



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

Issued by the Chief Inspector

Name of designated centre:	The Ash
Name of provider:	Corlann
Address of centre:	Clare
Type of inspection:	Unannounced
Date of inspection:	18 June 2026
Centre ID:	OSV-0004759
Fieldwork ID:	MON-0045351

About the designated centre

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

This centre is located in a residential area on the outskirts of the busy town. The location of the centre facilitates access to a range of services, shops and recreational opportunities. The premises is a bungalow type residence divided into two separate units. A residential service is provided to a maximum of two residents with one resident residing in each unit. Each unit is self-contained and provides each resident with their own bedroom, bathroom, living room, kitchen and laundry facilities. An administration office for staff is also provided in each unit. The centre operates fifty-two weeks of the year providing wraparound residential and day supports for both residents. Residents are assessed as having medium to high support needs in the context of their disability and other needs such as physical and health needs. Residents are supported by a staff team comprised of social care workers and support workers. The person in charge manages and oversees the day-to-day operation of the centre supported by a social care worker.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	2
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How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Thursday 18 June 2026	09:25hrs to 16:25hrs	Maureen McMahon	Lead
Friday 19 June 2026	09:30hrs to 15:25hrs	Maureen McMahon	Lead

What residents told us and what inspectors observed

This was an unannounced inspection carried out to monitor the provider's compliance with the regulations. This centre has an additional condition attached to its registration since 2024 in response to previous unsatisfactory inspection findings. Prior to this inspection the Chief Inspector of Social Services sought and received a compliance plan update. This was sought to review the status of the actions committed to by the provider in September 2025 to improve its compliance with regulatory requirements. This compliance plan update advised that the provider had completed the actions it said it would to improve compliance and the quality and safety of care provided to residents. The inspector found that the provider had completed the actions it said it would to improve its compliance with the regulations. However, further improvements were required as demonstrated by these inspection findings and the provider continued to demonstrate non-compliance with regulatory requirements.

Residents living in this centre were supported to achieve best possible health. While a range of activities were available, this inspection found opportunities for a resident to participate in activities they may enjoy were sometimes limited due to current staffing arrangements.

On arrival there were three staff members present. Two staff members were providing direct support to residents on a 1:1 basis. The coordinator had just facilitated a staff meeting and remained in the centre to facilitate this inspection. These meetings were timed specifically to ensure staff working night duty were able to attend. This meeting was chaired and overseen by the coordinator. Both residents were in the centre and were beginning to commence their morning routines. The inspector had the opportunity to meet both residents and observe how they lived as they went about their morning routines. A resident was observed entering the main house from their apartment with staff support to view a visual roster that was prominently displayed in the kitchen area of the main house. Another resident was observed by staff to choose their morning breakfast with support and begin preparations for their meal. The presence of the inspector was not found to impact residents and staff said both residents were presenting as comfortable throughout the morning.

The centre comprised of a main house with an adjoining apartment, connected through a shared garden area to the rear of the property. The main house and separate apartment were each occupied by one resident. The centre was welcoming, pleasantly decorated, and personalised throughout. During a walk-around of the centre, the inspector observed that bedrooms were spacious, were en-suite or had bathroom facilities nearby. Both the apartment and the main house had well-equipped kitchens where food could be prepared and stored hygienically.

Both residents had high support needs in relation to their assessed needs in areas such as positive behaviour support, maintaining a safe environment, healthcare needs, and communication. Both residents were supported by staff on a 1:1 basis between 8:00 and 20:00 each day. The centre operated on a reduced level of staffing overnight with one staff working a waking night duty. The provider had measures in place to support the supervision and safety of residents overnight, including bed occupancy monitors and audio monitors.

The layout of the centre supported residents to live independently from each other, and no concerns were identified in relation to negative peer-to-peer interactions.

The inspector had the opportunity to sit and engage with both residents. Their assessed needs of both residents included communication differences. One resident used some verbal communication and told the inspector their name. The other resident actively engaged in Lámh and gestures. Staff on duty were observed practicing Lámh throughout the inspection. Visual schedules were in use across the centre and supported residents to understand areas such as, staff rosters, upcoming activities, and meal choices. The inspector observed a resident actively reviewing the staffing arrangements and seeking reassurances from staff in relation to the visual roster. Throughout the inspection, this resident was observed contently relaxing in their apartment, watching preferred television, and making plans with staff to do the grocery shopping locally. Staff told the inspector this resident was well known locally and would meet friends and acquaintances as they went about their shopping and errands. Another resident on the day of inspection was supported to attend a medical appointment at short notice. This required a 2:1 staff ratio and the coordinator on duty fulfilled this front line duty.

The inspector had the opportunity to meet staff working in the centre. Staff who spoke to the inspector said they felt supported to raise any concerns they had and described specific supports offered following a recent incident. They described meeting with the local management for a debrief and also described changes to practices and revised guidance that had promoted a safer environment and lessened the likelihood of an incident of a similar nature. Some staff had worked in the centre for many years and had a good understanding of residents care and support needs. The inspector observed staff engaging in a friendly and warm manner with residents. In relation to activities for residents, staff described a range of activities that residents participated in and discussed some limitations on access to swimming due to a staff vacancy. From records reviewed and these discussions it was found that one resident's access to swimming was currently limited due to the vacant post in the centre.

Overall, the inspector found that residents had opportunities to engage in a range of activities. These included community-based activities such as socialising with friends, bowling, shopping, meals out, and day trips to the beach and other amenities. Staff also described a range of home-based activities that residents enjoyed including watching television with a specific interest in rugby, art and crafts, sensory activities and listening to music.

Although this inspection identified some improvements in previously identified regulatory findings, deficiencies in the governance and management arrangements continued to impact the overall quality and safety of care delivered to residents. These deficiencies resulted in ineffective oversight and inconsistent review of key areas, including the provision of written agreements, maintenance issues and, risk assessment including those relating to the use of restrictive practices. In addition, the provider had not adequately assessed the impact of the staff vacancy on the governance arrangements within the centre or the limitations this placed on a residents access to swimming. This inspection found that the provider had not ensured that the role of the person in charge were carried out in accordance with the regulations.

The next two sections of this report present the inspection findings in relation to the governance and management in the service, and describes how governance and management affect the quality and safety of the service provided.

Capacity and capability

Based on the findings of this inspection, the inspector was not assured that the governance and management arrangements in place were effective in ensuring the delivery of a safe, high-quality service to residents. The lines of accountability were not clearly defined, and staff were unable to describe recent changes to the governance structure or reporting arrangements.

The provider had appointed a suitably qualified and experienced person in charge. However, the person in charge had other responsibilities and observations during this inspection indicated that many of the responsibilities of the person in charge were being undertaken by the coordinator. The coordinator, had recently transitioned from a social care worker role and facilitated this inspection over two days. They demonstrated a good knowledge of residents and their support needs.

Discussions with both the coordinator and the person in charge confirmed that, in addition to the delegated responsibilities, the coordinator was also covering a vacant social care worker post while recruitment was ongoing. Overall, the provider needed to review its governance and management arrangements to ensure that the person in charge fulfilled the responsibilities of the role in line with the regulations, was regularly and consistently engaged in the operational management of the centre and had sufficient oversight and knowledge of the service. Based on these inspection findings these core elements of governance and management and regulatory requirements were not in place.

The provider had ensured that written agreements were in place for all residents. These were completed on admission and updated as required. The agreements included relevant information. However, they required review to ensure that all additional charges, including costs such as for bed linen and fuel, were clearly

outlined and agreed. Provider oversight of the agreements and their accuracy was not evidenced as none of the agreements in the centre were signed by the provider to demonstrate that they had been reviewed and approved. While residents had signed their agreements, it was not evident how their capacity to understand and consent had been considered, particularly where other assessments indicated that they required support to manage their personal affairs and may not fully understand the value of money.

The provider had quality assurance systems in place for maintaining oversight of the quality and safety of care. These systems included provider unannounced audits undertaken every six months and an annual review of the service. The inspector read the provider unannounced audit undertaken in June 2026. While this audit identified some similar findings to those found on this inspection, including improvements required in relation to risk management and restrictive practices, it did not identify any concerns or limitations regarding the governance and management arrangements within the centre. These audit findings differed from the findings of this inspection, which identified significant deficiencies in the governance arrangements and found that substantial improvements were required to ensure effective oversight and delivery of a safe, high-quality service to residents. In addition, the audit described the delegation of the person in charge role to the coordinator of the service. This arrangement was found not to be in line with the regulations.

Training records reviewed identified that all staff had completed all mandatory training. In addition, staff had received training in areas such as human rights, personal outcome measures, and report writing to support them in their roles.

Notwithstanding some positive findings identified during this inspection, overall significant improvements were required in the governance and management arrangements within the centre. The governance structure did not provide clear lines of responsibility and accountability, which impacted the provider's effective oversight of the quality and safety of care and support provided to residents. For example, responsibilities for matters relating to the premises were shared across local management, resulting in a lack of clarity regarding accountability and delays in completing repairs. In addition, decision-making processes lacked clarity, as the person with delegated responsibility for the day-to-day management of the centre was required to refer matters to the person in charge, who was not routinely present in the centre. Records reviewed during the inspection did not demonstrate that matters relating to the operation, quality, and safety of the centre were being discussed or monitored through formal governance arrangements.

Regulation 14: Persons in charge

The person appointed as person in charge had other responsibilities and managed more than one centre. Based on these inspection findings this arrangement did not

ensure the effective governance, operational management and administration of this centre.

The provider had appointed a person in charge to the centre in April 2026. The inspector reviewed information submitted to the Chief Inspector at this time and had sought assurances in relation to the capacity of the person in charge to fulfil the requirements of the person in charge. It was evident from this inspection that the assurances given to the Chief Inspector were not in place nor appropriate to ensure the effective governance of this centre.

Records reviewed by the inspector did not demonstrate the person in charge attended the centre on a frequent basis. For example, the person in charge was not recorded on the centre roster and records from 27 April 2026 to the 18 June 2026 did not evidence the person in charge attending the centre at any time. Prior to taking up the role of person in charge, the person in charge held the role of person participating in management. From January 2026 to their appointment as person in charge in April 2026, there was no evidence available to the inspector to demonstrate them having attended the centre. The inspector discussed these findings with the person in charge who verified they do not attend the centre and also confirmed they do not attend team meetings.

It was evident from the inspectors review of the providers own annual service review and mentorship meetings notes that the provider was required to consider its responsibilities in relation to the function, role, and responsibilities of the person in charge. For example, records reviewed indicated that the responsibilities of the person in charge had been delegated to a member of local management.

Judgment: Not compliant

Regulation 15: Staffing

Care was delivered to a good standard. However, a vacant post in the centre of 70 hours each fortnight had resulted in a staffing resource gap. Although this did not present a medium or high risk to residents, it had an impact on the consistency of staff available to attend certain activities that required a 2:1 staff ratio, such as swimming.

The inspector reviewed the staffing roster for May 2026 and up to 18 June 2026 and found that planned and actual rosters were well maintained. Two staff were rostered to work each day between 8:00 and 20:00. Where additional staff were required, for example to support a medical appointment, the coordinator in the centre facilitated this or the on-call manager directed supports to the centre.

However, a vacant social care worker post was clearly noted on the centre roster, this vacancy was across seven days. From discussions had, staff verified they utilised the supports of the coordinator or on-call arrangements when additional staff were required. This gap in resources was found to impact on staffs ability to

consistently offer some activities to a resident where a 2:1 staff ratio was required. The inspector observed on the day of inspection the coordinator supported staff on the floor to attend a medical appointment. The gap in resources also impacted on the governance and management arrangements the provider had put in place.

No agency staff were currently in use in the centre and regular relief staff were available.

One resident required nursing support in relation to assessed healthcare needs. These supports were available from a community based nursing team and were found to be effective in managing a residents needs. For example, on the day of inspection the support of this team was sought, a timely appointment was made and the resident received care in a prompt manner.

Judgment: Substantially compliant

Regulation 16: Training and staff development

The provider had ensured that staff who worked in the centre had received appropriate training to equip them to provide suitable care to residents.

The inspector reviewed the training records which showed that staff had received mandatory training in areas such as fire safety, positive behaviour support, and adult safeguarding. Staff had also attended training relevant to their roles and the assessed needs of the residents, such as training in feeding, eating and drinking (FEDs), medicines management, epilepsy and rescue medicine administration, and manual handling.

Staff supervision meetings were taking place frequently, a schedule of planned and actual supervision meetings were available to view in the centre. Staff who spoke to the inspector confirmed that they had received regular supervision.

Judgment: Compliant

Regulation 23: Governance and management

Based on the findings of this inspection the governance and management structures were neither known nor clearly defined. Staff were unaware of who was in charge of the centre. This inspection identified that the governance and management arrangement in place was not effective, did not provide for clear lines of responsibility, accountability and oversight and created a potential risk to the quality and safety of the service.

Records reviewed, such as the annual review, meeting minutes and records of individual meetings indicated that the person in charge was not actively participating in and fulfilling their role in the centre. Staff feedback in the centre demonstrated they understood a member of the local management team to be the person in charge, and they described seeing the registered person in charge, that is the person in charge as notified to the Chief Inspector, every few months.

Therefore, while there was a management structure in place, roles, responsibilities and reporting relationships were not clearly defined. Although the provider had given assurances to the Chief Inspector prior to this inspection in relation to the appropriateness of the governance structure in place to manage the centre, these arrangements were found to be ineffective on the day of inspection. For example, the person in charge was found to have delegated their regulatory responsibilities to a local manager in the centre. This was evidenced in records reviewed including the providers own internal audit and in feedback received throughout the inspection. During verbal feedback of these inspection findings the person in charge was informed that the role of person in charge cannot be delegated to another staff member. In accordance with the requirements of the Act, the person in charge is the person whose name is notified to the Chief Inspector and entered in the register of designated centres maintained by the Chief Inspector and no other person.

A provider unannounced audit had been carried out in June 2026. This audit did not reflect some of the findings of this inspection particularly in relation to the deficits in the governance and management arrangements in place. For example, the governance and management arrangements were found to be effectively managed. In addition, the audit found that the staff vacancy was effectively managed and the reviewer had not considered the impact this vacancy had on the management structure in place or the impact it had on residents' activities.

The inspector reviewed records of team meetings that had taken place in the centre in 2026. Records were available for meetings held in February and April 2026. Agenda items included resident updates, incident reviews, restrictive practices, and safeguarding. Records indicated that some staff members frequently did not attend meetings. Although meeting minutes included a signature sheet to confirm that staff who were absent had read the minutes, it was evident that this process was not consistently followed. It was unclear how information sharing took place in this instance, who led and took ownership of staff attendance and whether an effective system was in place or not to ensure good communication in the centre.

Judgment: Not compliant

Regulation 24: Admissions and contract for the provision of services

Written agreements were in place for the provision of services to residents. However, these agreements required review to ensure that all details, including

additional charges, were clearly outlined and that the agreements and charges to residents were overseen and signed as agreed by the provider.

The inspector reviewed both residents' written agreements and found that neither had been signed by a provider nominee. While one resident had signed their agreement, it was unclear what measures had been taken by the provider to ensure that the resident understood the terms of the contract and the fees payable under it. The inspector reviewed the assessments completed by the provider for this resident, which indicated that they were unable to understand the value of money and required support to manage their personal affairs.

All fees payable by residents were not clearly specified within their written agreements. When the inspector reviewed resident's financial records the inspector found that the said agreements did not adequately specify all charges that residents were deemed personally liable for. For example, the inspector saw that one resident had paid for bed linen, the agreement in place did not clearly outline that the supply of bed linen was the residents own responsibility. One resident owned their own vehicle, this vehicle was used by staff to transport this resident to and from the centre as needed. However, there was insufficient detail in the written agreement and the inspector was told there was no formal agreement in place outlining associated costs with this transport arrangement. Expenditure records evidenced that this resident was responsible for expenses such as fuel, tolls, parking charges, and vehicle maintenance.

Judgment: Not compliant

Regulation 3: Statement of purpose

A written statement of purpose was in place. However, improvements were required to ensure that it accurately reflected the current governance and management arrangements within the centre.

The inspector read the statement of purpose and found that some of the named management structure were no longer working in the centre. As a result, the governance and management arrangements outlined in this document were not up to date and did not accurately reflect the current management structure. A recent provider audit had identified the statement of purpose required updates and had discussed these with local management.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

The provider had maintained a record of all incidents occurring in the centre.

The inspector reviewed incidents and accidents that had occurred in the centre from January 2026 to 18 June 2026. The inspector found that all notifications, such as quarterly notifications had been submitted appropriately.

Judgment: Compliant

Quality and safety

Based on the findings of this inspection, there were notable improvements in compliance with Regulation 18: Food and nutrition and Regulation 8: Protection. The inspector found that residents' nutritional needs were being well met including compliance with prescribed modified diets. No safeguarding concerns were identified during this inspection. Safeguarding arrangements including access to the designated safeguarding officer and staff who had received appropriate safeguarding training were in place.

However, improvements were required to ensure that maintenance issues were escalated promptly and resolved in a timely manner. The implementation of restrictive practices and the associated risk assessments also required review. The provider needed to consider its own policy and procedures prior to any restrictive practice being implemented and ensure that there was a clear, well-documented rationale for its use.

The design and layout of the centre met residents social care needs. Each resident enjoyed their own space and choose to visit one anothers section of the centre as they wished. Each resident had a spacious bedroom personalised to their interests, with adequate storage for personal storage. The centre was equipped with Wi-Fi, televisions, and music devices that residents could use for entertainment and to access information.

The provider had systems in place for the identification, assessment, management and review of risk. These systems were mostly found to be effective in the management of identified risks in the centre. However, a new practice in the centre in relation to restrictive practices required further risk assessment to ensure its appropriateness for all residents.

Personal plans had been developed collaboratively with residents, their representatives and their key workers. Personal plans reviewed by the inspector found that residents had identified personal goals and were progressing towards these goals. Residents had some high support needs in relation to healthcare. Detailed care plans were available to guide staff on the management of these conditions. In addition, the provider had ensured that residents had access to

medical and healthcare services, and that their healthcare needs were consistently well met.

Positive behaviour support plans were in place for both residents. Following the previous inspection, a compliance plan was put in place to address identified areas for improvement under Regulation 7: Positive behaviour support. In response, the provider introduced a restrictive practice of locking the front door of the main house to support the safety needs of one resident safely, this was observed to be in place on the day of inspection. While some improvements had been made in relation to restrictive practices, the inspector found that the provider had not followed its own procedures when implementing a new restrictive practice in the days prior to the inspection. The provider had introduced a practice of locking the patio door of the main house between 8:00 and 20:00. The inspector found that the provider had not followed its own procedures in relation to the implementation of this restrictive practice, and in doing this had not followed best practice.

Regulation 17: Premises

The centre was visibly clean and suitably decorated throughout.

The centre was made up of a single-storey house and an adjoining apartment, each of which could accommodate one resident. Residents had access to individual spaces where they could relax or participate in activities they enjoyed. For example, one resident had access to a sensory room while another chose to spend time relaxing in their own sitting room, watching television in their comfortable chair. Each resident had a spacious bedroom with adequate furniture, including wardrobes for personal belongings. Residents also had access to an enclosed garden shared between the house and apartment, with dedicated seating areas available for relaxation. However, the garden was not fully accessible to residents due to hazards, such as steps. While measures such as handrails had been installed to support residents' assessed mobility needs, resident could not safely access the outdoor area without support from staff.

During the inspection, it was identified that laundry facilities in the apartment had been out of order for approximately two months. This meant that should the resident choose to do laundry with support and encouragement from staff, they were required to access the laundry facilities in the main house. This involved leaving their apartment, navigating the steps into the main house. The resident used a mobility aid. While the repairs to the washing machine and drier were completed prior to the conclusion of this inspection, the length of time taken to fix laundry facilities and the alternative arrangements provided during this period were not appropriate to the resident's assessed needs, including their risk for and history of falls.

The inspector observed on the day of inspection that the provider had not responded in an appropriate manner when completing repairs to a door lock in April 2026. While repairs had been completed, a lock that was different to the others in

use had been provided. The centre's emergency procedures relied on the same lock and key being used in all external doors and effective key management to support the safe evacuation of residents in the event of an unplanned evacuation of the centre. However, these emergency procedures were no longer applicable given the different lock and key that had been provided in April 2026. The inspector saw that keys to this door were available in the main house and the apartment hanging beside each door. This and the fact that two keys were now required to open the doors created a risk that in the event of an emergency such as a fire emergency there may be a delay in the releasing of locked doors, or the required key may not be available to staff as they were hanging loosely as observed. The practice of the universal key is good practice and was put in place following a HIQA inspection in April 2024.

Judgment: Not compliant

Regulation 18: Food and nutrition

There were adequate amounts of food and refreshments available to residents. Both residents were prescribed modified diets and staff were knowledgeable on the requirements for residents. Where food items such as fruit were available, residents were fully supervised in accessing these and staff modified these items as per speech and language therapist recommendations.

The inspector observed the dining experience in the centre for both residents, choice was available and offered. Some residents had set routines in relation to setting the table and staff supported this activity.

Residents were supported to plan, shop, and prepare meals in line with their preferences. The inspector observed a resident plan with staff on duty and go to the local shops to do the food shopping.

Judgment: Compliant

Regulation 26: Risk management procedures

The provider had a system in place for the assessment, review, response and monitoring of risks in this centre. There were also systems in place to record, monitor and respond to adverse events with evidence of good adherence to incident reporting.

Although risk management was generally well managed, improvements were required in relation to the management of the known risks, including absconding and slips, trips, and falls. As discussed under regulation 7, this inspection found

inadequate oversight in relation to the use of restrictive practices. The provider had not comprehensively assessed the risks associated with implementing a restrictive practice or considered the potential impact of the decision on other residents within the centre. For example, the provider had decided to unlock a door to allow one resident to access the main house. However, this created a risk for the other resident in the main house, who required full support to leave the house. This scenario was not sufficiently risk assessed to ensure all options had been considered.

In summary, the provider had not adequately considered how recent changes could create or increase risks for residents when considered across the wider centre. This inspection found that the combined risks associated with the unlocked door, reduced nighttime staffing levels, and the supervision needs of both residents required further comprehensive risk assessment and review.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The provider had measures in place to safeguard residents, staff and visitors from the risk of fire. The risk posed by the system in place at the time of this inspection in relation to opening exit doors has been addressed above under Regulation 17.

The inspector reviewed records of fire drills for 2026, personal emergency evacuation plans (PEEPs), staff training records, and equipment servicing records. Fire evacuation drills involving staff and residents were being carried out frequently and evacuations were being achieved in a timely manner both during the day and night, with many evacuations taking place in two minutes or less. The inspector spoke to staff who verified that fire drills took place regularly and residents evacuated in a timely manner.

Each resident had a PEEP developed and this identified supports required in the event of a fire, such as equipment and assistance required. Training records viewed by the inspector confirmed that all established staff had attended up-to-date fire safety training.

Judgment: Compliant

Regulation 7: Positive behavioural support

Since the last inspection of the centre the provider had ensured that all positive behaviour support plans were reviewed and available to staff. The provider had developed a specific protocol outlining the supervision requirements for one resident

who spent time alone. However, improvement was required to ensure that restrictive practices and their implementation was supported by the providers own internal policy.

The inspector read two positive behaviour support plans. They were up to date and outlined to staff possible scenarios that may arise and the control measures in place. These control measures included guidance on managing incidents that occurred in the community and the requirement for staff to carry out dynamic and ongoing risk assessments whilst accessing the community.

However, this inspection identified ongoing inconsistencies in the implementation, oversight, and decision-making in the use of restrictive practices. For example, a door was locked during periods of peak staffing levels, while this same door remained unlocked at night despite reduced staffing levels. This decision was not made in accordance with the providers' own policies and procedures, which required multidisciplinary team involvement to ensure decisions were informed, proportionate, and reflected the least restrictive option available. As a result, there was insufficient assurances that this restrictive practice was suitably assessed, implemented, and reviewed to ensure it was appropriate to residents' needs and rights.

Judgment: Substantially compliant

Regulation 8: Protection

This inspection found residents were protected from all forms of abuse. Safeguarding measures were in place to ensure that staff provided intimate care in line with resident's personal plans and in a dignified way.

All staff working in the centre had received training in adult safeguarding. Staff spoken with confirmed they had completed the training and records were available to view.

Where intimate care was identified as complex for a resident, the provider had measures in place such as an occupational therapy sensory assessment, the involvement of the multidisciplinary team, including positive behavior support, and detailed guidance and review records to track progress with interventions.

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
Capacity and capability	
Regulation 14: Persons in charge	Not compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Admissions and contract for the provision of services	Not compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 18: Food and nutrition	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 28: Fire precautions	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Compliant

Compliance Plan for The Ash OSV-0004759

Inspection ID: MON-0045351

Date of inspection: 19/06/2026

Introduction and instruction

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

This document is divided into two sections:

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

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

A finding of:

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 14: Persons in charge	Not Compliant
Outline how you are going to come into compliance with Regulation 14: Persons in charge: The registered provider will ensure the following actions are taken to achieve compliance with Regulation 14: Person in Charge · The current local coordinator will be registered as the Person in Charge for the Designated Centre. [Planned Completion: 31/08/2026] · The ongoing Mentorship programme with the Coordinator and Community Manager will continue until the planned completion date of the 11/11/2026. [Planned completion: 11/11/2026]	
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: The registered provider will ensure the following action is taken to achieve compliance with Regulation 15: Staffing: · Recruitment and selection process to be undertaken to identify a suitable qualified candidate for the role. [completed 17/08/2026] · Social care worker in place and commenced employment on 17/08/2026 [Completed 17/08/2026]	

Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The registered provider will ensure the following actions are taken to achieved compliance with Regulation 23: Governance and Management The current local coordinator will be registered as the Person in Charge for the Designated Centre. NF30 has been submitted on 29/07/2026 and prescribed documentation forwarded via Hiqa portal. · The ongoing Mentorship programme with the PIC and Community Manager will continue until the planned completion date of the 11/11/2026. [Planned completion: 11/11/2026] · The coordinator will schedule a mandatory team meeting for all staff to attend to discuss the findings of this report as well as discuss and agree a process to manage attendance and communication for team meetings. [Completed 19/08/2026] · Any concerns regarding team meeting attendance will be managed through support and supervision meetings. [as required] · The coordinator will review minutes from team meeting thus far in 2026 and ensure that all staff have read and signed same. [Planned completion 01/09/2026]	
Regulation 24: Admissions and contract for the provision of services	Not Compliant
Outline how you are going to come into compliance with Regulation 24: Admissions and contract for the provision of services: The registered provider will ensure the following actions are taken to achieve compliance with Regulation 24: Admissions and contract of the provision of services: The Community Manager will link to the Finance manager with regard for guidance in relation to transport agreement in place for one resident and his vehicle. [Planned completion 06/09/2026] The Community Manager and PIC will review both Individual service agreements in place and ensure they clearly outline the services provided and are signed by all required parties. [Planned Completion 13/09/2026]	

Regulation 3: Statement of purpose	Substantially Compliant
Outline how you are going to come into compliance with Regulation 3: Statement of purpose: The registered provider will take the following actions to achieve compliance with Regulation 3: Statement of Purpose and Function: · The coordinator, supported by the Community Manager, will review and update the Statement of Purpose and function to ensure it reflects with the current governance and management structures in place in the center. [Completed 13/08/2026]	
Regulation 17: Premises	Not Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: The registered provider will take the following action to ensure compliance with Regulation 17 Premises: · The laundry facilities will be repaired and the resident will be supported to complete laundry supervised and assisted by staff. [Completed 19/06/2026] · An easy read guide will be developed by the coordinator to support one resident to understand how to safely use laundry facilities to ensure they are not repeatedly broken. [Completed 17/08/2026] · A restrictive practice has been implemented by the provider where by one resident cannot access the laundry facilities unsupported. [Completed 14/07/2026] The replaced lock which operated with a different key will be replaced to ensure one key operated all locks within the house. [Completed : 04/08	
Regulation 26: Risk management procedures	Substantially Compliant
Outline how you are going to come into compliance with Regulation 26: Risk management procedures: The registered provider will ensure the following action is taken to achieve compliance with Regulation 26 : Risk management procedures : The coordinator and community manager will further assess the risk related to the door lock and subsequent risk of falls for both residents. [Completed 29/06/2026]	

A restrictive practice is to be implemented where by the patio door off one resident's kitchen is to be locked at all times. [Completed 18/06/2026] Additional chimes will be placed on all exit's doors in one resident's apartment to ensure that if this resident exits a door while unsupported staff will be alerted to same and can go to the resident to support. [Completed 01/07/2026] · All associated restrictive practice protocols will be completed and signed by all required MDT, management and representatives. [Completed 17/08/2026]	
Regulation 7: Positive behavioural support	Substantially Compliant
Outline how you are going to come into compliance with Regulation 7: Positive behavioural support: The registered provider will ensure the following actions are taken to achieve compliance with Regulation 7: Positive behavioral Support: · The coordinator and community manager will further assess the risk related to the door lock and subsequent risk of falls for both residents. [Completed 29/06/2026] · A restrictive practice is to be implemented where by the patio door off one Resident's kitchen is to be locked at all times. [Completed18/06/2026] · Additional chimes will be placed on all exit's doors in one resident's apartment to ensure that if this resident exits a door while unsupported staff will be alerted same and can go to the resident to support. [Completed 01/07/2026] · All associated restrictive practice protocols will be completed and signed by all Required MDT, management and representatives. [Completed 17/08/2026]	

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 14(4)	A person may be appointed as person in charge of more than one designated centre if the chief inspector is satisfied that he or she can ensure the effective governance, operational management and administration of the designated centres concerned.	Not Compliant	Orange	11/11/2026
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	17/08/2026

Regulation 17(4)	The registered provider shall ensure that such equipment and facilities as may be required for use by residents and staff shall be provided and maintained in good working order. Equipment and facilities shall be serviced and maintained regularly, and any repairs or replacements shall be carried out as quickly as possible so as to minimise disruption and inconvenience to residents.	Not Compliant	Orange	17/08/2026
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Not Compliant	Orange	17/08/2026
Regulation 23(1)(b)	The registered 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.	Not Compliant	Orange	11/11/2026
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the	Not Compliant	Orange	01/09/2026

	designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.			
Regulation 24(3)	The registered provider shall, on admission, agree in writing with each resident, their representative where the resident is not capable of giving consent, the terms on which that resident shall reside in the designated centre.	Not Compliant	Orange	13/09/2026
Regulation 26(1)(e)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: arrangements to ensure that risk control measures are proportional to the risk identified, and that any adverse impact such measures might have on the resident's quality of life have been considered.	Substantially Compliant	Yellow	17/08/2026
Regulation 03(2)	The registered provider shall review and, where necessary, revise the statement of purpose at	Substantially Compliant	Yellow	13/07/2026

	intervals of not less than one year.			
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.	Substantially Compliant	Yellow	17/08/2026