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:	Hawthorns
Name of provider:	Health Service Executive
Address of centre:	Co. Dublin
Type of inspection:	Unannounced
Date of inspection:	02 April 2026
Centre ID:	OSV-0003359
Fieldwork ID:	MON-0049849

About the designated centre

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

Hawthorns provides residential care for up to 16 adults, both male and female, with an intellectual disability. The centre consists of five detached bungalows and a self-contained apartment on a campus setting with green areas to the back and front. Each bungalow has an open plan living room with a defined dining area. Each home has a kitchen, a utility room and laundry facilities. Each resident has their own bedroom and access to a number of bathrooms. The centre is in a suburban area of Dublin close to a local village with easy access to shops and other local facilities. The centre is close to public transport links including a bus and train service which enables residents to access local amenities and neighbouring areas. Residents are supported by a staffing team 24 hours a day seven days a week and the team comprises of a person in charge, clinical nurse managers, staff nurses and care staff.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	14

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 2 April 2026	10:30hrs to 18:30hrs	Karen Leen	Lead
Thursday 2 April 2026	10:30hrs to 18:30hrs	Sarah Guing	Lead

What residents told us and what inspectors observed

This inspection was an unannounced risk-based inspection completed in April 2026. It was scheduled subsequent to high levels of non-compliance found on a previous inspection of the designated centre in August 2025.

The previous inspection found that improvement was required in the systems in place related to protection, residents' general welfare and development, staffing, training and staff development, positive behaviour supports and governance and management of the centre. This inspection was conducted to assess compliance with the regulations and to assess the implementation of the compliance plan submitted to the Office of The Chief Inspector of Social Services (Chief Inspector) following a warning meeting with the provider.

Following the inspection in August 2025 the provider had submitted a time bound compliance plan which demonstrated how the provider would come back into compliance with the regulations. In addition to the compliance plan the provider had detailed a 14 month overview for the designated centre which included supporting residents to transition from the campus setting in line with the Health Service Executive (HSE) policy "Time to move on from Congregated Settings".

Overall, the inspectors found that the provider had made a number of significant improvements to the service and the systems in place which had brought about positive changes in the quality and safety of care provided to residents who used this service. However, further improvements were required in order to bring all regulations reviewed into compliance. The inspectors found that improvements were required in relation to Regulation 15: Staffing, Regulation 23: Governance and Management and Regulation 13: General Welfare and Development. These deficits will be discussed later in the report under the relevant regulations.

The designated centre provides residential service for up to 16 adults with an intellectual disability, at the time of this inspection there were two vacancies. The centre comprises of five bungalows and one single occupancy apartment situated on a campus setting in South Dublin. As previously discussed, as part of the providers compliance plan they were in the process of reducing the centres overall capacity. Inspectors found that since the first inspection the provider had made significant progress towards transitioning residents to community settings either under the provider's remit or through consultation with external stakeholders. The inspectors found that the reduction in the centres capacity had a significant impact on the lived experience of residents and was resulting in a reduction in safeguarding concerns within the centre.

The centre is made up of 5 houses and one stand alone apartment. Inspectors visited the five houses, but did not visit the apartment as requested by the resident living there. The inspectors found that while each of the houses provided a homely

environment for residents, a number of maintenance repairs were outstanding and some clinical infection prevention and control (IPC) measures were in place which took away from the homely atmosphere in the centre. This will be discussed further under Regulation 17: Premises.

During the course of the inspection, the inspectors had the opportunity to meet and speak with a number of people about the quality and safety of care and support in the centre. This included meeting 12 of the 14 residents living in the centre, 11 staff members, a clinical nurse manager grade one, the person in charge, the person in a position of management, and the director of nursing. The inspectors did not have the opportunity to meet with two residents as one resident did not wish to meet with the inspectors and one resident was away from the centre for the day. Documentation was also reviewed throughout the inspection detailing how care and support was provided, and how the provider ensures oversight and monitoring of the quality of care and support in the centre.

Residents communicated using a variety of methods including speech, eye contact, body language, sign language vocalisations, gestures and behaviour. Residents were also supported by familiar staff who understood their communications styles and were able to assist them in detailing how they liked to spend their day and activities they liked to avail of in their home and local community. Staff discussed with inspectors residents preferred form of communication and supported residents to show inspectors activities that they like to participate in.

In one house, staff supported residents to show the inspectors the activities that they participated in for the month of March. Two residents demonstrated to inspectors through their electronic tablets a slide show of pictures. The pictures illustrated the activities that they had enjoyed during each month of the year. The pictures showed that each resident was participating in daily choices such as, coffee out with friends or staff, nature and beach walks and attending parties. Pictures on each slide show also demonstrated how the residents was meeting a number of goals that they had identified for the coming year.

Inspectors met with one resident who informed them that they were delighted the inspectors were in the centre as they wanted to show them a new item which had been put in place in their home. The resident asked the inspectors to follow them to the outside of their home where they showed the inspectors a new shed which was being used to store a large quantity of well-kept and good working condition tools. The resident informed the inspectors that they like to collect tools. They do not use them but they liked to have a working station in their home and collect different forms of tools. The resident discussed with the inspectors that it was safe for them to have the tools as they have their own key to the shed and that staff supported them to find tools they could manage. They informed the inspectors that they were very proud of the collection that they had made and they were happy that staff supported them to upgrade their tools.

One resident told the inspectors that they were very happy in their home. They discussed that they used to live alone, however, due to a change in their health and a number of hospital admission they had moved into Hawthorns. The resident stated

that they were very happy in their home, things had improved now that they lived with only one peer and they got on well with this peer.

In one house, the inspectors observed a resident making tea for themselves and their peers. Staff provided support to the resident by offering words of encouragement and reminding the resident to be mindful that the kettle was hot. Staff members offered gentle reminders throughout the process and supported the resident to set out cups and small snacks for their peer members. The inspectors observed the resident smiling at the staff member throughout.

The inspectors had the opportunity to meet another two residents in another house. On arrival to the house, both residents were observed sitting at the dining room table enjoying a hot beverage. The inspectors asked the residents if they would be happy for the inspectors to sit with them and for the residents to tell them a little about what it would be like to live in the centre. Both residents invited the inspectors to sit and have a chat. They told the inspectors that they loved their home and that they would not change anything. The residents told the inspectors that their friend had recently moved out to a new home, they discussed that their former peer had planned to move to an apartment for some time and they were happy for them.

The residents told the inspectors that they liked their home the way it was and that they would not like anyone else to move into the house since their friend had moved. Later in the conversation, both residents agreed that if someone was to move into their home they would prefer if it was a female resident.

The inspectors met a further two residents in another house of the centre, one resident was finishing their breakfast. The second resident greeted both inspectors with a handshake and brought them to look at an easy read document which had been prepared for all residents to inform them that a new person in charge was commencing and that the previous person in charge was moving to a new area. The resident told the inspectors' staff had discussed the easy read with them over the last few weeks. The resident said they liked the old person in charge and the new one.

Overall, the inspection found that the provider had implemented a number of actions from the compliance plan and had a robust plan in place for the completion of the remaining actions. The inspectors found that the compliance plan was subject to weekly review and a monthly meeting with the quality and improvement oversight team which had been formed by the provider in order to maintain oversight of the compliance plan.

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

Capacity and capability

This risk-based inspection was completed to determine progress by the provider towards completion of its stated actions as submitted to the Chief Inspector following an inspection in August 2025. In addition this inspection sought to verify if these actions had resulted in improvements for residents. Overall, inspectors found that the provider had made significant progress in addressing regulatory non-compliance as found on the previous inspection of this centre.

The inspection found that while the provider had completed a number of stated actions in line with their submitted compliance plan and their warning letter response, a number of actions remained in progress. The inspectors acknowledge that some outstanding actions coincide with residents transition plans, staff recruitment and the provider identified time frame for the reduction of registered beds in the centre.

The inspectors found that there were effective management systems in place to ensure that the service provided to residents living in the centre was safe, consistent, and appropriate to their needs. The provider was in the final stages of a planned agency conversion, which meant that agency staff who had been working in the centre for a number of years were moving to staff permanency within the designated centre.

Regulation 15: Staffing

At the time of the inspection the centre was operating with nine whole time staffing equivalent vacancies. The provider had completed a number of recruitment campaigns for the designated centre and there were a number of agency staff who had been working in the centre from 18 months to six years. Inspectors found that a number of these agency staff were in the process of converting to permanent staff and the conversion of staff was in the final stages of human resources agreement with agency personnel.

The provider had identified seven health care assistants and one staff nurse who were in the process of signing conversion agreements. This meant that for the most part there would be a consistent staff team in place who were familiar to residents and could support them to meet their needs.

However, the inspectors found that while the provider was actively participating in recruitment campaigns the identified vacancies in the centre was having an impact on the continuity of care for residents in the centre. The person in charge was reliant on agency support in order to support vacant shifts across the roster. For the most part, the person in charge was attempting to use regular agency staff and agency staff in the process of conversion agreements, however, due to planned and unplanned leave this was not always available.

The inspectors completed a review of the planned and actual rosters in place for the centre from January to March 2026 and found a high reliance on agency support. For example, from 12 of January to 18 of January 2026 a total of 77 shifts were covered by 33 different agency staff in the centre. This was having an impact of the continuity of care for residents. When agency were required to work within the designated centre, the person in charge was reviewing rosters to ensure that agency were supported by a minimum of one regular staff member in each house in the centre.

In addition, from January to March 2026, the inspectors found that five shifts could not be covered in the centre with core staff. Inspectors found that when shifts could not be covered by agency staff, the provider sought support from external designated centres within the providers remit or senior management supported staff. This inconsistency was further impacting the continuity of care for residents.

In order to try minimise the impact of inconsistent staff providing care inspectors found from the dates reviewed that when an agency staff was working in the designated centre there was a permanent and regular full time member of staff working alongside the agency to further support residents.

Inspectors had the opportunity to meet with eleven staff during the course of the inspection, including four agency staff. The inspectors found that staff were knowledgeable of the assessed needs of each resident. Furthermore, the inspectors reviewed evidence of staff advocating on behalf of residents during planned transitions from the designated centre.

Judgment: Substantially compliant

Regulation 16: Training and staff development

The provider had ensured that systems were in place to record and regularly monitor staff training in the centre. The inspectors found that the training record was subject to regular review by the person in charge. The provider had completed a review of the training matrix held for all staff in the centre to ensure that permanent staff and agency staff were clearly identified.

The provider held a local level agreement with agency to ensure that all agency staff had completed mandatory training for the centre such as safeguarding and manual handling training. Agency staff attended in house provider led fire and safeguarding training tailored to the needs of residents in the designated centre.

The person in charge held a supervision schedule for all staff in the designated centre. At the time of the inspection, all staff were in date for supervision. Supervision was being carried out by the person in charge and supported by two clinical nurse managers grade one. The inspectors reviewed the supervision notes for ten staff and found that they were detailed in nature and identified training

needs and goals for the coming year and a review of the keyworker role for support staff.

The inspectors reviewed staff meetings occurring in the centre from September 2025 to January 2026. The provider had implemented a new template for the recording of staff meetings minutes. The inspectors found that the new template gave an overview of agenda topics and set out actions with clear timeframes.

The inspectors found that a small number of staff were outstanding in non-mandatory training such as risk management and goal setting. These matters will be discussed further under Regulation 23: Governance and Management and Regulation 13: General Welfare and Development.

Judgment: Compliant

Regulation 23: Governance and management

The inspection found that while the provider had made clear progress in the levels of compliance in the designated centre, a number of actions from their compliance plan remained in progress. For example, a number of staff were waiting to complete risk management training which the provider had identified for completion by December 2025.

The inspectors found that the provider had completed a six-monthly unannounced visit to the centre which took place on the 21 of August 2025 and an additional six-monthly unannounced carried out between the 29 of December 2025 and the 05 January 2026. However, these visits had failed to identify a number of actions highlighted during the course of the inspection, including maintenance issues in premises within the designated centre. The inspectors acknowledge that local level audits had identified a number of concerns in relation to the premises, however, these concerns had not been escalated through the appropriate channels to ensure these deficits were addressed.

Through discussion with staff in the designated centre it was evident staff were knowledgeable of the compliance plan that was submitted by the provider. However, inspectors found that while the provider had a plan in place for the reduction of the centres capacity, this information had not been disseminated appropriately amongst the staff teams in the centre. The inspectors acknowledge that the provider had submitted a formal proposal for the future planning of the designated centre and following the inspection had completed a number of staff meetings in order to further inform and update residents and support staff.

Following the last inspection of this designated centre the provider completed a number of reviews of the monitoring and oversight systems in place. The provider commissioned a quality and improvement oversight team with terms of reference in place consisting of multidisciplinary support, a quality and patient safety advisor, safeguarding members, a patient engagement officer, complaints manager and the

day opportunities manager. The team were maintaining a quality improvement plan (QIP) which was reviewed at each meeting and following the completion of set actions. Inspectors found that the QIP was subject to regular review by senior management.

The quality and improvement oversight team conducted a suite of audits across the designated centre focused on residents' satisfaction, safety, care planning and support and quality of the service provided. Inspectors found that the team was meeting at regular intervals to review the compliance levels in the designated centre following the inspection in August 2025 and had set clear actions and timeframes.

An annual review of the quality and safety of care had been completed for 2025, which consulted with residents and their families and or representatives. The review included goals for the coming year and improvement plans identified by residents and staff.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

The provider had established and implemented effective complaint handling processes. For example, there was a complaints and compliments policy in place. The inspectors found that the person in charge was completing weekly reviews of the complaints log in order to ensure that all complaints in the centre were being logged correctly.

In addition, following the inspection completed in August 2025 the person in charge was completing weekly reviews of incident reports in the centre to ensure that complaints or safeguarding concerns were identified and reported through the correct procedure in order to ensure that supports were in place for residents.

The inspector observed that the complaints procedure in place was accessible and in a format that the residents could understand. Residents were supported through the complaints process, which included having access to support of staff when making a complaint or raising a concern.

Staff spoken with during the course of the inspection were aware of the complaints process. Residents informed inspectors that they knew who to speak to if they had a complaint to make or if they were unhappy with an aspect of their care. Residents informed the inspectors that there was a new person in charge in the centre who had introduced themselves to the residents on a number of occasions. Residents discussed that part of the introduction was to inform residents that the complaints officer had changed to the new person in charge.

Inspectors reviewed the complaints log held by the person in charge and found that it was subject to weekly review. At the time of the inspection there was one open

complaint, the complaint was in line with the providers' policy with all stakeholders updated as to the stage of the complaint in the process.

Judgment: Compliant

Quality and safety

Overall, the inspectors found that the provider had made a number of improvements which had enhanced the lived experience of residents in the designated centre and had resulted in a more person-centred quality for residents. However, the inspectors found that further improvements were required in relation to premises, residents goal planning and review of gaol achievements.

The registered provider had implemented systems, underpinned by written policies and procedures, to safeguard residents from abuse. Staff working in the centre completed safeguarding training to support them in the prevention, detection, and response to safeguarding concerns.

Regulation 13: General welfare and development

A commitment had been made by the provider to complete person-centred planning and goal setting training to both permanent and agency staff in order to further support residents to identify and achieve goals in their daily life, community and home. The aim of this training, was to assist staff to support residents to set and achieve social goals which were SMART (Specific, Measurable, Achievable, Relevant and Time-bound), captured correctly and accurate. The inspectors found that a number of staff had not completed the training in line with the providers' timeline for completion as set out in the compliance plan.

Inspectors reviewed a number of goals set out for residents and found that the goals had been devised with residents and supported by staff. However, inspectors found that a number of barriers existed for residents in order to complete or meet their goals. For example, during the month of March for one resident an identified goals of attending sensory gardens could not be met on two occasions as there was no transport available to support the residents.

One resident who had a love for music had identified that they would like to attend a tribute band for one of their favourite artists. The concert had been discussed with the resident at a goal review on the 17 March 2026, staff documented that the resident was excited about going to the show. Staff noted on that date that tickets were available on line to purchase. A second review meeting was held on the 20 March 2026 which discussed that the tickets had not been purchased for the

resident and that the concert was sold out. The meeting did not discuss what would be done to address this for the resident and the resident was not informed of the change to the goal.

The inspectors observed that residents had access to a number of local community social activities of their choosing including meals out, cinema, walks, library visits, sensory room visits, shopping trips, attending mass and visits to family. The inspectors found that the person in charge was regularly reviewing choice and access for residents and was seeking improvements for residents through communication and training of staff in the centre. In addition, the person in charge had identified that greater goals and activities required further input from staff and had implemented a tracker and review of activities. This tracker was completed on a weekly basis by the person in charge in order to highlight areas of improvement and what supports were required to enhance residents goals and activities.

Judgment: Substantially compliant

Regulation 17: Premises

The inspectors visited five of the houses that made up this designated centre and identified a number of maintenance concerns. Some of the concerns had been identified by support staff and reported to the maintenance department, however, inspectors found that there was no plan in place for the work to be completed despite being logged by staff.

During a walk through of the premises inspectors noted the following which required attention:

- in one house inspectors reviewed a fuse box inside a cabinet which had been removed from the wall. The exterior of the fuse box was found upright on the floor of the cabinet with the wires exposed from the wall
- plug socket and Internet cable half removed from wall with wire exposed in main dining area
- floor boards on entry to one premises had large area of floor board removed or scuffed
- floor boards in the dining room and hallway of one premises was worn down
- the information board in the main hallway of one premises had large quantities of dust
- the plastering above the bedroom door of one resident had a gap evident between wall and top of door frame
- the back door entrance to one house had wiring loose above the frame, the curtain attached to the back door required replacement.

On the day of the inspection, the person in charge highlighted the concerns in relation to premises to the providers maintenance department in order to set a time frame for completion post inspection.

In addition, inspectors found that the main entrance for residents and guests to two of the houses had a large table laid out with boxes of latex gloves. Inspectors found that no residents in the centre were experiencing current medical conditions which required the use of latex gloves that required staff to have gloves as an immediate point of contact. Inspectors found that the storage of IPC precautions was taking away from the homely environment for residents living in the centre.

Inspectors found that each resident had their own bedrooms, which were decorated in line with each individuals taste and preference. Communal areas were decorated with residents art work and pictures of important events and milestone birthdays. Each of the premises was found to be accessible to residents needs and when required adaptations had been made to support them in their home.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

The provider had ensured that where residents required behavioural support, suitable arrangements were in place to provide them with this. The inspector reviewed one resident's positive behaviour support plans and found that they clearly documented both proactive and reactive strategies.

Clearly documented de-escalation strategies were incorporated as part of residents' behaviour support planning with accompanying risk assessments and support plans. The inspectors found that documentation was subject to weekly review by the person in charge and monthly review by the clinical nurse specialist in behaviour supports. As part of this review, the person in charge was ensuring that residents were not requested to move to different areas of their home if a peer member was upset or distressed within their environment.

Staff had up-to-date knowledge and skills to respond to behaviours of concern and to support residents to manage their behaviour. Restrictive practices were regularly reviewed with clinical guidance and risk assessed to use the least restrictive option possible.

At the time of the inspection, two staff were out of date for positive behaviour support training, however, both staff had been scheduled to attend training by the end of April 2026

Judgment: Compliant

Regulation 8: Protection

The provider had completed a review of relevant documentation in relation to residents in the designated centre in order to provide assurances that all possible incidents of abuse or incidents which required safeguarding monitoring had been reviewed.

The provider had completed a number of planned transitions from the centre in line with their planned move to reduce the capacity of the designated centre. Inspectors spoke to a number of residents throughout the course of the inspection who discussed that the reduced numbers in their home had a positive effect on their overall wellbeing.

The provider had completed bespoke in person training with all staff in the designated centre including agency staff. This training was completed in addition to mandatory provider safeguarding training and incorporated training from psychology and the providers designated officer. The training reviewed residents emotional and positive behaviour support plans and an overview of safeguarding plans in place. It also incorporated a review of documentation to support staff to identify possible allegations of abuse.

Where incidents of concern were identified these had been appropriately reported and investigated and where staff practice was under review the provider had robust systems in place to protect residents while investigations were ongoing. The person in charge was completing weekly reviews of incidents and resident documentation to ensure that all allegations of abuse were appropriately screened and reviewed.

Staff spoken with were knowledgeable about their safeguarding remit. Safeguarding plans were reviewed regularly in line with organisational policy. Formal and interim safeguarding plans were implemented and were supported by risk assessments. The control measures to protect residents from abuse were seen to be proportionate, person-centred and mindful of the residents' rights and wishes

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 16: Training and staff development	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 13: General welfare and development	Substantially compliant
Regulation 17: Premises	Substantially compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Hawthorns OSV-0003359

Inspection ID: MON-0049849

Date of inspection: 02/04/2026

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: 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. Regulation 15(3) The Statement of Purpose and Function will be updated to reflect the staffing mix and complement as recruitment progresses and agency staff transition to HSE contracts. Rolling recruitment campaigns for nurses, care assistants, and social care workers are ongoing. Agency staff receive a clear induction in each home and are assigned to work alongside familiar, regular staff members attached to that home. This supports continuity and consistency of care for residents. 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. Regular and consistent rostering of agency staff will continue to address gaps within the rosters. Rostering arrangements have been streamlined, with specific staff identified for each house to reduce turnover of both HSE and agency staff. This supports continuity of care for residents. Agency staff receive a clear induction in each home and are assigned to work alongside familiar, regular staff members within the home. This further enhances continuity and consistency of care.	
Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:

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. Regulation 23(1)(a)

An application to vary the conditions of registration will be submitted to HIQA prior to any required changes within the designated centre. The Statement of Purpose and Function will be amended to reflect any such changes.
Any changes to the floor plans, size, or layout of the designated centre will also be reflected in the Statement of Purpose and Function, ensuring the centre continues to operate within its conditions of registration.
The regulator will be consulted in line with regulatory requirements.

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.
Regulation (23)(C)

Staff training has taken place to address outstanding training needs identified through the training tracker. The tracker has been updated, and further training dates are planned in specific areas of risk management.
Bespoke training on goal setting and care planning is being provided to staff, including agency staff.
The annual assessment and review of residents' needs inform each care plan, alongside the will and preference of the resident.
All audits, including six-monthly unannounced visits and annual reviews, will identify any gaps in service provision. These findings will be cross-referenced with other audit reports, including HIQA inspection reports, and action plans will be developed to address identified issues.
Systems and processes are being developed to support individualised management and monitoring of each home, moving away from a centralised campus-style model. This includes house-specific IT systems, rostering, training, monthly checks, and documented follow-up actions.

The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of Care and support.
Regulation 23(2)(a)

Six-monthly unannounced visits will capture the outcomes of all local audits and associated action plans. A checklist has been developed to support this process, ensuring the required information is recorded and that clear actions and timeframes are identified to progress any outstanding issues.

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 registered provider shall provide the following for residents; opportunities to participate in activities in accordance with their interests, capacities and developmental needs.
Regulation 13: General welfare
An emphasis on social activities is reflected in residents' care plans and SMART goals.
Training on goal setting is currently being reviewed to further promote a person-centered approach, supporting residents to take part in activities of their choice and increasing opportunities for community participation.
The role of the keyworker, including clear roles and responsibilities, continues to be discussed at staff meetings.
The project lead continues to support staff with goal setting, documentation, and gathering evidence of activities and social outings.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:

A weekly maintenance list is compiled for non-urgent issues and followed up until completion. Urgent maintenance requests are submitted as required, and an out-of-hours maintenance system is in place.
Any issues that are not resolved are escalated to the PPIM and addressed with the maintenance foreman. Plans to upgrade the designated centre are outlined in the Quality Improvement Plan. Following the planned works in 2027, the houses will be painted, and any required internal upgrades will be addressed at that time.

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	01/12/2026
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Substantially Compliant	Yellow	01/12/2026
Regulation 15(3)	The registered provider shall ensure that residents receive	Substantially Compliant	Yellow	01/12/2026

	continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.			
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Substantially Compliant	Yellow	01/12/2026
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	01/12/2026
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	01/12/2026
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered	Substantially Compliant	Yellow	31/07/2026

	provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.			