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:	Cork City North 7
Name of provider:	Horizons
Address of centre:	Cork
Type of inspection:	Unannounced
Date of inspection:	11 September 2025
Centre ID:	OSV-0003297
Fieldwork ID:	MON-0048097

About the designated centre

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

Cork City North 7 comprises four houses on a campus setting in Cork city. There are other designated centres on this campus. The centre can currently provide a residential service to 25 people, who live in the centre on a full-time basis. The centre provides services to both males and females, over the age of 18 years. Each house is a two-storey building with the same layout. This includes a kitchen, separate dining room, sitting room and sun room. Each house has both downstairs and upstairs bedrooms. Some residents in each house share their bedrooms with others. The centre is staffed at all times. The staff team consists of care assistants, nurses and activities coordinators. The stated aim and objective of the centre, as outlined in the statement of purpose, is to promote a welcoming and homelike environment ensuring always that residents' dignity and safety is promoted.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	23

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Thursday 11 September 2025	13:30hrs to 20:55hrs	Deirdre Duggan	Lead
Friday 12 September 2025	08:30hrs to 17:00hrs	Deirdre Duggan	Lead

What residents told us and what inspectors observed

From what the inspector observed and from speaking to staff and management, residents' physical day-to-day care needs were being met in this centre. However, ongoing issues including an over-reliance on agency staff and compatibility issues meant that some residents were not always in receipt of fully effective and safe services and that some institutional practices were ongoing. At the time of this inspection, the provider had identified that there were a number of ongoing issues to be addressed in this centre and a comprehensive action plan had recently been developed by a Service Improvement Team appointed by the provider. The provider was also making some progress in relation to the planned partial de congregation of the centre. However, some of the actions being taken by the provider were recent or not yet completed and this meant that the provider had not yet brought the centre into compliance with the regulations at the time of this inspection.

Cork City North 7 comprises four two-storey houses on a campus setting in Cork city. There are other designated centres, and a day service operated by the provider also based on this campus. Some residents had their own bedrooms, and others shared bedrooms. There were 23 residents living in the centre at the time of the inspection. The registration of the centre had been renewed with a reduced capacity of 25 residents in 2023. Since the previous inspection in July 2024 one resident had moved to a community home in line with the providers' de-congregation plan. Eight residents lived in one house and there were five residents living in each of the other three houses.

This was an unannounced inspection that took place over two consecutive days, including one evening. Since the previous inspection, the Chief Inspector had received both solicited and unsolicited information of concern from this centre. Two provider assurance reports had been submitted by the provider to the Chief Inspector in respect of this information. The management team of the centre were not present on the inspectors' arrival to the centre, and another member of management working on the same campus facilitated the inspection until the arrival of the person in charge and person participating in management.

The inspector had an opportunity to walk around and spend time in all four houses in the centre and spent time reviewing documentation and observing residents going about their daily routines in all four houses of the centre. Some of these visits were brief due to the preferences and needs of the residents and to reduce the impact of an additional person being present in some of the busier areas of the centre. Some documentation was also reviewed in an office on campus and members of the staff and management team were spoken with also. In total, 20 residents were met or observed in their homes during the inspection. The inspector also interviewed the person in charge, area manager, three care staff, a Clinical Nurse Manger 1, an individual appointed to provide oversight during the vacancy in the person in charge role, and the night manager.

For the most part, residents were seen to be content in their homes and the inspector observed some positive interactions between residents and the regular staff that supported them. Residents were seen to be nicely presented and some residents were observed enjoying one to one time with staff such as having their nails done and table-top activities. Generally residents presented as content for the inspector to spend time in their homes but residents' wishes were respected in relation to this. Some residents showed the inspector around their homes and their bedrooms. Over the two days, residents were observed enjoying snacks and meals in their dining rooms and relaxing while watching TV or listening to music in the sitting room and conservatory areas of their homes. Some residents were observed in their bedrooms relaxing. Some residents liked to move about their homes and were observed moving around the communal areas and interacting with the staff present.

The inspector observed staff interacting with residents in a respectful and caring manner, although in some instances it was observed that staff were seen to be busy and unable to carry out specific activities with residents on request. For example, one resident clearly indicated they wished to go for a walk, leading staff to their wheelchair. While this resident did go out for a short walk on campus, they indicated they wished to go out again on their return and staff informed them they would have to wait until another resident had a walk first. Staff spoken with spoke respectfully about residents and presented as committed in their roles. Staff were observed to knock on bedroom doors before entering and heard to offer and provide personal care in a respectful manner.

Some of the houses were clearly busy environments and at at times some residents were heard to be vocal, which did contribute at times to the noise levels in some houses. For example, in one house, there were eight residents and three staff present when the inspector arrived to visit and most of these individuals were gathered in the communal areas of the home. The inspector observed that some staff were not very familiar with residents and that while some residents did leave the campus for activities during the inspection, some residents spent a large amount of time sitting or walking around the communal areas of their home or going on short walks on the campus in wheelchairs. While generally residents were seen to have staff supervision provided in communal areas, in line with some safeguarding plans in place, often agency staff who were new to the centre were allocated this duty and it was not always evident that these staff members were familiar enough with residents to support them in a meaningful way that was in line with their assessed needs and preferences.

Overall, all parts of the centre were observed to be clean, homely and decorated and maintained to a reasonable standard. Some residents' photographs were on display in communal areas and the decor in some units was adapted to suit the preferences of the residents living in them, such as sensory equipment, a projector screen, sensory board, and a fish tank. Residents had tv's and radios available to them in communal areas and in their bedrooms if they wished. Six residents continued to share bedrooms. The layout of these rooms promoted privacy and

dignity for residents and the inspector was told that there were plans for these shared bedrooms arrangements to cease when the numbers in the centre reduced.

There were plans in place for four residents to transition into new homes and also some internal transitions to occur on the campus that would further reduce the numbers accommodated in this centre. The inspector was told that three residents had been to visit their potential new home for the first time on the day before the inspection and about the work that was being done prepare residents for this move. The inspector also reviewed the de-congregation plan that was in place and a transition plan that had been completed for one of these residents and included details of the discovery process, engagement with the resident and multidisciplinary input. Details of plans for advocacy input and easy-to-read information for residents about the process was also viewed.

Seven satisfaction surveys issued by the provider completed by family members were provided to the inspector. Overall, these did indicate that family members were satisfied with the service provided in the centre to residents. It was seen that where issues had been raised, the incoming person in charge had met with the families of the residents to discuss these.

Overall, this inspection found evidence of non compliance with the regulations and that this meant that residents were not always being afforded quality services to meet their assessed needs. However, the provider had acknowledged this and recently commenced a service improvement action plan that had the potential to address some long standing issues present in the centre. 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

This inspection found that residents in this centre were not yet receiving a service that was fully safe or appropriate to meet their needs and there was evidence of non compliance with the regulations. The provider had not completed all of the actions identified in previous compliance plans and provider assurance reports within specified timelines. Issues were identified in relation to governance and management, staff consistency and staff training and development. There were, however, positive indications that improvements were recently occurring in the centre and that team service improvement team were working towards bringing the centre into compliance.

While the previous inspection had also found some positive indications that improvements were occurring for residents in the centre, the provider had not ensured that the plans in place at that time were implemented or carried out in full. There had been a significant increase in safeguarding concerns reported from the centre since the previous inspection had taken place. Poor consistency of staff was

impacting on the service received by residents and there were indications that this was also impacting on staff culture and moral in the centre. Actions and improvements that were identified in compliance plans and provider assurance reports submitted by the provider had not been completed within the time-frames identified and there was limited evidence of enhanced or effective provider level oversight since the previous inspection or while key management roles had been vacant in the centre.

However, it is acknowledged that the provider had recently recognised that residents in the centre were not being offered a good quality service and that a number of issues present remained unaddressed. In the month prior to the inspection notified the Chief Inspector that a Service Improvement Team (SIT) was in place in the centre. An experienced person in charge had been appointed to the centre in August 2025 and a comprehensive action plan developed by this team was in progress to address numerous issues identified. This was provided to the inspector during this inspection alongside minutes of fortnightly meetings to review and discuss actions. This was seen to comprehensively identify ongoing issues in the centre and also the actions required to address these issues, including those responsible and realistic time-frames. The incorporated actions were derived from previous provider assurance reports, compliance plans, unannounced visits and a safeguarding review completed in the centre in 2024. While this action plan was seen to be in progress at the time of this inspection and was seen to have the potential to address non compliance identified in the centre, this was in the early stages and a large body of work remained to be completed in the centre to bring it into compliance with the regulations. The management team in the centre reported that the provider was supportive and providing the necessary resources to ensure that the actions outlined were completed.

The inspector saw that some of the actions in the providers service improvement plan had already been completed and the provider had put in place a strong management team to oversee and drive the changes identified in this plan. This management team including an experienced and committed person in charge and an area manager. Both these individuals made themselves available for the inspection and spoke with the inspector about the service improvement plan that was being implemented and the efforts that they were making in recent times to engage with staff and foster a "ground up" approach in the centre to improve staff culture and resident outcomes.

An application to renew the registration of this centre was progressed in May 2023 with the addition of two restrictive conditions. These set out that the provider could not admit any new residents to this centre and also that the provider would complete actions related to de-congregation of the centre. No new admissions had taken place and this inspection found that the provider was making progress with a decongregation plan for the centre but would not complete the plan in line with the restrictive condition in place. The inspector was told that the provider intended to apply to extend the date attached to one of the restrictive conditions to ensure that all actions were completed to the satisfaction of the Chief Inspector. This was received in the weeks following this inspection.

At the time of this inspection, one community based premises was reported to be almost ready and there were plans to transition three residents to this home, while another premises was reported to have been sourced and it was hoped that a further three residents would transition to this home by mid-2026. The inspector was told that funding arrangements the provider arranged to be in place would ensure that staffing levels in the centre would remain the same. This, combined with the corresponding reduction in the number of residents accommodated in each house in the centre, was expected to have a significant impact on the quality of life of residents that remained living in this designated centre.

The next section of the report will reflect how the management systems in place were contributing to the quality and safety of the service provided in this designated centre.

Regulation 15: Staffing

The registered provider had not ensured that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis. This issue was impacting residents in a number of areas, including safeguarding and activation.

The registered provider had also not fully ensured that the the skill mix of staff was appropriate to the number and assessed needs of the residents. As outlined more comprehensively under Regulation 8, the high turnover of agency staff in the centre meant that all staff working in the centre were not always fully aware of the residents care and support needs. The providers' service improvement plan in place and for the centre also identified that there were concerns around clinical oversight and skill development within the nursing team and this was also discussed with the inspector on the day of the inspection and during the feedback meeting held following the inspection, with some initiatives planned to address this outlined to the inspector.

The inspector was told during the introductory meeting that there were seven care staff and one nursing staff vacancies on the staff team at the time of the inspection. The activation team duties were also being filled by regular staff due to these two posts being vacant also. The inspector was informed of plans the provider had to recruit an additional bank of staff across the organisation and some staff were identified to begin in the centre in the coming weeks. However, at the time of this inspection, staff turnover remained high and there was evidence that this was impacting on residents.

A sample of two months planned and actual staff rosters was provided and reviewed by the inspector. These showed that overall the provider was maintaining appropriate staffing numbers in the centre in line with their statement of purpose. The service improvement plan included details of a staffing audit had been completed by the provider for July and August 2025 and this showed that minimum staffing levels had been maintained at all times. However, the staff rosters showed

that there was a heavy reliance on agency and relief staff to supplement the existing staff team and cover vacancies in the centre. For example, for a one week period reviewed, twelve different agency staff had provided supports in the centre. The inspector also met or observed a number of agency staff during the inspection, some of whom had never or rarely worked in the centre before.

The inspector observed and was told that familiar staff working in the centre were put under additional pressure due to a high reliance on agency staff to cover vacancies in the centre. A number of staff met by the inspector over the two days were on their first shift in the centre and were noted to be unfamiliar with the residents they were supporting. For example, one staff member was unsure of residents' names when speaking to the inspector. While these staff ensured that the minimum staffing numbers could be maintained in each house, the inspector noted and was told that regular staff found it challenging to deal with a constant influx of unfamiliar staff, particularly given the high support needs and safeguarding concerns present in some areas of the centre. As a result, it was observed that much of the regular duties in the centre were performed by the familiar staff on duty. The unfamiliar staff generally provided supervision to residents or took residents on short walks on the campus, but were not utilised to reduce the workload on regular staff in any significant manner. This meant that the regular staff team, who knew residents preferences and support needs best, did not always have the time or opportunity to carry out "non-essential" care duties such as taking residents out, spending 1:1 time with residents, or progressing residents goals. The presence of unfamiliar agency staff also had the potential to limit staff from leaving the centre with residents on occasion due to a need or preference for familiar staff to be present for other residents.

Judgment: Not compliant

Regulation 16: Training and staff development

There were clear improvements noted in the area of staff training since the incoming person in charge had commenced working in the centre. For example, the initial service improvement action plan indicated significant gaps in training that had since been addressed. The training needs of staff were being appropriately considered. Some training was outstanding but there was a clear plan in place to address this. This meant that the staff team would be well equipped to offer residents safe and good quality care and support appropriate to their needs. The inspector reviewed a training matrix for forty one staff that worked in the centre.

The matrix reviewed showed that mandatory training provided included training in the areas fire safety, safeguarding, hand hygiene and positive behaviour support. Safety intervention training had been identified as required for the staff team and the inspector saw that while this had not yet been completed, this training had been scheduled for all staff in the coming months. Staff that spoke with the inspector told the inspector about some of the training they had completed, included on site

training completed recently with the designated officer in the area of safeguarding. Half of the staff team had completed this training, with the remaining staff scheduled to complete this before the end of 2025. The management team also reported that more staff were also now trained to adminster rescue medications, which improved the opportunities for some residents to attend activities without requiring the nursing staff to be present.

The person in charge provided the inspector with a copy of a supervision/performance review schedule. This outlined an eight week plan to provide each staff member working in the centre with formal supervision by the end of the year.

- Safety Intervention training had not yet been completed by the staff team
- Five staff had not completed manual handling training and ten staff were overdue refresher training in this area
- Three staff were overdue hand hygiene training

Judgment: Substantially compliant

Regulation 23: Governance and management

The registered provider had not ensured that the designated centre was resourced to ensure the effective delivery of care and support in accordance with the statement of purpose. The providers own improvement team review identified numerous issues that indicated oversight had not been fully maintained in the centre. This showed that the arrangements that had been in place since the previous inspection were not fully effective and were not robust in ensuring continuity of oversight. It is acknowledged that some of the issues identified had since been addressed and that there was a very robust and comprehensive service improvement plan in progress at the time of this inspection. However, given the high level of non compliance identified and the ongoing nature of some issues that impacted on residents' quality of life further improvements were required to ensure that the governance and management arrangements in place are fully effective to provide for a safe and person centred service to residents.

At the time of this inspection provider had ensured that there was a clearly defined management structure in the designated centre. However, the centre had no person in charge appointed between April and July 2025 and there was evidence that the providers oversight of the centre since the previous inspection had been impacted by management changes and resource issues. While this had been addressed at the time of the inspection with the appointment of a strong management team, this had not been addressed in a timely manner and the management systems in place had not fully ensured that that the service provided was safe, consistent and effectively monitored. While there were indications that this was being addressed at the time of

this inspection, a significant body of work was still required to be completed in the centre. While the inspector was told about efforts to address some staff culture issues identified in the centre, there was limited evidence to demonstrate that action in relation to this had been completed in a timely manner. Some staff spoken to were not aware of the service improvement plan that was underway in the centre.

The inspector was told that an annual review of the quality and safety of care and support had been completed for 2024 but that this could not be located since the previous management team had departed the centre. An annual review completed by the current management team to replace this was provided to the inspector on the second day of the inspection. Three unannounced visits by a representative of the provider had taken place within the previous year.

The provider had identified in their own Service Improvement plan that the centre was insufficiently resourced for residents' needs. Staffing levels in the centre were seen to be adequate to provide for the basic care needs of residents and additional staffing had been provided to support one resident through a challenging period. However, there was a heavy reliance on unfamiliar agency staff and this was impacting on the quality of the service provided.

While interim arrangements had been put in place for local oversight during a period when the person in charge, there was little evidence to show that the provider had maintained full oversight of all of the issues in the centre since the previous inspection. The systems in place did not always ensure that the service provided was effectively monitored and this impacted on the quality and safety of the services being provided. For example, following a significant increase in the number of safeguarding incidents reported from the centre the provider responded to a provider assurance report request from the Chief Inspector. This outlined a number of actions that would be taken to protect residents. However, some of these actions had not been completed within the timelines provided and were not addressed until the service improvement team commenced in the centre in August 2025.

- The annual review was unable to be located on the first day of the inspection and it was undetermined if this had been completed. This meant that actions had not been escalated or tracked for a significant period of time. A copy completed by the incoming management team was made available to the inspector on the second day of the inspection.
- Not all actions arising from the providers audit and review systems had been completed in a timely manner.
- Actions outlined in provider assurance reports provided to the Chief Inspector had not been completed within the timelines specified.
- Despite some actions taken by the provider, there was ongoing compatibility and safeguarding concerns in some areas of the centre.
- Staffing levels were adequate for basic care needs but inconsistency of staff was prevalent, with an over-reliance on agency staff.
- Some documentation was not up-to-date including some personal plans, resident information and risk assessments. There had been limited oversight of this documentation for a period, although it was evident that reviews of personal plans were in progress at the time of the inspection.

- The provider had made some progress with the de-congregation plan but at the time of the inspection, was not in line to meet the timelines in a restrictive condition attached to the registration of the centre. The inspector was informed that the provider intended to submit an application to vary to extend this.
- The incoming person in charge had remit over two designated centres, this had been identified as too large of a remit by the service improvement team, given the body of work to be completed in the centre.
- Actions identified in a June 2024 external safeguarding report in relation to improving staff culture and development in the centre had not been completed in a timely manner.

Judgment: Not compliant

Quality and safety

While overall, the day-to-day care and support provided to residents was seen to be good and the regular staff team in the centre presented as caring and committed to the residents they supported and some recent changes were bringing about improvements, at the time of this inspection residents were not yet always in receipt of safe services that fully met their needs. Issues were identified in the areas of personal plans, safeguarding, positive behavioural support and general welfare and development.

Some work had been completed in the previous year in relation to safeguarding in the centre. Staff working in the centre had completed online safeguarding training and approximately half of the staff team had completed face-to-face safeguarding training from the providers' designated officer in 2025 as part of the providers' efforts to enhance safeguarding practices in the centre. However, the arrangements in place had not been fully effective to protect residents from abuse at all times. Some residents' responsive behaviours continued to impact on other residents that they shared homes with, and this will be covered in further detail under Regulation 8. Some issues found in relation to positive behavioural support also impacted on this area.

Some good practice was observed in the centre. For example, mealtimes were protected to ensure that residents had the full attention of staff and could be supported to enjoy their meals in a relaxed and comfortable manner. Some very positive interactions were observed between residents and the staff that supported them, and the familiar staff were seen to promote a comfortable and relaxed homely environment. For example, the inspector heard a staff member singing with residents as they went about their work. Staff spoken with were very familiar with the residents that they cared for. Residents were well supported with personal care and healthcare needs in the centre and staff interactions with residents were seen to be kind and caring. Residents had access to a day service activation building for

activities and some residents enjoyed this on a daily basis. The inspector also observed numerous photos documenting day trips residents had taken with their peers and residents celebrating and enjoying important dates such as birthdays and some residents had enjoyed overnight trips for the first time since the previous inspection.

It was evident, however, that familiar staff working in the centre were put under additional pressure due to a high reliance on agency staff to cover vacancies in the centre. A number of staff met by the inspector over the two days were on their first shift in the centre and were noted to be unfamiliar with the residents they were supporting. For example, one staff member was unsure of residents' names when speaking to the inspector. While these staff ensured that the minimum staffing numbers could be maintained in each house, the inspector noted and was told that regular staff found it challenging to deal with a constant influx of unfamiliar staff, particularly given the high support needs and safeguarding concerns present for some residents. As a result, much of the regular duties in the house were performed by the familiar staff. While the unfamiliar staff provided supervision to residents but were not utilised to reduce the workload on regular staff in any significant manner and potentially curtailed from leaving the centre due to a need for familiar staff to be present for some residents. This meant that staff would not always have the time or opportunity to carry out "non-essential" care duties such as taking residents out or spending 1:1 time with residents.

In summary, while the provider had recently put in place a service improvement team and this was beginning to have an impact on the quality and safety of the service received by residents, a lack of full provider oversight had led to a significant delay in fully addressing ongoing issues that were present in the centre. Ongoing momentum and commitment to the action plan put in place by this team and the providers' de-congregation plans was required to ensure that safe and good quality services were consistently provided to the residents living in this centre.

Regulation 13: General welfare and development

Although some incremental improvements were noted, the registered provider had not always provided residents with sufficient opportunities to participate in activities in accordance with their interests, capacities and developmental needs. There was ongoing non compliance in this area. As identified in previous inspections, all residents were not offered regular choices in relation to the activities they participated in, or provided with opportunities to regularly leave the centre. Also, there were ongoing vacancies in the activation team employed in the centre. While these vacancies were filled by regular staff, the actions outlined in the previous compliance plan submitted in respect of this centre were not being completed. A sample of three residents' activity charts were viewed and a sample of daily notes were also viewed. Three staff were interviewed, and other staff were met informally over the course of the inspection. While there did appear to be an increased focus on meaningful activity and staff spoke about regularly leaving the centre, the

documentation reviewed by the inspector and observations during this inspection indicated that a culture of providing meaningful choice and activation for residents was not yet embedded in this centre. More group outings and day trips did appear to be taking place and some residents were now enjoying overnight breaks, but some day-to-day institutional practices in relation to activation prevailed. For example:

- The inspector saw activity records that documented walking to the on-site day service building as an activity. This building was located a couple of hundred metres from the houses that made up the designated centre.
- Other activity records showed that some residents did not participate in community based activities or leave the campus for meaningful activity for days or weeks at a time. One resident had nine "spins" documented as the only external activity for August and September 2025 to date.
- All of the sample of residents' activity records documented "spins" but some of these appeared to have little function, with residents often not documented as having left the bus or completed an activity during these trips. When staff were asked about this it was indicated that residents would sometimes get off the bus to go for a walk or sometimes go for a drive -thru coffee or meal. The activity records did not indicate that this occurred most of the time.
- The inspector observed agency staff being asked to walk some residents around the campus on a 1:1 basis or in their wheelchairs as they were indicating they were anxious to go outside. However, these walks were perfunctory in nature, usually short in duration, and another resident would be waiting for their "turn" once they returned to the centre. While it was evident that these residents enjoyed getting out of the house, there did not appear to be a focus on incorporating this into community based activities or offering choices to residents about this.
- There was evidence that some efforts were being made in relation to increasing meaningful activation for residents, but these efforts were not consistent and the oversight of these was not in line with what was identified in the compliance plan received following the previous inspection.
- Staff culture in the centre was identified as an issue in a safeguarding review completed in 2024. However, there was limited evidence of sustained and monitored action to address this until the Service Improvement Team were put in place in August 2025.
- Some further issues are highlighted under Regulation 7: Positive Behavioural Support including a resident not accessing known community based activities that they enjoyed and were recommended by an allied health professional.

The inspector acknowledges that some good practice was observed and this is outlined under the quality and safety section above.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

The incoming person in charge had taken steps to ensure that personal plans would be in place for residents that reflected their assessed needs, outlined the supports required to maximise residents' personal development in accordance with their wishes, age and nature of their disability. The person in charge had arrangements in place to ensure that an assessment of the health, personal and social care needs of each resident was carried out as required to reflect changes in needs and circumstances on an annual basis. Annual multi-disciplinary reviews of the assessed needs of residents had been completed and were viewed in the sample of resident files reviewed.

Personal plans were in place for residents. A sample of three personal plans were reviewed by the inspector. Some of the information contained in these plans was not fully reflective of the current support needs of residents and the person in charge and provider had identified this prior to this inspection taking place. The incoming person in charge had put in place arrangements for the review and updating of the plans in place and evidence that these reviews were being completed was seen in review sheets at the front of residents' files. At the time of this inspection, had not yet been fully completed for all residents but was underway and was being tracked as part of the service improvement action plan in place.

The registered provider had some arrangements in place to meet the assessed needs of the residents living in this centre. For example, staffing levels were in place that would be appropriate to meet the assessed needs of the residents living in the centre in line with the statement of purpose. Issues in relation to the effectiveness of these arrangements are addressed under other sections of this report. Healthcare records viewed in three residents' files showed that residents had support plans in place that provided good guidance to staff and contributed to residents receiving appropriate healthcare supports. Residents also had access to a variety of allied health professionals as required and residents had recently updated dental care plans in line with the providers' service improvement plan. Incident reports and safeguarding plans reviewed in the centre alongside other documentation such as multidisciplinary reports and the providers' service improvement action plan showed that residents continued to be impacted by each other in this centre and that the provider was struggling to meet the assessed needs of some residents while their current living arrangements continued. However, the provider was exploring other options for some residents and had advanced plans in place to transition some residents from the centre into community based homes in line with their own will and preference and it was anticipated that this would contribute significantly to the ability of the provider to meet the needs of both these residents and the residents that remained living in this centre.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

This inspection found that where a residents' behaviour necessitated intervention, timely efforts had not been made to identify and alleviate the cause of the resident's challenging behaviour.

The provider had submitted a provider assurance report in July 2025 following the receipt of unsolicited information by the Chief Inspector. Some of these improvements focused on supporting the resident to manage their behaviours and reducing the impact of those behaviours on other residents, including that a positive behaviour support plan that had been due to be reviewed in May 2024 would be reviewed by the end of July 2025 and that all staff would attend safety intervention training. The inspector reviewed information relating to one resident that included allied health professional reports, daily reports for specific dates, incident reviews, healthcare protocols and a positive behaviour support plan. The inspector also spoke to three staff and a number of members of management about the strategies in place to support this resident. It was seen that the provider had put in place an additional staff member to support this resident and reduce the impact of these responsive behaviours and that this had been effective to a certain degree. Also, as outlined below, recent efforts had been made to progress actions identified in the provider assurance report. However, timely interventions to alleviate the cause of the residents challenging behaviours was not demonstrated and some issues were identified in relation to positive behavioural support for this resident:

- A review of the residents' positive behaviour support plan had commenced at the time of the inspection but had not been completed in line with the dates identified by the provider in the provider assurance report submitted. Given there was a volume of safeguarding incidents involving this resident, this did not indicate that the provider had responded fully in a timely manner to support this resident to manage challenging behaviours.
- Training records reviewed showed that safety intervention training was planned at the time of this inspection but was not completed as per the timeline set out in the provider assurance report.
- There was no evidence to show that a 'read and sign' sheet for staff for this positive behaviour support plan was in place. This was to be put in place to provide assurances that all staff were fully aware of the strategies to support this resident to manage responsive behaviours.
- Occupational health recommendations dated December 2024 included strategies and actions to support a resident with meaningful activation, which was an integral part of the strategies to support this resident and reduce the impact and likelihood of responsive behaviours. This included recommendations for the resident to trial specific identified activities. There was no evidence to demonstrate that some of these activities had been trialled with the resident or incorporated into his regular schedule up to August 2025. For example, suggested activities included weekly swimming sessions, Special Olympics, trialling a trampoline park and using a treadmill and none of these were fully in place at the time of this inspection. A staff

member spoken with was not fully aware of these recommendations, despite demonstrating a very good understanding of this resident and their needs, including regular activation. The inspector also observed this staff member supporting this resident to engage in regular activity, including physical exercise and household tasks, on the day of the inspection.

- A review of the records showed that there was little evidence to demonstrate oversight of the efforts to alleviate the causes of the residents' behaviour. For example, a multidisciplinary review completed in May 2025 noted that the resident had a "positive behaviour support plan in place with good effect" and included details of the occupational therapy recommendations mentioned above but did not evaluate or identify if these had been completed or not.
- In response to some behaviours displayed by a resident that impacted on themselves and their peers, staff supported the resident in a separate location on the campus for a number of hours by night on one occasion. There was no evidence that this had impacted negatively on the resident and a member of management that was present on that night spoke with the inspector. They confirmed that the environment was better suited to the resident on this occasion who was presenting as very active and had lots of space to move around, and the resident was provided with any required care and support during this period. They confirmed that the resident was not restricted from returning to their home if they wished. However, there was no guidance in place for staff should similar supports or interventions be required in the future.

Judgment: Not compliant

Regulation 8: Protection

The registered provider had not fully ensured that all residents were protected from abuse. The findings of this inspection indicated that the registered provider had taken some steps to protect residents and procedures to report, respond and investigate allegations of abuse but that these were not fully effective. The inspector reviewed, solicited information submitted by the provider to the Chief inspector, an external safeguarding review completed in 2024, a sample of safeguarding plans in place for two units of the centre and some incident reports. The inspector also interviewed the person in charge, area manager, three care staff, a Clinical Nurse Manger 1, an individual appointed to provide oversight during the vacancy in the person in charge role, and the night manager.

Overall, staff spoken with were familiar with safeguarding procedures and staff and management spoken with during the inspection reported that they felt that residents were well protected from harm in the centre. However, there had been a high volume of safeguarding incidents reported in the centre since the previous inspection, including a large volume of peer-to-peer incidents that were similar in nature. While some of these were low level incidents that did not significantly impact residents, others were physical in nature, including a number of occasions where a

resident would be unintentionally hit or pushed during occasions where another resident exhibited responsive behaviours.

While the safeguarding records viewed indicated that staff were aware of and reporting incidents of a safeguarding nature, a review of the incidents reported showed that some residents were regularly impacted by other people they shared homes with. For example, one resident had been impacted on at least twelve separate occasions since July 2024, with six of these incidents occurring over a five day period. The repeated nature of some of these incidents did not demonstrate timely intervention and response at provider level to ensure that residents were fully protected. For example, following a peer to peer safeguarding incident, a common action reported to be taken by the provider would be increased supervision by staff, but safeguarding records reviewed showed that sometimes similar incidents had occurred later on the same day indicating that these measures had not been effective in keeping all residents safe from peer-to-peer abuse.

It is acknowledged that the provider had, after repeated instances of a safeguarding nature in one unit of the centre, put in place additional staffing to support one resident and this had been helpful in reducing incidents of this nature in the period leading up to the inspection. The provider had also made some efforts to consider if an alternative placement for one resident was an option and this was part of a formal safeguarding plan in place. Staff and management spoken with on the day of the inspection all acknowledged that this residents' environment was not fully suitable for meeting their needs and this was impacting on both the resident and the other residents they shared a home with, but this had not yet been documented or explored fully through the residents' assessment of need or compatibility assessments, despite a case conference and safeguarding plan in place. Also, as will be discussed under Regulation 7, some recommendations from allied health professionals to support this resident had not been implemented and provider oversight of this also appeared to have been limited for a period of time.

A sample of safeguarding plans in the centre were reviewed and these seen to be in place in response to incidents of a safeguarding nature that occurred and these had been reported to the safeguarding and protection team as required. However, the recommendations from a safeguarding review carried out in 2024 had not been fully implemented at the time of this inspection, although the inspector saw that these were addressed in the service improvement action plan recently put in place for the centre.

The inspector noted that while the provider had put in place additional staffing to help address some safeguarding concerns, the inconsistency among the staff team was likely contributing to some safeguarding incidents that occurred in the centre. Regular staff spoke about the challenges this presented and indicated that it was very challenging to have to constantly inform new and unfamiliar staff about the care and support arrangements in place in the centre, particularly when they might be present for one shift only. While staff told the inspector that agency staff would be informed of safeguarding plans on arrival to the centre, the inspector was not assured that this was effective. An agency staff member who was observed by the inspector to be supervising residents in a communal area while the regular staff

completed care and support duties with other residents was unfamiliar with the names of the residents they were supporting. This indicated that unfamiliar staff might not have the knowledge required to fully implement safeguarding plans or recognise a scenario where a safeguarding incident might be more likely to occur and negated the impact of enhanced supervision arrangements put in place by the provider.
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 15: Staffing	Not compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 13: General welfare and development	Not compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Not compliant

Compliance Plan for Cork City North 7 OSV-0003297

Inspection ID: MON-0048097

Date of inspection: 12/09/2025

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant

Outline how you are going to come into compliance with Regulation 15: Staffing:
Recruitment
The registered provider has engaged in a number of initiatives to increase staff numbers including a city- and county-wide recruitment drive in November 2025. These campaigns aim to attract new staff members to enable the provider to allocate new full-time staff to designated centres across the organisation.
Since the inspection of CCN7 two care assistants and one staff nurse have been assigned and commenced duties in the centre. Further allocation of staff, including those supporting community engagement and activities, will take place as suitable candidates are identified through recruitment drives.
In the interim, the provider will continue to utilise familiar relief and agency staff wherever possible to maintain consistency of care and support.

Staff numbers & skill mix
A comprehensive staffing needs analysis was completed in October 2025 by the Service Improvement Project Lead, with input from the PIC, PPIM and ADON. This analysis, based on residents' assessed needs, will be used to inform the recruitment numbers and skill mix required to improve the service delivery in CCN7.
A business case is being developed to apply for additional funding to further enhance the staffing numbers and skill mix in CCN7 and meet the requirements of the Regulations and Standards. The business case includes provision for additional staffing, annual leave cover, staff training and measures to enable greater community engagement opportunities for residents. The business case aligns with the provider's service improvement plan to enhance the service across all areas including Regulations 5, 14, 15 and 23.

Staff roles & remit

The provider intends to reduce reliance on new agency staff as recruitment progresses. Work is ongoing to convert suitable agency staff to contracts with the provider where possible.
The induction of agency staff is being reviewed to enhance measures to address the issues relating to unfamiliarity with residents. This includes the compilation of local induction packs containing concise resident profiles, safeguarding plans, and residents' personal preferences. This will assist in addressing the issues identified by the Service Improvement Team and contribute to supporting agency staff members' understanding of their role in addition to ensuring effective task distribution among staff (agency and provider) until such time as all posts are filled by staff employed directly by the provider. Measures have been taken to enhance staffing including assigning core staff to each house where possible and assigning agency staff a core staff 'buddy' to ensure they receive the required support and mentoring

Clinical Oversight
Actions relating to clinical oversight are documented under Regulation 16: Training and Staff Development.

Other relevant actions
Performance achievement initiatives are being reviewed
Regular communication is taking place via the staff newsletter, internal staff site and team meetings, reinforcing how engagement improves standards and addresses cultural challenges.

Regulation 16: Training and staff development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
• A training matrix is maintained, updated as required and reviewed monthly by the Person in Charge (PIC). It is discussed at Service Improvement Plan (SIP) meetings to ensure effective oversight.
• Training expiry dates are proactively monitored; any expired or soon-to-expire training is promptly tracked and scheduled for completion.
• All new staff members complete a structured induction programme, which includes orientation to organisational policies and procedures, as well as the completion of all mandatory training requirements.
• Continuous Professional Development (CPD) opportunities are provided through a combination of external courses and internal workshops to enhance staff skills and knowledge.
• The PIC, CNM1, PPIM, and ADON completed performance achievement training in August 2025. Performance achievement reviews for all staff will be finalised by 31 December 2025.
• Clinical supervision for nursing staff is scheduled to commence in Quarter 1 2026.

• Findings and actions arising from audits and reviews are documented, tracked, and escalated as necessary to maintain regulatory compliance.
• The PIC monitors compliance through the training matrix, monthly audits, and team meetings, ensuring that any gaps are identified and addressed promptly.
• Completion of mandatory training has progressed since the inspection, with staff completing courses in fire safety, manual handling, CPI, safeguarding, Children First, and PBS. A detailed schedule is in place to ensure all staff achieve full compliance with required training as soon as possible.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
• The issues relating to compatibility and safeguarding, staffing are responded to under the relevant Regulation responses.
• The de-congregation of the centre is dependent on a number of factors, most notably the availability of housing. The provider is reliant on the HSE and other bodies to fulfil this. While some housing has come on stream it has been delayed due to issues outside the provider's control. The provider continues to work with the relevant bodies responsible for housing to address any barriers and access the required housing in as timely a manner as is possible.
• The provider is reviewing the management structure in the centre and the wider area the centre is located in. This will include a review of the remit of the person in charge of CCN7. Any required changes will be progressed when resources are allocated by the funder consistent with the application referenced in the response to Regulation 15.
• All actions, including those from the Provider Assurance Report, safeguarding report, and six-monthly audits, are incorporated into the Provider's Service Improvement Plan for the designated centre. Completion will be tracked through this process.
• The provider will ensure the annual reviews are stored in the appropriate folder on the system to ensure it is accessible to all management in the event there are any further management changes. This will include the tracking and monitoring system for ensuring items identified for improvement are progressed.
• Staff culture and development is a key part of the work of the Service Improvement Team and actions have taken place. These include:
o staff consultations by the service improvement lead to identify cultural and practice-related concerns and gather first-hand feedback on living and working in CCN7. These insights informed staff forum agendas. Engagement sessions occurred on 11 March 2025, 01 April 2025, 09 April 2025, and 25 August 2025.
o forums to enhance staff culture, awareness, and engagement,
o staff engagements facilitated by the Chief Operations Officer, PPIM, and PIC were held on 19 September 2025. For staff unable to attend, a summary note was circulated on 03 October 2025.
• The provider is implementing a number of other improvements to enhance the

governance and management including:
o PIC and PPIM governance meetings commencing January 2026 to ensure all aspects of service improvement plans, compliance plans and audits are actioned as appropriate and escalated where required.
o Performance reviews of the PIC by the PPIM to ensure the PIC is supported in their role.
o A member of the EMT will ensure oversight of the Service Improvement Plan on behalf of the provider and report to the EMT and CEO.
o Progress on the service improvement plan will be shared with all staff to ensure staff have up to date information relevant to their roles.
o Improvement Champions have been assigned for key areas including audit and training oversight (overseen by CNM1/PIC and administrative personnel)

Regulation 13: General welfare and development	Not Compliant

Outline how you are going to come into compliance with Regulation 13: General welfare and development:
• A comprehensive review of all residents' activity records is underway to ensure accuracy and alignment with assessed needs. This review will incorporate recommendations from Multidisciplinary Team members and is scheduled for completion by 31 December 2025.
• A community-mapping exercise was completed on 21 November 2025 to identify and expand opportunities for residents based on their individual preferences.
• Staff culture concerns identified in the 2024 safeguarding review have been addressed through structured staff forums facilitated by the COO, PPIM, and PIC. These sessions were completed on 19 September 2025, and the Service Improvement Team will maintain ongoing oversight to embed positive cultural change and new ways of working.
• Expectations regarding meaningful engagement, community integration, and resident-led decision-making have been communicated to all staff through onsite safeguarding training and regular staff meetings. Initial sessions were completed on 19 September 2025, with additional sessions scheduled for completion by 30 December 2025.
• The ADM Inclusion Ireland Training Programme has been scheduled for three sessions in November and December 2025 to support residents in decision-making and enhance staff knowledge. Completion is expected by 31 December 2025.
• Since September 2025, the Person in Charge (PIC) has introduced unannounced thematic practice observation walkabouts to monitor and ensure staff interactions uphold residents' rights and organisational policies.
• Five Positive Behaviour Support (PBS) plans requiring updates have been fully reviewed and completed on 12 November 2025.
• In line with Regulation 15, a business case has been developed to secure an appropriate skill mix of staff compatible with the needs of the centre.

• The HSE has funded Horizons to engage with a National Independent Advocacy Service

to support transitions through empowerment and participation during de-congregation. This initiative will commence in 2026.
• The provider is committed to reducing the number of registered beds in CCN7. By year-end 2025, the designated centre will have reduced its bed capacity by one third (30 registered beds in 2023 to 20 occupied beds).
• The provider has secured two community homes and obtained funding for staffing these homes as part of the de-congregation plan for CCN7.

Regulation 5: Individual assessment and personal plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
As noted by the inspector the person in charge had identified that personal plans required improvement and a plan was and is in place to improve these. This includes an audit which will be completed by 31 December 2025. All actions required will be addressed including refresher training for staff, ensuring residents are fully supported to develop their plans and ensuring the required support for the development and review of health action plans and MDT plans are provided.

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
• Five residents' Positive Behaviour Support (PBS) plans have been completed by the Positive Behaviour Support Team (completed on 14 November 2025). Updates for five additional residents are in progress and scheduled for completion by 31 March 2026.
• A mandatory read-and-sign process has been introduced for all staff to confirm awareness and understanding of PBS strategies.
• Since the inspection, five staff members completed Safety Intervention Training on 10 November 2025. Further training sessions are scheduled for 1 December 2025 and 10 December 2025 for the remaining five staff members.
• A trial of activities recommended by the Occupational Therapist for one resident has been completed, and a document evidencing the outcomes of these trials has been developed.
• The preferred activities identified for this resident have been incorporated into their weekly schedule (completed on 17 November 2025).
• Ongoing monitoring and evaluation of the effectiveness of the preferred activities and

PBS plans will be carried out by the local team and through local quality audits.
• Local protocols are in place to guide staff in providing appropriate interventions when responding to behaviours that may impact the resident or others.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
• Weekly handover meetings now include safeguarding reviews to monitor incidents, actions, and emerging trends.
• Recommendations from the 2024 external safeguarding investigation have been integrated into the Service Improvement Plan (SIP). The SIP action plan is reviewed regularly, with oversight provided by the Executive Team.
• A mandatory safeguarding induction will be implemented for all new staff members.
• Following a recent compatibility review and with the consent of the individuals involved, two residents are transitioning to another designated centre.
• An internal reconfiguration within the designated centre will adjust occupancy levels in each house to enhance resident protection. These planned transitions will reduce the total number of residents in CCN7 from 23 to 20, with completion targeted for 15 December 2025.
• The de-congregation plan for CCN7 remains ongoing, with a further seven residents scheduled to transition into two community homes in 2026.
• Additional actions that will positively impact safeguarding and support compliance with Regulation 8 (Protection) are detailed under Regulations 7, 5, 13, 23, 16, and 15 above.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 13(2)(a)	The registered provider shall provide the following for residents; access to facilities for occupation and recreation.	Not Compliant	Orange	31/03/2026
Regulation 13(2)(b)	The registered provider shall provide the following for residents; opportunities to participate in activities in accordance with their interests, capacities and developmental needs.	Not Compliant	Orange	31/03/2026
Regulation 13(2)(c)	The registered provider shall provide the following for residents; supports to develop and maintain personal relationships and links with the wider community	Not Compliant	Orange	31/03/2026

	in accordance with their wishes.			
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.	Not Compliant	Orange	30/06/2026
Regulation 15(3)	The registered provider shall ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.	Not Compliant	Orange	30/04/2026
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	31/03/2026
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and	Substantially Compliant	Yellow	30/06/2026

	support in accordance with the statement of purpose.			
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	31/03/2026
Regulation 23(1)(d)	The registered provider shall ensure that there is an annual review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards.	Substantially Compliant	Yellow	30/11/2026
Regulation 23(3)(a)	The registered provider shall ensure that effective arrangements are in place to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.	Not Compliant	Orange	31/12/2026

Regulation 05(2)	The registered provider shall ensure, insofar as is reasonably practicable, that arrangements are in place to meet the needs of each resident, as assessed in accordance with paragraph (1).	Substantially Compliant	Yellow	31/03/2026
Regulation 05(3)	The person in charge shall ensure that the designated centre is suitable for the purposes of meeting the needs of each resident, as assessed in accordance with paragraph (1).	Substantially Compliant	Yellow	31/03/2026
Regulation 05(6)(c)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall assess the effectiveness of the plan.	Substantially Compliant	Yellow	31/03/2026
Regulation 05(6)(d)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances,	Substantially Compliant	Yellow	31/03/2026

	which review shall take into account changes in circumstances and new developments.			
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	31/01/2026
Regulation 7(5)(a)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation every effort is made to identify and alleviate the cause of the resident's challenging behaviour.	Not Compliant	Orange	31/01/2026
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	30/06/2026