residents from Monday to Friday and closes each weekend and during holiday periods. The other house can support two residents and is open seven days a week. All residents have their own individual bedrooms and other rooms in the three buildings include sitting rooms, living-dining rooms, kitchens and bathrooms. Overall, the centre had a maximum capacity of 26 residents and supports those who are over the age of 18 of both genders with intellectual disabilities. Staff support to residents is provided by the person in charge, clinical nurse managers, nursing staff, care assistant and house parent assistants.

**The following information outlines some additional data on this centre.**

|                                                |    |
|------------------------------------------------|----|
| Number of residents on the date of inspection: | 14 |
|------------------------------------------------|----|

## 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 31 July 2025 | 08:45hrs to 18:35hrs | Conor Dennehy  | Lead    |
| Thursday 31 July 2025 | 08:45hrs to 18:35hrs | Deirdre Duggan | Support |

## What residents told us and what inspectors observed

Some residents who availed of this centre were not present on the day of inspection. This included all of the residents who availed of one house that made up to the centre. Engagement with residents that were present on the day of inspection varied. A quiet atmosphere was encountered in the building where inspectors spent much of the inspection day.

This designated centre was made up of three separate buildings. One was a large building which was registered to provide full-time care for 15 residents and respite care for one resident. The second was a detached house open Monday to Friday that was registered to provide residential care for eight residents while the third was a semi-detached house that could support up to two residents. Inspectors commenced the inspection in the larger building of the centre and were informed that 12 full-time residents were present there along with one respite resident. A fourteenth resident who could avail of residential care in that building was not present on the day as they were with their family while there were two vacancies.

Some residents of the larger building generally attended day services operated by the same provider but inspectors were informed that day services were closed the week that this inspection occurred. As a result, all 13 residents in this building on the day of inspection were present during the course of the inspection. Inspectors were also informed that five residents were currently availing of the houses registered for eight but that all of these five residents were at home with their families on the day of inspection due to the day services being closed. For the remaining house, two residents were availing of that house with one of these residents present while the other was at staying with their family at the time of the inspection.

Therefore, 14 residents in total were present on the day of inspection. Given that the majority of these residents were in the larger building, inspectors spent most of their time in that building but did visit the other two houses near the end of the inspection. Across the inspection, 11 residents were met or seen by inspectors. Some of those residents that were met did not interact with the inspectors but other residents did speak with inspectors during the course of the inspection. A family member of one resident was also briefly met during the inspection but inspectors did not receive any feedback from them on the services provided in the centre.

When inspectors arrived at the larger building, most residents were still in bed or being supported with care. The atmosphere was quiet and calm at this time and as the morning progressed residents began to get up and have their breakfast. Staff members on duty at this time were overheard to be respectful in their interactions with residents. Examples of this included, residents being offered breakfast, staff knocking on residents' bedroom doors before entering and one resident being reminded to put in their hearing aids. Residents in this building spent much of the inspection in communal areas of the centre although some did leave the building at

times.

While some residents were in communal areas, inspectors did get some chances to speak with them. One such resident told an inspector they would be going to Dublin on the day of inspection to stay with a relative. When asked by the inspector if they liked living in the building, the resident responded by saying "kinda". When asked by the inspector what they liked about living in the building, the resident indicated that they liked the food and nothing else. When asked what they did not like about living in the centre, the resident responded by saying that there was nothing they did not like about living in the centre. This resident was also asked if they felt safe living in the centre. The resident answered this by stating that someone had to stay with them and that this was always done in the centre.

Another resident told an inspector that they were off day services but would be going back the following week. However, the resident indicating that they were not looking forward to going back to day services as there was "annoying people" that were there. The resident did say though that they liked living in their current home. They also mentioned that they had previously lived in an apartment area of the larger building but had changed the location of their bedroom which they were happy with. When asked what they would be doing later in the day, the resident indicated that they would be just taking it easy for the rest of the day.

The same resident later told the same inspector that they had had a nice lunch during the day while a different resident also informed an inspector that they were good. Some residents were seen to spend time together in the larger building and the atmosphere was sociable. This included one resident telling an inspector about another resident's upcoming birthday and a resident complimenting the shirt that a peer was wearing. After receiving this compliment, the complimented resident was seen to smile. Overall, while inspectors were in the larger building, things were quiet in the centre although records reviewed from this building indicated that there had been some incidents of shouting or talking aggressively that had occurred. This will be returned to later in this report. After leaving the larger building, inspectors went to the other two houses of the centre.

As mentioned earlier, only one resident was present on the day of the inspection between these two houses. Both inspectors met this resident as they brought some waste out of their house to a bin. The resident did attempt to hug and kiss one of the inspectors at different points while this inspector was in their home. However, with encouragement from the inspector and a staff member present the resident instead greeted the inspector with handshakes or high fives. With further encouragement from the staff member, the resident showed the inspector the garden area of their house which was seen to be nicely presented. While the inspector spoke with this staff member, the resident watched some television. As the inspector was leaving their home, the resident was sat with two members of staff. The resident appeared very comfortable with these staff with both engaging pleasantly with the resident.

In summary, 11 residents were met during this inspection. While some residents engaged verbally with inspectors, others did not. Staff members on duty were seen

to interact with residents in a pleasant and respectful manner during the inspection. Records indicated that instances had occurred of shouting or talking aggressively in the larger building but things there were quiet on the day of inspection.

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

## Capacity and capability

Overall, improvement continued to be made from the January 2024 inspection of this centre. Improvement was required though related to the notifications from this centre.

This centre had been previously inspected on behalf of the Chief Inspector of Social Services in January 2024 where progress was noted from a previous inspection in February 2023 albeit with a number of regulatory actions remaining. The provider's compliance plan response for that inspection, which outlined the measures that the provider would take to come back into compliance, was accepted. As a result, a decision was made to renew the registration of the centre until June 2027 without any restrictive conditions. Following that the decision, some assurances were requested from the provider during April 2024 related to some safeguarding notifications received. Aside from that, there been no other significant regulatory engagement for this centre since the January 2024 inspection.

As such, given the length of time since the January 2024 inspection, the current inspection was conducted which was initially intended to focus specifically on safeguarding in line with a programme of inspections commenced by the Chief Inspector in 2024. While this remained the primary focus on the inspection, the inspection was slightly altered to allow for Regulation 31 Notification of incidents to be included in the report. This was done as inspectors were not assured that this regulation had been complied with. Aside from this, the inspection overall indicated that the progress noted during the January 2024 inspection was continuing.

## Regulation 15: Staffing

Discussions with staff in the larger building of the centre, raised no concerns around the provision of staffing for the centre. Such staff also indicated that three staff were always on duty in this building at night. It was noted that since the January 2024 inspection, the number of residents living in or availing of the centre had decreased while the stated whole-time equivalent (WTE) staffing had increased. This was based from a statement of purpose dated June 2025 which indicated that the

total WTE for the centre was 26.7. The previous statement of purpose on file for the centre from March 2024 indicated a total staffing WTE of 22.9.

While this increase was positive, both the March 2024 and June 2025 statements of purpose indicated that there was to be a clinical nurse manager 1 (CNM1) for the centre as part of the staffing compliment. However, no CNM1 was in place for the centre at the time of this inspection. A member of management of the centre did highlight recruitment challenges in filling this CNM1 role.

Beyond the CNM1 role, it was also highlighted there had been some recent changes in staffing for the centre and that the risks associated with staffing for the centre were being increased. There was no indication though that such changes had impacted the centre at the time of this inspection. Following the January 2024 inspection, the provider had indicated that they would submit a business case to reflect a request for a catering staff within the larger building. On the current inspection, it was indicated that such a business case had not been funded but that the centre hoped to employ a multitask attendant pending advertisement and recruitment.

Judgment: Substantially compliant

### Regulation 16: Training and staff development

This regulation requires that staff are appropriately supervised. During this inspection it was indicated that no formal supervision of staff took place. However, it was highlighted that the presence of a CNM2 for two houses of the centre and the presence of the person in charge in the larger building of the centre, allowed for informal supervision of staff. Aside from supervision, a training matrix provided indicated that the majority of staff had completed training in areas such as fire safety, safeguarding and manual handling. It was noted though that six staff were not indicated as having completed training in positive behaviour support. This is addressed under Regulation 7 Positive behavioural support.

Judgment: Compliant

### Regulation 23: Governance and management

The January 2024 inspection highlighted that the monitoring systems in operation for this centre needed improvement. On the current inspection, the following monitoring and support systems were found to be in place:

- Scheduled audits were conducted on a monthly basis. An inspector reviewed recent monthly audits and found that audits in areas such as cleaning,

- personal plans, mealtimes and fire safety had been completed as scheduled.
- Since the January 2024 inspection, three provider unannounced visits had been completed in June 2024, December 2024 and June 2025. All of these visits were reflected in written reports.
- An annual review for the centre had been completed in July 2025. This assessed the centre against relevant national standards. This was a notable improvement as both the February 2023 and January 2024 inspections had found that such an annual review had not been completed.
- Staff team meetings were occurring on a quarterly basis. Notes of two such meetings from February 2025 and June 2025 were reviewed which referenced matters such as safeguarding, audits and safeguarding being discussed although notes were written very broadly. Two further staff meetings for scheduled for September 2025 and December 2025.
- An inspector was informed that most staff had completed performance appraisals. At the time of inspection, it was indicated that there were reviews outstanding for three staff members but that this was contributed to by different forms of leave.

Given that the systems outlined above were in place, it was noted that, overall, improvement noted during the January 2024 inspection had continued. However, some of the findings on this inspection, particularly under Regulation 8 Protection, indicated that the monitoring systems in operation were not ensuring that relevant matters were being appropriately recorded and being managed through the correct processes.

Aside from this, during previous inspections, the potential for this centre to be split into two or for the overall capacity of the centre to be reduced had been raised. During the current inspection, it was indicated that neither of these were under active consideration. It had also been previously indicated that business cases had been submitted relating to a third night-time staff for the larger building and to keep the house that was open from Monday to Friday open on a full-time basis. On the current inspection, it was indicated that there been no updates regarding both business cases. However, it was acknowledged that the provider had continued to ensure that, irrespective of the status of the business case, a third staff was provided for the larger building as referenced under Regulation 15 Staffing.

Judgment: Substantially compliant

### Regulation 31: Notification of incidents

Under this regulation, the Chief Inspector must be notified of any allegation or incident of a safeguarding nature within three working days. During this inspection, when reviewing certain records for one resident, a query was raised as whether a safeguarding incident had occurred on 15 June 2025. Following the inspection, it was confirmed that a safeguarding incident had occurred on this date. This incident had not been notified to the Chief Inspector by the time the current inspection had

occurred. It was further noted that other records reviewed referenced a resident making allegations. Such allegations had not been notified either at the time of the inspection but these were deemed by the provider not to be safeguarding in nature. This is discussed further under Regulation 8 Protection.

The Chief Inspector must also be notified of certain injuries on a quarterly basis. A notification of such injuries had been submitted for the second quarter of 2025 on 8 July 2025. This notification detailed three injuries. However, on reviewing incident records in the larger building on the day of the inspection, it was noted that the notification submitted on 8 July 2025 did not include all relevant injuries that had happened during the second quarter of 2025. As the time frame for notifying such injuries was 31 July 2025, such matters were highlighted to management of the centre during the inspection day. Two further notifications for the second quarter of 2025 were subsequently submitted on the same day.

Judgment: Not compliant

## Quality and safety

Safeguarding plans were found to be in place although safeguarding processes were not initially followed for a relevant incident. A resident's personal plan needed some improvement but overall, the personal plans reviewed during this inspection raised no high concerns.

Residents had personal plans in place which were generally seen to be of a good standard although some of the content of one resident's personal plan did need some improvement. Aside from personal plans, safeguarding plans were in place although not all staff had signed to indicated that they were aware of these plans. Such plans were put in place around notified safeguarding incidents that had occurred leading up to this inspection. However, it was identified that a relevant incident had not been initially managed through safeguarding processes. Queries were also raised with management of the centre concerning documented allegations that one resident was recorded as making.

## Regulation 10: Communication

The registered provider was ensuring that residents were assisted and supported to communicate in accordance with their needs and wishes. Staff were observed to be very familiar with, and respectful of, residents' communication methods and styles. Inspectors reviewed the communication guidance in residents' personal plans and saw that relevant guidance was available to staff in relation to supporting residents to communicate. Communication preferences were documented in a sample of resident files reviewed. It was noted though that one resident's personal plan

contained some different information about how the resident communicated. This is addressed under Regulation 5 Individualised assessment and personal plan. It was acknowledged though that a recent referral had been made to a speech and language therapist to further explore the supports that could be offered to this resident around their communication.

Wi-Fi Internet access had been provided there since the previous inspection of this centre. However, it was highlighted that similar Wi-Fi Internet access was not present in one of the other two houses. It was indicated to inspectors though that fixed line Internet was present in that house and that a house mobile could be used to facilitate Wi-Fi Internet if required.

Judgment: Compliant

### Regulation 17: Premises

When visiting all three of the buildings that made up this centre, it was observed that all three were generally presented in a clean, well-maintained and well-furnished manner on the day of inspection. Inspectors were informed that new furnishing, floors and curtain had been added to the larger building with new furniture also due for one of that building's communal rooms. One bathroom in the same building was also due to be refurbished while All three houses that made up the centre, were seen to have various resident photographs and information posters on display.

Judgment: Compliant

### Regulation 5: Individual assessment and personal plan

Inspectors saw that individualised personal plans were in place for residents based on a sample of five residents' personal plans reviewed. This was in keeping with the requirements of this regulation. As part of the personal planning process, residents had participated in annual person-centred planning meetings with such meetings involving input from residents' families. As part of this process, residents had been supported to identify goals. Examples of completed goals that residents had achieved included residents taking short breaks away, attending concerts and trying out new activities. However, while there was evidence of progression, completion and ongoing review of goals in some residents' personal plans, two personal plans reviewed did not consistently reflect this. In addition, for one resident it was noted that short-term and long-term goals had been identified for the resident to achieve but the stated time frames for both sets of goals was the same.

The documentation reviewed within residents' personal plans indicated that annual

multidisciplinary reviews and health assessments were completed although one resident's health assessment did not complete a section around vaccines. A number of support plans arising from the health assessments completed were reviewed. These contained relevant guidance for staff about the assessed needs of residents. These were being updated as required to reflect any change in circumstances. Some improvement though was noted regarding the guidance in place for one resident. This included the following:

- The resident's personal plan contained some different information in different documents about how the resident communicated.
- The same resident's personal plan contained limited guidance on how to support the resident to engage in positive behaviour despite incidents that had occurred in the centre.

Aside from matters related to residents' personal plans, this regulations also requires that appropriate arrangements are in place to meet the assessed needs of residents. Overall, inspectors were satisfied that appropriate arrangements were in place at the time of inspection. However, there were indications that some residents' needs were increasing, particularly related to residents developing dementia. Staff spoken with were familiar with residents' changing needs but the arrangements in place to meet such needs would need close monitoring in the future.

Judgment: Substantially compliant

### Regulation 7: Positive behavioural support

When reviewing residents' personal plans, the inspectors reviewed the guidance in place for three residents to encourage them to engage in positive behaviour. Support plans in place reflected strategies to support residents to manage issues such as anxiety and self-injurious behaviour while some of the guidance in place was also observed to have been recently reviewed. It was noted though that one resident's personal plan contained limited guidance on how to support the resident to engage in positive behaviour support. This is addressed under Regulation 5 Individualised assessment and personal plan but it was acknowledged that an internal referral had been made within the provider's positive behaviour team seeking such guidance.

Regular staff working in the larger building on the day of this inspection knew the residents living in that building well and presented as familiar with how best to support residents to engage in positive behaviour. As part of this, staff told inspectors about various strategies that were used to support residents in this area. In addition, one staff member, who was covering unanticipated leave, and was not familiar with residents, was seen to be provided with and reading the relevant guidance. Most staff working in the centre had completed relevant training in positive behaviour support. However, as referenced under Regulation 16 Training

and staff development, six staff members had yet to complete this training.

Aside from positive behaviour, there were some restrictions in place in the centre. These were in place to safeguard residents from specific risks. Rights restriction logs were viewed and these were seen to be reviewed regularly while it was indicated that these were considered during multidisciplinary reviews. The provider had a policy in place for restrictive practices and this was seen to be in date.

Judgment: Substantially compliant

## Regulation 8: Protection

At the time of the current inspection occurring, the Chief Inspector had been notified of 18 safeguarding incidents occurring in the centre with most of these relating to the larger building. An inspector reviewed documentation relating to the nine most recent safeguarding incidents notified on the day of inspection. This documentation indicated that all of these nine incidents had been appropriately screened, referred to a relevant statutory body and had a safeguarding plan put in place. Such plans outlined measures to prevent such incidents reoccurring. Staff members spoken with mostly demonstrated some good knowledge around the safeguarding plans that were in place but some areas were noted where management of these plans and staff awareness of same could be improved. For example:

- The safeguarding plans seen had a sheet for staff to sign to indicate that they were aware of these plans. Although inspectors were informed that such sheets were a relatively recent addition, there was variance in the number of staff who had signed the plans. For example, one safeguarding plan had been signed by 14 staff while another had been signed by five staff members.
- One staff member spoken with during the inspection, did not demonstrate an awareness of all relevant safeguarding plans.
- The safeguarding plans outlined actions to be completed but it was noted that it was not documented in the safeguarding plans if these actions were completed or not. It was acknowledged that other records reviewed and discussions during the inspection, did indicate that such actions had been completed.

From the safeguarding documents that were reviewed, there was two noticeable trends of incidents whereby the presentation of two residents had impacted their peers. Such instances had involved residents shouting, talking aggressively or physically interacting with their peers. For one of these residents, it was acknowledged that they were infrequently in the centre. It was also noted though that relevant guidance related to their presentation was not in place at the time of this inspection. This is addressed under Regulation 5 Individual assessment and personal plan. For the other resident, it was highlighted how their mental health

needs was contributing to incidents that were occurring.

This resident had impacted other residents in the centre. Some of these were reflected in safeguarding incidents while others were reflected in complaints made. Early into this inspection, inspectors were informed that this resident had been complained about by a peer the previous day with this complaint being processed as a safeguarding concern given its nature. In addition though, when reviewing monitoring records for this resident, two entries were seen which suggested that the resident had impacted others but without these being processed as safeguarding concerns. This was highlighted to management of the centre and following the inspection, it was indicated that one of these had not impacted any other resident but the other one had been of a safeguarding nature. As a result, safeguarding processes were enacted for this retrospectively.

Aside from this, when reviewing records for another resident, two recent entries were seen which indicated that the resident had made allegations of a safeguarding nature. Neither of these were managed through safeguarding processes based on documentation presented on the day of inspection. These were again highlighted to management of the centre who suggested that such allegations were not founded. Management also indicated that, given the needs of the resident involved, the allegations made by the resident were to be recorded on a "concerning statements log" with this log to be reviewed periodically by the provider's designated officer (person who reviews safeguarding concerns). No such log was provided during the inspection day. Following the inspection, guidance on the use of such logs was provided while it was indicated that such a log had been introduced for the resident in question. The post inspection communication received also indicated that the designated officer had been contacted about the allegations made when they had occurred.

Judgment: Not compliant

## Regulation 9: Residents' rights

The evidence found on this inspection indicated that residents' rights were respected in this centre. Residents were seen to be supported to exercise choice and control in their daily lives and to participate in decisions about their own care and support. For example, staff were seen and heard to consult with residents about activities and mealtimes. Residents were observed to come to the kitchen for meals and refreshments at a time of their own choosing during the day and residents were afforded the opportunity to remain in bed and take a lie-in if they wished.

Residents were afforded privacy in their own personal spaces and staff were observed to interact with residents in a dignified and supportive manner. The layout of the larger building also provided each resident living there with ample living space. This included being provided with their own bedroom. Staff spoken to during the inspection presented a positive overview of residents and their lived

experiences, and had a strong awareness of residents' preferences and communication styles.

Based on documentation reviewed, capacity assessments had been completed that covered areas such as finances and medicines while residents took part in weekly resident forums and monthly advocacy meetings. Such meetings were documented and a review of meeting notes indicated that residents were being consulted with and informed about various issues. An easy-to-read advocacy policy was seen during this inspection and efforts had been made to make advocacy information relatable to residents. For example, an inspector saw documents titled "Inspirational Advocacy Stories" that were based on residents' own experiences.

Judgment: Compliant

## Appendix 1 - Full list of regulations considered under each dimension

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

| Regulation Title                                      | Judgment                |
|-------------------------------------------------------|-------------------------|
| <b>Capacity and capability</b>                        |                         |
| Regulation 15: Staffing                               | Substantially compliant |
| Regulation 16: Training and staff development         | Compliant               |
| Regulation 23: Governance and management              | Substantially compliant |
| Regulation 31: Notification of incidents              | Not compliant           |
| <b>Quality and safety</b>                             |                         |
| Regulation 10: Communication                          | Compliant               |
| Regulation 17: Premises                               | Compliant               |
| Regulation 5: Individual assessment and personal plan | Substantially compliant |
| Regulation 7: Positive behavioural support            | Substantially compliant |
| Regulation 8: Protection                              | Not compliant           |
| Regulation 9: Residents' rights                       | Compliant               |

# Compliance Plan for North County Cork 2 OSV-0003707

Inspection ID: MON-0047835

Date of inspection: 31/07/2025

## 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                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Substantially Compliant |
| <p>Outline how you are going to come into compliance with Regulation 15: Staffing:<br/>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. A recent recruitment day has taken place to support maintaining WTE numbers as per SOP</p> <ul style="list-style-type: none"><li>• A CNM1 position remains vacant and is currently undergoing the recruitment process. To be completed by 31.01.2026</li><li>• A multitask attendant position will be advertised.</li></ul>                                                                                                                                                                                                                                |                         |
| Regulation 23: Governance and management                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Substantially Compliant |
| <p>Outline how you are going to come into compliance with Regulation 23: Governance and management:</p> <ul style="list-style-type: none"><li>• Performance appraisals for three staff will be completed by 30/09/2025</li><li>• Processes and follow up for Concerning statements Log are now in place and has been discussed with all staff to ensure that all relevant matters are being appropriately recorded and managed through the correct processes. Completed on 01/08/2025.</li><li>• Protocol in place for concerning statements.</li><li>• Quarterly meetings are held with DO and PIC to discuss all safeguarding incidents including concerning statements.</li><li>• All concerning statements and safeguarding's incidents are reported to PIC and DO to ensure that monitoring systems are effective in identifying and addressing matters in a timely manner.</li></ul> |                         |

- As outlined in the inspection report findings the issues relating to Governance and Management relate to the findings under Regulation 8 and as such the registered provider's response is included under that. As per the inspector's findings on the day there has been significant improvement since the previous inspections of the centre. The registered provider will continue to ensure effective governance and management systems are in place.

|                                          |               |
|------------------------------------------|---------------|
| Regulation 31: Notification of incidents | Not Compliant |
|------------------------------------------|---------------|

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

- Incident on the 15th of June was discussed with the designated officer and a retrospective PSF1 was submitted to safeguarding and a NF06 was submitted to HIQA. Completed on 05/08/2025
- Allegations that had been made by another resident had been discussed with the DO at the time of the incident however, these had not been documented in a concerning statement log. This has now been completed for both of those incidents and all staff informed of the process. Completed on 01/08/2025
- Processes and follow up for Concerning statements Log are now in place and has been discussed with all staff to ensure that all relevant matters are being appropriately documented and managed through the correct processes. Completed on 01/08/2025
- The PIC will ensure that a robust system is in place for submitting quarterly returns. To be completed 31.10.2025

|                                                       |                         |
|-------------------------------------------------------|-------------------------|
| 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:

- One resident's personal plan has been reviewed to reflect the correct information relating to the resident's communication profile. Completed on 21/08/2025
- Old documentation with conflicting communication has been filed. Completed on 21/08/2025
- An interim Positive behavior support guidance document has been created in the larger residence for two people we support, until the positive behaviour team become involved. Completed on 21/08/2025
- PCP goals have been discussed with keyworkers to ensure that timeframe for completion are set out with realistic plans and ensuring timeframes for both sets of goals

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|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|
| <ul style="list-style-type: none"> <li>• One resident's OK health check section on vaccine will be updated to reflect vaccination history. Requested information from GP service. To be completed by 30.09.2025</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                         |
| Regulation 7: Positive behavioural support                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Substantially Compliant |
| <p>Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:</p> <ul style="list-style-type: none"> <li>- 3 staff are booked to complete Positive Behaviour Support (PBS) training on the 30/09/2025</li> <li>- 3 staff are booked to complete PBS training in October 2025</li> </ul> <p>All staff will have received training no later than 28/11/2025</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                         |
| Regulation 8: Protection                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Not Compliant           |
| <p>Outline how you are going to come into compliance with Regulation 8: Protection:</p> <ul style="list-style-type: none"> <li>- The sign in sheets had been introduced in the centre shortly before the inspection and therefore not all staff had signed the sheets when the inspector reviewed. It was clarified to the inspector that this was an ongoing piece of work.</li> <li>- It is recognised that a staff member was nervous when speaking with the inspector and did not demonstrate their knowledge. Following the inspection feedback the person in charge spoke with the staff member and is assured they have all the required knowledge in relation to the safeguarding plans.</li> <li>- As noted by the inspector the system for follow-through on required actions for the safeguarding plans are tracked elsewhere.</li> <li>- As noted by the inspector there are residents who require support with mental health needs and are being appropriately supported by the organisation. While this has an impact on a peer at infrequent intervals the peer the house set up has been reconfigured to ensure both people have sufficient private space. Additionally, the peer has demonstrated their desire to continue engaging with this person.</li> <li>- A review is being carried out to ensure all safeguarding allegations, particularly where they are received via other mechanisms, for example as a complaint, are identified as such and the appropriate processes are followed. Retrospective submissions have been</li> </ul> |                         |

made to the relevant bodies as required.

- The concerning statements process is being overseen by the Principal Social Worker (PSW) who holds the role of Designated Officer (DO) for the organisation. The issues raised had been discussed with the PSW who provided advice and support and is the relevant professional with expertise in regard to safeguarding. The PSW or their designate will continue to work with the person in charge and staff team to ensure the use of the concerning statements log for residents are consistent with the organisation's processes. The person in charge will work with the DO to ensure the process is implemented and is effective to support the resident. Other members of the multi-disciplinary team will also provide support as required.

## 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. | Substantially Compliant | Yellow      | 31/01/2026               |
| Regulation 23(1)(c) | The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.                   | Substantially Compliant | Yellow      | 30/09/2025               |
| Regulation 31(1)(f) | The person in charge shall give the chief inspector                                                                                                                                                                                      | Not Compliant           | Orange      | 31/10/2025               |

|                     |                                                                                                                                                                                                                                       |                         |        |            |
|---------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|--------|------------|
|                     | notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: any allegation, suspected or confirmed, of abuse of any resident.                                                      |                         |        |            |
| 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 | 30/09/2025 |
| Regulation 07(2)    | The person in charge shall ensure that staff receive training in the management of behaviour that is challenging including de-escalation and intervention techniques.                                                                 | Substantially Compliant | Yellow | 21/08/2025 |
| Regulation 08(2)    | The registered provider shall protect residents from all forms of abuse.                                                                                                                                                              | Not Compliant           | Orange | 30/09/2025 |