



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

Issued by the Chief Inspector

Name of designated centre:	Cois na hAbhann
Name of provider:	Inspire Wellbeing CLG
Address of centre:	Kildare
Type of inspection:	Unannounced
Date of inspection:	07 January 2026
Centre ID:	OSV-0005451
Fieldwork ID:	MON-0039944

About the designated centre

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

The centre is registered to provide residential care and support for 21 adults on the autistic spectrum. The centre is located in a rural setting on a large campus in County Kildare. The centre comprises five houses and four single studio apartments which are each linked to one of the houses. Residents in the single apartments avail of the kitchen and laundry facilities in the houses which they were linked to. The centre supports both male and female adult residents. Residents all have their own bedrooms and each house while configured differently, contains a kitchen, sitting room and adequate numbers of bathrooms. The campus has a large grounds, with gardens and a poly tunnel where some residents engage in horticultural activities. The centre is staffed by a mixture of social care staff, care workers and has nursing support available.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	19
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This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 7 January 2026	09:45hrs to 20:30hrs	Lisa Walsh	Lead
Wednesday 7 January 2026	09:45hrs to 20:30hrs	Gearoid Harrahill	Support

What residents told us and what inspectors observed

Inspectors greeted and spoke with 16 of the residents in the centre and spent time in the communal areas of the houses observing resident and staff engagement to gain an insight into residents' experiences of living in Cois na hAbhann. Some of the residents were unable to tell the inspectors about their views of living in the centre. Other residents said they liked living in the centre and happily brought the inspectors to their bedrooms to show them around. Staff and resident interactions were observed to be kind, with staff being familiar with residents' needs. Residents' were engaging in activities in the community and observed to have an active life. Overall, the inspection found that there were some significant improvements required to protection against infection, fire precautions and premises. Inspectors found that the compliance plan previously submitted by the provider for premises had not been fully actioned, which led to repeated non-compliance and impacted a resident's rights to privacy and dignity. Some incidents of unexplained bruising were also not investigated in line with the provider's own safeguarding policy. Inaccurate information was provided for the application to renew registration of the centre and within the statement of purpose for the centre. Further improvements were also required in staffing, individual assessment and personal plans and medicines and pharmaceutical services.

The centre is located on a large campus on a farm in rural Co. Kildare beside another designated centre on the same campus. On arrival, inspectors were greeted by the person in charge and then guided on a tour of the premises by the team leaders in each of the houses and apartments which comprise the designated centre. Inspectors observed areas to be visibly dirty and poorly maintained. There were five houses and four apartments, three of which were linked to one of the houses. Residents sleeping in the apartments would also use the associated house for recreation and meals. One apartment was supported by staff from one of the houses, however, the resident did not access any of the houses and lived fully in the apartment. During the night, staff would do a visual check of residents in the apartments. Apartment doors were alarmed with sensors, which would sound an alarm in one house to notify staff if the front door of an apartment had been opened.

The centre was registered to accommodate 21 residents, however, two of the rooms registered as residents' bedrooms had been converted into an office without prior consultation with the Chief Inspector of Social Services. As a result the maximum occupancy was reduced to 19 residents. On the day of inspection there were 19 residents residing in the centre and there were no plans for any new admissions to the centre.

Each of the houses consisted of a dining room, kitchen, sitting room and shower or bathroom. The sitting rooms in each of the houses were comfortably furnished and nicely decorated. The first and fourth house were registered to accommodate four

residents in each house. On the day of inspection there were three residents living in each house. The fourth bedroom in both houses had been converted to an office. Other parts of the designated centre were not clearly set out in the layout of the premises and some buildings in use for the designated centre were not detailed at all in information submitted to the Chief Inspector. For example, two store rooms were not detailed on the centre floor plans or in the statement of purpose. Two separate buildings located on the property were used to cook food for residents and also used for some residents' activities and were not part of the designated centre.

One apartment was designed to be very minimalistic to meet the needs of the resident and comprised of a bedroom and toilet facilities only. Two other apartments were laid out like studio apartments with an open plan bedroom, living room and kitchen area with a bathroom. They were pleasantly decorated and had a homely atmosphere. However, one apartment kitchen was not functional due to a lack of running water and the space was used as storage.

Following an April 2024 inspection, one resident had transitioned to live in the fourth apartment to have an individualised service provided to them with a dedicated one-to-one staff on a 24-hour basis to meet their needs and ensure all residents in the centre were safeguarded. During that inspection it was identified that the apartment did not provide adequate private accommodation for the resident at night, in particular, when their one-to-one staff also shared their open plan space. They also had no kitchen and there was limited cooking facilities available for this resident. The registered provider had submitted a compliance plan to reconfigure the layout to ensure privacy and add a kitchen by the 31 December 2024. However, this had not been completed on the day of inspection. In the interim, a privacy curtain was to be installed at the resident's bedroom area. The inspectors were informed that this had been completed, however, on the day of inspection, there was no privacy curtain in place. The person in charge informed inspectors that building works were due to commence the following week.

Overall, residents' bedrooms were pleasantly decorated and personalised with items of interest or activities they enjoyed. Residents had art hanging in their rooms, some of which they had created themselves and pictures of their family and friends. A number of bathrooms and shower rooms had been upgraded to a good standard. Inspectors were also informed of additional upgrade works planned for the centre, such as new flooring in parts of the centre and further improvements to be made to the remaining bathrooms and shower rooms. While some improvements to the premises were planned, inspectors identified that further works were required to ensure the premises met the needs of the residents. For example, throughout the centre door handles were loose and hanging off the doors. In addition, sections were cut around the door handles on fire doors, which would impact fire safety. Parts of the centre had holes and cracks in walls as well as general wear and tear which required painting. Some holes were observed in ceilings or around pipes which also impacted fire containment.

Inspectors found that the centre was not cleaned to a high standard and some practices did not protect residents from the risk of a healthcare associated infection. For example, one apartment lacked soap or towels for a resident to wash their

hands after going to the toilet. The resident had to pass through several touch points, both in their apartment and in the house, which they used for recreational activities and meals before reaching facilities to wash their hands. Some residents' toiletries were stored on the floor in bathrooms and in containers which had a heavy build-up of mildew and grime. Other resident toiletries were stored in a hot press next to dirty pipes.

Inspectors were provided with information on trips and events enjoyed by residents in recent months. This included overnight trips with family and friends, and Halloween and Christmas events. Residents had pictures in their personal plans related to their hobbies and interests, including photos of the residents riding tractors or going to the racecourse, buying their own furniture, going out for lunch or to the pub, and enjoying pet therapy and pottery class.

Residents were observed to attend a range of activities in the community on the day of inspection. Several of the residents attended a fun fair that day and went out for dinner after this and others attended chair yoga in the local community. Some residents did activities within the centre like arts and crafts, working on the farm and gardening. One resident enjoyed photography and was travelling into the local town to print off their photographs.

Inspectors observed that some of the activities or routines enjoyed by a small number of residents impacted the rights of other residents. For example, a resident wanting to direct when certain doors opened or closed and if lights were turned on or off. This impacted on other residents who wanted to have the lights on when they were in the room or easily access the kitchen which had a keypad lock on it and needed staff support to open.

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

Inspectors found that there were established management structures in place in the centre, with key roles clearly identified within the management team to oversee the operation of the centre. While there were management structures in place, the systems to ensure that the service provided was safe, appropriate to residents' needs, consistent and effectively monitored were not robust and at times were ineffective. This impacted a range of areas including the provider's application for renewal of the centre registration, premises, protection against infection, fire precautions, residents' rights, protecting residents from abuse and statement of

purpose. Some improvement was also required in respect of staffing, and medicines and pharmaceutical services.

This unannounced inspection was carried out over one day by two inspectors. The purpose of this inspection was to assess compliance with regulations, review the registered provider's compliance plan following the previous inspection and to inform a decision on an application to renew registration for the centre, which was under review. Inspectors used observations and discussions with residents, alongside a review of documentation and conversations with key staff and management to inform judgments on the residents' quality of life.

Inspire Wellbeing CLG is the registered provider for Cois na hAbhann. The person in charge had been in their role for over three years and was observed to be well-known by both residents and staff. They were responsible for the centre's day-to-day operations and reported to the director of services, who in turn reports to the chief executive officer and registered provider. They worked full-time and were supported by several team leaders in their role. Each individual house within the designated centre had a team leader appointed to it. In addition to this, there were three relief team leaders, who also worked as support workers and provided cover for the team leaders when they were off. The person in charge also had oversight of a staff team, who were knowledgeable about the support needs of the residents living in the centre.

There was documentary evidence of communication occurring between the person in charge and service manager. However, the minutes of these meetings were not available for inspectors to review. Therefore, it was unclear what level of oversight the registered provider had regarding key quality and safety areas. Within the centre communication occurred at team leader level and staff meetings. The records of these meetings were limited and inconsistently documented. There were no time-bound actions identified, or persons responsible for implementing these actions.

The inspectors reviewed the provider's last two six-monthly provider-led audits and the latest annual review. They found that the audits focused on the same few areas, such as, staffing, notifiable incidents, restrictive practice, safeguarding and complaints and failed to identify areas of concern found on inspection. As such they were ineffective in driving quality improvement, in particular with reference to the outstanding premises issues, fire safety and protection against infection. The annual report for 2025 did not comment on issues relating to either staffing or premises and also contained limited commentary and feedback from residents on their opinions, experiences, achievements and challenges.

Inspectors met with staff during this inspection and reviewed the staffing arrangements in the houses, alongside the statement of purpose and centre rosters. At the time of this inspection, the provider had some staffing vacancies and used agency personnel to fill shifts and where possible, this was done using a consistent set of personnel. Despite cover arrangements in place, rosters identified that shifts were not always filled in line with house requirements and residents' needs. While a planned and actual staff roster was maintained, the systems in place to manage this

were ineffective. This led to multiple versions of actual rosters, which were all different.

Registration Regulation 5: Application for registration or renewal of registration

An application to renew registration of the designated centre in accordance with the requirements set out in the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulation 2013 had been made by the registered provider. This application was in the process of being reviewed at the time of inspection.

During the inspection, inspectors identified that the registered provider had made changes to the centre, which were not included in the application. For example, the registered provider had applied to register an occupancy of 21 residents to be accommodated in the centre. However, two bedrooms had been converted into offices, meaning that a maximum occupancy of 19 residents only could be accommodated.

The description of the premises was also inaccurate. For example:

- Two store rooms within the centre which were used in the running of the designated centre were not reflected on the design and layout of the premises.
- Two buildings which were used in the running of the designated centre were not reflected on the design and layout of the premises.
- An office had also been converted to storage.
- A kitchen in one apartment was not functioning. There was no running water in the sink and the space was used as storage.

Judgment: Not compliant

Regulation 15: Staffing

Inspectors met with staff during this inspection and reviewed the staffing arrangements in the houses alongside the statement of purpose and centre rosters. At the time of this inspection, the provider had staffing vacancies equivalent to five whole time equivalent (WTE) posts. The staffing complement supported houses to have local team leaders, and staff in each location demonstrated a good knowledge of the residents, their support needs and active risks associated with the service.

The inspectors were provided with evidence to indicate that the staffing complement for day and night shifts were being reviewed in light of changes to residents and their support needs. Roster records indicated that where the provider was required to use agency personnel to fill shifts, this was done using a consistent regular set of

personnel to maintain continuity of familiar staffing which was important for the quality of resident support. Inspectors reviewed worked rosters for July to December 2025. Records identified staff on sick leave and when shifts required agency cover. Despite these cover arrangements, rosters identified that shifts were not always filled in line with house requirements, with some months noting between eight and 10 days with shifts not covered. In addition, the oversight system in place to manage actual worked rosters was ineffective. While reviewing rosters, inspectors found that there were multiple versions of actual rosters for each month, which were all different.

Judgment: Substantially compliant

Regulation 23: Governance and management

While the registered provider had implemented management systems to monitor the quality and safety of service provided to residents, this was not always effective. For example, some actions from the previous inspection in respect of premises had not been completed, which were set out by the provider in their compliance plan. Other impacted areas included the application for registration renewal, premises, and protection against infection, fire precautions, residents' rights and protecting residents from abuse, which are all detailed under each respective regulation.

There were communication systems in place to ensure the registered provider had oversight of the centre and management meetings with the person in charge and team leaders in the centre. Inspectors were informed that the provider was having regular meetings with the person in charge and there was evidence of an agenda for monthly meetings. However, there were no meeting minutes available for the inspectors to review to reflect discussions held, decisions, actions, person(s) responsible and action due dates.

The registered provider had also removed two bedrooms and converted them into offices in the designated centre without informing the Chief Inspector. This meant the centre was not operating as required by Condition 1 and Condition 3 of the centre's certificate of registration.

The registered provider was completing six monthly unannounced provider led audits of the centre. However, these audits were ineffective in capturing and actioning key areas of concern in the centre as highlighted in the course of inspection, such as, premises, protection against infection and fire safety. They were also not completed at least once every six months.

Inspectors reviewed the annual report for the service dated August 2025. This report collated information from healthcare matters, adverse incidents and events in the centre. However, there was a limited summary section commenting on all 19 residents' in which the provider collectively described activities and holidays, with

limited evidence of the feedback and commentary collected through consultation with the residents in the creation of the report.

Judgment: Not compliant

Regulation 3: Statement of purpose

A written statement of purpose was available to inspectors on the day of inspection. However, considerable action was required to ensure that it was in compliance with the regulation. For example, the information in relation to services and facilities to be provided was inaccurate and did not reflect the service on the day of inspection.

Judgment: Not compliant

Quality and safety

Inspectors observed kind and compassionate staff treating the residents with dignity and respect, as described above. However, this inspection identified areas where improvements were required to ensure a good standard of care and support was provided to residents, specifically in relation to residents' rights, safeguarding, premises, protection against infection, and fire precautions. Further improvements were also required in medicines and pharmaceutical services, and individual assessment and personal plan.

An up-to-date safeguarding policy was in place to guide staff in the event of a concern of abuse arising. Inspectors found that training was provided to staff in relation to safeguarding residents and the prevention, detection and response to abuse. Each resident's welfare was promoted, and care and support was received in an environment where efforts were made to prevent the risk of harm. While the provider had systems in place to protect residents from harm and investigated any serious incident or allegation of abuse, the process for investigation of a suspicion of abuse was not always followed. This resulted in some suspicions of abuse not being reviewed or investigated in line with the provider's own safeguarding policy and not being considered as possible safeguarding concerns.

Inspectors completed a walk-through of all houses and apartments in this designated centre. In the main, residents' bedrooms were observed to be personalised and appropriately decorated for each resident, with space in which residents could store personal belongings and clothes and display photos, collectibles, artwork and items related to their hobbies and interests. Some residents had preferred hangout spots in the houses or gardens. Actions identified from the previous inspection in respect of premises had not been completed. Other issues

were also identified on the day of inspection with considerable action required for premises to be compliant with the regulations.

There were a range of appropriate fire precautions in place that were specific to the centre, documented and readily available for staff use. The provider had ensured that fire precautions did not unnecessarily reduce residents' quality of life. The provider had ensured that all fire equipment required was provided and maintained in line with the associated standard and by competent service personnel. Fire safety checks were taking place regularly and were recorded, however they were not identifying the areas of concern found on inspection. For example, holes in the ceiling, incorrect fire maps of the premises and fire doors being wedged open, which could impact containment in the event of a fire.

Medicines were stored in a secure location within the designated centre and prescribed by a registered prescriber. There were appropriate practices relating to ordering, receipt and disposal of medicines. Residents had been risk assessed to determine if they could administer their own medicines or needed staff support to do so. There were systems in place for administering medicines. However, these were not always effective and there had been several medication errors.

Regulation 17: Premises

As referenced elsewhere in this report, some areas required review to ensure they were suitable for the preferences and requirements of the residents. For example, some areas were not optimal to provide privacy for residents, which is a repeated non-compliance from previous inspections. For instance, where a staff member supported a resident in an open plan studio apartment there was no privacy screen around the resident's bed for when they slept. The provider had not ensured a resident had access to kitchen or bathroom facilities in their own living space. Some resident furniture was damaged and required replacement.

Some areas of the premises were observed to not be clean or kept in a good state of maintenance. A number of storerooms including where food or cleaning equipment were stored, were observed to be dirty with debris, rubbish, cobwebs, dead insects, mould and mildew. Some walls and floors were seen to have flaked, cracked or worn surfaces which impacted on the homeliness of the centre as well as having an impact on their ability to be cleaned.

Judgment: Not compliant

Regulation 27: Protection against infection

As referenced in relation to premises, inspectors observed a number of areas across the premises which were not clean on this inspection. This included storage rooms

for medicine boxes and food which were dirty or cluttered with rubbish. Worn, flaked, rusted or torn surfaces around the premises impacted on the ability to effectively clean and sanitise surfaces. A build-up of mildew and grime was observed on items such as shower spaces and chairs, and on containers used for toothbrushes and razors. Some toiletries and mop heads were stored on floors, which was not optimal for infection control practices. Cleaning equipment such as mop poles, buckets and brooms were observed to be dirty or not stored in a clean space between uses.

Some handwashing areas including bathrooms, were not equipped with soap or hand towels. This resulted in a routine practice of some residents travelling to another house to wash their hands after using the toilet, which carried risk related to touch-surface contact.

Judgment: Not compliant

Regulation 28: Fire precautions

The registered provider had taken adequate precautions against the risk of fire in the designated centre with suitable fire-fighting equipment. The arrangements in place for detecting and containing fires however, required substantial review. For example:

- Some fire doors were wedged open and could not automatically close in the event of the fire alarm being activated.
- There were two holes in the ceiling which could impact the spread of a fire and smoke.
- Several fire doors and door frames had holes in them. Several fire doors also had sections cut-out around the door handles and placed back into the frame loosely. Some gaps were also observed between the fire doors and the door frames.
- Fire escape route maps were incorrect.

Regular fire drills were taking place and inspectors reviewed a sample of reports from these practice evacuations. Staff advised that there was a resident who may refuse to leave the building when prompted to evacuate. However, this was not recorded in the resident's personal emergency evacuation plan (PEEP). In a sample of drill reports for one house, an evacuation was noted to have taken more than three times longer than the recommended time to evacuate all residents' and staff. However, there was no explanation recorded for why this was and what action could be taken to address the matter for future reference; this was a lost opportunity to educate staff on procedures.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

While there were appropriate measures in place relating to administering medication as prescribed, there had been several incidents of medication errors, which led to residents not receiving medicines as prescribed. The systems around the review of administration of medicines were not found to be effective.

A sample of records reviewed showed that for one resident it was over a year since their medicines had been reviewed to ensure they met their needs.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

The inspectors reviewed assessments of need and associated health, social and personal care plans for a sample of four residents in this centre. Overall, support plans were person-centred in nature and based in evidence from incidents and changing support needs. Residents with modified diets or precautions around certain types of food were under the care of the dietitian and routinely reviewed. Residents were assessed for their specific support needs in behavioural support, intimate and personal hygiene, and preferences regarding personalisation of their living space and ownership of household chores.

The inspectors observed evidence that residents had worked with their keyworker to establish meaningful personal development and recreational goals including events, holidays and areas in which the resident was supported to be more independent.

Some gaps were observed in personal assessments and support plans. For example, in the case of one resident who was assessed as being at high risk of falls with multiple risk controls in place; inspectors were advised that there had been no assessment by an occupational therapist of the resident's environment which included multiple stairways and trip hazards. In the sample of care plans reviewed, there was also limited commentary on the evaluation of effectiveness of support plans.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

The inspectors reviewed a sample of care and support plans for residents who may respond to anxiety or frustration in a manner that could present a risk to themselves or others. In these plans, the inspectors observed functional assessments which

identified each behaviour and described the reason for the presentation. This included residents who expressed behaviours to communicate that there was too much noise in their vicinity, or could become fixated on certain items or areas if these were in plain view. Staff were provided with guidance on how each resident may present when experiencing distress and how a low-arousal environment could be maintained. Guidance was also provided on de-escalation strategies in response to aggression or physical risks, and these interventions were informed by formal assessment by the clinical psychologist as well as observations by the front line staff team.

Residents were subject to environmental, physical and rights-based restrictions in this service. For these practices and interventions, the rationale for their use was clear and person specific. The inspectors observed how these were kept under review and how risk assessments and adverse incidents were used to justify their retention, and what criteria would have to be met to phase them out and move towards a restraint-free environment.

Judgment: Compliant

Regulation 8: Protection

While the provider had systems in place to protect residents from harm and investigate any incident or allegation of abuse, the process for when there was a suspicion of abuse was not always followed. For example, the Chief Inspector had been informed of incidents of unexplained bruising for some residents at times through a written report at the end of each quarter. However, these had not been reviewed or investigated in line with the provider's own safeguarding policy and had not been considered as possible safeguarding concerns. Another incident had been recorded for a resident who sleeps in an apartment unsupervised and had been found very upset with injuries noted. This also was not considered as a possible safeguarding concern and therefore had not been investigated.

Judgment: Not compliant

Regulation 9: Residents' rights

Residents using the service have freedom to exercise choice, in so far as such choice does not interfere with the rights of other people using the service. Inspectors observed that some of the activities or routines enjoyed by a small number of residents impacted the rights of other residents. For example, a resident wanting to direct when certain doors opened or closed and if lights were turned on or off. This impacted on other residents wanting to have the lights on when they were in the

room or on how easily they could access the kitchen which had a keypad lock on it as they needed staff support to open.

Residents should have an opportunity to be alone as they choose and to have their privacy and dignity respected in all aspects of their lives and at all times. As described in other parts of the report, one resident's apartment did not provide adequate private accommodation for the resident at night, in particular, when their one-to-one staff also shared their open plan space, which had been the case since the last inspection in April 2024.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 5: Application for registration or renewal of registration	Not compliant
Regulation 15: Staffing	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Not compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 27: Protection against infection	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Cois na hAbhann OSV-0005451

Inspection ID: MON-0039944

Date of inspection: 07/01/2026

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
Registration Regulation 5: Application for registration or renewal of registration	Not Compliant
<p>Outline how you are going to come into compliance with Registration Regulation 5: Application for registration or renewal of registration:</p> <p>Reg 5(1)</p> <ul style="list-style-type: none"> • The Provider has updated the Application for renewal of the Centre's Registration to be submitted no later than 27/03/26, to reflect the maximum number of residents who can be accommodated at the centre, and the maximum number who will be accommodated during the period of registration; • The Provider will submit updated floor plans to accompany the updated application, to reflect: <ul style="list-style-type: none"> o The usage of two store rooms in the centre. o The two additional building used by Residents but not previously captured on the floor plans; o The office in House 1 now converted to a storage room; o A bedroom in House 1 now converted to an office o A bedroom in House 4 now converted to an office o The new floor plans for the House 1 Apartment which was refurbished since the inspection <p>Reg 5(3)(g)</p> <ul style="list-style-type: none"> • The Provider will update the Statement of Purpose, no later than 27/03/2026, to reflect the maximum number of residents that can be accommodated at the centre; <p>Reg 5(3)(h)</p> <ul style="list-style-type: none"> • The Provider has updated the Statement of Purpose, no later than 27/03/2026, to reflect the maximum number of residents who will be accommodated at the designated centre at any one time during the period of registration. 	

Regulation 15: Staffing	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 15: Staffing:</p> <p>Reg 15(1)</p> <ul style="list-style-type: none"> • The PIC and Provider shall review and update, no later than 03/04/26, the centre's staffing contingency plan. This includes required measures to cover gaps, a dynamic risk assessment on the adequacy of arrangements, and required escalation to the PIC. • The Provider has a rolling recruitment plan in place to fill staffing vacancies. <p>Reg 15(4)</p> <ul style="list-style-type: none"> • The PIC has reviewed the local process for planned and actual rota creation on 09/03/26. The PIC shall ensure a single version of each, and will continue to monitor to support full implementation by all staff. 	
Regulation 23: Governance and management	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 23: Governance and management:</p> <p>Reg 23(1)(c)</p> <ul style="list-style-type: none"> • The Provider has implemented revised meeting templates on 30/04/2026 for local meetings and departmental management meetings to ensure adequate records and reflection of timebound actions. • The Provider is undertaking a review of quality monitoring processes to address gaps in the identification of improvements found at inspection. Review will be completed by 01/05/26. • The Provider will, as of 01/05/26, increase its frequency of quality monitoring to monthly support earlier identification of issues of quality and compliance. <p>Reg 23(1)(d) The Provider shall review the training & guidance provided to those undertaking Annual Reviews by 01/05/2026 to ensure the reports effectively capture the quality and safety of care and support provided and the identification of any improvements needed in a timely manor.</p> <p>Reg23(1)(e) The Provider's review of training and guidance will ensure a clear focus is given to increasing the quality and volume of feedback from residents included in the report (by 01/05/2026).</p> <p>Reg 23(2)(a)</p> <ul style="list-style-type: none"> • The Provider has, on 12/03/26, reviewed its schedule of monitoring to ensure a suitable person is allocated to complete a quality monitoring visit at least every six months. • The PIC will continue to generate a Service Improvement Plan (SIP) plan where improvements are identified, and the implementation of these SIPs will be monitored through subsequent monitoring visits and the PIC's supervision. • The Provider will review with those allocated to complete reports, the requirements for adequate completion of six-monthly reports and action plans with all those allocated the 	

responsibility. This will take place no later than 01/05/26,	
Regulation 3: Statement of purpose	Not Compliant
Outline how you are going to come into compliance with Regulation 3: Statement of purpose: The Provider will review and update, no later than 27/03/26, the Statement of Purpose to accurately reflect the Services and facilities provided in the centre, the number of residents, and floor plans for all areas in use for the Residents.	
Regulation 17: Premises	Not Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: The Provider is undertaking a programme of refurbishment in partnership with the HSE funder: <ul style="list-style-type: none"> • Reg 17(1)(a) A new kitchen and bathroom has been built into the apartment of one resident on 07/02/26, to ensure they have access at all times in their own accommodation. • Reg 17(1)(b) A programme of repairs to damaged walls and worn surfaces on floors has commenced with a planned completion of 30/05/26. • Reg 17(1)(c) The PIC has reviewed and amended the cleaning schedule to enhance deep-cleaning tasks commencing 23/03/26. Reg 17(4) The PIC has ordered replacement sofas, expected delivery 30/06/26. Reg 17(7) The provider has renovated the Apt in House 3 to create adequate private space for the resident in their own accommodation, a private bathroom and a separate kitchen area with cooking and cleaning facilities on 07/02/26.	
Regulation 27: Protection against infection	Not Compliant
Outline how you are going to come into compliance with Regulation 27: Protection against infection: <ul style="list-style-type: none"> • The Provider has reviewed and amended the cleaning schedule to enhance deep-cleaning tasks on 23/03/26. <ul style="list-style-type: none"> o A check for adequate soap and hand towels has been added to the daily tasks on the centre's cleaning schedules. o The PIC has completed a check and cleaning programme of all areas of the centre to address issues identified at inspection. • The PIC has scheduled IPC audits to be completed across the centre by 31/05/26. 	
Regulation 28: Fire precautions	Not Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions:	

Reg 28(3)(a)

The PIC has addressed a number of fire precaution issues in the Service:

- Removed door wedges from the centre on 15/03/26.
- Provided instruction to the team on the prohibition of wedging doors open on 15/03/26 by email.
- Provided instruction to the team on adequate completion of daily fire checks to ensure all fire precautions are consistently implemented on 15/03/26.
- Instigated works to rectify holes in the ceiling, defective fire doors and frames, to be completed by 31/03/26.
- Engaged an architect to update floor plans with correct fire escape routes. Updated plans will be in place no later than the 31/03/2026.

Reg 28(4)(b)

- The PIC has reviewed with the team (in their staff meeting 25/02/2026 the correct method of completion of fire drills and clarified expectations on recording. This will be discussed further through team meetings held during April 2026.
- The PIC has reviewed all PEEPs, with updates to be completed by 20/03/2026. |

Regulation 29: Medicines and pharmaceutical services

Substantially Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:

- The Provider shall complete an audit of medication administration within the service no later than 01/06/26.
- The PIC shall, as of 31/03/2026 commence the inclusion of Review and Trend analysis for medication errors in their existing quarterly incident review. A Service Improvement Plan will be implemented and communicated to the team on the completion of each review.
- The PIC will complete an audit of medication records no later than 31/03/26 and will arrange a review of medication for any person without a timely review having already been completed.

Regulation 5: Individual assessment and personal plan

Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:

Reg 5(1)(b)

- The PIC shall complete an audit of all residents' Assessment of Needs no later than 08/04/26. Where gaps are identified, assessments will be updated and where needed MDT input sourced. The PIC shall action any recommendations made on assessment of needs and MDT input when received.

Reg 5(3)

- The PIC has requested and received (16/01/26) an OT assessment for the individual highlighted in the report. The PIC has reviewed and updated the persons care plan.

Reg 5(6)(c)

- The PIC has implemented a documented monthly evaluation of the effectiveness of personal plans to be completed by keyworkers. Initial reviews shall be complete by 30/04/26. The PIC shall audit completion of evaluations. |

Regulation 8: Protection

Not Compliant

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

Reg 8(2)

- The Provider will provide no later than 20/03/26, give additional guidance to the centre's team on the requirement and method of escalation to a Designated Officer any concerns identified.

Reg 8(3)

- The Provider has issued additional guidance to all staff in the Centre on the 15/03/26, to remind all that unexplained bruising must be reported and responded to through the organisations' Safeguarding Policy.
- The PIC will ensure reporting of unexplained bruising is the subject of a reflective practice discussion in team meetings, no later than 01/05/26.
- The PIC will undertake and audit of recent incident event records, to consider against Safeguarding Policy, no later than the 31/03/26. The PIC will ensure that any previously unreported issues are appropriately addressed.
- The PIC has reviewed and recorded a response, through the organisations Safeguarding Policy, to the event raised at inspection on 13/03/26. |

Regulation 9: Residents' rights

Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:

Reg 9(2)(b)

- For the identified issue of compatibility, the Provider and PIC shall review living arrangements and preferences, no later than 01/05/26, to identify actions to minimise the impact of shared living.
- The Clinical Psychologist Behavioural Consultant has completed a review of the individual (whose behaviours impact others) behavioural support plan on 09/03/26. On receipt of updated plans, the PIC will review with the team the actions required to support the person and to minimise the impact of behaviours on others.
- The PIC will review, no later 01/05/26, the positive behaviour support arrangements with the MDT for the individual whose behaviours impact others to ensure all possible support is in place to appropriately address behaviours.

Reg 9(3)

- The PIC has completed remedial work, on the 16/01/26, in the apartment for the person identified in the report to provide separation of their living and sleeping space. A confirmation of planning compliance form will be submitted. Floor plans have been updated. |

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
Registration Regulation 5(1)	A person seeking to register a designated centre, including a person carrying on the business of a designated centre in accordance with section 69 of the Act, shall make an application for its registration to the chief inspector in the form determined by the chief inspector and shall include the information set out in Schedule 1.	Not Compliant	Orange	27/03/2026
Registration Regulation 5(3)(g)	In addition to the requirements set out in section 48(2) of the Act, an application for the registration or the renewal of registration of a designated centre shall be accompanied by a statement of the maximum number	Not Compliant	Orange	27/03/2026

	of residents the applicant considers can be accommodated at the designated centre.			
Registration Regulation 5(3)(h)	In addition to the requirements set out in section 48(2) of the Act, an application for the registration or the renewal of registration of a designated centre shall be accompanied by a statement of the maximum number of residents who will be accommodated at the designated centre at any one time during the period of registration, and for which the registered provider is requesting approval by the chief inspector in the application for the registration or the renewal of registration of the designated centre.	Not Compliant	Orange	27/03/2026
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	Substantially Compliant	Yellow	03/04/2026

	size and layout of the designated centre.			
Regulation 15(4)	The person in charge shall ensure that there is a planned and actual staff rota, showing staff on duty during the day and night and that it is properly maintained.	Substantially Compliant	Yellow	09/03/2026
Regulation 17(1)(a)	The registered provider shall ensure the premises of the designated centre are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.	Not Compliant	Orange	30/05/2026
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Substantially Compliant	Yellow	30/05/2026
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Not Compliant	Orange	23/03/2026
Regulation 17(4)	The registered provider shall ensure that such equipment and facilities as may be required for use by	Not Compliant	Orange	30/06/2026

	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.			
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Not Compliant	Orange	07/02/2026
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	01/05/2026
Regulation 23(1)(d)	The registered provider shall ensure that there is an annual review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards.	Substantially Compliant	Yellow	01/05/2026

Regulation 23(1)(e)	The registered provider shall ensure that the review referred to in subparagraph (d) shall provide for consultation with residents and their representatives.	Substantially Compliant	Yellow	01/05/2026
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.	Substantially Compliant	Yellow	01/05/2026
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and	Not Compliant	Orange	31/05/2026

	control of healthcare associated infections published by the Authority.			
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	31/03/2026
Regulation 28(4)(b)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Substantially Compliant	Yellow	30/04/2026
Regulation 29(4)(b)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine which is prescribed is administered as prescribed to the resident for whom it is prescribed and	Substantially Compliant	Yellow	01/06/2026

	to no other resident.			
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose containing the information set out in Schedule 1.	Not Compliant	Orange	27/03/2026
Regulation 05(1)(b)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out subsequently as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.	Substantially Compliant	Yellow	08/04/2026
Regulation 05(3)	The person in charge shall ensure that the designated centre is suitable for the purposes of meeting the needs of each resident, as assessed in accordance with paragraph (1).	Substantially Compliant	Yellow	16/01/2026
Regulation 05(6)(c)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or	Substantially Compliant	Yellow	30/04/2026

	circumstances, which review shall assess the effectiveness of the plan.			
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Substantially Compliant	Yellow	20/03/2026
Regulation 08(3)	The person in charge shall initiate and put in place an Investigation in relation to any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.	Not Compliant	Orange	01/05/2026
Regulation 09(2)(b)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability has the freedom to exercise choice and control in his or her daily life.	Substantially Compliant	Yellow	01/05/2026
Regulation 09(3)	The registered provider shall ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships,	Not Compliant	Orange	16/01/2026

	intimate and personal care, professional consultations and personal information.			
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