Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	Tullycoora House
Name of provider:	Trinity Support and Care Services Limited
Address of centre:	Monaghan
Type of inspection:	Unannounced
Date of inspection:	22 September 2025
Centre ID:	OSV-0008059
Fieldwork ID:	MON-0048019

About the designated centre

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

Tullycoora House consists of a large two-storey and a stand alone one bedroom apartment (on the grounds of the main house) located in a rural setting in County Monaghan. The designated centre provides care and support to four adults with disabilities (three live in the main house and one lives in the apartment). Each resident has their own private bedrooms decorated to their individual style and preference. There are garden areas to the front and rear of the main house and, the apartment has its own private garden. Communal facilities include a fully equipped kitchen cum dining room, a number of bathrooms and two sitting rooms. Transport is provided to the residents so as they can access nearby towns, shops and other community-based facilities. The centre is staff by a full-time person in charge, nursing staff, social care workers and assistant social care staff.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	4

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Monday 22 September 2025	07:50hrs to 15:20hrs	Raymond Lynch	Lead
Monday 22 September 2025	07:50hrs to 15:20hrs	Florence Farrelly	Support

What residents told us and what inspectors observed

This was a risk-based inspection following up on the compliance plan as submitted to the Office of Chief Inspector after the last inspection of the designated centre on 04 March, 2025. At that inspection Regulation 23: governance and management was assessed as not-compliant for a number of reasons to include issues with the effectiveness of the auditing process, issues to do with the upkeep and maintenance of some documentation, issues to do with some healthcare assessments and a delay in accessing a service from an allied healthcare professional. While a number of these issues had been addressed at the time of this inspection, some remained ongoing. Additionally, Regulation 26: risk management and Regulation 31: notification of incidents were found to be not compliant. Regulation 6: protection and Regulation 13: general welfare and development were also found to be substantially compliant. These issues are discussed later in this report, under the relevant regulations.

When the inspectors arrived to the service at 07.50am it was observed that there was no bell to alert staff there was someone trying to access the centre. However, the telephone number on the house was provided on the gate. On calling that number the inspectors found that it went straight to voice mail. The inspectors called a number of stakeholders (to include the person in charge, the director of operations and the provider representative) so as to alert them that they were trying to gain access to the centre however, were not able to make contact with any of them. Eventually at 08.10am the two staff working in the centre observed that the inspectors were at the gate and opened it to allow them in. Later on in the day, the inspectors met with the provider representative and informed them of this issue with trying to access the centre.

On entering the house the inspectors were met with a team leader and staff nurse. This centre comprised of a large detached two storey house and a stand-alone one bedroom apartment on the grounds of the property. One inspector stayed in the main house and the other went over to the apartment so as to meet the resident living there. The residents in the main house were in bed so the inspector reviewed a number of documents at this time. The inspector that went to the apartment observed the staff handover from waking night staff to day staff where updates and news concerning the resident was discussed. For example, it was discussed that the resident's family had visited them the day before this inspection. It was the resident's sisters birthday and they all had cake and the resident presented their sister with a bouquet of flowers and chocolates to celebrate the event. Staff reported that the resident very much enjoyed spending time with their family.

The apartment was decorated to suit the individual style and preference of the resident. For example, they had access to toys, books and stuffed animals (such as a panda bear and a teddy bear). In their private garden area they had access to a trampoline, a buggy with a trailer and garden furniture so as they could relax and have lunch in their garden in times of good weather. Staff were observed chatting

with the resident and cleaning their apartment on the morning of this inspection. They were also observed the be attentive to the needs of the resident. For example, the resident requested juice and cereal for breakfast and staff ensured this request was followed up on. However, at the time of this inspection, this resident did not have access to an adequate mode of transport to access community-based facilities or for social outings and this needed review. This issue is discussed in more detail under Regulation 13: general welfare and development.

Another resident in the main house spoke with one inspector on the morning of this inspection. They reported that they were happy in the house and had everything they needed. For example, they had their own bedroom and were happy with it. They were not attending any day service at the time of this inspection however, the person in charge said that they were looking into volunteering programmes in the community that the resident might be interested in, such as a tidy towns project. The resident told the inspector that they liked to go out each day for drives and for social outings and, do personal shopping in one of the nearby towns. On the morning of this inspection the resident went out for the day with staff support to participate in social and community-based activities of their choosing. This resident also liked to keep in contact with their family.

The other resident in the main house did not speak with the inspectors however, they appeared settled in their home and comfortable in the company and presence of the staff team. When they wanted something they were observed to approach staff and, staff were observed to be attentive to the needs of this resident at all times over the course of this inspection.

The house and apartment were observed to be generally well maintained and clean on the day of this inspection and decorated to the individual style and preference of the residents.

Overall, while residents appeared settled and comfortable in their home on the day of this inspection, issues were identified with risk management, notification of incidents, protection and general welfare and development.

The next two section of the report present the findings of this inspection in relation to the governance and management arrangements and how these arrangements impacted the quality of care and support being provided to residents.

Capacity and capability

Residents appeared happy and content in their home on the day of this inspection.

The centre had a clearly defined management structure in place which was led by a person in charge. The person in charge was a qualified health/social care professional and demonstrated a knowledge of the residents' assessed needs.

A review of a sample of rosters indicated that there were sufficient staff on duty to meet the needs of the residents as described by the person in charge on the day of this inspection.

Staff spoken with had a good knowledge of residents' assessed needs. Additionally, from a sample of training records viewed, staff were provided with training to ensure they had the necessary skills to respond to the needs of the residents.

It was observed however, that Regulation 31: notifications of incidents required review as two notifiable events that occurred in the centre prior to this inspection, had not been reported to the Office of Chief Inspector.

The provider had systems in place to monitor and audit the service and for the most part, the issues as found on the previous inspection of this service on 04 March 2025, had been addressed.

Regulation 14: Persons in charge

The person in charge was responsible for the day-to-day operational management of the designated centre.

They were a qualified health/social care professional and as found on the previous inspection of this centre on 04 March 2025, they demonstrated a knowledge of the assessed needs of the residents in the designated centre.

They also had systems in place for the oversight and supervision of their staff team.

Judgment: Compliant

Regulation 15: Staffing

From a review of the rosters from 15 September 2025, to the 28 September 2025, it was found that there were sufficient staffing on duty each day with required training to meet the needs of the residents.

One inspector completed a review of the rosters as above. This demonstrated to the inspector that safe minimum staffing levels were maintained in order to meet the assessed needs of the residents.

For example, the person in charge worked Monday to Friday in the centre each week. In addition to the person in charge, six staff members worked each day in the centre. Two residents were on 2:1 staff support throughout the day and the other

two residents were on 1:1 staff support. Additionally, three staff worked each night in the centre, with one of those staff stationed in the apartment.

It was observed that the staffing levels could reduce where a resident may be on a visit home.

There were agency staff covering some shifts however, the person in charge explained to the inspectors that they never worked on their own in the apartment but were placed in the house where there were always experienced and trained staff on duty.

Staff personnel files were not reviewed as part of this inspection process.

Judgment: Compliant

Regulation 16: Training and staff development

Staff were provided with training so as they had the skills and knowledge to meet the assessed needs of the residents.

From reviewing the training matrix staff had undertaken the following training:

- safeguarding
- Children's First
- online first aid
- diabetes
- blood pressure
- management of behaviours of concern
- positive behavioural support
- fire safety
- manual handling
- medication management
- ligature risk reduction.

One inspector asked to see the safeguarding and Children's First certificates of four staff members and they were made available for review prior to the end of the inspection.

The person in charge also confirmed in writing that all relief and agency staff were vetted and they had all documents pertaining to schedule 2 in their files. The person in charge also confirmed that these staff had completed the required training to work with the residents. They also confirmed that agency staff who had not completed strategies for preventing, de-escalating, and managing aggressive behaviour did not lone work with a resident who presented with behaviours that challenge (there was a risk assessment in place for this).

The last inspection of this centre on 04 March, 2025 found that there were formalised supervision arrangements in place and from a review of one staff file and from speaking with the person in charge at that time, supervision was occurring as per the frequency of the provider's guidance.

Judgment: Compliant

Regulation 23: Governance and management

There were clear lines of authority and accountability in this service at the time of this inspection.

The team consisted of a person in charge, two team leads, nursing staff, social care workers and assistant social care staff. The person in charge was also supported in their role by director of operations and member of the quality management team. Additionally, an out of hours on-call management system was available to staff as or if required.

Additionally, a number of the issues as found on the last inspection on 04 March 2025, had been addressed. For example:

- a blood pressure support plan for one resident that required review, had been updated
- health assessments where required, had been completed
- positive behavioural support plans that required updating, had been reviewed
- medication support plans had been reviewed
- hospital passports had been reviewed
- a neurology appointment for one resident had been facilitated with the provision of pre and post consultation documents
- the maintenance log had been reviewed and updated
- a personal emergency evacuation plan (PEEPs) had been updated as required
- an issue was also identified regarding one aspect of the management of complaints on the day of this inspection however, prior to the end of the process the person in charge provided assurances that this issue had been addressed.

While it was observed that issues were found on this inspection with notifications of incidents, general welfare and development, protection and risk management, these issues are discussed and actioned under the relevant regulations as set out below.

Judgment: Compliant

Regulation 31: Notification of incidents

While the person in charge demonstrated a knowledge of their legal remit to notify the Chief Inspector of notifiable events occurring in the centre, it was observed that two such incidents were not notified as required.

For example, prior to this inspection one resident had briefly absconded from the centre. While they came to no harm, an NF05 (a form reporting an unexplained absence of a resident from the designated centre) was not submitted to the Chief Inspector reporting this incident.

Additionally, a resident made a serious allegation against a staff member prior to this inspection and, the person in charge informed the inspectors that this was dealt with internally. Additionally, they also reported that at that time, they had no grounds for concern regarding this allegation. However, no NF06 (a form for the allegation, suspected or confirmed, of abuse to a resident) was submitted to the Chief Inspector reporting this issue.

This was of concern to the inspectors as notifications to the Chief Inspector provide information on what impact (if any) the issue had on the resident and more importantly, what actions had been taken to ensure the safeguarding of the resident. Notifications also provided assurances that the issue reported was managed using a person-centred approach and was reviewed as part of the provider's continual quality improvement measures. In turn this process once followed, would enable effective learning and help to prevent a possible reoccurrence of the issue.

Judgment: Not compliant

Quality and safety

The residents living in this service were supported to live their lives based on their individual preferences and choices however, issues were identified with general welfare and development, risk management procedures and protection.

Residents were supported with their health and emotional needs and had access to allied healthcare professionals where required. It was observed that most of the issues as identified on the previous inspection had been addressed regarding healthcare however, there remained a delay in accessing speech and language therapy (SALT) for one resident.

Residents were supported with their general welfare and development and to maintain links with family and friends. However, an issue with one mode of transport was impacting on one residents ability to access community-based activities which required review.

There were systems in place to manage and mitigate risk and keep residents safe in the centre. However, (and as found in the previous inspection) aspects of the risk management process continued to require review. Systems were also in place to safeguard the residents however, as discussed under Regulation 31: notifications of incidents, an allegation of abuse by a resident was not reported to the Chief Inspector as required by the designated centre's own policies and procedures and by the Regulations.

Fire precautions were not reviewed as part of this inspection however, the issue regarding the personal emergency evacuation plans as identified on the last inspection of the centre 04 March 2025, had been addressed.

The issues as identified with Regulation 8: protection , Regulation 13: general welfare and development and Regulation 26: risk management are discussed under the relevant regulations as set out below in the next section of this report.

Regulation 13: General welfare and development

Residents were supported and encouraged to maintain connections with family and friends. They were also supported to use community-based facilities.

On the day of this inspection one resident was at home visiting with their family. This resident when in the centre also liked to sing, play the guitar and listen to music. They also liked to go for drives, or go shopping in nearby towns with staff support.

Another resident who recently had a visit to the centre from their family, had a number of long and short-term goals identified in their care plans. Some of these goals were related to building independence skills, health-related goals and visiting their family home. One inspector met with this resident and they appeared happy and settled in their home. It was observed however, that this resident required a special mode of transport to access community-based facilities. However, at the time of this inspection, that transport had not been available to the resident since July 2025 which meant the resident did not leave the centre since July. This needed review so as to ensure the resident had access to an adequate mode of transport to access community-based facilities and for social outings and trips away from the designated centre.

Another resident in the main house spoke with one inspector on the morning of this inspection. The reported that they were happy in the house and had everything they needed. They were not attending any day service at the time of this inspection however, the person in charge said that they were looking into volunteering programmes in the community that the resident might be interested in. For example, joining a tidy towns project. The resident told the inspector that they liked to go out each day on drives and or outings and, do personal shopping in one of the nearby towns. On the morning of this inspection the resident went out for the day

with staff support to participate in social and community-based activities of their choosing. This resident also liked to keep in contact with their family.

Overall, while residents were supported to keep in contact with family and friends and to participate in community-based activities of their choosing, one resident did not have access to an adequate mode of transport to access community-based facilities at the time of this inspection and this required review.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

While systems were in place to manage risk and support residents' safety in the centre, aspects of the risk management precautions required review.

For example, on review of one resident's individual risk management plans it was identified that they required 1:1 staff support and supervision throughout the day due to a risk of absconsion and the risks associated with being in the community. Such risks included getting knocked down, exploitation, unsafe sexual activity, buying alcohol and substance misuse and, the resident was deemed to be vulnerable.

However, another risk risk assessment on the resident's file contradicted the above information as it stated that the resident could actually spend time alone in the community despite the above identified risks. This required review so as to ensure the information provided in the risk assessments was consistent and provided clear and explicit information to staff as to when and under what circumstances it was safe for the resident to spend time alone in the community.

Additionally, the resident was also at risk of suicidal ideation so all sharps held in the centre, were kept under lock and key. However, there was inadequate information available on the risk assessments as to how staff were assured the resident would not access sharps while spending time on their own in the community or the possibility of covertly bringing sharps back to the house. This was of concern to the inspectors as on 26 August 2025, the resident cut their arm on seven occasions with a sharp object and also tried to cut their stomach and neck. The police had to be called in order to support staff manage the issue which resulted in the resident being detained under mental health legislation. In turn, the control measures in place to ensure the resident was safe on returning to their home after being alone in the community required further review so as to ensure the resident had no objects on them, that they could possibly use to self-harm.

On 07, July 2025, the resident also took a lanyard from a staff members neck and placed it around their own neck as a ligature. The resident was verbally and physically aggressive towards staff and it was also reported they went into the kitchen to retrieve a knife. Again during this incident, staff had to call the police for support and, the resident was removed to hospital. This incident was concerning as

a risk assessment for the resident informed that they had a history of suicidal ideation and on the day of this inspection, most staff continued to wear lanyards around their neck with some staff wearing two lanyards. While staff wore these lanyards primarily for identification and safety reasons, they were a safety hazard as could also serve as a ligature point for the resident with suicidal ideation. This required review.

Additionally, while staff had training in ligature risk reduction, they did not have training in ligature cutting. Taking into account this residents history of suicidal ideation and the incident that occurred on 07 July 2025, this also required review. This training was important as it could help keep the resident at risk of self harm safe. Of equal importance, it would also provide staff with the knowledge required to safely cut ligatures to free a resident who might use them to self-harm.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

Systems were in place for the safe ordering, administering and return of medicines kept in the designated centre.

Each resident had a medication support plan in place and where required, an administration protocol for the administration of medication was in place.

One inspector observed a team lead administering medication to one resident and no issues were identified as medicines were administered as per protocol. It was also observed that only staff trained in medication management, administered medication.

Where required, medicines were reviewed with the input from psychiatry and a general practitioner(GP).

Additionally, where a medication error occurred, it was investigated and corrective actions taken so as to ensure there was no reoccurance of the issue.

Judgment: Compliant

Regulation 6: Health care

As found on the last inspection of this service on 04 March 2025, residents were being supported with their healthcare-related needs and had access to a range of allied healthcare professionals. Additionally, the healthcare-related issues as

actioned under Regulation 23: governance and management and regulation 21: records as found on the inspection in March 2025 had largely been addressed.

For example,

- health assessments where required, were completed
- blood pressure support plans had been updated
- medication support plans had been reviewed
- hospital passports had been reviewed.

One resident had also attended a neurology appointment as required and, their medical records were being maintained in the centre

Additionally, residents also had as required access to GP services.

It was observed however (and as found on the last two inspections of the service), access to a speech and language therapist was not being provided for in a timely manner. The inspectors acknowledged that the person in charge had made numerous attempts to address this issue since the last inspection of the service in March 2025 however, it remained ongoing at the time of this inspection.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

One inspector reviewed a positive behavioural support plan for one of the resident's residing in this service. This plan clearly detailed a number of proactive strategies that were implemented to support the resident to develop skills so as to improve their overall quality of life.

One staff member spoken with was familiar with this plan and was able to identify what the triggers to challenging behaviour were for the resident and, how to implement the strategies in place to manage behaviour.

All staff had training in positive behavioural support/management of challenging behaviour and the person in charge confirmed with the inspectors that to date, physical restraint was not used in this designated centre.

Additionally, access to psychology support was available to the centre to support with the overview and implementation of positive behavioural support plans.

Judgment: Compliant

Regulation 8: Protection

While policies and procedures were in place to protect the residents from abuse in this centre, aspects of the safeguarding process required review.

As explained under Regulation 31: notification of incidents, in August 2025 a resident made an allegation against a staff member prior to this inspection and, the person in charge informed the inspectors that this was dealt with internally. Additionally, they also reported that at that time, they had no grounds for concern regarding this allegation. However, no NF06 (a form for the allegation, suspected or confirmed, of abuse to a resident) was submitted to the Chief Inspector reporting this issue.

This was of concern as notifications when submitted to the Chief Inspector, provided assurances that the issue reported was managed using a person-centred approach and was reviewed as part of the provider's continual quality improvement measures. In turn, this process would enable effective learning from the incident and help to prevent a possible reoccurrence of the issue.

Additionally, the providers policy on safeguarding stated that the Chief Inspector should be informed within the required time frames using an NF06 form of any allegation of abuse occurring in the centre. Again, this was of concern to the inspectors as adhering to policy and procedure was important for promoting a safe and compliant service for the residents.

In a compatibility assessment/safeguarding peer-to-peer review undertaken in September 2025 regarding the three residents residing in the main house, it was acknowledged further support could be made available for two of the residents to engage in community based activities. It was also recognised that there was a risk of a physical altercation between two residents. This required further review so as to ensure adequate supports were in place at all times to adequately safeguard both residents.

Notwithstanding, the inspectors observed the following:

- staff had training in safeguarding and Children's First
- information on how to contact the designated safeguarding lead was available in the centre
- the person in charge said that they were confident their staff would approach them if they had any concerns about the residents
- additionally, one staff member spoken with said they would have no concern whatsoever bringing a concern about any of the residents to the person in charge's attention
- this staff member also confirmed that they had undertaken training in safeguarding
- residents seemed comfortable and happy in the company and presence of staff over the course of this inspection.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Compliant
Regulation 31: Notification of incidents	Not compliant
Quality and safety	
Regulation 13: General welfare and development	Substantially compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 6: Health care	Substantially compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Substantially compliant

Compliance Plan for Tullycoora House OSV-0008059

Inspection ID: MON-0048019

Date of inspection: 22/09/2025

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 31: Notification of incidents	Not Compliant

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

An NF05 form was submitted to the Chief Inspector on 24 September 2025, following the inspection. The Registered Provider acknowledges that the incident met the criteria for notification and should have been submitted earlier. The Registered Provider has reviewed the organisations internal reporting procedures to ensure that all unexplained absences are notified promptly in line with the regulations and organisational policy and procedures

An NF06 form was submitted to the Chief Inspector on 24 September 2025. The National Safeguarding Team were also notified on the same date, and the matter was closed on 25 September 2025. While the allegation was addressed internally and no grounds for concern were identified at the time, the Registered Provider recognises the importance of notifying all allegations to the Chief Inspector to ensure transparency and regulatory oversight.

The Centre staff team will receive refresher training on HIQA notification requirements. A monthly audit of incidents and notifications will be conducted to ensure ongoing compliance.

The incident management process has been reviewed and enhanced. All incidents are now reviewed and signed off by: The Person in Charge, Clinical Quality Assurance Manager, Person Participating in Management (Level 1 & Level 2), Registered Provider (Level 1), and escalated to the organisation's Corporate Risk Register where required

Regulation 13: General welfare and development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 13: General welfare and development:
A service vehicle identified to meet the assessed transport needs of one resident was delivered to the Designated Centre on 16 October 2025. This ensures that the resident now has access to an appropriate mode of transport to support their participation in community-based activities, social outings, and trips away from the centre.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
A full review of the resident's risk assessments was completed by the Person in Charge to ensure consistency and alignment across all documentation. Each risk assessment now cross-references the others and provides clear, explicit guidance to staff regarding the resident's support needs and circumstances under which time alone in the community may be considered.

An individual risk assessment was created on 25 September 2025, addressing the resident's risk of self-harm and the potential for accessing sharps. Control measures have been strengthened, including protocols for post-community outing checks to ensure the resident does not bring harmful objects back to the centre.

An Environmental Ligature Risk Assessment was completed on 25 September 2025. Staff have been advised to wear breakaway lanyards only, and alternative identification methods are being explored to reduce ligature risk. This measure directly responds to the incident on 07 July 2025 and the resident's history of suicidal ideation.

Practical ligature cutting training has been scheduled for all staff in the designated centre and will be completed by 30 November 2025. This training will enhance staff preparedness and ensure they can respond effectively to incidents involving ligatures.

Monthly service audits are conducted in the designated centre, including a review of all risk assessments to identify when updates or revisions are required.

Regulation 6: Health care	Substantially Compliant
Outline how you are going to come into compliance with Regulation 6: Health care: While the Person in Charge has made numerous documented attempts to resolve this issue since March 2025. This has been escalated to the Registered Provider and a Speech and Language assessment will be completed with recommendations by 30 November 2025.	
Regulation 8: Protection	Substantially Compliant
Outline how you are going to come into compliance with Regulation 8: Protection: An NF06 form was submitted to the Chief Inspector on 24 September 2025 in relation to the resident's allegation against a staff member. The National Safeguarding Team was notified on the same date, and the matter was closed on 25 September 2025. A compatibility assessment and safeguarding review was completed in September 2025 for the three residents in the main house. To reduce the risk of physical aggression between residents, a Physical Aggression Risk Assessment is in place and is reviewed quarterly or as required. Control measures are in place to ensure adequate supervision and support at all times. Weekly activity planners are completed in collaboration with residents to support meaningful engagement. One resident has commenced a volunteering project with Tidy Towns, and another is applying for an apprenticeship in mechanics, reflecting the service's commitment to person-centred planning and community inclusion.	

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 13(2)(a)	The registered provider shall provide the following for residents; access to facilities for occupation and recreation.	Substantially Compliant	Yellow	30/10/2025
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Not Compliant	Orange	30/11/2025
Regulation 31(1)(e)	The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: any	Not Compliant	Orange	25/09/2025

	unexplained absence of a resident from the designated centre.			
Regulation 31(1)(f)	The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: any allegation, suspected or confirmed, of abuse of any resident.	Not Compliant	Orange	25/09/2025
Regulation 06(2)(d)	The person in charge shall ensure that when a resident requires services provided by allied health professionals, access to such services is provided by the registered provider or by arrangement with the Executive.	Substantially Compliant	Yellow	30/11/2025
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Substantially Compliant	Yellow	25/09/2025