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:	L'Arche Cork An Cuan
Name of provider:	L'Arche Ireland
Address of centre:	Cork
Type of inspection:	Announced
Date of inspection:	27 May 2025
Centre ID:	OSV-0001963
Fieldwork ID:	MON-0038320

About the designated centre

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

L'Arche Cork An Cuan is comprised of three houses located in the suburbs of Cork City. Combined the three houses have a total capacity for ten residents. The centre provides full-time residential accommodation for residents over the age of 18, both male and female, with intellectual disabilities. Each resident has their own individual bedroom and other rooms in the three houses include kitchen-dining rooms, bathrooms, utility rooms and lounges. Support to residents is provided by the person in charge, staff and volunteers with residents also having access to a community nurse.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	10

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Tuesday 27 May 2025	09:45hrs to 19:28hrs	Conor Dennehy	Lead

What residents told us and what inspectors observed

Based on discussions during this inspection and documentation reviewed, feedback from residents was generally positive. Residents spoken with talked about some of the things that they liked to do such as play golf and rugby. All three houses where residents lived were visited as part of this inspection which gave an opportunity to observe and overheard some resident and staff/volunteer interactions.

This centre was made up of three separate houses which, combined, provided a home for 10 residents. While these houses were visited later in the day, the inspector commenced the inspection by going to a day services building operated by the same provider. While in this building the inspector spoke with management of the centre and reviewed certain documentation. Amongst the documentation reviewed were surveys that had been issued to the provider in advance of this announced inspection. Such surveys asked questions about residents' home, what residents did every day, staff and those that residents lived with.

Eight of these surveys had been completed by residents with the support of staff or volunteers. Overall, the surveys contained positive responses with specific comments made including "I am happy where I live", "I like being here" and "all are good to me". One survey did indicate though that thing could be better for knowing the staff team and for staff knowing the resident's likes and dislikes. Another survey also indicated that things could be better regarding staff telling the resident about new things. A comment was also made in the same survey that "it can be hard to talk to people when there is too many people around".

Residents of this centre attended the building where the inspection commenced for their day services with two of these residents speaking with the inspector while he was there in the presence of the person in charge at residents' request. The first of these residents told the inspector that they liked living in the centre and liked attending their day service where they did gardening, music and computer courses. When asked what why they liked living in the centre, the resident responded by saying that "it's like a home". In terms of things that the resident liked to do when in their home, they mentioned having movie nights, going bowling, getting coffee out and attending the cinema.

The resident also talked about going to play golf later in the day and mentioned a recent trip that they had taken France which they had enjoyed. When asked, the resident indicated that they felt safe in their home and got on with the other residents that they lived with. Similar views were expressed by the second resident met in the day service building. They did however reference that sometimes the residents they lived with did fight but that they made up after. This second resident also outlined how if something was not right that they could say it to staff or their key-worker (a staff member specifically assigned to help support the resident).

As with the first resident, the second resident spoken with in the day service building had also gone on the recent trip to France and had enjoyed it. The second resident talked about some of the other things that they did such as knitting, walks, bingo, bowling and dinner out. This resident had a big interest in art and was participating in a course in this at the time of inspection. They mentioned that some of the art that they had completed were on display in the home and had also been displayed in Dublin and New York. Later in the inspection, when the inspector was in the resident's home, he saw some art works created by the resident on display in the house's living room.

In the afternoon of the inspection, the inspector visited all three houses of the centre. On arrival at the first of these houses, none of the three residents living there were initially present. A staff member present told the inspector that one of the residents had gone golfing while the other had gone to the cinema. While the inspector was speaking with this staff member, the third resident living there returned home. The inspector briefly meet this resident shortly after they returned but the resident did not initially engage with the inspector. However, after this the resident sat with the inspector in the lounge of the house while the resident was having a cup of coffee.

The inspector chatted to the resident and asked what they had been doing earlier in the day. The resident said that they had been busy working which involved painting wooden fences. The resident mentioned the other two residents that they lived with but said that they could be nervous around them because "they're big". The resident said that they played video games but did not like some games as they were too long and stopped the resident going fishing. When asked what they were doing later in the day, the resident responded by saying that they did not know. Shortly after the discussion ended and this resident was not spoken with again by the inspector.

After reviewing some documentation in the first house visited, the inspector went to the second house where three residents also lived. On the inspector's arrival to the second house, he was warmly greeted by one of these residents who shook the inspector's hand. This resident then showed the inspector a "Welcome HIQA" sign that had been put on display in the house's lounge. A second resident then came up to the inspector and asked where the inspector was from. When the inspector responded to this, the resident then said where they were form. This resident also said some more things which the inspector could not make out. The inspector was also introduced by staff member to the third resident living in this house but they did not interact with the inspector.

The inspector's time in this house was relatively brief but it was noted that atmosphere in the house was relaxed with residents mixing with staff and volunteers present. The person in charge also arrived to this house while the inspector was present with a resident immediately hugging them. One of the three residents living in the house briefly sat with the inspector and talked to him. Amongst the things that the resident indicated during this talk was that they liked living in the house and liked the food provided. The resident also indicated that they would be having eggs for supper and would be watching television later in the day.

In the final hours of the inspection, the third house of the centre was visited where four residents were living. Upon arrival there, the inspector was informed that only two of the residents were present with one of the others having gone golfing with the remaining resident having gone to another centre operated by the provider for dinner. The inspector quickly met one of the residents who was present. This resident greeted the inspector by name and indicated that they would be going out for rugby training which they did twice a week. A staff member present then informed the inspector that this resident would be going to a mixed ability rugby world cup in Spain and was being filmed for this.

This resident then went to have dinner with the other resident present along with volunteers and staff. The atmosphere in this house was very calm and sociable at this time with residents heard to chat freely with the volunteers and staff at the dining table. The inspector briefly met the other resident during this time with this resident greeting the inspector. As the inspection reached its conclusion, the inspector was informed that that this resident was being helped to get their hair done by a volunteer, one resident had gone to their rugby training and the resident who had been golfing had returned to their house. This resident had been met in the day service building earlier in the day and indicated that the golf had been good.

In summary, eight of the ten residents living in this centre were met or spoken with during this inspection. Feedback from these residents along with survey response was generally positive. Calm, relaxed or sociable atmospheres were encountered in the houses visited during this inspection. Discussions with residents during the inspection indicated that they did various activities.

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

It had been identified by the provider that some additional staffing was needed for the centre. Residents were found to be well-supported in some areas. It was evident that management of the centre were aware of matters which had the potential to impact residents.

This designated centre was registered until October 2025 with no restrictive condition and had last been inspected by the Chief Inspector of Social Services in March 2024. During that inspection an overall good level of compliance was found although there were some actions identified relating to volunteers, personal planning and fire safety. Following this inspection, the provider submitted a compliance plan response outlining the measures that they would take to come back into compliance. Since that time, the provider had kept the Chief Inspector updated relating to fire safety works for the centre (as will be discussed further in this

report), appointed a new person in charge and submitted an application to renew the registration of the centre until October 2028.

As such, the current inspection was conducted to inform a decision on this application, to review some matters raised during the March 2024 inspection and to assess some regulations not reviewed during that inspection. Overall, the current inspection found evidence of good supports in a number of areas such as the provision of residents' activities and health supports. However, it had been self-identified by the provider that additional staffing was needed for the centre. There were also indications of increasing needs for one resident and some residents impacting others. It was acknowledged though that the provider was aware of such issues and was making efforts to supports the residents involved.

Regulation 14: Persons in charge

Based on documentation reviewed, the person in charge appointed for this centre had the necessary experience and qualifications to fulfil the role. From discussions during this inspection, the person in charge demonstrated a good awareness of the operations of the centre and the needs of residents.

Judgment: Compliant

Regulation 15: Staffing

Under this regulation, specific documentation relating to all staff (including staff employed directly by the provider and agency staff) working in a centre must be obtained. This documentation includes written references, evidence of registration with professional bodies (where relevant), full employment histories and evidence of Garda Síochána (police) vetting. Documentation for three staff members employed directly by the provider were reviewed with all of the required documentation found to be in place. In addition, checklists were reviewed for two agency staff members which indicated that all of the required documentation was maintained for these agency staff. It was also indicated that the use of agency staff had decreased since the previous inspection. Staff employed directly by the provider and agency staff were reflected in staff rotas maintained for the centre. However, when reviewing actual rotas for two houses from 1 April 2025 on it was noted that some rotas did not indicate the full name of some staff while in one house it was not stated what hours a particular night shift covered.

Aside from documentation relating to staff working in the centre, it is also important that staffing arrangements in a centre are keeping with the assessed needs of residents. The workforce for this centre was made of staff and volunteers in line with the provider's model of care. At least one volunteer was present overnight in all

three houses and volunteers also provided support during daytime hours. As such, these volunteers supplemented the staff working in this centre but it was indicated that the provider was exploring to moving to full-staffing in the longer term. It was noted though that three previous unannounced visit reports for the centre, as conducted by representatives of the provider, indicated that additional staffing resources were required. Two of these visits reports made reference to additional nursing hours being required. Nursing staff was not explicitly indicated as being part of the centre's staffing whole-time equivalent according to the centre's statement of purpose.

However, the statement of purpose did indicate that a community nurse was available to the centre. This community nurse worked part-time and supported the provider's other activities in the Cork area as well as his centre. During the inspection, it was indicated that the provider had funding for a second community nurse and was in process of recruiting for same. Aside from this, the most recent provider unannounced visit report from April 2025 indicated that additional staffing levels in one house were not sufficient with a time frame of 30 July 2025 indicated for address this. When queried on the current inspection, it was indicated that this related to providing one resident with additional one-to-one staffing support given their increasing needs. While no additional staffing had been sourced since the April 2025 provider unannounced visit, the inspector was informed that the centre used existing staffing and volunteer resources to provide this resident with one-to-one support.

Judgment: Substantially compliant

Regulation 19: Directory of residents

A directory of residents was being maintained for this centre which was made available to the inspector for review during this inspection. This was found to contain most of the required information such as residents' names and addresses. However, after querying some matters with the person in charge, it was identified that some residents' stated dates for when they first resided in the centre were not accurately stated in the directory of residents.

Judgment: Substantially compliant

Regulation 22: Insurance

Based on documentary evidence provided during the inspection, appropriate insurance arrangements were in place for this centre.

Judgment: Compliant

Regulation 23: Governance and management

In keeping with this regulation's requirements, the provider had a defined organisational structure in place for the centre which was outlined in the centre's statement of purpose. This structure provided for line of accountability and reporting from staff and volunteers working in the centre through management of this centre to the provider's board of directors. This regulation also requires that the management systems in operation for a centre ensure that the services provided are safe, appropriate to residents' needs and effectively monitored.

The findings of this inspection in areas such as Regulation 6 Health care and Regulation 13 General welfare and development indicated that the management systems were supporting the needs of the residents. Some safeguarding incidents were occurring in two houses of the centre, as discussed further under Regulation 8 Protection, but it was acknowledged that the provider was aware of such matters and was attempting to respond to these to ensure that residents were safe. There was also evidence found during inspection of monitoring of the services provided in this centre. For example, some audits were being carried out while unannounced visits to the centre had been conducted by representatives of the provider.

Under this regulation such visits must be conducted every six months. Since the March 2024 inspection, three provider unannounced visits had been conducted in June 2024, December 2024 and April 2025. Reports of these visits were provided during this inspection and it was seen that these visits considered relevant matters related to the quality and safety and care and support provided to residents. It was noted though that the findings of the December 2024 and April 2025 unannounced visits appeared inconsistent related to safeguarding. In particular, the December 2024 unannounced visit report highlighted peer-to-peer incidents as occurring but the April 2025 made no reference to these despite similar incidents that had occurred in the intervening time.

Another regulatory requirement is to conduct an annual review of the centre to assess the centre against relevant national standards. An annual review for the centre had been completed in November 2024 with the report of this also provided to the inspector. This annual review focused on areas such as human rights, growth opportunities and pursuing interests but it did not explicitly assess the centre against national standards. In addition, while the annual review included resident feedback (which was positive), it did not include feedback from residents' representatives as required under this regulation.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

A statement of purpose is an important governance document as it describes the services and supports to be provided to residents. Under this regulation, the statement of purpose must also contain specific information such as details of the organisational structure for the centre, separate facilities for day care and the arrangements made for respecting the privacy and dignity of residents. The statement of purpose provided on the day of this inspection was found to contain the required information but a slight inconsistency was identified regarding the stated admission criteria for the centre. After highlighting this to the person in charge, a revised statement of purpose was provided during the inspection process that addressed this.

Judgment: Compliant

Regulation 30: Volunteers

In keeping with the provider's model of care, volunteers were involved in the operations of the centre. The inspector reviewed documentation relating to two such volunteers. Such documentation confirmation that volunteers were in receipt of supervision, had evidence of Garda vetting in place and had their roles and responsibilities set out in writing. Such matters were in keeping with the requirements of this regulation.

Judgment: Compliant

Regulation 31: Notification of incidents

This regulation requires certain injuries to be notified to the Chief Inspector on a quarterly basis. While one injury of this nature for the first quarter of 2025 had been notified on 29 April 2025, when reviewing incident records the inspector identified a second injury from March 2025 which had not been notified as required.

Judgment: Not compliant

Regulation 34: Complaints procedure

Information about complaints was observed to be present in the three houses that made up this centre. Processes were also in operation for any complaints made to

be recorded. Accordingly, the inspector reviewed complaints records from two houses of the centre. The complaints records for one house outlined the nature of the complaints made, actions taken in response, the outcome of the complaints and whether or not complainants were satisfied with the outcome. This was consistent with the requirements of this regulation.

However, when reviewing the complaints records for the other house, it was seen five complaints of a similar nature had been made by one resident about a second resident. The records for all five complaints outlined the nature of the complaints and the actions taken in response. However, the outcome of the complaints and whether or not the complainant was satisfied with the outcome of these was not documented for four of the complaints. Given the nature and similarity of these complaints, it was queried during this inspection, if these complaints amounted to safeguarding concerns. The person in charge, who was also the designated officer for the centre, indicated that they did not. It was noted though that there had been other incidents of a safeguarding nature between these residents which will be discussed further under Regulation 8 Protection.

Judgment: Substantially compliant

Regulation 4: Written policies and procedures

Having policies in place is important to offer guidance on practices to be followed in designated centres. As such, in accordance with this regulation, the provider must ensure that specific policies, in areas such as medicines management, complaints and admissions, are in place. On the day of inspection, the centre's policies were reviewed and it was found that most of the required policies were present. However, it was noted that policies that covered when a resident goes missing and recruitment/selection of staff were not provided on the day of inspection. After raising this, copies of these policies were subsequently sent to the inspector in the days following the inspection. All of the policies reviewed during or after the inspection, were marked as being reviewed within the previous three years. This was consistent with the requirements of this regulation.

Judgment: Compliant

Quality and safety

Good supports and good compliance levels were found during this inspection related to residents' health and the activities that they did. Some safeguarding incidents had occurred in two houses of the centre which had involved peer-to-peer incidents.

The needs of residents were set out in their personal plans and, overall, this inspection found good evidence that the health, personal and social needs of residents were being met. For example, residents were supported to participate in various activities which helped to provide for their social needs. Support was also given to residents to avail of various health services or professionals with appropriate medicine management practices found to be followed also. Despite this, there were indications that some residents in two houses could impact other residents that they lived with. This was reflected in safeguarding incidents that had occurred. The provider was making efforts to respond to such matters while all staff and volunteers had completed safeguarding training. Fire safety training had also been provided for the centre's workforce while a health and safety review related to fire safety in one house had been completed shortly before this inspection.

Regulation 13: General welfare and development

Based on discussions with management, staff and residents during this inspection, residents were encouraged and supported to avail of activities in the community and activities which they were interested in. For example:

- Some residents recently gone on holiday to a France.
- Residents were supported to pursue courses in art and computers.
- A resident had a job in the local area.
- Some residents played golf while another resident was actively involved in rugby.
- Residents had coffee and dinners out.
- Community activities such as bowling and the cinema were availed of by residents.

Documentation reviewed also indicated that residents were involved in a person-centred planning process where goals were identified for them. Such goals included trips to Dublin and London, going swimming and availing of a salon. Time frames and responsibilities were assigned for supporting residents with these goals.

Judgment: Compliant

Regulation 17: Premises

The three houses visited during this inspection were observed to be clean, well-maintained and well-furnished on the day of inspection. Such houses were also presented in a homely way. For example, resident photographs were seen to be on display in all three houses while in one house it was observed that art works done by one resident and a trophy won by another resident were present in a communal room. Each resident in the centre also had their own bedrooms with the inspector

seeing three of these bedrooms. These bedrooms were observed to well-furnished with storage facilities provided. No issues were observed during this inspection related to the overall facilities provided in the three houses such as the kitchens.

Judgment: Compliant

Regulation 20: Information for residents

This centre had a residents guide in place which was marked as having been reviewed during April 2025. When reading this guide it was noted that it was presented in an easy-to-read format and that it contained all of the required information including details of terms and conditions for residency.

Judgment: Compliant

Regulation 26: Risk management procedures

A risk management policy was in place for this centre which had been reviewed in February 2024. This policy provided for the identification, assessment and management of risk while also outlining measures to mitigate specific risks as required under this regulation including self-harm and unexpected absence. Aside from this policy, some risk assessments related to individual residents were also reviewed during this inspection. Such risk assessments were noted that have been reviewed in recent months. However, it was noted that, on the day of inspection, a risk assessment relating to the impact from a peer was not in place for one resident while another resident did not have a risk assessment relating the potential impact that they could have on others. While it was acknowledged that such risk assessments were put in place after being highlighted during the inspection, the two previous provider unannounced visits to the centre, in December 2024 and April 2025, had identified actions relating to risk assessments for the centre.

Judgment: Substantially compliant

Regulation 28: Fire precautions

During this inspection, it was observed that all three houses had fire systems in place such as emergency lighting, fire extinguishers and fire alarms. It had been previously identified that fire safety works, particularly fire containment works, were required for the three houses of this centre. At the time of the March 2024 inspection, the provider was in process of completing such works for two houses

and had carried out some works in the third but further fire containment works were outstanding for the third house. Communication received since that inspection confirmed that works in the first two houses were completed but that no further works had been completed in the third house. As a mitigation measure, waking night staff had been previously introduced into the third house which remained in place at the time of this inspection.

In April 2025, the provider had an external body conduct a health and safety review of the third house which assessed fire safety there. This review considered relevant documentation, fire safety systems and the fabric of the building. The review found that there no major fire safety issues in the house and that management were doing all that could be reasonably expected to ensure safety in relation to fire. A revised fire works schedule provided following the inspection indicated that some works relating to the fire containment in the ceilings and wall were not being carried out due to the risk mitigating measures in place such as waking night staff. The same work schedule did indicate though that a rear exit door was to be replaced and that fire doors (which help prevent the spread of smoke and fire) were to be reviewed further. Discussions with management during this inspection and documentation reviewed indicated that the provider had a long-term intention to replace this house.

Other records reviewed in the same house indicated that the fire safety systems in place, such as the fire alarm, had been subject to recent maintenance checks by an external contractors to ensure that they were working as intended. Internal daily checks were also carried out on a daily basis for various fire safety measures such as escape routes and fire extinguishers based on records reviewed from 17 March 2025 on. Fire drills were also documented as having occurred regularly in the house during 2025 with low evacuation times recorded. Training records provided indicated that all staff and volunteers, working across all three houses of the centre, had completed fire safety training.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

Medicines management practices were reviewed in one house of this centre. In this house it was found that secure facilities were present for medicines to be stored in. The inspector was informed that no specific facilities were available in the house for medicines that required refrigeration but that there was no such medicines in use in the house at the time. The medicines storage provided was viewed by the inspector and found to be appropriately organised with a box also in place for any medicines that needed to be returned. A sample of medicines for two residents were reviewed which were found to be in-date and appropriately labelled. Medicines documentation for two residents were also reviewed which were found to contain relevant information. Such documentation also indicated that medicines were being given to

residents as prescribed while residents were also being assessed to determine if they could self-administer their own medicines.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

Each resident is required under this regulation to have an individualised personal plan in place. Such plans are intended to provide guidance for staff in supporting residents by outlining their health, personal and social needs. The personal plans of three residents were reviewed during this inspection which were found to have been reviewed within the previous 12 months, were available in an accessible format and contained care plans on how to support residents' needs in areas such as their health. Such findings were in keeping with the requirements of this regulation.

Other than matters related to documentation, this regulation also requires that arrangements are in place to meet the health, personal and social needs of residents. The findings of this inspection, as reflected in the judgements under Regulation 6 Health care, Regulation 13 General welfare and development and Regulation 29 Medicines and pharmaceutical services, indicated that there were good arrangements in place, generally, to meet the assessed needs of residents. However, as had been highlighted during the previous inspection, one resident's needs were increasing related to cognitive decline. This matter was being kept under closed review and it had been identified that additional staff support was required for this resident. This is addressed under Regulation 15 Staffing.

Judgment: Compliant

Regulation 6: Health care

Guidance on supporting residents with their assessed health needs was contained within their personal plans. For example, one resident had a detailed diabetes care plan provided which outlined how to support the resident if they presented with hypoglycaemia or hyperglycaemia. In addition, since the last inspection, it was noted that a care plan had been put in place related to one resident's cognitive decline. Records reviewed during this inspection indicated that residents were supported to attend or avail of appointments or reviews with various health and social care professionals. Such professionals included a general practitioner, an optician, a dentist, a psychologist, an audiologist and a chiropodist. Other records read also confirmed that residents were facilitated to avail of national screening services.

Judgment: Compliant

Regulation 7: Positive behavioural support

Where required, guidance was in place within residents' personal plans around how to support them to engage in positive behaviour. Such guidance was noted to have been recently reviewed based on the personal plans reviewed for two specific residents. In the context of one of these residents, a staff member spoken with demonstrated a good awareness of the guidance to support this resident to engage is positive behaviour. Aside from such guidance, it was also noted that training had been provided to staff in managing behaviour that is challenging and positive behaviour support. When queried though, it was indicated that such training covered different areas but the majority of staff had not completed training in the former. The inspector was informed that this training was focused on following plans and de-escalation.

Judgment: Substantially compliant

Regulation 8: Protection

During a provider unannounced visit to the centre in December 2024, it had been identified that it had not been possible to prevent a number of peer-to-peer incidents taking place. Such incidents had been of a safeguarding nature whereby some residents had impacted other residents. Since the December 2024 unannounced visit there had seven further peer-to-peer incidents which had been notified as being safeguarding concerns. Documentation reviewed indicated that such incidents had been referred to relevant bodies with safeguarding plans put in place where required while all staff and volunteers had completed safeguarding training. However, it was noted that six of the seven safeguarding notifications received since December 2024 related to two houses. In each of these two houses some safeguarding trends were noted.

In one of these houses, incidents had occurred before, during and after December 2024 where the same two residents had impacted on one another. The nature of these incidents tendered to be verbal in nature but could also be physical. One of these residents had also made five complaints about the other resident during 2025 relating to the latter resident entering the former's bedroom or knocking on their bedroom door. It was also indicated that these two residents could trigger one another and that staff attempted to prevent this by keeping these residents separate. Despite this, the inspector was also informed by the person in charge and a staff member that both residents had lived together for a long time and wanted to continue living together.

Regarding the other house, in the months leading up to this inspection there had three notified safeguarding incidents whereby one resident had adversely impacted another resident. Such incidents had involved the first resident pushing or upsetting the other. Shortly before this inspection occurred, there had been an escalated incident that had occurred which resulted in the second resident becoming scared and having to go to another house of the centre for a period. It was acknowledged that the provider had responded to this matter by reviewing a relevant positive behaviour support plan and putting in place a safeguarding plan while also making a referral to an external body for additional support. It was also indicated that the presentation of this resident may have been influenced by certain habits which they had.

Despite this, during the introduction meeting of the inspection, it was indicated that the presentation of this resident was adversely impacting the other residents that they lived. It was indicated that this impact primarily affected the resident referenced in the safeguarding notifications received. This resident was not met during this inspection but a staff member working with them told the inspector that the resident had been vocal in saying that they were impacted by their peer. When reading this resident's accessible personal plan, the inspector noted that the following was stated: "A person in my household is not very kind to me. I felt hurt and scared". Support was being given to this resident in this regard and during the feedback meeting for the inspection, a member of management informed the inspector that the provider was exploring alternative options for the resident in this house who had impacted their peer.

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	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 19: Directory of residents	Substantially compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Regulation 30: Volunteers	Compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Substantially compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Compliant
Regulation 20: Information for residents	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Not compliant

Compliance Plan for L'Arche Cork An Cuan OSV-0001963

Inspection ID: MON-0038320

Date of inspection: 27/05/2025

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: - Rosters updated to include staff surnames. - Rosters updated to include the night shift working hours - The Statement of Purpose has been updated to reflect the nursing hours allocated to the designated centre. - Additional 15 nursing hours allocated for this designated centre – the post to be filled by 25 September 2025. - Additional 39 hours care staff post being sourced for this designated centre to support the additional needs of some residents –post to be filled by 25 September 2025.	
Regulation 19: Directory of residents	Substantially Compliant
Outline how you are going to come into compliance with Regulation 19: Directory of residents: - Action Complete - Directory of residents is updated in line with paragraph 3, schedule 3.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: - L'Arche Ireland Audit Team have ensured that the annual review of quality and safety is conducted in line with the standards as outlined in Regulation 23(1)(d). - L'Arche Ireland Audit Team have ensured family members are consulted as part of the annual review as per regulation 23(1)(e). - L'Arche Ireland Audit Team will ensure that when conducting unannounced inspections	

that previous inspection action plans are reviewed and monitored as part of the unannounced inspection process as per regulation 23(2)(a). - The above has been approved formally at a leadership meeting of the 27 June 2025.	
Regulation 31: Notification of incidents	Not Compliant
Outline how you are going to come into compliance with Regulation 31: Notification of incidents: Notifications are now crosschecked with incident reports and quarterly reports at management team meetings – Completed 17 June 2025.	
Regulation 34: Complaints procedure	Substantially Compliant
Outline how you are going to come into compliance with Regulation 34: Complaints procedure: - Complaints form updated to ensure actions and outcomes are reviewed quarterly. Completed 25 June 2025. - System for recording of outcomes in House 1 replicated to House 2 in line with Regulation 34(2)(f). Completed 25 June 2025.	
Regulation 26: Risk management procedures	Substantially Compliant
Outline how you are going to come into compliance with Regulation 26: Risk management procedures: - The recommendations from the December 24 and April 25 audits were implemented (a)risk assessment in place for one resident experiencing changing needs and (b) review of risk ratings - Risk assessments in place for peer to peer impact of behaviour - Management Team to review Risk Register as per policy (six monthly and/or sooner as changing needs arise.	
Regulation 28: Fire precautions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: - Current fire doors to be upgraded by 31 August 2025. - Back sliding door to be replaced with new doors by 31 August 2025.	
Regulation 7: Positive behavioural support	Substantially Compliant
Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:	

- Training has been secured in line with regulation 07 (2) to be delivered by 30 September 2025.

Regulation 8: Protection	Not Compliant

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

House 1
Resident A
Specific measures have been put in place to support this resident as follows:
1. Additional staff are being sourced as per action in Regulation 15. In the interim staff have been reallocated to provide one to one support for the said resident which enables all residents to participate in separate activities to comply with safeguarding plans.
2. The resident's Positive Behaviour Support Plan has been updated to reflect slow and fast triggers identified in the past three safeguarding concerns. All supporting staff and assistants are familiar with this plan.
3. The resident in question is engaging with external supports and their healthcare plan has been adapted to address changes to their supports. The resident is responding well to changes in medication, the additional staff support and the multidisciplinary input.
4. Risk assessments have been completed on the impact of the resident on other residents with appropriate control measures in place. Based on these assessments' the above-mentioned points reduce the likelihood of this resident impacting others.
Resident B
Specific measures have been put in place to support the resident affected as follows:
1. The resident has met with, and has support from, their psychiatrist and has been offered counselling.
2. Regular reviews of current safeguarding plans to continue in consultation with the relevant resident.
3. Reviews of safeguarding concerns are included as a standard item on weekly house meetings with oversight from the Person in Charge.
4. In consultation with the resident, the layout of the kitchen area has been satisfactorily adapted to prevent unwanted interactions with the resident causing concern.
5. Rosters have been adapted to ensure that the affected resident is not alone with the resident causing concern.
6. Safeguarding concerns is a standing agenda item on the weekly team meetings with oversight from the Person in Charge and designated safeguarding officer.
7. Behavioural risk reduction strategies are discussed at the weekly team meeting, to monitor the effectiveness of the strategies for all residents and ensure ongoing knowledge sharing in the team.
8. All of the above are in place to support this resident and reduces the risk of further safeguarding concerns.
House 2
Risk assessments have been carried out to reduce the impact the two residents have on each other with the following control measures in place:
1. Reminders of both residents' Positive Behaviour Support plans with emphasis on fast/slow triggers and de-escalation techniques included at weekly team meetings.
2. Safeguarding concerns is a standing agenda item on the weekly team meetings with oversight from the Person in Charge and the designated officer.
3. Reminders of appropriate behaviour towards each other discussed at weekly house

meetings which includes residents, staff and volunteers with any concerns noted and appropriate action taken.
4. Care plans for each resident reflect current safeguarding plans which reinforce de-escalation techniques.
5. Residents have a reference person whose role is to review with each resident their day-to-day life in the house. Each resident meets with their reference person monthly and as required and any concerns are reported to the house leader and/or PIC.
6. Easy-to-read safeguarding information available for both residents.

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	25/09/2025
Regulation 19(3)	The directory shall include the information specified in paragraph (3) of Schedule 3.	Substantially Compliant	Yellow	28/05/2025
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	Substantially Compliant	Yellow	27/06/2025

	accordance with standards.			
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	27/06/2025
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	27/06/2025
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	Substantially Compliant	Yellow	04/07/2025

	responding to emergencies.			
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	31/08/2025
Regulation 31(3)(d)	The person in charge shall ensure that a written report is provided to the chief inspector at the end of each quarter of each calendar year in relation to and of the following incidents occurring in the designated centre: any injury to a resident not required to be notified under paragraph (1)(d).	Not Compliant	Orange	17/06/2025
Regulation 34(2)(f)	The registered provider shall ensure that the nominated person maintains a record of all complaints including details of any investigation into a complaint, outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.	Substantially Compliant	Yellow	25/06/2025
Regulation 07(2)	The person in charge shall ensure that staff receive training in the management of behaviour that	Substantially Compliant	Yellow	30/09/2025

	is challenging including de-escalation and intervention techniques.			
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	25/09/2025