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:	19 March 2026
Centre ID:	OSV-0003297
Fieldwork ID:	MON-0049111

About the designated centre

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

Cork City North 7 is a designated centre operated by Horizons. It provides a residential service to a maximum of twenty five adults with a disability. The designated centre comprises four houses located on a campus setting in Cork city. Each house is a detached two-storey building with the same layout. Each house comprises of a kitchen, dining room, sitting room, sun room, office and a number of resident bedrooms. There are a small number of shared bedrooms in use in the centre. The staff team consists of care assistants, staff nurses, clinical nurse managers. The staff team are supported by the person in charge.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	20

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 19 March 2026	10:30hrs to 17:30hrs	Conan O'Hara	Lead
Thursday 19 March 2026	10:30hrs to 17:30hrs	Deirdre Duggan	Support

What residents told us and what inspectors observed

This was an unannounced risk inspection conducted which was completed by two inspectors over one day. The purpose of this inspection was to review actions taken by the provider, as outlined in their compliance plan, to address areas for improvement identified in the previous inspection undertaken in September 2025.

The previous inspection in September 2025 found that while residents' physical day-to-day care needs were being met in this centre, there were areas in need of attention including an over-reliance on agency staff, compatibility concerns and some institutional practices.

This inspection found that the provider had implemented a number of the actions outlined in the service improvement plan including:

- the numbers of residents had reduced from 23 in September 2025 to 20. The provider had supported two residents to move to appropriate alternative placements. Sadly, one resident passed away;
- moving residents within the four houses under the designated centre to reduce the number of shared rooms and address compatibility concerns;
- increased focus on activation; and
- review of staffing arrangements and recruitment of staff.

Also, the provider had two new community designated centres at advanced stages of being established as part of a long-term deconcregation plan. Overall, while inspectors found that improvements had been made, further work was required in staffing, governance and management and general welfare and development.

The centre comprises of four houses located on a campus based setting. There is another designated centre and a day service operated by the provider also based on this campus. The four houses had the same layout and consist of kitchen, dining room, sitting room, sun room, office, resident bedrooms and a number of bathrooms. There were a small number of remaining shared bedrooms in the centre which had the potential to impacted the privacy and dignity of the residents. There was a partition wall which divided the shared bedrooms which minimised the impact of this on the privacy and dignity of individuals. At the time of the inspection, two residents shared a bedroom. Overall, residents' bedrooms were nicely decorated and personalised to reflect residents' interests and preferences.

On arrival, the inspectors completed a walk around of the four houses accompanied by the person in charge. The inspectors had the opportunity to meet with the 20 residents living in the centre over the course of this inspection. The residents used both verbal and alternative methods of communication, such as vocalisations, facial expressions and gestures to communicate their needs. In the afternoon, the

inspectors returned to each house to spend time with the residents, speak with nine staff and review documentation.

In the first house, which was home to six residents, the inspectors were welcomed by five residents in the morning. One resident had chosen to have a lie-in. The residents were spending time in the sitting room watching TV. Two residents were supported to go for a walk around the grounds. Later in the afternoon, an inspector was told two residents were attending planned appointments, two residents were visiting the on-site activation centre and that the remaining residents were spending their afternoon enjoying the sunny day and were in and out of the garden in the company of staff.

In the second house, which was home to four residents, in the morning the inspectors met with three residents in sitting room while one resident chose to have a lie-in. The inspectors were informed that the house were planning to visit 'Fota House' in the afternoon for a walk in the gardens. In the afternoon, an inspector saw that residents were relaxing in the sitting room and conservatory and their bedrooms for a period before being supported by staff to get ready to go out. Prior to departing this house two residents were observed in the service vehicle ready to leave on their outing. The inspector was told one resident had chosen not to go out.

In the third house, which was home for five residents, three residents had left to go for a coffee and two residents were in the house watching TV. In the afternoon, the inspector met with the five residents in their house and spent time in the sitting room. The residents appeared content in their home and in the presence of staff. The inspector was informed that there were plans to go to the cinema in the afternoon.

In the fourth house, which was also home to five residents, three residents had left the service for the morning to go for a drive and coffee. The inspectors met the two remaining residents in the house were one was spending time resting in the sitting room and the other welcomed inspectors into their home in the sun room of the centre. In the afternoon, the inspector met with the three residents as they returned from their morning out and they appeared to be happy to be home. There were plans for two residents to join their peers going to the cinema in the afternoon. Overall, the residents appeared relaxed and comfortable in their home.

Overall, the inspectors found that the provider had implemented a number of actions as outlined in the service improvement plan. The inspector observed the staff team supporting the residents in an appropriate and caring manner. However, areas of staffing, governance and management and general welfare and development required continued work.

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

Capacity and capability

Overall, there was a defined management system in place striving to ensure that the service provided was safe, consistent and appropriate to residents needs. The centre was managed by a full-time, suitably qualified and experienced person in charge. The person in charge was in charge of this designated centre alone and was supported in their role by a clinical nurse manager 1.

There was evidence of regular quality assurance audits taking place to ensure the service provided was effectively monitored. These audits included the provider annual review and unannounced six-monthly visits as required by the regulations. The provider had developed implemented a service improvement plan which had implemented a number of actions to address identified areas for improvement. However, continued work was required to effectively implement the service improvement plan.

On the day of inspection, the staffing levels were in line with the roster and there was evidence of improved continuity of care. The inspectors were informed that the provider had successfully recruited seven whole time equivalents and reduced the reliance on agency staffing. On the day of inspection, no agency staff was present in the designated centre. The provider had undertaken an assessment of staffing needs and identified the need for additional resources.

Regulation 15: Staffing

The inspectors found that there had been improvements in the staffing arrangements to meet the assessed needs of the residents. However, continued work was required to come into compliance with Regulation 15

The person in charge maintained a planned and actual roster. From a review of the roster for February 2026 and March 2026, it was demonstrable that staffing levels were maintained. The twenty residents were supported by at least nine staff during the day and five staff at night.

Since the last inspection, the provider had recruited seven whole time equivalent staff. The roster demonstrated that there was a reduced reliance on relief and agency staffing. The staff team spoken with noted that there was improvements in consistency in staffing but highlighted there remains challenges at times.

At the time of the inspection, the inspectors were informed that the centre was operating with 1.2 whole time equivalent residential staff vacancies which the provider was actively recruiting for. This ensured improved continuity of care and support provided to residents. Where relief and agency was being used, the

inspectors observed local induction packs which contained concise resident profiles, safeguarding plans, and residents' personal preferences.

However, as noted continued work was required to come into compliance with Regulation 15. For example, there was an established restrictive practices in place on a daily basis at times of reduced staffing which impacted 11 residents. For example, kitchen doors were locked in residents homes when there was reduced staffing due to supporting residents with personal care or to support staff to take breaks. The inspectors were informed that this practice was in place on the day of inspection.

In addition, while the 20 residents could access the day service on the campus on sessional basis, they were dependent on the staff team and activation staff to complete activities away from the campus. At the time of the inspection, the inspectors were informed that the residents were supported by two activation staff Monday – Thursday between the hours of 3-5. This activation staffing level was not in line with the centre's statement of purpose of 0.8 whole time equivalents.

Following a staffing assessment in October 2025, the provider has submitted a business case to their funder seeking an additional four whole time equivalents to enhance the staffing resources for annual leave, staff training and measures to enable greater community engagement opportunities for residents. This was not in place on the day of inspection.

Judgment: Substantially compliant

Regulation 23: Governance and management

There was a clearly defined management structure in place. The person in charge reported to a Regional Manager, who in turn reports to the Chief Operations Officer. The person in charge was responsible for this designated centre alone and was supported in their role by a Clinical Nurse Manger 1 and the staff team.

There was evidence of quality assurance audits taking place to ensure the service provided was appropriate to the residents needs. The quality assurance audits included an annual review completed in April 2025 and two six-monthly provider visit completed in October 2025 and January 2026. In addition, there was evidence of local audits carried out by the person in charge including unannounced thematic practice observation walkabouts and personal plans checks. The audits identified a number of areas for improvement. A service improvement plan was in place to address these areas.

The centre was registered in 2023 with two restrictive conditions which included no new admissions and the implementation of a decongregation plan. Since 2023 the number of residents in the designated centre has reduced from 25 to 20. Also, the

provider has two new community designated centres at advanced stages of being established as part of a long-term deconcregation plan for this designated centre.

Overall, it was evident that the provider was implementing the actions as outlined in their service improvement plan and decongregation plan. However, continued work was required to effectively implement the service improvement plan and address the prolonged areas for improvement including staffing arrangements and general welfare and development. For example, in the compliance plan submitted in response to the previous inspection, the provider outlined that the centre would be in compliance with Regulation 13: General Welfare and Development. While the inspectors found that provider's systems and processes had improved further improvement was required in the providers systems was required to come into compliance with Regulation 13.

Judgment: Substantially compliant

Quality and safety

Overall, the inspectors found that the service was striving to provide a quality and person centred care and support to the residents. However, continued attention was required in General Welfare and Development. .

The inspectors reviewed the nine residents' personal files in relation to their goals and activation. Overall, it was evident there had been an increased focus on ensuring residents had sufficient opportunity for activities. However, this was an establishing practice and process and inspectors found that continued work was required to further develop residents activation and embed the practice.

There were appropriate systems in place to keep the residents safe. For example, a review incidents and accidents demonstrated that the were appropriately managed and responded to.

Regulation 13: General welfare and development

There were improvements in ensuring residents were provided with sufficient opportunities to participate in activities in accordance with their interests, capacities and developmental needs.

The inspectors reviewed a sample of nine residents goals and activity charts. Overall, there had been an increased focus on providing opportunity for meaningful activity. The residents were supported with activities by the residential staff and activation staff during the week. Each resident had goals identified for the upcoming

year. The goals included visiting sensory parks, visiting family, going on holidays and attending a concert. However, one resident's file reviewed goals had yet to be developed. In addition, there was some gaps in the daily recording of residents activation.

While there had been incremental improvement, this was an establishing practice and process in this centre. The inspectors found that continued work was required to further develop residents opportunities for activation and embed the practice.

Judgment: Substantially compliant

Regulation 8: Protection

The registered provider and person in charge had systems to keep the residents in the centre safe. The inspectors reviewed a sample of incidents which demonstrated that incidents were appropriately managed and responded to. Overall, there had been a reduction in the number of notifiable incidents in the last six months since the last inspection. The inspectors were informed that the reduction in numbers and internal movement of residents within the houses of the designated centre has lead to a reduction in peer to peer incidents. Staff spoken with were found to be knowledgeable in relation to keeping the residents safe and reporting allegations of abuse. The residents were observed to appear relaxed and content in their home.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Quality and safety	
Regulation 13: General welfare and development	Substantially compliant
Regulation 8: Protection	Compliant

Compliance Plan for Cork City North 7 OSV-0003297

Inspection ID: MON-0049111

Date of inspection: 19/03/2026

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: The provider welcomes the recognition of improvements made in staffing arrangements within the designated centre. Since the previous inspection, significant progress has been achieved through the recruitment of seven whole-time equivalent staff members, resulting in improved staffing consistency and reduced reliance on agency and relief staffing. The provider remains committed to ensuring that staffing levels continue to reflect the needs of residents and support the delivery of safe, person-centred care. Recruitment remains ongoing to address the remaining 1.2 whole-time equivalent vacancies identified at the time of inspection. Interim measures continue to be implemented to ensure continuity of care, including the use of a consistent relief panel and induction processes for all relief and agency staff. A review of staffing arrangements and roster management is undertaken on an ongoing basis by the Person in Charge and regional management team to ensure planned and actual staffing levels are maintained. As mentioned in the report the provider has submitted a business case to the funding body seeking additional staffing resources to further strengthen service delivery, facilitate staff training, support annual leave coverage, and promote increased community engagement opportunities for residents. The provider will continue to monitor staffing arrangements through governance and oversight systems, including regular roster audits, supervision, and review of residents' needs, to ensure sustained compliance.	
Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management: The provider welcomes the recognition of the governance and management arrangements in place within the designated centre. The provider remains committed to maintaining effective oversight, strong governance structures, and continuous quality improvement to ensure safe, person-centered services for residents. The designated centre continues to operate under a clearly defined management structure, with the Person in Charge supported by the Regional Manager, Chief Operations Officer, Clinical Nurse Manager 1, and wider staff team. Regular management meetings, audit reviews, risk management systems, and monitoring of action plans are in place to ensure that areas identified for improvement are progressed in a timely manner. Governance and oversight systems remain in place, including annual reviews, six-monthly provider visits, thematic audits, practice observation walkabouts, and personal plan audits. Findings from these audits are reviewed regularly, and identified areas for improvement including staffing and general welfare which are incorporated into the centre's service improvement plan. The provider acknowledges that continued progress is required in relation to the implementation of the overall service improvement and de-congregation plans. Since registration in 2023, resident numbers have reduced from 25 to 20, demonstrating ongoing progress toward de-congregation objectives. In addition, two community designated centres are at advanced stages of development as part of the provider's long-term de-congregation strategy. The provider continues to engage with relevant internal and external stakeholders to progress registration applications for these centres. Ongoing support is received through independent advocacy services to support individuals will and preferences and to walk alongside the individual to find a home of their own. Ongoing De-congregation planning continues with identified actions and is being overseen by the organisations De-congregation project lead. Recruitment for the new community homes is currently underway. Any new starters will shadow more experienced staff with CCN7 so they can be competent and confident with supporting the individuals prior to transitioning out to the community. The provider remains committed to ensuring sustained compliance through ongoing review of governance systems, continued implementation of the service improvement plan, and progression of the de-congregation programme.	
Regulation 13: General welfare and development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 13: General welfare and development: The Person in Charge continues to review residents' goals, activation plans, and daily recording systems to ensure residents are supported to participate in activities that	

reflect their individual interests, preferences, capacities, and needs. The Person in Charge has implemented a peer representative initiative within the centre to support oversight with regards to activation and person-centred goals.

The resident identified during inspection as not having fully developed goals has since had a keyworker meeting completed, with person-centred goals now developed and incorporated into their personal plan.

To address gaps identified in daily recording practices, staff guidance and oversight arrangements have been strengthened through discussions through staff meetings for reinforcement.

Staff have been reminded of the requirement to accurately document residents' participation in meaningful activities and daily activation supports. This is reinforced through the peer representatives.

Although all staff within CCN7 are responsible for activation, specific staff are identified daily to initiate activation and opportunities to participate in activities in accordance with their interests.

Community links have been made since inspection to support evening activities through the sports and physical activity department.

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)(b)	The registered provider shall provide the following for residents; opportunities to participate in activities in accordance with their interests, capacities and developmental needs.	Substantially Compliant	Yellow	30/06/2026
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 in accordance with their wishes.	Substantially Compliant	Yellow	30/05/2026
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the	Substantially Compliant	Yellow	30/09/2026

	number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.			
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.	Substantially Compliant	Yellow	30/09/2026
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Substantially Compliant	Yellow	30/06/2026