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:	Morenane House and Apartments
Name of provider:	St Joseph's Foundation
Address of centre:	Limerick
Type of inspection:	Unannounced
Date of inspection:	30 January 2026
Centre ID:	OSV-0001819
Fieldwork ID:	MON-0049567

About the designated centre

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

Morenane House and Apartments consists of a detached house and two apartments located in a rural area within close driving distance to a nearby town. The centre provides full-time residential support for a maximum of six residents of both genders over the age of 18 with intellectual disability and/or Autism who may have additional needs. Each resident had their own individual bedroom and other rooms in the house and apartments include kitchens, living rooms, a sitting room, a conservatory, a utility room, bathrooms and staff rooms. Residents are supported by the person in charge, social care staff and care staff.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	5

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
Friday 30 January 2026	08:25hrs to 16:25hrs	Conor Dennehy	Lead

What residents told us and what inspectors observed

This inspection was initially intended to focus on safeguarding following a May 2025 inspection of the centre where concerns were raised in this area. However, the inspection type was changed to a risk based inspection to enable Regulation 31 Notifications of incidents to be included. Overall, the current inspection did find some improvement compared to the May 2025 inspection but regulatory actions were found in most regulations reviewed. These included required notifications not being submitted and up-to-date guidance not being in place related to positive behaviour support for two residents.

Morenane House and Apartments was made up of a main house which could provide a home for four residents and two apartments to the rear of the house with each apartment intended to support one resident each. At the time of this inspection, four residents were living in the main house with just one of the apartments in use. This meant that five residents were present at the time of this inspection, all of who were met by the inspector during this inspection (the inspector also spoke with management of the centre and four members of staff). At the time of the previous inspection of this centre in May 2025, another resident had been residing in the other apartment. Due to a change in circumstance since then, that resident had been discharged from the centre although the inspector was informed that their personal belonging remained in the apartment.

At the time of the current inspection occurring, some painting work was ongoing in the apartment that was in use in this centre. Early into the inspection, the inspector met with the resident living in this apartment who showed the inspector around their apartment while the works were ongoing. The resident was noted to interact warmly with the painter present during this time and informed the inspector that they had picked the paint colours for their apartment. The resident also mentioned that a bed had been removed from a room in their apartment to make it a dressing room and that a couch in their living room was to be replaced. It was indicated by the resident that they liked their apartment but they did comment that their bathroom was "a little small".

During the previous inspection of this centre, this resident had told the inspector that they wanted to live in another area. The resident confirmed to the inspector on the current inspection that this remained the case but that they were happy to continue living in the centre. In saying so, the resident highlighted that the staff supporting them were very good to them and helped them with cooking. The resident also indicated that they felt safe living in the centre. However, they did mention that they sometimes stayed away from the main house of the centre due to the presentation of some residents living there.

The resident went on to voice their view that the provider did not have enough vehicles and they said that they had to cancel a hearing test the previous week as

the centre's bus was in the garage. When the inspector queried this with centre management, he was informed that the previous week the centre's bus was unavailable for a period which meant that the resident's hearing appointment had to be rescheduled. It was highlighted though that the centre did have access to two vehicles to support the five residents which was observed on the day of inspection. The May 2025 inspection highlighted a need for a third vehicle for the centre but as one resident had since been discharged from the centre, the inspector was informed that the need for this no longer remained.

Some of the other residents living in this centre did not communicate verbally but all of the four residents present in the main house during this inspection did interact with the inspector to varying degrees. One of these residents asked the inspector some questions as well as offering the inspector tea, coffee and some buns during the inspection. Another resident was seen to move freely around the main house and its external courtyard area with this resident smiling on occasions when greeted by the inspector. A third resident referred to the inspector as their friend and greeted the inspector with high fives and fist bumps at various points during the day.

While the fourth resident living in the main house did not communicate verbally, they did communicate with sign language and was able to read and write. As such, with the assistance of staff, the inspector met with this resident and wrote down some questions that he wanted to ask the resident. The resident read these questions and through a mixture of hand gesture and their own written responses indicated that they liked living in the centre while also highlighting some of the things they wanted to do at Christmas. These things included getting a coffee and going shopping with a relative.

This relative along with all other residents present during this inspection were noted to leave the centre during the inspection with staff support. This included one resident being brought to see their family and another resident being supported to attend a literacy class in a nearby town. The overall atmosphere in the centre on the day of inspection was largely calm although one resident was occasionally heard vocalising in the main house. The staff on duty were overheard and observed to interact with residents in an appropriate manner throughout the inspection. It was also seen on the day of inspection that the main house was generally presented in homely manner. It was observed though that the stairs in the house was worn, part of the oven in the kitchen-living room was broken and some kitchen work surfaces were chipped. The inspector was informed that a new kitchen was to be installed during February 2026.

In summary, some positive feedback from one resident was received on living in the centre while another resident was seen to smile at times. Staff supported residents to leave the centre with such staff interacting appropriately with residents. Some painting work was ongoing in one apartment of the centre while kitchen works were intended for February 2026. Regulatory actions identified during this inspection will be discussed in the following sections of this report.

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

Capacity and capability

Improvement was found during this inspection compared to the previous inspection. Regulatory actions were identified in areas including notifications and staffing.

This centre was previously inspected on behalf of the Chief Inspector of Social Services in May 2025. That inspection identified areas for improvement particularly related to safeguarding and positive behaviour support. The provider's compliance plan response for that inspection for Regulation 8 Protection did not provide assurance that all of the safeguarding concerns raised by that inspection would be addressed. Following that, notification of a serious incident related to safeguarding prompted a provider assurance report (PAR) to be issued to the provider in July 2025. In light of such regulatory engagement, the decision was made to conduct the current inspection which was initially intended to focus on safeguarding as part of a programme of inspection commenced by the Chief Inspector during 2024. However, the inspection type was changed to enable Regulation 31 Notifications of incidents to be included given a regulatory action identified in this area. Overall, the current inspection did find some improvement compared to the May 2025 inspection but regulatory actions were found in most regulations reviewed. This included actions relating to staffing, supervision and safeguarding. Such findings indicted that aspects of the management and monitoring systems in place did need some improvement

Regulation 15: Staffing

Under this regulation a centre's staffing arrangements must be in accordance with the needs of residents and the centre's statement of purpose. The centre's statement of purpose, which had been reviewed during January 2026, outlined specific staffing levels that were to be in place in the centre by day. Initial discussions with staff and management during the inspection indicated that it was rare that such staffing levels would not be met. However, discussions with other staff later in the inspection indicated that the outlined staffing levels by day might not always be in place. After further discussions, it was confirmed by staff and management of the centre that the centre had been down staff, the day before this inspection occurred.

In addition, when reviewing the personal plan of one resident it was highlighted that due to the resident's assessed needs of epilepsy, only staff who were trained in epilepsy were to take the resident on outings. On the day of inspection, the same staff member was observed to leave the centre with this resident twice on outings. From discussions with this staff member and a training matrix reviewed, it was confirmed that this staff member did not have training in epilepsy. After seeking further information in this area, it was subsequently confirmed that a similar occurrence had also taken place on 28 January 2026. While no harm was indicated for the resident involved due to these instances, the provision of staffing support for the resident on the day of inspection and on 28 January 2026 was not in keeping with their assessed needs.

This regulation also specific documentation relating to all staff working in a centre must be obtained. This documentation includes written references, full employment histories, evidence of registration with professional bodies, and evidence of Garda Síochána (police) vetting. During this inspection, the inspector requested to review the staff file of one staff member. This was readily provided by the person in charge. When reviewing this staff file, it was found that it contained all of the documents required by this regulation. This included recent evidence of Garda vetting from October 2025.

Judgment: Substantially compliant

Regulation 16: Training and staff development

To comply with this regulation, staff working in a centre must be appropriately supervised. It was indicated to the inspector by management of the centre that staff were to receive formal supervision on a quarterly basis. A log of supervisions for 2025 and 2026 were provided during this inspection. These were used to indicate when formal supervisions were planned for and to confirm if these supervisions took place. These records did confirm that staff had received supervision since the May 2025 inspection of the centre and that some staff had received supervision during January 2026. However, when reviewing these records it was also noted that some planned supervision for six staff in 2025 had not taken place with most of these relating to the fourth quarter of 2025. As such while some staff were in receipt of quarterly supervision, not all were.

Judgment: Substantially compliant

Regulation 23: Governance and management

The provider had ensured that some requirements for this centre under this regulation were being completed. This was evidenced by the inspector being

provided with written reports of two unannounced visit to the centre conducted by a representative of the provider in June 2025 and November 2025. Under this regulation, such visit should be conducted every six months to assess the quality and safety of care and support provided to residents. When reviewing the reports of these visits, it was seen that they assessed relevant areas such as complaints and restrictive practices while also including action plans for addressing any areas for improvement identified. The provider is also required to conduct an annual review for the centre under this regulation. No annual review for this centre had been completed since the May 2025 inspection but the inspector was informed that the centre's annual review for 2025 was to be completed by the end of March 2026.

Aside from such regulatory requirements, it was also noted based on documentation reviewed, that audits in specific areas were being carried out in the centre. For example, the provider's designated officer (person who reviews safeguarding concerns) had conducted a safeguarding audit in July 2025 while a member of centre management had carried out a risk management audit in January 2026. Staff team meetings were also occurring regularly in the centre. Based on meeting notes reviewed, four such meetings had taken place since 28 August 2025 with topics such as advocacy, complaints, training policies and safeguarding being discussed.

Such findings did provide some assurances that there was management and monitoring systems in operation to ensure that residents received a safe and consistent service that was appropriate to their needs. There was also improvement found on the current inspection compared to the May 2025 inspection which resulted in improved compliance in areas such as Regulation 8 Protection and Regulation 10 Communication. However, the current inspection did identify regulatory actions in most regulations reviewed on this inspection. This included regulations which were previously highlighted as areas for improvement in the May 2025 inspection such as Regulation 7 Positive behavioural support and Regulation 31 Notification of incidents. Such findings indicated that some improvement was needed to ensure that relevant issues were identified and addressed in a timely manner by the centre's management and monitoring systems.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

Under this regulation the Chief Inspector must be informed of specific events that happen in a designated centre within a specific time period. On each of the three previous inspections of this centre in May 2025, June 2024 and August 2023, it had been identified that some required events had either not been notified or notified outside of the required time period. Amongst the events that must be notified are allegations of a safeguarding nature which must be notified within three working days. Since the May 2025 inspection, the Chief Inspector had received six notifications of a safeguarding nature from the centre before the current inspection which had been submitted in a timely manner. However, when reviewing

safeguarding and staff team meeting records during the current inspection, the inspector noted reference to an incident that had occurred on 13 October 2025. After querying this incident with management of the centre, it was highlighted that this incident should have resulted in two separate safeguarding notifications being submitted to the Chief Inspector. Neither of these had been submitted at the time that this current inspection occurred. As such, they had not been notified within three working days as required by this regulation. It was acknowledged that management of centre did believe that these had been appropriately notified to the Chief Inspector at the time they occurred and that both were submitted retrospectively in the days following this inspection. It was also acknowledged, as referenced under Regulation 8 Protection, that the safeguarding matters from 13 October 2025 had followed appropriate safeguarding procedures which had been done in a timely manner.

Judgment: Not compliant

Quality and safety

Residents had personal plans in place which contained guidance on their communication needs. Guidance for two residents related to positive behaviour support needed improvement. Safeguarding plans were put in place in response to safeguarding incidents.

Since the May 2025 inspection, there had been a reduction in the rate of safeguarding notifications from this centre. For the safeguarding incidents that had occurred, these had been preliminary screened with safeguarding plans put in place. It was found though during this inspection that not all staff were aware of some recent safeguarding incidents that had occurred. Staff spoken with did have an improved general knowledge related to positive behaviour support although guidance for two residents in this area needed improvement. Some training relevant to positive behaviour support had been undertaken by staff although some training gaps were noted. The provision of training in sign language to support the communication needs of one resident had improved since the previous inspection. Guidance on supporting residents with their communication was present within their personal plans. Such plans were also available in accessible format and had been subject to annual multidisciplinary reviews.

Regulation 10: Communication

When reviewing two residents' personal plans, it was noted that both contained guidance on how these residents communicated. One of these residents did not communicate verbally and used sign language as one method to help them

communicate. This was reflected in the resident's personal plan and some staff were observed using sign language when communicating with the resident. The previous inspection of the centre in May 2025 had identified that not all staff had completed training in this sign language. A training matrix reviewed on the day inspection, that was dated January 2026, indicated that 13 of 19 staff working in the centre had completed training in this area. When queried with management of the centre, it was suggested that more staff had completed this training. An updated training matrix provided in the days after the inspection indicated that 18 of the 19 staff working in the centre had completed this training.

Judgment: Compliant

Regulation 26: Risk management procedures

To comply with this regulation, the provider must have a risk management policy in place and ensure that there are systems in place for the assessment, management and ongoing review of risk in the centre. During this inspection, a risk register for the centre was provided which outlined identified risks for the centre and the residents living there. This risk register was indicated as being reviewed in January 2026 with each outlined risk having its own individual risk assessment. Such risk assessments described the risks in question and outlined control measures to mitigate their potential likelihood of occurring.

It was noted that the identified risks reflected areas reviewed on this inspection such as the assessed needs of residents. However, for one resident it was noted that their risk assessment for behaviour that challenges listed a behaviour support plan for the resident as an existing control for the identified risk. As discussed further under Regulation 7 Positive behavioural support, the strategies outlined in the resident's behaviour support plan were indicated as not being effective.

Maintenance of the risk assessments reviewed and the risk register was in keeping with provider's risk management policy which had been reviewed in September 2025. This policy was read by inspector and was found to provide for the identification, analysis, evaluation and treatment of risk. The policy also outlined measures to mitigate specific risks required under this regulation including self-harm. The overall contents of this policy were found to be in keeping with the requirements of this regulation.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

Personal plans are intended to outline the health, personal and social needs of the residents while also providing guidance for staff in how to meet these needs. Having such personal plans in place is specifically required by this regulation which also requires personal plans to be informed by a comprehensive assessment of needs. During this inspection, the inspector reviewed the personal plans of two residents. In doing so it was noted that the guidance in these personal plans was informed by clear assessments in various which covered residents' health, personal and social needs. The guidance and assessments in these personal plans were indicated as being reviewed in December 2025 and January 2026 while the personal plans were available in accessible format. These residents' personal plans had also been subject to an annual multidisciplinary review in September 2025. Such findings were consistent with the requirements of this regulation.

Despite such positive findings, some improvement was identified as being required relating to the guidance in residents' personal plans related to behavioural support. This is discussed further under Regulation 7 Positive behavioural support.

Judgment: Compliant

Regulation 7: Positive behavioural support

Under this regulations, staff are to have up-to-date knowledge and skills to respond to behaviour that is challenging and to support residents to manage their behaviour and also be provided with relevant training. During the May 2025 inspection it was found that improvement was needed staff guidance and staff knowledge in this area including around particular interventions to use with residents if required. Management of the centre informed the inspector on the current inspection that efforts had been made since the previous inspection to promote a better consistency of staff approach in this area. As part of this it was indicted that resident specific training in the area of positive behaviour support had been provided to staff with further training planned.

From the staff spoken with during this inspection, it was evident that there was improved knowledge in this area generally compared to the previous inspection. For example, staff spoken with were aware of the potential use of a PRN medicine (medicine only taken as the need arises) if a resident displayed particular behaviours. This had not been the case during the May 2025 inspection and the improvement in this area was positively noted. A training matrix provided indicated that all staff had completed relevant training in de-escalation and intervention. Some staff had also completed additional training in behaviours of concern and positive behaviour support but not all had. In total five staff had not completed behaviours of concern training and 13 had not completed positive behaviour support training. It was acknowledged that all of these staff are indicated on the matrix provided as being booked to receive this training on 9 February 2026.

Aside from staff knowledge and training, the residents' personal plans reviewed were found to contain some guidance on supporting the residents to engage in positive behaviour support. Having such guidance can be a way to ensure that staff have up-to-date knowledge in this area. However, for one resident it was documented in their personal plan that "a lot of the strategies in the current behaviour support plan are not working". This was queried with management of the centre who confirmed that this was accurate. As such, this resident's personal plan did not have up-to-date guidance for staff on supporting their assessed needs in this area. The inspector was informed though that a behavioural therapist was currently working with the resident to update their behaviour support plan.

For the other resident, their personal plan contained some guidance on supporting their needs in this area but it did not contain any guidance on how to respond to the resident if they behaved in a physically aggressive manner. A similar observation was also made during the May 2025 inspection and based on incident records reviewed for the centre on the current inspection and previous inspections, the resident could behave in such a manner. This was queried with management of centre who confirmed that no such guidance was in place but that the resident was also to be reviewed by a behavioural therapist. It was acknowledged that, no incident of the resident behaving in a physically aggressive manner was recorded as having occurred in the centre since 26 November 2025. However, given the nature of such incidents and the impacts that it could have for staff, at the time of this current inspection, the resident's personal plan did not contain relevant and up-to-date guidance for staff in this area.

Judgment: Not compliant

Regulation 8: Protection

Previous inspections of this centre had highlighted that the presentation of some residents could impacts others in their home. This was reflected in an increase in safeguarding notifications that were received in the lead up to the May 2025 inspection and the circumstances that led to the issuing of the PAR in July 2025. The May 2025 inspection also highlighted a possible "placement breakdown" for one resident that resulted in that resident being reviewed by the provider's admissions, transitions and discharge (ADT) committee at that time. Following the July 2025 PAR, the provider also committed to conducting a compatibility assessment of residents for this centre.

In the time leading up to the current inspection, it was noted that the rate of safeguarding notifications from the centre had decreased. It was also communicated by the provider that, due to one resident no longer residing in this centre, the compatibility assessment was not being carried out. During the current inspection, the inspector was informed that the resident who had been previously suggested as a having had a possible "placement breakdown" continued to live in the centre and was no longer being reviewed by the provider's ADT committee. Management of the

centre indicated that due to the reduction in safeguarding incidents in the centre since the May 2025 inspection, this resident's placement in the centre was now "viable".

Six notifications of a safeguarding nature had been received from this centre since the May 2025 inspection at the time that the current inspection occurred. Five of these involved residents impacting other with three of these occurring since 31 December 2025. Documentation was provided which confirmed that that six of these of safeguarding notifications and the incident from 13 October 2025 (as referenced under Regulation 31 Notification of incidents) had been appropriately screened as safeguarding concerns. This documentation also confirmed that safeguarding plans were put in place in response to such incidents with these safeguarding plans outlining measures to prevent incidents from reoccurring.

Amongst the safeguarding measures that were outlined in such safeguarding plans was staff being made aware of safeguarding incidents that had occurred. A training matrix provided indicated that all staff working in this centre had completed safeguarding training while staff spoken with demonstrated a good knowledge around the types of abuse that could occur. However, of the four staff spoken with, two staff members did not demonstrate an awareness of all the recent safeguarding incidents that had occurred since 31 December 2025. For example, one staff member indicated that they were only aware of one recent safeguarding incident that had occurred. This did not assure that all staff working in the centre had been made aware of safeguarding incidents that had occurred contrary to the safeguarding plans in place.

Judgment: Substantially compliant

Regulation 9: Residents' rights

It had been identified by the provider that particular arrangements were in place related to three residents' finances which amounted to restrictions. These restrictions meant that residents did not have direct access to and control over their personal financial accounts. Such arrangements impacted the residents' legal rights and were also not consistent with the provider's policy on residents' finances. This stated that the provider would "respect a resident's right to control their finances" and was "committed to supporting residents who use our services to use and manage their money". While this impacted residents' legal rights, the inspector was informed during this inspection indicated that residents were never short of money.

Of the other two residents, one had a greater control over and access to their finances compared to their peers while the remaining resident's finances were managed differently. At the time of the May 2025, it was indicted that the latter resident's financial arrangements had not been raised with a relevant stakeholder and that it was unknown if the resident had their own bank account. On the current

inspection, the inspector was informed that this matter had been raised with the relevant stakeholder and that the resident did have their own bank account.

During the May 2025 inspection, it was also highlighted how one resident was expressing a wish to live elsewhere and that the resident was being reviewed by the provider's ADT committee. The inspector met this resident during the current inspection who again indicated that they wanted to live elsewhere. However, the resident did inform the inspector that they were happy to continue living in Morenane House and Apartments. Management of the centre informed the inspector that the resident continued to be reviewed by the provider's ADT committee but that the setting which the resident wished to live in was not available within the provider.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 31: Notification of incidents	Not compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Morenane House and Apartments OSV-0001819

Inspection ID: MON-0049567

Date of inspection: 30/01/2026

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**
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: The Registered Provider wishes to assure the Chief Inspector that going forward, staffing levels will be in accordance with the Statement of Purpose. In the event of staff shortages, the supernumerary PIC is available to support residents and staff should the need arise. This is further supported by the Area Manager. The organisation has a pool of relief staff and employ the services of agencies to support in the event of staff shortages. The guidance on replacing staff has been reiterated to all staff members. These arrangements have been reaffirmed to all staff during staff supervision and subsequent team meetings post inspection. The PIC wishes to acknowledge that shortcomings were noted in the training matrix of a relief staff member. The PIC wishes to confirm that this has now been rectified and can confirm that the staff member has received training on the 11th of February 2026 for Epilepsy. Following on from a review of the training Matrix, further staff training has been planned for the 11th, 18th and 25th of March along with the 8th and 16th of April 2026, to ensure all staff members are fully trained in epilepsy medication administration whether assigned to the resident with epilepsy needs or not, to build and support knowledge going forward.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: The PIC wishes to confirm going forward that all staff members -permanent and relief will receive formal supervision on a quarterly basis. This will be reflected in the supervision schedule. The PIC wishes to inform the Chief Inspector that social care workers and nurses have received additional training on supervision in order to support and maintain the supervision schedule in conjunction with the PIC. The PIC wishes to confirm that six staff members identified during the inspection have now received supervision.	

Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The Provider wishes to confirm that an annual review will be completed by the 31st of March as confirmed on the day by the PIC.
The Provider wishes to assure that going forward it will notify the Chief Inspector within three working days of any allegation suspected or confirmed of abuse of a resident via the Portal.
Furthermore, the learning regarding the timeline for notifications held in draft format will be shared with all the Registered Provider's PICs.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
As acknowledged by the Inspector of Social Services within this report, the Registered Provider believes it has correctly notified the Chief Inspector through the Portal System within the three days as required as the submission and receipt of same is noted on the portal.

The notification was subsequently cancelled without a request from the PIC. As a learning from this incident, the Registered Provider will ensure that all PIC's will be vigilant post the submission of a notification to ensure that any cancellation of a notification is noted and acted upon if required.

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
The PIC wishes to confirm to the Chief Inspector that four out of the five staff who did not complete Behaviour's of Concern training and 12 of the 13 staff that have not completed Positive Behavior Support training completed same on the 9th of February 2026. The one remaining staff member who was unable to attend the training on the 9th of February attended the training for Behavior of Concern and Positive Behavior Supports on the 12th of March 2026. The PIC wishes to confirm to the Chief Inspector that one resident's positive behavior supports plan is currently being reviewed by a Behavior Therapist with an expected completion date of April the 30th 2026. This update will include guidance for staff on supporting the residents assessed needs. Furthermore, the Registered Provider wishes to confirm that it conducts mandatory training for staff in regard to Crisis Prevention Intervention (CPI 1 & 2) which included training on de-escalation techniques, blocks, breakaways and approved holds if required, to support and manage possible physical aggression. However, notwithstanding this, it is acknowledged that for another resident who has previously behaved in an aggressive manner, their positive behavior support plan does not include the necessary supports for staff in regard to same. This resident's Positive Behaviour Support Plan will be updated to include relevant up to date guidance for staff by April 30th 2026.

Regulation 8: Protection	Substantially Compliant
Outline how you are going to come into compliance with Regulation 8: Protection: In relation to staff awareness of safeguarding, the PIC can now confirm that this has been addressed and has increased staff awareness through face to face education with the staff, house meetings, spot checks and in handover notes. Staff's knowledge of open safeguarding concerns in the Centre is now addressed through the morning and evening handover process which now includes safeguarding as a standing item.	
Regulation 9: Residents' rights	Substantially Compliant
Outline how you are going to come into compliance with Regulation 9: Residents' rights: The Provider wishes to confirm it is actively reviewing its practices in terms of supporting residents to manage and access their finances. This involves reviewing and updating the policy impacting our residents, particularly our finance and restrictive practice policy, mindful of our responsibility of implementing the Assisted Decision Making Act 2015 and the Healthcare Act 2007. As previously indicated the Registered Provider has been liaising with its banks, in relation to accessing to finances for its service users. The Registered Provider wishes to assure the Chief Inspector that it is fully committed to resolving this and thus coming into compliance with Regulation 9. To that end, it has now envisioned that a solution will be implemented by the 31st of May 2026. The bank's compliance unit and its local compliance manager are involved at both local and national level in determining a solution. The Registered Provider wishes to assure the Chief Inspector that until this issue is resolved, that monies are available to all residents at all times through the finance department and in line with the Registered Provider's policy; To support people who use our services to manage their money.	

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Substantially Compliant	Yellow	16/04/2026
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	18/02/2026
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	Substantially Compliant	Yellow	30/04/2026

	and effectively monitored.			
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	30/04/2026
Regulation 07(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.	Not Compliant	Orange	30/04/2026
Regulation 07(2)	The person in charge shall ensure that staff receive training in the management of behaviour that is challenging including de-escalation and intervention techniques.	Substantially Compliant	Yellow	12/03/2026
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Substantially Compliant	Yellow	28/02/2026
Regulation 09(2)(c)	The registered provider shall ensure that each	Substantially Compliant	Yellow	31/05/2026

	resident, in accordance with his or her wishes, age and the nature of his or her disability can exercise his or her civil, political and legal rights.			