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 South 1
Name of provider:	Horizons
Address of centre:	Cork
Type of inspection:	Unannounced
Date of inspection:	29 April 2025
Centre ID:	OSV-0003695
Fieldwork ID:	MON-0045948

About the designated centre

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

Cork City South 1 consistent of three large detached two-storey houses located on the outskirts of a city. Combined the three houses can support up to 25 residents. The houses mainly provide a full-time residential support for residents with intellectual disabilities and autism of both genders, over the age of 18 but can also provide some respite. Individual bedrooms are available for all residents in each house and other facilities in the houses include bathrooms, sitting rooms, dining rooms and kitchens. Support to residents is provided by the person in charge, care assistants and staff nurses.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	19

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Tuesday 29 April 2025	09:45hrs to 18:10hrs	Conor Dennehy	Lead
Wednesday 30 April 2025	11:00hrs to 18:10hrs	Conor Dennehy	Lead
Tuesday 29 April 2025	09:45hrs to 18:10hrs	Elaine McKeown	Support

What residents told us and what inspectors observed

All residents present during this inspection were met by inspectors. While some residents did not engage much with inspectors, other chatted with inspectors with positive feedback received. Residents were observed and overheard to be supported by staff members in an appropriate manner.

This centre was made up of three different houses all of which provided residential care mainly but also some respite care. Two of the houses were located side-by-side one another and were open seven days a weeks while the third house was located 15 minutes' drive away and operated on a Monday to Friday basis. All three houses were visited by at least one inspector during the course of this two day inspection. On the first day of inspection, two inspectors went to the two houses that were located side-by-side while on the second day, one inspector went to the remaining house. Combined the three houses had a maximum capacity of 25 residents. On the day of the inspection 19 residents were present with 17 of these being residential residents and the other two being respite residents. All 19 of these residents were met by at least one of the inspectors during their time in these houses. A 20th resident who generally availed of residential support in one house, was with their family at the time this inspection took place and so was not met during this inspection.

When inspectors arrived to commence the inspection, they entered one of the house and initially met three of the residents who were living there. One of these residents was having breakfast at the time while the other two residents greeted inspectors with one of them shaking an inspector's hand. After an introduction meeting with the person in charge a further two residents living in this house were met. Both of these residents did greet an inspector although verbal interactions with these residents were limited overall. At this time five residents were present in the house with one spending time watching television while another did some colouring. Three of these residents later left the house with a staff member to go for a walk.

These residents returned to the house early in the afternoon and it was observed that staff were very pleasant in their general interactions with residents. For example, at one point a resident became teary but was immediately reassured by a staff member. One of the residents was noted to spend much of their time wandering in the upstairs hall of the house. As the inspector was concerned that his presence may have been impacting the resident, he raised this with the person in charge but was informed that this was normal for the resident. Near the end of the first day of inspection, two more residents returned to the house having been at day services earlier in the day. Both of these residents were briefly met by an inspector but interactions with them were limited. Things were generally quiet in this house from the inspector's observations during the first day of this inspection.

All five residents living in the neighbouring house were met by an inspector in the afternoon of the same day of inspection upon their return from their day services.

All greeted the inspector and reported they had enjoyed an active day which included music and quiz games, meeting friends and art work. The residents completed their usual routine before spending time chatting with the inspector. This included putting on their slippers, preparing their lunch for the following day or having a shower. The residents were observed to complete these activities independently with no staff present. They were observed to engage in conversations with their peers and support each other to have space to complete their preferred routines. For example, one resident liked to sit in their preferred chair in the sitting room while another prepared their lunch in the kitchen.

The flow of conversation between the residents was sometimes at a fast pace for the inspector to fully understand what was being said, but residents appeared to understand each other very well. They were observed to explain to the inspector at times what their peers had said. This was observed to be done in a respectful way. Residents appeared to be happy to chat with the inspector for over an hour. The staff member who commenced their shift during this time was introduced to the inspector by the residents. The inspector was given lots of information about the busy lives each resident had. One resident spoke of a planned trip to another country with a staff member on the weekend after this inspection. They also spoke of how they had enjoyed a trip to an important location to them with a large community group in 2024 and explained how they felt this trip had brought them health and peace.

Three of the residents in this house spoke with the inspector in a group conversation. All three spoke about the plans for them to move to a new location. They spoke about important items which they each required to be present in the new house. These included Wi-Fi, smart televisions and large shelving units to store personal items. One resident had written a list of their requirements and showed this to the inspector. All of the residents stated they were happy in their current house but were looking forward to visiting a house that was being proposed as their new home. The residents spoke of going out on activities at the weekends with staff which included trips to scenic locations and shopping. One resident travelled independently on trains to visit family members and also spoke of how staff supported them to visit a very special friend who had re-located to another designated centre. Another resident briefly greeted the inspector when they arrived home and explained they needed to get themselves ready for a planned activity with a friend.

On the second day of this inspection, an inspector visited the third house of the centre. No residents were initially present in this house with all resident attending day services. In the final hours of the second day of inspection, all seven residents who were availing of the house at the time of this inspection returned to the house. These residents were overheard to be warmly greeted by a staff member on duty and the person in charge upon their return. After returning all seven residents spent much of their time together in the house's larger sitting room with staff on duty and the person in charge also present for part of this time. The inspector sat with the residents for an hour which gave him an opportunity to speak with the residents and observe their interactions with each other and with the staff that were on duty.

When the inspector entered the larger sitting room, he was immediately greeted by one of the residents who remembered the inspector from previous inspections. This resident chatted to the inspector and told the inspector that they loved the house, loved the people there and loved having their own bedroom. They did say though that they wanted a new electric shower for their en suite bathroom with the person in charge telling the resident that they would look into this. When asked by the inspector, the resident indicated that their current shower was working. A second resident also mentioned wanting a new bed with the person in charge telling the resident that this had been ordered and would be delivered soon.

The first resident also talked about being in day services and doing a dancing course. They mentioned that they would like to do more walking in day services but that there was not enough people there for it. The inspector asked if he could see the residents' bedroom but the resident indicated that they did not want this. This was respected by the inspector. A different resident entered the large sitting room shortly after the inspector had entered and hugged both the inspector and a staff member. This resident also talked about attending day services but mentioned that they did not like pole walking. When asked what they did like doing the resident mentioned swimming, community walks and art.

When the inspector asked what kinds of art the resident liked, they got a mobile phone and used it to show the inspector and a staff member pictures and a video of art that they had created. The resident appeared to be very proud and happy as they showed these to the inspector and the staff member. Soon after this, the inspector sat beside another two residents with both residents greeting the inspector. The inspector had difficulty in understanding one of these residents but they appeared happy in their environment. The other resident was wearing a t-shirt from an amusement park and mentioned going to this park. They also talked about their family, going to day services and playing tennis. One resident who had not been initially present when the inspector entered the larger sitting room arrived and greeted the inspector by shaking his hand. This resident along with two other residents did not engage verbally with the inspector. It was notable though that all residents appeared very comfortable in each other's' presence and were happy to engage with one another.

For example, one resident was wearing a particular brand of socks which was commented upon by the person in charge. When other residents heard this they talked to the resident about the socks. It was also apparent that residents were very comfortable with the person in charge and the staff present. Numerous examples of this were observed and overheard by the inspector. These included a staff member facilitating a request from a resident to speak in private and the person in charge helping another resident to look for their phone. Residents mentioned that they would be going shopping with one of the staff members later in the evening with residents looking forward to this. It was also seen that some residents got excited when a member of the provider's management arrived at the house. This member of management warmly greeted the residents with such interactions contributing to a very positive atmosphere in this house.

In summary, the feedback from residents during this inspection was positive with residents seen to be comfortable with the staff on duty. The residents spoken with talked about some of the things that they did such as playing tennis and trips to scenic locations. While such feedback was positively noted by inspectors, a number of regulatory actions were identified during this inspection relating to areas such as the premises, fire safety, staffing and resourcing. These will be discussed further elsewhere in this report.

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

Capacity and capability

While some changes had taken place from previous inspections, a number of regulatory actions remained. Such findings raised ongoing resourcing concerns for the centre.

During the centre's previous registration period (from March 2021 to March 2024), the centre had been subject to various regulatory engagement. This included a cautionary meeting, the issuing of a warning letter and five risk based inspections. The last of those inspections had taken place in December 2023 where, similar to previous inspections, high levels of noncompliances had been identified in areas such as staffing, oversight and resourcing of the centre, and fire safety. The provider's compliance response to the December 2023 inspection did not provide assurances in these areas. In February 2024 the provider was requested to submit a specific plan on how it would come back into compliance with specific regulations that were judged non-compliant during the December 2023 inspection. The provider submitted the requested plan which was similar in its overall content to the December 2023 compliance plan response but with time frames extended. Following receipt of this plan, the centre had its registration renewed by the Chief Inspector of Social Services until March 2027 with a restrictive condition attached on complying with this plan by 31 December 2026. The purpose of the current inspection was to assess the provider's progress with this plan.

Overall, this inspection did identify that some changes that had taken place since the December 2023 inspection such an increase in whole-time equivalent (WTE) staffing for the centre and the appointment of a new person in charge. Evidence was also seen of the monitoring of the services provided in the centre. However, there remained a number of actions identified on this inspection with some of these being similar in nature to previous inspection findings. Most notably, the provider had given a commitment to complete corrective maintenance works to fire doors in two houses of the centre by 30 April 2024 but during the inspection, it was indicated that this had not been done. Additionally, despite the WTE staffing increase, there

remained clear indications that sufficient staffing arrangements were not in place for the centre with a risk related to this having been escalated for the centre internally to the provider on multiple occasions. Other risks had also been escalated for the centre in areas such as governance and premises which continued to raise resourcing concerns for the centre.

The provider had previously indicated that it was looking to transition residents from two houses of the centre into different living environments. The plan that formed the basis of the centre's restrictive condition gave a time frame of the December 2026 for completing this but also referenced that this was "Funding & Housing Dependent". An update on this was requested during this inspection and inspectors were informed that since the December 2023, resident numbers in the two houses had decreased with other residents having transitioned elsewhere due to their needs. It was also indicated that a new house that could be potentially used for four residents of this centre had been identified although the provider had yet to take possession of this house. Some initial transition discussions with potential residents for this house had taken place. However, a provider unannounced visit report from February 2025 indicated that there was no clear update on progress with this proposed transition with inspectors informed that this remained unchanged at the time of this inspection. It was indicated though that a member of the provider's senior management was due to speak with residents and staff about the proposed transition to different living environments in the week following this inspection. It was also highlighted during the inspection that because of the intended transition of residents away from two houses of the centre, both houses were closed to new long-term residential admissions.

Regulation 15: Staffing

Based on documentation reviewed, discussions and observations during this inspection, the following were positive aspects relating to the staffing arrangements for the centre:

- Since the centre had its registration renewed, the staffing WTE for the centre had increased from 13.83 WTE to 15.29 WTE. The number of full-time residents in two of the houses had decreased in the same time period.
- While there was some staff vacancies at the time of the inspection, it was indicted that two new staff were due to commence working in the centre in May 2025.
- A sample of planned and actual rotas for the designated centre from 10 March 2025 until 4 May 2025 were reviewed by an inspector. The details contained within the rotas clearly identified the start and end times of each shift, in addition to identifying the senior staff on duty and which staff was responsible for the administration of medicines.
- A skill mix of nurses and care staff was evident on actual and planned rotas for one of the centre's houses. This houses had higher medical needs compared to the other two other houses of the centre.

- The centre had a core staff team in place with five regular relief staff available to support this core staff team. This helped to provide for a consistency of staff support.
- Flexibility was demonstrated by the staff team to support residents to attend social events. For example, some residents had attended a musical event on the evening of 26 April 2025 and two of the core staff team had worked extra hours to facilitate residents to attend.
- Rotas indicted that additional staff resources were also frequently available mid-week from approximately 4pm to 8pm, to assist residents to engage in individual activities if they wished to do so.

Despite this, there remained clear indications that over a period of time, sufficient staffing arrangements were not in place to support to consistently support residents' needs. This was evidenced by the following:

- The centre's rights restriction log, as reviewed during this inspection, included a restriction regarding residents' reduced access to the community with this being linked to reduced staffing levels at certain times. This had been consistently notified as being a restriction in quarterly notifications submitted for the centre since the December 2023 inspection including one that was submitted on 24 April 2025.
- While additional staff resources were frequently available at certain times, there were occasions where there was reduced staffing in place. In one house this could result in one staff member supporting up to six residents and one staff supporting up to eight residents in a second house. This had limited residents' access to the community at these times. It was reported by the person in charge that only one staff was on duty in one of these house on the first day of this inspection. In the other house, a staff member spoken with referenced a day the previous week when they had been the only staff member on duty.
- There was an escalated risk open at the time of this inspection related to staffing which had been escalated during February 2025. While it was indicated that this escalated risk would be closed once two new staff commenced working in the centre during May 2025, this risk had been escalated two times previous in July 2024 and November 2024.
- The escalated staffing risk assessment made reference to there being an unsafe staff to resident ratio. In one house, risk assessments and support plans of multiple residents made express reference to these residents requiring supervision and support from staff when using the stairs in this house. Despite this, one of these residents was seen to use the stairs on three occasions without any staff being in the immediate vicinity to provide supervision and support. While the resident was observed to use the stairs without incident, it was apparent that the resident had some difficulty when descending the stairs.
- Other escalated risk assessments related to staffing made reference to business cases being submitted for the centre. Copies of these business were provided during this inspection which indicated that additional staffing, above

the centre's current staffing WTE, was needed to support the needs of residents.

Judgment: Not compliant

Regulation 16: Training and staff development

The statement of purpose for this centre dated March 2025 and a training matrix provided during this inspection indicated that mandatory training requirements for all staff in this centre included:

- Fire safety training (to be done once a year).
- Safeguarding Vulnerable Persons at Risk of Abuse (to be done every three years).
- Positive behaviour support training.
- Hand hygiene training.

However, based on the details in the training matrix seen during this inspection and records provided following the inspection, some training gaps were present at the time of inspection. These were:

- Three staff were overdue refresher training in fire safety.
- One staff member had not completed safeguarding training.
- Three staff had not completed positive behaviour support training.
- Two staff had not completed hand hygiene training.

Based on such figures, staff working in this centre did not have access to appropriate training, including refresher training.

Judgment: Substantially compliant

Regulation 23: Governance and management

The following management and monitoring systems were found to be in place at the time of this inspection:

- At the time of the December 2023 inspection, the person in charge in place at that time was responsible for two designated centres. Since then a new person in charge had been appointed who was over this centre only.
- A new regional manager had also been appointed as a person participating in management for the centre. This regional manager had a lower number of designated centres under their remit compared to the previous regional manager. However, the current regional manager held person in charge responsibilities for two other designated centres at the time of this inspection.

- The person in charge and regional manager met to discuss the centre and its operations with notes of these meeting provided.
- The person in charge had systems in place to ensure an overview of incidents that were occurring in the designated centre. This included quarterly reviews with details of actions taken to address issues. The person in charge was trending incidents occurring over a period of time while a protocol around the reporting of incidents had also been introduced.
- A schedule of audits was in place for his centre which set out specific audits that were to be completed and the months of the year that they were to be completed in. Upon viewing this schedule, an inspector requested copies of audits that had been conducted in February 2025 and March 2025 in one house. On the second day of inspection audits reports for February 2025 were provided that covered areas such as fire safety, personal possessions and the risk register. While it was indicated that copies of audits for March 2025 were not available on the second day of inspection due to "technical issues", copies of such audits were provided the day after the inspection concluded. These audits covered areas such as infection prevention and control (IPC), cleaning and personal plans.
- An annual review for the centre had been completed in November 2024 which was reflected in a written report. When reading this report it was seen that it assessed the centre against relevant national standards.
- Two unannounced visits to the centre had been conducted on 6 September 2024 and 27 February 2025 by representatives of the provider. Such visits were reflected in written reports which included action plans for addressing any areas for improvement identified.

Despite such management and monitoring systems, some inconsistencies in their application were identified. For example:

- Inspectors were initially informed that that the person in charge and regional manager met on a monthly one-to-one basis. This had also been committed to by the provider in the compliance plan response to the chief inspector for the December 2023 inspection. However, notes of such meetings and discussions with the person in charge on the second day of inspection, confirmed that such meetings were not happening at this frequency. In particular it was noted that only one such meeting had taken place between 6 December 2024 and 17 March 2025.
- Provider unannounced visits are required to be conducted every six months. However, the provider announced visit for the centre done in September 2024 was the first such visit since October 2023.

In addition, there continued to be a number of regulatory actions identified on this inspection with some of these being similar previous inspection findings. This included findings related to complaints, IPC and fire safety. Most notably, the provider had previously given a commitment following the December 2023 inspection to complete corrective maintenance works to fire doors in two houses of the centre by 30 April 2024. However, as will be discussed further under Regulation 28 Fire precautions, there remained obvious defects with such doors and during the inspection it was indicated that no corrective maintenance works had been carried

out. This was despite, a compliance plan update, as submitted to the Chief Inspector in October 2024, appearing to suggest that such works had been completed. Such matters raised concerns around the oversight of the centre.

It was noted though that concerns around the governance of the centre had been escalated by the person in charge in February 2025. Such concerns were reflected in a risk assessment that highlight issues such as the person in charge being unable to complete their role, a reduced ability to meet regulations, and reduced effective oversight of daily operations amongst others. This escalated risk remained open at the time of this inspection along with three other escalated risk related to staffing, the premises and reduced community inclusion for residents. Such risk assessments had been reviewed in April 2025 with the escalated risk related to governance referencing that business cases were in place. Copies of these business cases were provided during this inspection. The business cases were seeking additional staffing resources and for one house of the centre to become a standalone centre that operated seven days a week with a separate person in charge. These business cases, which had also been provided during the December 2023 inspection, remained unfunded. Given the ongoing reference to these business cases, the escalated risks identified for the centre and findings of this inspection, this indicated that the centre was not appropriately resourced.

Judgment: Not compliant

Regulation 24: Admissions and contract for the provision of services

In keeping with this regulation, any admission to a designated centre should be in accordance with the centre's statement of purpose. The statement of purpose in place for this centre at the time of this inspection included information on admission criteria for the centre and indicated that the centre was not open to emergency admissions. Despite this, inspectors were informed, on multiple occasions, that one respite resident present in one house during this inspection had been admitted on an emergency basis. Records subsequently provided following the inspection suggested that there had been some pre-planning in advance of the resident's admission to the centre. However, while it was acknowledged that there was particular circumstances behind this admission, another document provided following this inspection indicated that a contract for the provision of services had not been agreed with the resident upon their admission to the centre. This was not in keeping with the requirements of this regulation.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

Issues around complaints had been highlighted during the two previous inspections of this centre in July 2023 and December 2023. On the current inspection it was found that information about the complaints process was on display in the centre and that the person in charge had introduced a system to review complaints made since their appointment to the role. Complaints records were reviewed during both days of this inspection and it was found that entries in the centre's complaints logs had been documented as being resolved to the satisfaction of the complainants. The entries in the complaints logs included issues relating to the closure of day services due to poor weather conditions in January 2025. Where complainants were not initially satisfied this was documented and further actions taken were detailed. This included the complainants receiving an easy-to-read letter from a member of the centre's management to outline the reasons why the residents' day service had to close. The residents were reported to have been satisfied with the response they received.

However, when reviewing notes of resident forum meetings in one house from December 2024 on, an inspector saw that reference was made to additional complaints being made by residents. These included matters such as residents wanting to go out more, needing a bigger car and wanting new beds. Discussions during this inspection indicated that measures had been taken in response to such matters. For example, it was indicated that additional transport was available from the provider's day services in the evening time and new beds had been delivered for two residents with two others awaiting delivery. While such information was noted, none of the complaints referenced in the resident forum meeting notes reviewed were documented in the complaints log. As such, it was not recorded what the outcome of these complaints were, what action had been taken and whether complainants had been satisfied or not. This was not consistent with the requirements of this regulation and also did not provide assurances that residents were being made fully aware of and assisted to understand the provider's complaints processes. This was a similar finding to the July 2023 inspection.

Judgment: Not compliant

Quality and safety

Based on discussions, documentation read and observations, the premises provided for some residents was not suited to their needs. Concerns were raised regarding the provision of fire doors in the centre.

It was highlighted early into this inspection that the needs of residents were increasing with this particularly relevant to residents who had been diagnosed as having dementia. Given such needs, the houses were some residents were living were not suited to them with some maintenance issues also observed in these house. These houses had fire safety systems provided but it apparent that two of these houses had not been provided with an appropriate fire doors which is

important in containing the spread of fire and smoke if required. In one of these house though, fire drill records provided during the inspection process indicated that residents living there could be evacuated in a timely manner. This was a noted improvement from previous inspections. Guidance on supporting residents to evacuate the centre if required were outlined in personal emergency evacuation plans (PEEPs). These PEEPs were contained within residents' overall personal plans with inspectors reviewing a sample of these. Such plans were found to contain guidance on supporting residents' health needs with residents also supported to avail of various health and social are professionals.

Regulation 13: General welfare and development

As referenced earlier in this report, there was an escalated risk open for this centre at the time of this inspection relating to residents having reduced community inclusion. This related to some residents not being able to access the community to avail of activities given staffing levels in place. Such matters had been raised during the July 2023 and December 2023 inspections also and is addressed further in the context of Regulation 15 Staffing. In addition to staffing, for much of 2024, it had also been notified that residents had limited access to transport which further limited their ability to engage in activities away from the centre. However, on the current inspection it was indicated that arrangements had been put in place to obtain additional transport from the provider's day services. This was a positive development but during the first day of inspection, in one house it was highlighted that no staff on duty were licensed to drive the vehicle available for the house at that time. It was stressed though by staff members spoken with that this was a rare occurrence.

Notwithstanding the highlighted staff and transport issues, discussions with staff and residents along with documentation reviewed indicated that residents had availed of activities through their day services or in the community. For example, some residents did circuit training, mindfulness, yoga and dancing in their day services with community based activities done at evening and weekends including cinema, shopping, visiting friends and playing tennis. Plans were in place for some social activities during 2025 such as concerts locally, special Olympic events and running/walking events. Some of these plans reflected goals that had been identified for residents during a person-centred planning process completed with them as part of their personal plans. Records reviewed indicated that residents had been supported to progress or achieve these goals. These included going to a music show and going to an amusement park. Such completed or progressed goals had clear steps outlined on how residents were supported with these goals.

However, for some residents' goals, it was not documented what, if any, progress had been made with certain goals identified in 2024 while a stepped approach was not outlined for other goals. In addition, one resident had two different documents in place which indicated different sets of goals for 2025. It was also identified that the quality of goals in one house where more basic in nature compared to residents'

goals in other houses. It was acknowledged though that residents in this house had different needs and independence levels compared to the residents in the other two houses.

Judgment: Substantially compliant

Regulation 17: Premises

The houses that made up this centre were reasonably presented in some areas. Given the sizes of the houses, sufficient communal space was available for residents and each resident having their own individual bedrooms. Some bedrooms were seen during this inspection which were observed to be personalised. However, some parts of the houses did appeared dated, such as some flooring in residents' bedrooms being of an older style compared to flooring in communal areas in two houses. In addition, a number of maintenance issues were observed in the houses. For example, in one house:

- Wear and tear was evident in areas which included black marks/staining around the shower enclosures in two bathrooms.
- Rust was evident on hand rails installed to assist residents to stand up in the same two bathrooms.
- Damaged paintwork was evident in one hallway.
- A broken drawer was in a fridge (which had jagged edges evident) while there was damaged to a surface on a kitchen counter.

In another house a maintenance log was seen which listed the following:

- Baths in two bathrooms were to be replaced to create wet rooms.
- Painting of all rooms was to be done.
- A hole in the kitchen-dining room wall was to be filled.

All of the above had been raised in November 2024 but had not been addressed at the time of this inspection. For example, the hole in kitchen-dining room was seen to be still present. The person in charge informed an inspector that the change of two bathrooms into wet rooms was being done with a view to better supporting the needs of residents living in that house. While it was indicated that approval had been given for such works, it was unknown when they would commence. The inspector was also informed that an assessment of one resident's living environment and their use of the stairs in the same house was to be conducted by an occupational therapist and a physiotherapist. The provider's health and safety officer had already reviewed such matters during the second day of this inspection with such assessments being conducted due the resident's needs changing. On account of the resident's changing needs, which were related to a dementia diagnosis, an inspector was informed that this resident was being discussed by the provider's

admissions, discharge and transitions (ADT) committee. This was with a view to finding the resident a more suitable premises to live in.

Aside from this resident, there was also clear indications that the premises provided for two residents in another house were not suited to their needs given their diagnoses of dementia. Both of these residents had bedrooms on the first floor of the house where they lived but for one of these residents, it was read that the provider's dementia care team had identified in November 2023 that it was unsafe for the resident to be using the stairs. While it was indicated that the resident's circumstances had stabilised since then, they remained open to the ADT committee to find the resident a more suitable premises to live in. For the second resident, an inspector was informed that that the provider's dementia care team had reviewed this resident on the first day of inspection and made a similar recommendation as to the first resident. During the first day of inspection, the second resident was seen using the stairs and was observed to have some difficulty when descending the stairs. This resident was also open to the provider's ADT committee for similar reasons and it was highlighted that both of these residents had been considered for a possible transition to another of the provider's designated centre which consisted of a ground floor building only.

While such considerations were noted, the findings of the current inspection indicated that the premises provided for some residents were not suited to their needs. Given that the numbers of residents with dementia had increased from previous inspections, with other residents being assessed for dementia, it was likely that the needs of such residents would increase in the future. It was acknowledged though that, since the December 2023 inspection, some residents with similar needs and similar concerns around their suitability to use stairs, had been transitioned by the provider to different designated centres that better suited these residents' needs. It was also acknowledged by inspectors that the premises issues impacting Cork City South 1 were known to the provider as evidenced by the open escalated risk relating to the premises. The same open escalated risk also referenced maintenance issues in the centre.

Judgment: Not compliant

Regulation 18: Food and nutrition

During the inspection it was highlighted that dinners for two houses were delivered Monday to Friday from a canteen operated by the provider. A provider unannounced visit to the centre in February 2025 indicated that these arrangements offered residents a limited choice of food and also raised concerns around the re-heating of dinners that was delivered from the canteen. During the current inspection, it was indicated that each day residents had the choice of two different dinners from the canteen based off a rotating menu. When asked if residents could choose something else if they did not want either of these two dinner option, one staff member indicated that residents did not have a choice but another staff member indicated

that additional dinner options could be got for the residents. Regarding the re-heating of delivered dinners, one staff member spoken with demonstrated a good knowledge in this area. A notice was also seen on a fridge to remind staff to check temperatures along with guidelines on the safe food temperatures to be attained when re-heating meals.

Outside of the dinners that were delivered to these two houses, all other meals were prepared in the centre. To support residents with such meals, menu planners were available in an easy-to-read format with meal diaries indicating that homemade soup and roast dinners were prepared at weekends. Facilities were provided within the houses of the centre for food to be stored in such as presses and fridge-freezers. However, some areas for improvement related to food storage were identified during this inspection. These included:

- Not all opened food items had the date of opening indicated on them. This included open jars of mayonnaise, jam and butter.
- An original package containing uncooked raw meat was opened, with no date documented. This package was stored on top of another food item which was not in-line with the safe storage of food items.
- Some fresh foods had been frozen, but the date this had occurred was not recorded and therefore it was unclear how long they had been in the freezer.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

When reviewing residents' personal plans on the first day of inspection, inspectors noted that risk assessments were in place specific to these residents. However, it was also noted that such risk assessments were overdue a review. When queried with the person in charge, it was indicated that these risk assessments had been reviewed but had yet to be printed off. As a result on the second day of this inspection, updated risk assessments for the same residents were provided. These risk assessments, along with other in-date risk assessments reviewed across both days of inspection, covered areas such as money management, falls, choking, transport and dementia. Such risk assessments also outlined existing control measures in place to mitigate the risks identified while also highlighting any additional controls that were needed. As mentioned previously, there were four escalated risk open for the centre at the time of other inspection with additional controls identified as being required for all of these. Such escalated risks are discussed further under other regulations in this report.

Judgment: Compliant

Regulation 27: Protection against infection

All houses of the centre were visited using the inspection and, for the most part, were seen to be clean. However, it was noted that an extractor fan in one house and some vents in another house required cleaning. Some cleaning in the centre was conducted by external contractors who visited each house one day a week. Cleaning by front-line staff was also conducted in the houses with cleaning schedules in place for the houses. However, when viewing the cleaning records in one house, some scheduled cleaning was not recorded as being done. For example, where daily cleaning activities were required according to the schedule, no cleaning was documented to have taken place on the reviewed cleaning records between 22 and 24 April 2025. In another house, where vents were seen to require cleaning, it was noted that the cleaning schedule did not include these vents. The same cleaning schedule also did not include one sitting in this house although this room was seen to be clean when viewed by an inspector.

Aside from cleaning, which is an important aspect of IPC, it was seen that a detailed IPC folder with updated information on issues such as respiratory infections and antimicrobial resistance was in place. There were also IPC related contingency plans which had been reviewed in August 2024 and April 2025. Such plans included details of the profile of the current residents, the environmental design of the three houses, the minimum required staffing levels, the lead representatives for IPC in each house, how daily activities were to be managed during an outbreak and IPC precautions. Amongst the IPC precautions that can be taken if required are the use of hand sanitiser and personal protective equipment (PPE) such as gloves and face masks. On the three previous inspections of this centre in October 2022, July 2023 and December 2023, it had been identified that there was some expired PPE in the centre. On the current inspection, most PPE seen was found to be in date but one box of face masks in one house had expired since August 2024. In another house, a bottle of hand sanitiser was found in a communal area with an expiry date of October 2023. Hand sanitiser plays a role in hand hygiene with gaps in training in this area addressed under Regulation 16 Training and staff development.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Residents living in this centre had PEEPs in place which outlined the supports they needed to evacuate the centre. Inspectors reviewed a sample of these in two houses and noted that they had been recently reviewed. It was noted though that PEEPs for some residents did not wholly correspond with other information about the residents. For example, one resident's PEEP indicated that they did not find the stairs difficult to use but during the first day of inspection, this resident was seen to have some difficulty when coming down a stairs in the house where they lived. The two previous inspections of this centre in July 2023 and December 2023 highlighted that in the same house a fire drill had not been conducted that reflected a night-time situation when residents would be in bed and minimal staffing would be on

duty. This was of particular concern given the number of residents in that house and their needs.

On the current inspection, records were provided of regular fire drills that had been done in this house within the previous 12 months. Low evacuations times were recorded for these drills which were done with varying levels of staff. However, none of these drills had been conducted to reflect a scenario when residents would be in bed. The day following the completion of this inspection, a drill record was provided that indicated that such a fire drill had been done with a low evacuation time recorded. This provided assurances that all residents could be safely evacuated from this house in a timely manner. Fire drills had also been conducted in the other two houses of the centre based on records reviewed with low evacuation times recorded also. In one of these houses though, it was identified that a fire drill that reflected a night-time situation had not been conducted in the previous 12 months.

The three houses of the centre had fire safety systems provided which included fire alarms, emergency lighting, fire extinguishers and fire blankets. Maintenance checks by external contractors were being conducted on such systems but it was seen that only three quarterly checks on the fire alarm in one house had been conducted in 2024 based on records reviewed. It was noted though that this fire alarm had received a maintenance check in March 2025. Internal staff checks were also being conducted but it was found that monthly checks on the fire extinguishers in another house had not been carried out in 2025. While all staff were listed as having done fire safety training, some were overdue refresher training in this area. While this is addressed under Regulation 16 Training and staff development, inspectors were informed that the provider was seeking to provide some staff with additional fire warden training.

Aside from fire safety systems such as fire alarms and extinguishers, which help to detect and fight fire, it is also important that there is sufficient fire containment measures in a centre. Such measures help to contain the spread of fire and smoke. An important aspect of ensuring fire containment is to provide fire doors. All of the houses of the centre were suggested as having fire doors. However, the three previous inspections of this centre in October 2022, July 2023 and December 2023 had all highlighted issues with these doors. This included such doors having gaps under them which would negate the intended function of these doors. Following the December 2023 inspection, the provider indicated that they would complete corrective maintenance works on the doors. Despite this, it was immediately evident on commencing this inspection that there were a number of defects with the doors in two of this centre's houses. For example, in one house gaps were noted under multiple doors while some doors did not fit into their doorframe or were missing screws. Two doors in the second house were seen to be held open at one stage which also negated their intended function.

It was subsequently indicated that no corrective maintenance works on the doors had been completed since the December 2023 inspection although some works in the attic areas of both houses had been done. Documentation was provided though that indicated that a review of doors in these two houses had been done earlier in April 2025. When reading this review is was seen that a number of issues had been

identified with the vast majority of these doors. These issues covered matters such as the doorframes, the hinges, the locks and intumescent strips amongst others. Ultimately, this review, coupled with the observations of inspectors on this inspection indicated that there was not sufficient fire containment measures in these two houses. Given the findings of the three previous inspections in this area, the provider had not taken timely and appropriate action to address such matters.

In the third house of the centre, it was seen that that the fire doors in that house were of a noticeably better standard. However, some of the doorframes were of an older standard compared to the doors themselves, one fire door had some screw holes in it and there was variance in the use and location of smoke seals and intumescent strips. As a result the inspector sought clarification as to the level of fire containment offered by these door. In response certification related to these was provided along with a copy of a fire door review that had been conducted for the house in April 2025. This review indicated that the fire doors were generally of a good standard but some issues were flagged regarding the door closers and intumescent strips. Other than fire doors in this house, during the second day of inspection, an inspector noted a small hole in the ceiling of one hot press which could also impact fire containment.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

Under this regulation, all residents must have an individualised personal plan in place. These personal plans should outline the health, personal and social needs of residents while also providing guidance for staff on how to support these needs. During the inspection, the inspectors reviewed the personal plans of seven residents across the three houses. These were found to contain guidance on how residents were to be supported. This included supports plans in response to identified health needs which will be discussed further in the context of Regulation 6 Health care. It was also noted that residents had been subject to an annual multidisciplinary review in keeping with the requirements of this regulation. A process of person-centred planning was used as part of the personal planning process which is reflected under Regulation 13 General welfare and development.

In addition, to personal planning, this regulation also requires that suitable arrangements are in place to meet the assessed needs of residents. During this inspection, it was highlighted that the needs of residents were increased. This was particularly relevant for some of the residents with dementia and some houses not being suited to the needs of such residents as highlighted under Regulation 17 Premises. It was noted though that both the November 2024 annual review and the February 2025 provider unannounced for the centre, referenced that residents' changing needs were not being reflected in their personal plans or their assessments

of needs. When queried, the person in charge indicated that residents' changing needs were being reflected in other ways such as multidisciplinary reviews.

However, under this regulation, residents' needs should be identified via a comprehensive assessment of needs. Such an assessments should be carried out an annual basis or to reflect changes in needs and circumstances. While some assessment documents were seen during this inspection, it was indicated that they were not comprehensive assessments of needs. When reviewing the escalated risk assessment for governance of the centre, reference was made to there being a need to do a full review and assessments of needs for all residents. The inspector queried with the person in charge if comprehensive assessment of needs had been conducted for residents. In response, it was indicated that the provider did not have an agreed process for conducting such assessments.

Judgment: Substantially compliant

Regulation 6: Health care

When reviewing residents' personal plans it was found that they contained guidance on supporting the assessed health needs of residents. These included specific areas such as dementia and weight management. Records were also reviewed that confirmed residents' health needs were regularly monitored. This included annual health checks and monthly nursing observations. Other records reviewed indicated that residents had availed of various health and social care professionals such as general practitioners, speech and language therapists, chiropodists, dietitians and psychiatrists. Residents had also been supported to avail of relevant national screening services based on further documentation read by inspectors. In the event that residents ever had to be admitted to hospital, hospital passports were provided for them that outlined key medical information.

Judgment: Compliant

Regulation 8: Protection

The majority of staff had completed safeguarding, one staff member had not. This is addressed under Regulation 16 Training and staff development. Staff spoken with during this inspection demonstrated a good knowledge of potential safeguarding concerns and how to respond to these. Such staff raised no safeguarding concerns with inspectors nor were any immediate safeguarding concerns identified during the course of both days of inspection.

It was noted though that since the December 2023 inspection, some incidents of a safeguarding nature had been notified as occurring in the centre. Documentation

reviewed during this inspection indicated that such matters had been subject to a preliminary screening, in keeping with relevant national policy, and where necessary appropriate safeguarding measures had been put in place. For example, in one of the houses one longer term resident had been impacted by a respite resident. After this was raised as a safeguarding concern, the respite resident did not avail of respite in that house again.

Safeguarding plans were also found to be place relating to certain residents in one house of the centre with the person in charge having discussed safeguarding with residents in the same house during a recent resident forum meeting. However, when reviewing these plans, it was noted that these were generic in nature rather than being specific to individual residents. For example, these plans made reference to residents having multi-element behaviour support plans but when queried it was indicated that none of the residents in this house had such support plans.

Residents also had intimate personal care plans in place. While such support plans generally reflected residents' support needs and/or independence in this area, for one resident it was seen that their intimate personal care plan indicated that the resident needed support in various areas without outlining what kind of support was actually needed. Another document for the same resident related to intimate personal care contained some inconsistent information to the previous care plan.

Judgment: Substantially compliant

Regulation 9: Residents' rights

During this inspection staff in all three houses were seen to interact with and support residents in a respectful manner. For example, in one house a staff member present was seen to bring residents drinks given the hot weather at the time and later went around to each resident individually to ask them what they wanted for a meal. To further help promote the rights of residents, the provider had its own internal advocate for residents to avail of if required. Inspectors also informed that two residents had recently undergone training to serve as resident advocates for the houses where they lived. This was a positive development and photos of one of these residents in class for this course were seen.

Resident forum meetings were also taking place in the houses based on notes reviewed. In one house it was seen that regular resident forum meetings were taking place which were structured to involve all residents with topics discussed including safeguarding, fire safety, meal choices and social activities. The meeting notes in the same house indicated that residents were being informed about potential transitions to a new house. Such residents also had individual one-to-one meetings with the person in charge and the provider's community transition co-ordinator about such matters. These residents had transition plans in place which outlined the steps required to support each resident to make a decision on the

potential move while also referencing that residents had the right to change their mind if they wished.

However, when reviewing notes of resident forum meetings in another house, it was identified that such meetings were taking place on an inconsistent basis. For example, three such meetings had taken place in December 2024 and two in March 2025 but there had been only one between 20 December 2024 and 11 March 2025. In the same house, it was observed that some personal information relating to individual residents' diets was on display in a communal area. Such information on display had the potential to impact residents' privacy related to their personal information. Inspectors were also informed that additional filling cabinets were needed in the centre's houses to provide for better storage. These were being sought in order to promote better privacy and confidentiality of residents' personal information.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Admissions and contract for the provision of services	Substantially compliant
Regulation 34: Complaints procedure	Not compliant
Quality and safety	
Regulation 13: General welfare and development	Substantially compliant
Regulation 17: Premises	Not compliant
Regulation 18: Food and nutrition	Substantially compliant
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Cork City South 1 OSV-0003695

Inspection ID: MON-0045948

Date of inspection: 30/04/2025

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:
2.5WTE vacancies within the designated center.
• The PIC has escalated local identified risks (including Staffing) from the risk register to the PPIM, these risks have been accepted and escalated accordingly as per policy and procedures.
Time Frame for Completion: Completed

• 1 WTE staff member commenced in June 2025. 2.75 WTE relief staff are supporting in the centre. Although some vacancies still exist in the centre. Any unforeseen gaps are covered by agency, familiar agency staff are requested where possible.
Time Frame for Completion: Completed

• The Provider through their HR department are planning on running a recruitment campaign in July 2025 with the aim to fill all vacancies in CCS1 before the end of 2025. To ensure there are no gaps in the roster, the provider will utilize relief staff for CCS1. This guarantees that if two staff members are scheduled, two will be on duty, preventing any negative impact on residents due to insufficient staffing. The PIC will ensure that staffing aligns with the SOP and residents' assessed needs. If necessary, familiar agency staff will be used to cover any unforeseen shortfalls.
Time Frame for Completion: 31-12-2025

• In line with Time to Move on from Congregation Settings and Article 19 of UNCRPD, the residents currently living in CCS1 are being supported through a transition pathway. 2 houses in the center are prioritized as part of a decongregation plan within the organization. One community house has been secured and will be available by Q4 2025, this will accommodate 4 residents who will start the process of transitioning to their new home. This is estimated to be completed by Dec 2025. A fifth resident will be transitioning to a vacancy in a nearby community house operated by the provider. On completion of these transitions this property will be vacated. The provider is seeking funding through the decongregation funding pathway, to provide additional staffing

resources, then is already available to these residents. The provider is confident that it will receive funding for the staffing required. If timely funding is not received the provider will look to staff the house through the original funding that is available and assigned to support the residents in their current home.
As part of this business case, a comprehensive skill mix review was completed for this new centre in terms of the funding and resources being sought for.
Time Frame for Completion: 31-12-2025

• The business case being submitted, through the decongregation funding pathway, requests additional funding on top of the existing CCS1 funding. This will enable greater staffing resources in the centre, allowing for more flexibility in the number of staff on duty to support residents throughout the day based on assessed needs.
• Time Frame for Completion: 31-12-2025

• Although a rights restriction is in place in CCS1 for residents' access to the community due to insufficient staffing resources due to staffing vacancies, the residents are supported to access the community through their day services. Additionally, staff and management of the centre persevere to ensure that residents do have access to their community where at all possible in line with their will and preferences. There is also evidence to show that residents have access to the community at evenings and weekends as outlined by the inspector in regulation 13.
Time Frame for Completion: Completed

• In addition to the business case highlighted above, a second business case has been drafted and updated by the PIC and PPIM for consideration by the HSE for the house that is not part of decongregation. This proposal seeks to fund opening this house 7 days a week and 24 hours a day. The Provider will submit this business case to support this proposal in Q3 2025.
Time Frame for Completion of submission of proposal: 31-08-2025

• In addition, the PPIM, PIC, and OT professionals working with the Providers Dementia Care Team are drafting and editing a proposal for modifications to the house that is not being considered for decongregation. This proposal aims to create downstairs bedrooms and ensuite bathrooms to accommodate residents with aging needs and mobility concerns, allowing them to stay in their homes as they age. The PIC/PPIM will submit this proposal to the Providers Requisition Committee for consideration in Q3 2024.
Time Frame for Completion of submission of proposal: 31-08-2025

• For the other residents in the residential areas that are being decongregated, specifically the residents with mobility issues, these residents have had referrals through the Providers ATD Committee for suitable accommodation in other residential settings under the provision of the Provider. Availability of suitable accommodation that has been identified is currently being explored. The residents will be offered these places in line with their Will and Preferences as they become available.
Time Frame for Completion: 31-12-2025

• In the interim the PIC, PPIM & Health & Safety Officer in conjunction with the providers Dementia Care Team will look to enhance the risk mitigation measures to ensure that residents with mobility issues are supported at all times while using the stairs. PIC, PPIM

& Health & Safety Officer will carry out a review of the current risk assessment and control measures that are in place.
Time Frame for Completion: 31-07-2025

Regulation 16: Training and staff development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
• Staff receive ongoing training within CCS1. The centres training scheduled has been updated, any staff requiring mandatory training or any training that the PIC deems to be necessary to completed by staff will be scheduled by the PIC.
Time Frame for Completion: 31-12-2025

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
Governance and Management
• The PPIM is in continuous phone contact with the PIC, a schedule has been put in place between the PPIM and PIC for minuted meetings between the PIC and PPIM, these meetings will include; review of staffing levels, risk, quality, health and safety, future plans and all issues and concerns in relation to CCS1. The PPIM also supports the PIC through fortnightly regional meetings where Governance and Management issues in relation to the Provider are discussed.
Time Frame for Completion: Completed

• The PPIM will monitor progress of the compliance plan with the PIC as part of the reoccurring 1:1 scheduled supervision meetings. The Executive Team will have oversight of the progress also.
Time Frame for Completion: 31-12-2025

• The PIC is to ensure Staff Supervision continues as per schedule, daily tasks list for staff to follow and team meetings agenda and minutes are shared and read by all staff. The PIC will also conduct residential forum reviews to ensure all issues or concerns are captured and actioned appropriately, for example if complaints are highlighted in residents' forums, then the appropriate documentation for complaints will be completed.
Time Frame for Completion: Completed

IPC
• The PIC will continue current oversight of the centre in terms of IPC and review compliance in line with this regulation as per the Providers scheduled audit plan that is in place for IPC. A detailed action plan for IPC is mapped out under Regulation 27 below in this compliance plan.
Time Frame for Completion: Completed

Internal Audit Inspections
• The Provider will ensure that internal 6 monthly inspection audits will be completed in an appropriate time frame. From September 2024 to date the Provider has recruited a full-time internal auditor to carry out these inspections. This staff member has a schedule set up for review of all centres and they are on track to their schedule at present time. In addition to this, the Provider has recruited a second auditor who has yet to commence their role to support the first auditor to carry out 6 monthly inspection audits for the Providers centres in accordance with Regulation 23.
Time Frame for Completion: Completed

Staffing
• To address the concerns in relation to staffing the Provider has recruited 1 WTE staff that has started in June 2025. 2.75 WTE relief staff are working in the centre. Although some staff vacancies are still in place. Any unforeseen gaps are covered by agency, familiar staff are requested where possible.
Time Frame for Completion: Completed

• The Provider through their HR department are planning on running a recruitment campaign in July 2025 with the aim to fill all vacancies in CCS1 before the end of 2025. As an interim measure to ensure that there are no gaps in the roster, the provider will utilize relief staff for CCS1. This guarantees that if two staff members are scheduled, two will be on duty, preventing any negative impact on residents due to insufficient staffing. The PIC will ensure that staffing aligns with the SOP and residents' assessed needs. If necessary, familiar agency staff will be used to cover any unforeseen shortfalls.
Time Frame for Completion: 31-12-2025

Premises
• A walkthrough of the property by the PPIM & Facilities Manager is scheduled on or before 18th July to establish any maintenance issues.
A detailed plan has already been put in place by the Provider to come into compliance with Regulation 17 and Regulation 28, the plan for these works are set out under these regulations below in this compliance plan.
Time Frame for Completion:31-07-2025

• The PIC and Facilities Officer will ensure that all required maintenance works, including the fire works, are completed as per the planned schedule of works to the properties, as highlighted in the Premises section of this compliance plan.
Time Frame for Completion: 31-12-2025

• The Provider will ensure that all necessary actions highlighted below in the premises response section to this compliance plan, specifically in relation to decongregation and the plans to source, secure, staff and transition residents to their new homes occurs in the appropriate time frames.
Time Frame for Completion: 31-12-2025

Fire
• The PIC with the Facilities Officer and the Health & Safety Officer will ensure all engineer checks of Fire Equipment (specifically emergency lighting and fire alarm systems) in CCS1 will occur quarterly and all Fire Fighting Equipment engineer checks will occur annually.
As per the national legislation and the providers fire life safety policy this can include a tolerance of +/- 4 weeks for each review to be carried out as set out below:
• Fire Equipment: Irish Standard I.S. 291:2015 Annual +/- 4 weeks from Due Date.
• Emergency Lighting Standard I.S. 3217:2023 Quarterly & Annual +/- 4 weeks from Due Date.
• Fire Detection System Standard I.S. 3218:2013 Quarterly & Annual +/- 4 weeks from Due Date.
Time Frame for Completion: Completed

• The PIC will ensure all additional checks and measures to ensure fire safety as highlighted in the Fire Regulation section of this compliance plan are carried out in the appropriate time frames.
Time Frame for Completion: 14-07-2025

• The PIC will ensure all fire evacuations drills in the centre are carried out and recorded as set out in the Providers policy and procedures in relation to fire.
Time Frame for Completion: Completed

• The PIC will ensure that all walk throughs with the necessary professionals (Health and Safety Officer and Facilities Officer) will take place in the appropriate time frames.
Time Frame for Completion: 31-07-2025

As part of a continuous fire life safety programme there is ongoing monitoring, review and collaboration between the PIC, Facilities Manager and the Health & Safety Officer. Please see Fire Regulation Section later in this compliance plan for a more detailed response.

Rights of the Residents and General Welfare and Development
• The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability has the freedom to exercise choice and control in his or her daily life, this will be achieved by:
• The PIC will ensure that the goals for the residents are reviewed as part of a PCP review schedule and to ensure goals are in line with NDA outcomes.
• The PIC will ensure all staff have completed PCP training. The PIC to highlight in team meetings the importance of goals being aligned to the NDA outcomes.
• The PIC will review daily schedules of residents and will ensure that staff offer and document activities to the residents that are meaningful to them, if in the event that

residents are not able to partake in activities in the community for unforeseen reasons. In weekly residential forum meetings, weekly in-house activities will be planned with the residents. This will ensure that in the unforeseen event of staff shortages, where community access is not possible, that each resident is still offered meaningful activities to them.
• The PIC will ensure that all personal information is stored securely in the residents.
• The PIC and Provider is actively looking to secure new accommodation for residents who are a part of the decongregation process and ensure any accommodation offered is in line with the residents will and preferences.
Time Frame for Completion: 31-12-2025

Complaints
• The PIC will ensure that all complaints are captured on the center's complaints log. That information in relation to complaints is on display in the center and is captured in the resident's guide. Through residents' forums reviews, the PIC will ensure no complaints go on documented through the appropriate channels in line with the Providers policy and procedure. The PIC will ensure that 'Complaints' is a topic of discussion at each residents forum.
Time Frame for Completion: Completed

Admissions and Contracts of Provision of Service
• The PIC has sent and received back from a respite resident, their signed contract of care which was not on file at the time of inspection.
Time Frame for Completion: Completed

Food and Nutrition
• The PIC will ensure that all staff have completed Food safety training. In addition, the PIC will ensure staff label and date food when it is opened. The PIC will conduct spot checks in relation to food labelling and dating.
Time Frame for Completion: 31-12-2025

Protection
• The PIC to complete a full review of current safeguarding plans and ensure that all plans are updated to ensure that they are not generic in nature and reflect the current needs of the residents within CCS1.
Time Frame for Completion: 31-08-2025

Individual Assessments and Personal Plans
• The PIC and Staff will ensure Care Plans are kept up to date and that information in these plans is accurate to the person. This will be achieved by scheduled audits of the care plans through the Providers comprehensive audit system in place.
Time Frame for Completion: 31-08-2025

Audits
• The Provider has a comprehensive audit system in place since 2024. The PIC will ensure all audits are completed as per schedule and any actions identified are completed

in the appropriate time frame.
Time Frame for Completion: Completed

Regulation 24: Admissions and contract for the provision of services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 24: Admissions and contract for the provision of services:
• The PIC will ensure that all respite residents who plan to avail of respite services in the centre have signed copies of the Providers respite contract of care, signed by either the resident or their representatives, on file in the designated centre.
Time Frame for Completion: 31-11-2025

• The PIC has sent and received back from a respite resident, their signed contract of care which was not on file at the time of inspection. This respite resident is part of the respite list for the centre and even though it may be an immediate personal situation for them needing respite it was not an emergency admission as they are part of the directory of residence.
Time Frame for Completion: Completed

• The Statement of purpose has been updated to reflect that the designated centre is closed to new admissions and information in relation to respite residents has also been updated.
Time Frame for Completion: Completed

Regulation 34: Complaints procedure	Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
• The PIC has completed retrospective complaint forms in relation to complaints raised in resident forum, all residents were happy with the resolution and the complaints are now resolved and closed.
• The PIC will update and review the complaints log to ensure that all complaints are logged correctly and resolved in a timely manner.
• The PIC is to carry out a review of resident's forums to ensure no concerns highlighted in residents' forums do not go undocumented or actioned as per the Providers Policy and Procedures in relation to complaints.
• The PIC will ensure that information in relation to complaints, and how to make complaints is provided and displayed in the center in a format that is appropriate for the

residents understanding. As well the PIC will ensure that information on the complaints process is captured in the resident's guide.
• Additionally, the PIC will ensure that the complaints process is discussed in the resident's forums and the topic of complaints is a weekly topic of discussion at these forums. The PIC will ensure this by doing a review of the residents forums template and ensuring 'Complaints' is a topic of discussion.
Time Frame for Completion: Completed

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 PIC will ensure:
• Full review of all ongoing goals has been completed.
• Review of goals to be completed on a 3-monthly basis. Scheduled review times are emailed to staff to ensure that goals are reviewed on this time frame. Staff to ensure goals are in a stepped approach for each goal that is developed with the resident.
• As residents within the designated center are in active retirement and require more activities and goals that reflect this – a more comprehensive retirement plan is currently being developed. This is in conjunction with current active retirement plans in place in each person plan.
• The PIC will explore the option of volunteers supporting activities for the residents with the volunteer coordinator.
Time Frame for Completion: 31-08-2025

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• 2 houses in the center are prioritized as part of a decongregation plan within the organization. One community house has been secured and will be available by Q4 2025, this will accommodate 4 residents who will start the process of transitioning to their new home. This is estimated to be completed by Dec 2025.
A fifth resident will be transitioning to a vacancy in a nearby community house operated by the provider. On completion of these transitions this property will be vacated.
Time Frame for Completion: 31-12-2025

• The new community house is also subject to review by the HIQA Case Holder over CCS1 through a planned application to register a new centre. The provider is confident

that the HIQA Case Holder will have no concerns with this property given its high standard of finish. This property has also gone through all necessary checks by the Providers facilities department and is deemed to be complaint in terms of all related regulations.
Time Frame for Completion: 31-12-2025

• Sourcing other new homes for the remaining residents in a second house is ongoing. Through the Providers ATD Committee and Decongregation Team some alternative locations have been identified for some residents, these locations are being explored at present time with the residents and their family representatives. In addition, the Providers Property Acquisition Manager is working towards sourcing and securing alternative properties for the remaining residents of CCS1, this is ongoing at present time. Due to the nature of the current property and labor market at present time and the current economic environment for buying and renovating properties, the Provider strives to negotiate these challenges as swiftly and as timely as it can.
Time Frame for Completion: 31-12-2025

• For the other residents in the residential areas that are being decongregated, specifically the residents with mobility issues, these residents have had referrals through the Providers ATD Committee for suitable accommodation in other residential settings under the provision of the Provider. Availability of suitable accommodation that has been identified is currently being explored. The residents will be offered these places in line with their Will and Preferences as they become available.
Time Frame for Completion: 31-12-2025

• In the interim the PIC, PPIM & Health & Safety Officer in conjunction with the providers Dementia Care Team will look to enhance the risk mitigation measures to ensure that residents with mobility issues are supported at all times while using the stairs. PIC, PPIM & Health & Safety Officer will carry out a review of the current risk assessment and control measures that are in place.
Time Frame for Completion: 31-07-2025

• PPIM is scheduled to meet the facilities manager to review CCS1 premises on or before the 18th July 2025 and review all maintenance due to be completed, a maintenance action plan has been put in place as follows:

Longer term planned decongregation house:
Fire door corrections due to commence by 14-Jul-2025 and planned to be completed by 08-Aug-2025.

Non decongregation planned house:
Bathroom 1 to Shower Room Conversion (1st Floor), due to commence by 06-Oct-2025 and due to be completed by 31-Oct-2025.
Bathroom 2 to Shower Room Conversion (1st Floor), due to commence by 02-Mar-2026 and due to be completed by 27-Mar-2026.
Deep Clean to be completed by 01-Jul-2025.
Rail Replacement to be completed by 01-Jul-2025.
Painting (Hallway) to be completed by 11-Jul-2025.
Painting (All Rooms) to commence by 06-Oct-2025 and to be completed by 10-Oct-2025.

Hole in kitchen-dining room wall to be completed by 01-Jul-2025
Broken fridge drawer and damaged kitchen counter to be replaced by 01-Jul-2025
Small hole in hot press ceiling to be repaired, completed by 01-Jul-2025
Fire Doors Inspection and Correction completed in April 2025

Completion Time Frame
All tasks to be completed by: 31-Dec-2025

• The PPIM, PIC, and OT professionals working with the Providers Dementia Care Team are drafting and editing a proposal for modifications to the house that is not being considered for decongregation. This proposal aims to create downstairs bedrooms and ensuite bathrooms to accommodate residents with aging needs and mobility concerns, allowing them to stay in their homes as they age. The PIC/PPIM aim to submit this proposal to the Providers Requisition Committee for consideration in the coming months.
Time Frame for Completion of submission of proposal: 31-12-2025

Regulation 18: Food and nutrition	Substantially Compliant

Outline how you are going to come into compliance with Regulation 18: Food and nutrition:
The PIC reviewed current systems in place for food and nutrition:
All food is to be labelled, the PIC and Staff in each house are to ensure that food is labelled when open or removed if staff are unsure of when it was opened.
• A notice has been displayed in each house in relation to labelling food.
• The PIC and staff to complete spot checks to ensure that food in fridge freezers are labelled in line with food safety.
Time Frame for Completion: Completed

• All staff to complete food safety training online.
Time Frame for Completion: 31-12-2025

Regulation 27: Protection against infection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
The PIC has completed or will ensure:
• All out of date PPE was removed from the houses.
• Cleaning documentation updated and reflects all rooms in all houses currently in use.

• All broken items such as drawer in the fridge was removed and new replacements requested
• All worn and used areas of the houses sent through PEMAC.
• All staff have completed Hand Hygiene training as per policy. Current training matrix was not updated to reflect this. This has been reviewed- request sent to CNS IPC to complete infection control audit of the designated center, this is due to be completed on 7-7-2025.
• Documentation review i.e. updated cleaning records: completed 4-6-2025
• All out of date PPE removed 1-5-025
• All worn and broken items removed from area: 4-6-2025
• IPC audit request completed: 3-6-2025
Time Frame for Completion: 07-07-2025

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
The PIC will ensure that:
• Updated Fire drill schedule in place.
• Updated fire books in place in each house.
• Minimum staffing drills completed.
• Fire Drills/Simulation of residents in bedrooms during night hours completed in each house increased.
• Fire safety risk assessment updated to reflect current concerns with fire doors.
• PEEPS reviewed and updated to reflect changes.
• GEEPS will be reviewed by the PIC and the Health & Safety Officer.
• Fire Door Audit reviewed and updated by PIC.
• Facilities Manager in conjunction with Health and Safety Officer will walk around the premises with affected doors and a plan for reducing risk, due to be completed on or before 18th July 2025.
Time Frame for completion: 31-07-2025

Weekly Fire Checks
• Any additional issues identified during the fire checks are reported through pemac maintenance system and through the PIC for actioning.
• Door closures checked on a daily basis
• Alarms sounded on weekly basis
• Fire Awareness for all residents to be reviewed and completed on a weekly basis- fire safety meetings easy read information to be in place in each person bedroom.
Time Frame for completion: 31-07-2025

Fire Equipment Engineer Checks
• The PIC with the Facilities Officer will ensure all engineer checks of Fire Equipment (specifically emergency lighting and fire alarm systems) in CCS1 will occur quarterly and all Fire Fighting Equipment engineer checks will occur annually. As per the national

legislation and the providers Fire Life Safety Policy this can include a tolerance of +/- 4 weeks for each review to be carried out as set out below:
• Fire Equipment: Irish Standard I.S. 291:2015 Annual +/- 4 weeks from Due Date.
• Emergency Lighting Standard I.S. 3217:2023 Quarterly & Annual +/- 4 weeks from Due Date.
• Fire Detection System Standard I.S. 3218:2013 Quarterly & Annual +/- 4 weeks from Due Date.
Time Frame for completion: Completed

Planned Fire Works
The Facilities Officer has outlined a plan of works for completion in Cork City South 1 which includes:

Longer term planned decongregation house:
Fire door corrections due to commence by 14-Jul-2025 and planned to be completed by 08-Aug-2025.

Non decongregation planned house:
Small hole in hot press ceiling to be repaired and completed by 01-Jul-2025
Fire Doors Inspection and Correction completed in April 2025

Time Frame for completion: 30-09-2025

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:
From discussion with provider assessment of need is not the same as the comprehensive assessment
• The personal plan is developed with each individual in mind and contains assessments individual to the persons needs which therefore creates a comprehensive assessment of needs for each resident. The assessment that was discussed on the day of inspection was an assessment of need in relation to supports required due to changing needs, this is currently under review by the provider
• PIC/Senior staff to complete review of documentation and ensure that same is accurate and in line with current changing needs
Time Frame for Completion: 31-08-2025

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
• The PIC is to complete a full review of current safeguarding plans and ensure that current plans are updated to ensure that they are not generic in nature and reflects the current needs of the residents within CCS1
Time Frame for completion: 31-08-2025

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• Schedule to be put in place for one of the houses within the designated center to ensure that Resident Forums are completed and reviewed as required.
• 2 residents have successfully completed an advocacy course in MTU.
• Decongregation support team currently supporting a group with the proposed transition to their new home- current discovery works have commenced to establish the residents hopes and dreams for the future
• Resident personal information was removed from the area highlighted by the inspector on the day of the inspection.
• The PIC will ensure resident confidential files are stored in a locked press in the designated centre.
• Storage of Personal File to be reviewed in two houses as on display.
• Full review of intimate care assessment completed for each resident to ensure documentation is consistent and accurate in personal plans
Time Frame for completion: 31-12-2025

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	31/08/2025
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	31/12/2025
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to	Substantially Compliant	Yellow	31/08/2025

	appropriate training, including refresher training, as part of a continuous professional development programme.			
Regulation 17(1)(a)	The registered provider shall ensure the premises of the designated centre are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.	Not Compliant	Orange	31/12/2025
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	31/12/2025
Regulation 17(6)	The registered provider shall ensure that the designated centre adheres to best practice in achieving and promoting accessibility. He. she, regularly reviews its accessibility with reference to the statement of purpose and carries out any required alterations to the	Not Compliant	Orange	31/12/2025

	premises of the designated centre to ensure it is accessible to all.			
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Not Compliant	Orange	31/12/2025
Regulation 18(1)(b)	The person in charge shall, so far as reasonable and practicable, ensure that there is adequate provision for residents to store food in hygienic conditions.	Substantially Compliant	Yellow	31/12/2025
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.	Not Compliant	Orange	31/12/2025
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	31/08/2025
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered	Substantially Compliant	Yellow	31/08/2025

	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 24(3)	The registered provider shall, on admission, agree in writing with each resident, their representative where the resident is not capable of giving consent, the terms on which that resident shall reside in the designated centre.	Substantially Compliant	Yellow	30/11/2025
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of	Substantially Compliant	Yellow	07/07/2025

	healthcare associated infections published by the Authority.			
Regulation 28(2)(b)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Substantially Compliant	Yellow	14/07/2025
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	30/09/2025
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.	Substantially Compliant	Yellow	16/06/2025
Regulation 28(4)(b)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Substantially Compliant	Yellow	31/12/2025
Regulation 34(1)(b)	The registered provider shall provide an effective	Substantially Compliant	Yellow	16/06/2025

	complaints procedure for residents which is in an accessible and age-appropriate format and includes an appeals procedure, and shall make each resident and their family aware of the complaints procedure as soon as is practicable after admission.			
Regulation 34(2)(c)	The registered provider shall ensure that complainants are assisted to understand the complaints procedure.	Substantially Compliant	Yellow	16/06/2025
Regulation 34(2)(f)	The registered provider shall ensure that the nominated person maintains a record of all complaints including details of any investigation into a complaint, outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.	Not Compliant	Orange	16/06/2025
Regulation 05(1)(b)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each	Substantially Compliant	Yellow	31/08/2025

	resident is carried out subsequently as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.			
Regulation 08(6)	The person in charge shall have safeguarding measures in place to ensure that staff providing personal intimate care to residents who require such assistance do so in line with the resident's personal plan and in a manner that respects the resident's dignity and bodily integrity.	Substantially Compliant	Yellow	31/08/2025
Regulation 09(2)(e)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability is consulted and participates in the organisation of the designated centre.	Substantially Compliant	Yellow	31/12/2025
Regulation 09(3)	The registered provider shall ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and	Substantially Compliant	Yellow	31/12/2025

	living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.			