Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	No.1 Cordyline
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Cork
Type of inspection:	Unannounced
Date of inspection:	26 August 2025
Centre ID:	OSV-0004575
Fieldwork ID:	MON-0047669

About the designated centre

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

No.1 Cordyline is based on a campus setting located in a rural area but within close driving distance to some towns. The centre can provide full-time or part-time residential support for a maximum of five residents, of both genders over the age of 25, with intellectual disabilities and autism including those who may have multiple and complex support needs and require support with behaviours that challenge. The designated centre is a two-storey, semi-detached building that is part of a larger building. There are five individual bedrooms available for residents to use with a separate apartment area for one resident on the centre's ground floor. Other rooms in the centre include a kitchen, living rooms, bathrooms, a laundry and a staff office. Residents are to be supported by the person in charge, a team leader, staff nurses, social care workers and care assistants

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	4

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Tuesday 26 August 2025	19:45hrs to 22:35hrs	Conor Dennehy	Lead
Wednesday 27 August 2025	09:50hrs to 16:40hrs	Conor Dennehy	Lead

What residents told us and what inspectors observed

Four residents were present in this centre across the two days of inspection. All four of these residents were met by the inspector but verbal interaction with them was limited. However, the inspector did get an opportunity to observe residents in their environments particularly during the first day of inspection.

This inspection was conducted over the course of two days with the first day of inspection specifically conducted at a varied time to assess the effectiveness of communication between day and night staff and management for the centre. This designated centre was registered for five residents but when the inspector arrived at the centre to commence the first day of inspection, he was informed that three residents were present in the centre. Shortly after he entered the centre, the inspector was approached by one of these residents who greeted the inspector with a handshake.

Staff present in the centre at this time were doing a handover between the day and night shift so the inspector did a brief walk around of the centre while this was ongoing. During this time it was seen that one resident was in their bedroom listening to music, one resident was sat with staff in a dining-living room while the third resident was sat in a separate living room. It was noted that all three residents were in their pyjamas at this time. When later queried, the inspector was informed that two residents could look to change into their pyjamas early and that wearing pyjamas might better suit the needs of one resident whose needs were highlighted as changing.

After completing the initial walk around, the inspector was greeted by the resident who had shook the inspector's hand earlier. This resident indicated what county they were from. When the inspector asked the resident where in this county they were from, he could not make out the resident's response. During this interaction, it was seen that a day staff member was waiting to say goodbye to this resident before they went off shift which they then did. After this day staff member left the centre, there was only dedicated night staff present in the centre with the three residents although a night coordinator/supervisor and a staff member from another centre on the campus where No.1 Cordyline was located were observed to attend the centre.

Later on during the first day of inspection, two residents were seen the centre's dining-living room with the night staff member. One of these residents was having a meal while the other resident was not. The second resident looked at the staff member who told this resident that they would have wait until the first resident finished their meal. However, when this second resident got up and went into the kitchen, the staff member then got the resident their meal and brought this into the dining-living room for the resident to have. It was observed by the inspector at this time that both of these residents were wearing large bibs as they had their meals. When later queried the inspector was informed that these bibs were to protect the

dignity of the residents and that they were taken off right after residents had finished their meals.

The atmosphere at this time was relatively quiet but the inspector did occasionally hear the third resident present vocalising from the separate living room. While this resident was in this living room on the first day of inspection it was noted that the door to this room remained closed. However, the door had a viewing panel and it was seen that the resident remained seated on an armchair with a tray in front of them. The inspector was informed that this resident could move this tray themselves if they wanted to. At one point during the first day of inspection, the inspector entered this living room and greeted the resident. The resident looked at the inspector but did not initially respond verbally. When the inspector asked the resident if he could sit with the resident in the living room, they responded "nah" so the inspector left the room.

Aside from the inspector, one of this resident's peers also briefly opened the door to the living room to look in at one point while staff were seen to enter to check on the resident at times. The night staff member on duty was also observed to make tea for two of the residents and encourage one of these residents to dispose of their tea bag themselves which they did. This staff member also did some cleaning and asked the same resident to help do some brushing. Again the resident proceeded to do this. The staff member from another designated centre who attended No.1 Cordyline was also observed to engage pleasantly with residents present. By the end of the first day of inspections, two of the three residents present had gone to bed while the remaining resident was sat with the night staff member in the dining-living room watching television. This resident seemed relaxed at the time and comfortable with the night staff member.

The following morning the inspector returned to the centre for the second day of inspection. When he arrived there he was informed that one of the three residents had already left the centre to go to day services, a second resident was being helped with breakfast and that the third resident was still in bed. After holding a meeting with the person in charge for the centre, one of these residents came into the staff office of the centre and shook the inspector's hand before being later seen to be supported to leave the centre by a staff member. The inspector was informed that this resident was also going to day services which were located on the campus. By 12pm on the second day of inspection, no resident was present in the centre.

Much of the remainder of the second day of inspection was spent by the inspector reviewing documentation but it was noted that two residents were seen back in the centre for a period to have their lunch. Staff sporting the residents at this time were overheard to engage pleasantly with the residents at this time. Near the end of the first day of inspection, the three residents who had been present on the first day of inspection had all returned to this centre while a fourth resident, who only stayed in the centre two nights a week, also arrived. This fourth resident was heard to be warmly greeted by staff when they arrived. The inspector briefly met this resident in the kitchen area of the centre as they waited for a pizza to be cooked.

This resident did respond when greeted by the inspector but the inspector did find it

difficult to make out what the resident was saying when he queried how the resident's day had been. Staff members on duty appeared to have no issues and were overheard to interact verbally with the resident. As the inspector left the centre again at the end of the second day of inspection, the atmosphere in the centre was quiet and it was seen that three residents were present in the diving-living room with staff members. The inspector said goodbye to all residents with one of the residents responding to the inspector.

In summary, staff member interacted pleasantly with residents during this inspection. The inspector had limited verbal interaction with residents during this inspection but the atmosphere encountered in the course of this inspection was generally quiet. One resident was seen to be encouraged to do some small household tasks which they did.

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

Improvement was found during this inspection in some previous areas of concern. Some regulatory actions did remain though. This included the centre continuing not have a team leader appointed.

During the previous inspection of this centre in July 2024, areas of non-compliance with the regulations were found in areas such as fire safety, the premises provided and staff supervision. It was also identified during that inspection that some actions previously committed to by the provider had not been completed in the time frames previously given by the provider following a June 2023 inspection. While the provider's compliance plan response for the July 2024 inspection was accepted, a compliance plan update received in December 2024 did not assure that all stated actions had been completed. As a result the provider was issued with a provider assurance report (PAR) seeking more assurances in this regard. The provider submitted a satisfactory response to this PAR in January 2025 after which the Chief Inspector of Social Services renewed the registration of the centre until April 2028.

Since then, in June 2025, some notifications received raised some concerns related to safeguarding and the effectiveness of communication between day and night staff and management for the centre. Due to the particular content of one of these notifications, a second PAR was issued to the provider that month with the provider's response to this also accepted. However, given that two PARs had been issued since the July 2024 inspection, a decision was made to conduct the current inspection to follow up on the PAR responses and areas of non-compliance from the July 2024 inspection. Overall, the current inspection found improvement related to the previously identified areas of non-compliance. Despite this, some regulatory

actions remained including the centre not having a team leader in place even though the January 2025 PAR response had suggested that one would be in place.

It was acknowledged though that since the January 2025 PAR, there had been a change in circumstances for the centre which had resulted in the number of residents availing of the centre reducing. The inspector was also informed that, related to this change in circumstances, the provider would be looking to vary the centre's conditions of registration to reduce the footprint and capacity of the centre. There was also a suggestion made that the provider was considering not keeping the centre open beyond its existing registration end date with existing residents transitioning elsewhere. No definitive plans were indicated for such resident transitions at the time of this inspection. At the feedback meeting for this inspection, management of the centre were advised that were the provider to close to the centre, the Chief Inspector would require formal notice of this six month in advance of the closure.

Regulation 15: Staffing

Based on discussions during this inspection and staff rotas reviewed from 1 July 2025 on, appropriate staffing supports was being provided to support the current residents availing of this centre. It was noted though that since the July 2024 inspection, the number of residents living in the centre had reduced which had in turn had resulted in the number of staff working in the centre also reducing. This meant that there was only one staff member specifically assigned to be on duty in the centre at night.

The inspector was informed though that to support the operations of the centre at night, a staff member from another designated centre located on the campus could come to No.1 Cordyline to help with areas such as medicines administration. This was observed to happen on the first day of this inspection. While the inspector was informed that could be some occasions when this staff support from the other centre at night might not be available, it was stressed that this was rare.

It was also highlighted that the staffing skill for the centre was to be made up of nursing staff, social care worker and care assistants. Although the inspector was informed that staffing for the centre had generally stabilised compared to 2024, it was indicated that that the centre did not have its full complement of social care workers at the time of this inspection. The centre's statement of purpose also indicated that a team leader was to form part of the staffing team for this centre but this role was not in place. This is discussed further under Regulation 23 Governance and management.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Previous inspections of this centre highlighted regulatory actions relating to the formal supervision of staff in this centre. On the current inspection, records provided indicated that most staff working in this centre had received timely formal supervision while a schedule was in place for future supervision of such staff. It was highlighted that two staff members were overdue some formal supervision but the inspector was provided with reasons for this.

Aside from staff supervision, a training matrix was provided during this inspection which listed 13 different staff members. This matrix indicated that all 13 staff had completed key trainings. Such training included fire safety, safeguarding, and manual handling.

Judgment: Compliant

Regulation 23: Governance and management

The centre's organisational structure, as outlined in the centre's statement of purpose, indicated that the staff team for the centre were to report to the a team leader who in turn was to report to the centre's person in charge. At the time of the July 2024 inspection, this team leader was not in place and the same role was also vacant at the time of issuing the provider a PAR in December 2024. In the PAR response submitted in January 2025, the provider had suggested that a team leader would be in place for No.1 Cordyline by the end of February 2025.

At the time of the current inspection, no team leader was in place for this centre with the inspector informed that no team leader had put in place for this centre since the January 2025 PAR response. It was indicated to the inspector though that the provider had recruited a team leader but had assigned this team leader to another designated centre on the campus. Staff members spoken with during this inspection highlighted to the inspector that communication in the centre could be improved. The absence of a dedicated team leader for the centre was put forward for as a reason for this with the person in charge having a wider remit as an area manager for the provider.

Such staff though did comment positively on the support that was provided by the person in charge who typically worked during the day. According to the centre's statement of purpose, the person in charge was to be supported in the running of the centre by night coordinators/supervisors. Given that the content of some notifications received in June 2025 raised some queries as to the effectiveness of communication between day and night staff and management for the centre, the current inspection was used to assess this area. To do so, the first day of this inspection was specifically conducted at a varied time to help in this assessment.

Taking into account discussions with staff, the person in charge and a night coordinator/supervisor along with documentation reviewed, the following structures were in place to support communication and oversight between day and night staff and management for the centre:

- Handovers took place between day and night staff while a communication book was used to share information between different shifts.
- Handovers took place between day and night management.
- Night management also completed a daily report that was provided to day management. While this report covered the campus overall, it did highlight any significant events that occurred in this centre on a given night.
- Night management generally visited the centre multiple times every night.
- There was formal meetings that occurred which involved day and night management.

The structures outlined above provide assurances that there was established links between day and night staff and management for the centre. The inspector was also informed that the person in charge and a senior management for the provider met regularly although no records of such meetings were provided. Aside from this, further documentation that was provided during this inspection indicated that there was monitoring of the services provided.

Such monitoring since the July 2024 inspection included two provider unannounced visits to the centre, an annual review for the centre and various audits that had been conducted. Where areas for improvement were identified during such monitoring, action plans were put in place to address such issues. It was noted though that progress with some actions was not always recorded or accurately recorded. For example, the action plan for the most recent provider unannounced visit in May 2025 highlighted an action to record actions for a November 2024 complaint. The action plan had recorded that this was completed but, as referenced under Regulation 34 Complaints procedure, an issue around the recording for actions for this complaint was identified during this inspection.

As will be discussed further under regulation 8 protection, it was also noted that there had not been timely follow up action taken regarding a computability assessment. Given the reasons behind the issuing of the December 2024 PAR, some of the findings of this inspection did indicate that timely follow up and adherence to stated actions did remain an area that needed some improvement. However, it was acknowledged that the current inspection did find improvement overall compared to July 2024 inspection particularly in areas such as staff supervision and fire safety.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The centre had a statement of purpose in place that had been reviewed in April

2025. This statement of purpose was found to accurately contain much of the information required under this regulation such as criteria for admission and the arrangements for residents to attend religious services. It was noted though that the description of some rooms in the centre and their sizes did not match the actual layout of the premises as observed on the day of inspection. Given that the statement of purpose forms the basis for a condition of registration, the inspector was informed the provider going to apply to vary the centre's registration conditions to address this. Such an application had not been received at the time of this inspection.

It was also indicated to the inspector that details of the staffing arrangements for the centre as outlined in the statement of purpose needed updating to reflect a reduction in resident numbers for the centre. As such, at the time of this inspection, the statement of purpose in place did not accurately reflect all aspects of the services provided in the centre.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

On the second day of this inspection, the inspector saw records of two complaints that had been made since the previous inspection, one from August 2024 and the other from November 2024. Under this regulation, a record should be maintained of all complaints including any actions taken on foot of complaints made, the outcome of the complaints and whether the complainants were satisfied. These requirements had been met for the August 2024 complaint.

For the November 2024, it was noted that the complaint record provided indicated that the complaint had been resolved and the complainant was satisfied. This complaints record also included details of some follow-up actions done. However, such records also indicated that the complainant was to be contacted by a member of management about their complaint but it was not documented if this contact took place for not. When queried, the person in charge was unsure if such communication had taken place. Communication received following the inspection indicated that the person in charge could not locate any evidence of follow up at the time of the complaint but had followed up with the complainant after the inspection.

An easy-to-read sign around the complaints process was in display in the centre. This indicated that residents could put a complaint in the complaints box but when the inspector asked if the complaints box was in place, he was informed that it was not. After highlighting this to the person in charge on the second day of inspection, during the feedback meeting on the same day, the inspector was informed that this sign had been changed to remove reference to the complaints box.

Judgment: Substantially compliant

Quality and safety

The provision of fire doors in the centre had improved in the centre since the July 2024 inspection. Previously committed to works in the centre had not been completed but this was influenced by a change in circumstances for the centre.

An apartment area was included within the layout of this centre for one resident. During the July 2024 inspection, it was highlighted that the layout of this apartment was not suited to meet the needs of the one resident living in that apartment. The provider had committed to complete some works in this apartment but owing to a change in circumstances no resident was using this apartment at the time of the current inspection. As a result, no works had been completed for this apartment with the provider planning on removing it from the footprint of the centre. Works though had been completed for the fire doors in the centre which was an improvement from the previous inspection. The July 2024 inspection also identified that one bathroom's flooring was worn. This remained the case on the current inspection but some recommended works on this bathroom did take place on the second day of inspection.

Regulation 17: Premises

During the July 2024 inspection of this centre, it was highlighted that the layout of the apartment areas of the centre was not suited to meet the needs of the one resident living there. The provider has committed to changing the layout of this apartment by July 2025 to meet the needs of this resident. However, owing to a change in a circumstances, no premises works had been completed for the apartment area and no resident was residing in there at the time of the current inspection. It was indicated to the inspector that the provider was planning on removing this apartment from the footprint of the centre although an application to vary the centre's registration conditions to reflect this had not yet been submitted.

Aside from this, it was seen that the communal areas of the centre and residents' bedrooms were clean and well-furnished. This included three resident bedrooms seen which had televisions and radios along with large wardrobes for residents' belongings (one resident's had most of their clothes kept in a separate room but this was related to the identified needs of this resident). The three bedrooms seen were also noted to be spacious, nicely decorated and personalised. For example, one resident had a personalised licence plate on display related to the county where the resident was from. Some parts of the centre though were noted to need some maintenance such as a stairwell area which had a number of marks and chips on the wall.

The flooring of a bathroom toilet was also seen to be worn while the inspector was

informed that some works had been recommended for this bathroom to better suit the needs of some of the residents using that bathroom. Some of this work, but not all of it, was noted to be carried out on the second day of inspection. The completed works related to a change in position for two grab rails but a change in the toilet of this bathroom still had to be completed.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Fire doors play an important role in fire containment as they are intended to help prevent the spread of fire and smoke. During the July 2024 inspection, it was identified that the provider had not completed remedial works on all fire doors in the centre despite issues about the fire doors provided having been raised by the June 2023 inspection of the centre. On the current inspection, it was found that all such works had been completed which was a positive development. It was observed though that one fire door to a store room was not closing fully while some cabling to the ceiling on the first floor of the centre had not been appropriately sealed from a fire containment perspective. Communication received in the days following this inspection indicated that such matters had been addressed. During the course of the second day of inspection, one fire door to a laundry was observed to be wedged open by a dust pan. Such action negated the intended purpose of this door. After highlighting this to the person in charge, it was later seen that this had been addressed.

The July 2024 inspection had also raised concerns around night-time fire evacuation from the centre particularly when only one staff member was on duty at night. At the time of the current inspection, only one staff was rostered on duty at night but since the July 2024 inspection, the number of residents availing of the centre had reduced. In the event that a fire evacuation was required at night, a night coordinator/supervisor and two staff from another centre on the campus were to attend No.1 Cordyline to support with any evacuation. This was reflected in a written evacuation plan that was on display while a member of staff and a night manager spoken with were aware of this plan. Fire drills records reviewed indicated that this fire evacuation plan was practiced with these drills which also recording low evacuation times.

Judgment: Substantially compliant

Regulation 8: Protection

Since the July 2024 inspection, the Chief Inspector had been notified of eight safeguarding incidents or allegations occurring in the centre. Documentation

provided during this inspection confirmed that such matters had been preliminary screened, notified to the Health Service Executive (HSE) Safeguarding and Protection Team and had safeguarding plans put in place where required. Copies of such safeguarding plans were present in the centre while staff members spoken with demonstrated an awareness of such matters. Information on how to contact the provider's designated officer (person who reviews safeguarding concerns) was also seen to be on display in the centre.

As mentioned earlier in this report, some notifications in June 2025 raised some safeguarding concerns. Four of these related to occurrences that had occurred on one particular day where three existing residents had impacted one another. Given the nature of these occurrences, the HSE Safeguarding and Protection Team had queried with the provider on 26 June 2025 as to whether a compatibility assessment for these three residents had been completed. When queried on the second day of inspection, the inspector was informed that a referral for such a compatibility assessment had to be made through the provider's interdisciplinary team but that this referral had not been yet been made. Communication received indicated that this referral was subsequently made in the days following this inspection.

The notification which prompted the June 2025 PAR to be issued also related to a safeguarding allegation and matters related to the personal care for one resident. In response to that PAR the provider had indicated that the resident's intimate personal care plan would be kept updated while a memorandum would be issued to all of the provider's outlining a need to record the time when certain personal care was delivered in daily recording books. On the current inspection, it was found that his memorandum was present in the centre while the resident's intimate personal care plan had been reviewed during July 2025. This intimate personal care plan also provided for the recording the times when certain personal care was delivered in daily recording books. However, when the inspector reviewed the resident's daily recording book for the seven days leading up to this inspection, it was observed that times when certain personal care was delivered was being recorded inconsistently.

Aside from such matters, during this inspection when reviewing incident records in the centre, the inspector read one entry where a resident was recorded as having bruises for unknown reasons. Given the description of this, it was unclear if this matter had been considered from a safeguarding perspective. This was highlighted to the person in charge on the second day of inspection. The day following the completion of this inspection, communication was received which indicated that the cause of the bruising was likely some minor falls that had happened before the bruising was noted. As such, it was indicated that there were no safeguarding concerns related to this.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 8: Protection	Substantially compliant

Compliance Plan for No.1 Cordyline OSV-0004575

Inspection ID: MON-0047669

Date of inspection: 27/08/2025

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: The Provider and Person in Charge undertook a review of the required skill mix in the centre to reflect the change in numbers of residents in the Centre and the Statement of Purpose was updated to reflect these changes. The Provider will continue to advertise and recruit for permanent staffing vacancies including for the post of social care leader and ongoing, as they may arise from time to time. The PIC continues to maintain an increased presence in the Centre until such time as the Team Leader post is in place.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The Provider continues to prioritise recruitment of identified vacancies in the management structure and measures are in place to support the team while the vacancy exist. Team Leader recruitment continues and next interview date is 25/9/25 when it is hoped that a person will be appointed within two months of that date. The Person in Charge will continue to review communication in the centre and ensure effective communication is maintained. This will be achieved by supporting staff to utilize existing supports and ensure recording of actions accurately on Audit tools. This will be discussed at a staff meeting [26/9/25]. The Provider will ensure that the PIC regularly reviews the Complaints log to ensure the process is complete for all Complaints.	

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:

The Provider, PPIM and Person in Charge have reviewed the Statement of Purpose:
• To ensure room sizes match the actual layout and reduced footprint of the centre
• To support the Application to Vary the conditions of Registration with the Authority [16/09/2025]
• To reflect the reduced numbers of residents and updated staffing arrangements.

Regulation 34: Complaints procedure	Substantially Compliant

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

The Provider has ensured the following actions are in progress
• The Person in Charge has removed and updated Complaints posters to remove reference to a complaints box and to include reference to using a complaint form instead. [26/8/25]

• The Person in Charge has reviewed complaint process for completeness and has followed up on the agreed actions from the August 2024 complaint identified during the inspection. The Person in Charge shall ensure all complaints are processed fully and evidence is captured they regarding the satisfaction or otherwise of the complainant. [29/8/25]

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:

The Person in Charge will ensure all maintenance works to maintain to upkeep the centre are identified to the facility manager and plan a schedule of works for same, including the maintenance of the stairwell and bathroom areas

The Person in Charge will ensure that all changes agreed with the Provider in relation to the environment to support changing needs of the residents, are carried out in a timely manner including replacing of toilet bowl and handrails which are scheduled to be completed by [31/10/25]

Regulation 28: Fire precautions	Substantially Compliant

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

The Provider continues to ensure that all remedial/fire compliance works identified via regular fire safety checks are given priority in maintenance scheduling, In particular the following actions are being carried out:-
• The Person in Charge has ensured that all fire doors in the centre are closing fully and that cabling, identified in the inspection, is sealed from a fire containment

perspective.[29/08/25]
• The Person in Charge shall ensure that Fire safety is discussed at team meeting including reminders on the purpose of fire doors and the need to avoid using wedges or other mechanisms that may negate intended purpose of doors. [26/9/25]

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:

The Provider continues to monitor all safeguarding concerns that may arise in the Centre and the possible impact on residents. In line with this the following actions are in progress have taken the following actions:
• The query from HSE Safeguarding team, arising from one incident of vocalization in the Centre, as to whether the Provider would consider the need for a compatibility assessment was discussed with the Provider's Designated Safeguarding Officer. It was agreed that a referral would be made regarding compatibility to support future accommodation planning for the residents via the Providers Admissions, Transfers and Discharges Team. It is anticipated that that this assessment will be completed by 15/11/2025.
• The Person in charge will ensure that where bruising is recorded, any consideration given that concluded that there is no safeguarding concern, to be recorded in the incident record. This will be discussed with the staff team at next team meeting [26/09/25]
• The Person in Charge will review recording of intimate personal care in the centre to ensure recording is consistent and captures fully when intimate personal care was delivered. This will be discussed with the staff team at next team meeting. [26/09/25]

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	30/09/2025
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Substantially Compliant	Yellow	31/10/2025
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Substantially Compliant	Yellow	31/10/2025
Regulation	The registered	Substantially	Yellow	26/09/2025

23(1)(b)	provider shall ensure that there is a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.	Compliant		
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	26/09/2025
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	26/09/2025
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose containing the information set out in Schedule 1.	Substantially Compliant	Yellow	16/09/2025
Regulation 34(2)(f)	The registered provider shall ensure that the nominated person maintains a record of all complaints including details of	Substantially Compliant	Yellow	29/08/2025

	any investigation into a complaint, outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.			
Regulation 08(6)	The person in charge shall have safeguarding measures in place to ensure that staff providing personal intimate care to residents who require such assistance do so in line with the resident's personal plan and in a manner that respects the resident's dignity and bodily integrity.	Substantially Compliant	Yellow	15/11/2025