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:	Buttevant House
Name of provider:	St Joseph's Foundation
Address of centre:	Cork
Type of inspection:	Announced
Date of inspection:	21 January 2026
Centre ID:	OSV-0003839
Fieldwork ID:	MON-0040878

About the designated centre

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

Buttevant House is a single storey detached bungalow located in a town. The centre comprises of two resident bedrooms, a sitting room, a kitchen, a utility room, an activity room, bathroom facilities and staff rooms. The centre has a maximum capacity of two residents and provides full-time residential care to residents with intellectual disabilities and autism who present with behaviour that challenges. Both male and female residents over the age of eighteen years can reside in the centre. The staff team comprises of a person in charge, social care workers and care assistants.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	2

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
Wednesday 21 January 2026	10:05hrs to 18:15hrs	Conor Dennehy	Lead

What residents told us and what inspectors observed

Both residents living in this centre were met during the inspection with feedback provided from them being positive. The inspector also spoke with two members of staff along with management of the centre during the inspection. Overall, this inspection found a good level of compliance with the regulations although some regulatory actions were identified relating to staff, medicines and residents' finances.

This designated centre had a maximum capacity for two residents. When the inspector arrived at this centre, neither of the two residents living there were present. The inspector was informed by management of the centre that both residents were attending day services with staff and would be back later in the afternoon. As such, after an introduction meeting with management of the centre, the inspector focused the initial part of the inspection on reviewing the premises provided and specific documentation.

Among the documentation that was reviewed by the inspector were surveys that had been completed for both residents in advance of this announced inspection. The two surveys were indicated as being completed by the residents with the support of staff and asked questions on various areas about what life was like for residents in the centre. Respondents were given an opportunity to indicate answers of 'yes', 'no' or 'it could be better'. Both of surveys contained positive responses to all areas queried including matters such as staffing, activities and the residents' home.

The house where residents lived was seen to be presented in a clean, well furnished and well-maintained manner on the day of inspection although the kitchen decor was older in style and appearance. Both residents had their own individual bedrooms with sufficient communal space provided by a sitting room, an activity room and a kitchen. A utility room was also present that had washing machines but this room included seating options if required. Overall, the house had a homely feel with efforts made to make it homelike. For example, the sitting room had a fish tank with two goldfish in it, art works of animals done by one resident were on display around the centre and the sitting room had personalised cushions for each resident.

As the afternoon of the inspection progressed, the two residents returned to the centre from day services in the company of staff. The inspector had an opportunity to meet and speak with both of these residents. The inspector initially met the first resident as they were relaxing in their bedroom. During this interaction, the resident told the inspector that they liked living in the centre and had been playing golf and soccer earlier in the day. When asked what the resident was doing later in the day, the resident responded by saying "relaxing".

Shortly after this, the resident briefly left the centre with a staff member to get ingredients for a pasta bake which the resident was then encouraged to help make on their return. The resident told the inspector that this was their favourite meal.

The inspector then went on to ask the resident some further questions about life in the centre. In response to these, the resident indicated that they liked the staff, felt safe in the centre and was friends with the other resident. It was also mentioned by the resident that they fed the two goldfish in the centre before the resident went on to show the inspector some of the art works they had completed which were on display around the centre.

A member of the centre's management praised the resident for their art works. It was then suggested that the inspector speak to the other resident in the presence of the same member of centre management due to the resident's familiarity with this manager and how the resident communicated. The inspector agreed to this suggestion and briefly met the resident in the centre's activity room. While the resident could give verbal responses to some questions asked, the resident also used a tablet device for communication.

The inspector asked the resident if they liked living in the centre, if they felt safe and if they liked the centre. The resident responded yes to all of these questions. When the inspector asked what the resident liked about living in the centre, the resident used their tablet device to indicate that they went swimming and fishing. The resident then left the activity room with the member of centre management informing the inspector that this meant that the resident was done speaking with the inspector. Soon after this both residents left the centre with staff to go swimming in a nearby hotel. Neither resident had returned to the centre by the end of the inspection.

In summary, positive feedback was received directly from residents and from surveys completed with staff support. Both residents indicated that they liked the staff with staff on duty on the day of inspection supporting residents to attend their day services and to go swimming. The house where residents lived was seen to be homely. Regulatory actions identified on this inspection 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

This inspection found an overall good level of compliance which indicated that residents were being provided with a safe and quality service. It was identified though that there had been some recent instances when staffing was not provided in line with the centre's statement of purpose.

Buttevant House was registered until July 2026 and had last been inspected by the Chief Inspector of Social Services in October 2024. The October 2024 inspection was focused on the area of safeguarding and found that residents were appropriately safeguarded and well supported. Since that inspection, the provider had applied in December 2024 to vary the centre's registration conditions to reflect a premises layout change. This application was subsequently granted and then in January 2026, the provider submitted a further application to renew the registration of the centre for three more years beyond July 2026. This current inspection was conducted to inform this application. Overall, a good level of compliance was found during inspection which indicated that residents continued to be well supported. Most regulatory requirements reviewed were being met. For example, unannounced visits by a representative of the provider were being conducted every six months. However, it was identified that the outlined staffing arrangements for the centre in the statement of purpose had not been met on some occasions during January 2026.

Regulation 15: Staffing

This regulation requires that staffing arrangements in a centre must be in accordance with the needs of residents and the centre's statement of purpose. The statement of purpose of the centre, outlined the staffing arrangements for the centre and indicated that by day in the centre, two staff were to be on duty with one being a care assistant and the other being a social care worker. The inspector was also informed of these staffing arrangements by management and staff of the centre with these parties also indicating that such staffing arrangements were maintained.

Staff rotas for the centre were reviewed for January 2026 with these rotas maintained in a planned and actual format as required under this regulation. The actual rotas reviewed generally indicated that the staffing arrangements outlined to the inspector were maintained. However, the inspector noted two instances from January 2026 where only one staff had been on duty for part of the day. On a third occasion, two care assistants had been on duty for part of the day with no social care worker on duty. As such, there had been some recent occasions where staffing had not be in line with the statement of purpose.

No occasions were identified from rotas reviewed where the outlined staffing arrangements for the centre at night were not in place. Staff spoken with also indicated that there was a good consistency of staff working in the centre. In addition, this regulation requires specific documentation to be maintained for all staff working in a centre such as written references and proof of identities. Documentation reviewed during this inspection indicated that audits had been conducted recently in the centre to ensure that staff had such documentation in place.

Judgment: Substantially compliant

Regulation 19: Directory of residents

It was found that a directory of residents was being maintained which was made available for the inspector to review during this inspection. From the initial reading of this directory on the day of inspection, it was noted that this directory contained most of the required information such as residents' names, details of residents' next-of-kin and details of residents' general practitioners. It was noted though that this directory of residents did not include the marital status of residents nor the name and address of any authority, organisation or other body, which arranged the residents' admissions to the designated centre. After highlighting this to management of the centre, the inspector was provided with a revised directory of residents before the end of the inspection which contained this information.

Judgment: Compliant

Regulation 22: Insurance

During this inspection documentation, dated January 2026, confirmed that appropriate insurance arrangements were in place for this centre.

Judgment: Compliant

Regulation 23: Governance and management

An overall good level of compliance was found during this inspection with no areas of non-compliance identified. This indicated that there was appropriate governance and management of the centre. As part of this the governance arrangements for the centre, the person in charge oversaw the staff team in the centre in keeping with the organisational structure for the centre. This structure was outlined in the centre's statement of purpose and provided for lines of reporting from staff working in the centre to the provider's board of directors. Staff spoken with during this inspection also commented positively on managerial support and indicated that there were no barriers to raising any concerns

In addition, the governance arrangements for the centre also included the following systems to monitor the services provided in the centre and provide support to staff:

- Three unannounced visits to the centre had been conducted by a representative of the provider since the centre was inspected in October

2024. Under this regulation, such visits must be conducted every six months with these three provider unannounced visits having been done in November 2025, May 2025 and November 2024. These visits were reflected in written reports, which were provided to the inspector. When reading these unannounced visits reports it was noted that they considered relevant matters about the quality and safety of care and support provided in the centre. This included areas such as staffing, safeguarding and restrictive practices. The unannounced visit reports also included actions plans to address any areas for improvement identified by the representative of the provider. These actions plans had been updated to indicate that areas for improvement identified were addressed.

- An annual review of the centre for 2024 had been completed in April 2025. Conducting such an annual review is another regulatory requirement. A report of this annual review was also provided to the inspector and it was seen that it assessed the centre against relevant national standards while also containing feedback from residents and their representatives. Further records reviewed indicated that this annual review had been made available to and discussed with residents at a May 2025 residents' meeting. This addressed a regulatory action from the October 2024 inspection of the centre.
- Based on documentation reviewed for 2025 and 2026, audits were being conducted on a scheduled basis in areas such as safeguarding, finances and medicines. This provided assurances that there was systematic monitoring of the services being provided in the centre.
- Taking into account notes reviewed, staff team meetings were taking place in the centre on a regular basis. Eight such meetings had been held since 4 July 2025 with the notes of these indicating that the person in charge attended all of these meeting while a regional manager for the centre attended three staff team meetings. From the notes of these meeting it was indicated that various topics were discussed including safeguarding, risk, and infection prevention and control.

Judgment: Compliant

Regulation 3: Statement of purpose

A statement of purpose is an important governance document that describes the services and supports to be provided to residents while also forming the basis for a condition of registration. Under this regulation, a statement of purpose must contain specific information such as a description of the rooms in the centre, the fire precautions and the arrangements for residents to attend religious services of their choice. The statement of purpose that was read during this inspection was found to contain all the required information. This statement of purpose had been reviewed during January 2026. This was in keeping with the requirements of this regulation which requires statement of purpose to be reviewed at intervals of not less than one year.

Judgment: Compliant

Regulation 4: Written policies and procedures

Under this regulation, a provider must have specific policies and procedures in place with these being important to guide staff practices. The required policies and procedures must also be reviewed in a timely manner at intervals not exceeding three years. During this inspection, all of the required policies and procedures, which covered areas such as communication with residents, the provision of intimate personal care and medicines management, were found to be in place. The policies and procedures reviewed on the day were mostly indicated as being reviewed within the previous three years. However, the documentation provided on the day of inspection indicated that the provider's policies and procedures on restrictive practices and staff training and development had not been reviewed since March 2022 and September 2022 respectively. Documentation provided the day following the inspection confirmed that both of these policies and procedures had been reviewed during 2025.

Judgment: Compliant

Quality and safety

Residents were supported to pursue activities away from the centre and to maintain contact their families. Personal plans were in place for both residents which had been recently reviewed.

The centre operated an open visiting policy while support was also being given to residents to maintain contact with their relatives outside of the centre. Residents were also being supported to participate in external activities (such as going swimming) and achieve goals. Goals were identified for residents through a person-centred planning process which involved the residents and their family. Documentation around these goals was outlined within residents' personal plans. These plans had been recently reviewed and were subject to multidisciplinary review as required under the regulations. The regulations also require appropriate medicines administration practice but, while such practices were generally found to be in order, a similar medicine administration error had occurred in December 2025 and January 2026. A fire drill had been conducted in January 2026 along with various other drills throughout 2025 with low evacuation times recorded. Staff working in the centre had completed training in fire safety and safeguarding. Members of staff spoken with during this inspection demonstrated a good awareness of active safeguarding plans in place.

Regulation 11: Visits

The centre's residents' guide indicated that there was an open visiting policy for the centre. Rooms available within this centre included a sitting room, a utility room, a kitchen and an activity room, all of which had seating options. As a result, based on this observed premises facilities and layout, space was available for residents to receive visitors in private in a room other than their bedrooms. Staff members spoken with and a visitors' log reviewed confirmed that one of the residents had received visits to the centre in recent months.

Judgment: Compliant

Regulation 13: General welfare and development

From discussions with residents, staff and management along with documentation reviewed, including residents' personal plans, there was evidence that residents were being supported to engage in meaningful community based activities and to maintain personal relationships. Examples of these included:

- Both residents were members of a leisure club in a nearby hotel with both residents leaving the centre to go to this hotel for swimming on the day of inspection.
- One resident had done work experience in a café.
- A resident was supported by staff to visit a relative while the other resident used a tablet device to keep in the contact with their relatives.
- The two residents had been supported to identify goals through a person-centred planning process. Such goals included performing a play, going to the ploughing championship and do a computer course with residents being supported in these goals.
- Residents did activities such as fishing, golf and soccer.

Judgment: Compliant

Regulation 17: Premises

The premises provided for residents to live in was seen to be clean, homely and well presented overall based on observations during this inspection. Sufficient communal space was available for both residents through rooms such as the sitting room and activity room. The two residents had their own individual bedrooms, both of which were seen to be well furnished and personalised. For example, one resident's bedroom had photos on the wall while the other bedroom had certificates obtained

by the resident on display. No issues were observed or raised relating to the bathroom facilities nor the provision of storage in the centre.

Judgment: Compliant

Regulation 20: Information for residents

This centre had a residents' guide in place as reviewed by the inspector during this inspection. When reading this guide it was noted that it contained all of the required information including details of terms and conditions for residency and the arrangements for visiting.

Judgment: Compliant

Regulation 28: Fire precautions

During this inspection, it was observed that the designated centre had fire systems in place such as emergency lighting, fire extinguishers and a fire blanket. Documentation provided indicated that such systems had been subject to maintenance checks by external contractors during 2025 to ensure that they were in proper working order. The centre was also provided with fire doors which are important to contain the spread of fire and smoke. During the inspection it was observed that one of these doors did not close fully under its own weight. After highlighting this to centre management, this issue was addressed before the end of the inspection.

Based on a training matrix provided, all staff working in the centre had completed fire safety training. Guidance for staff in how to support residents to evacuate the centre was contained within individual personal emergency evacuation plans (PEEPs) for residents. When reading these PEEPs, it was noted that they had been reviewed recently. Fire drills records reviewed for 2025 and 2026 indicated that such fire drills were being conducted regularly, at varied times of the day, with low evacuation times recorded.

Multiple fire exits were present in the centre with all seen to be unobstructed on the day of inspection. Following receipt of the application to vary the centre's conditions of registration in December 2024, a query was raised around the evacuation arrangements from the kitchen of the centre in the event of fire (the centre layout would mean that to exit the kitchen in the event of a fire, one would first have to pass through utility room). In response to this, the provider commissioned a review of centre which recommended that the existing back door (the exit off the utility

room) should be modified to include a push bar mechanism for rapid egress. On the day of this inspection, this push bar mechanism was seen to be in place.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

During this inspection it was observed that secure facilities were present in that centre for medicines to be stored in. When viewing inside this medicines storage it was found to be appropriately organised with a sample of medicines reviewed found to be labelled and in-date. A separate space was also present for medicines that needed to be returned if required. Medicines prescription documentation was also reviewed for both residents and was found to contain required information. This included when their prescribed medicines were to be administered and the route of administration. Medicines administration records reviewed for the residents for January 2026 highlighted that they generally received their medicines as prescribed.

However, for one resident it was noted that they had not received a monthly medicine on the prescribed date. While the resident did receive this medicine at a later date in January 2026 (and no adverse outcome was reported), after discussion with the person in charge it was highlighted that a similar medicine error had occurred in December 2025 also. In addition, when reviewing administration records for PRN medicines (medicines only taken as the need arises) for 2025 for the other resident, it was noted these administration records did not document the effect of these PRN medicines. This was despite, the recording of such information being required by the PRN administration records.

Further documentation reviewed in residents' personal plans, indicated that neither resident self-administered their own medicines. The inspector queried with the person in charge if this had been explored with the residents. The person in charge was unsure if this had been explored with the residents.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

This regulation requires that all residents living in a designated centre must have personal plans. Such plans are intended to set out the health, personal and social needs of the residents and provide guidance for staff in how to meet these needs. During the course of this inspection, the inspector reviewed both residents' personal plans. From these personal plans the following was noted:

- The personal plans contained various assessments which related to residents' needs such as their physical health, mental health and activities of daily living. Where such assessments highlighted a resident as having needs under any of these areas, a support plan was created which outlined how these needs were to be met.
- All assessments and support plans seen during this inspection had been reviewed in recent months.
- Annual multidisciplinary reviews of both residents' had taken place in October 2025. Notes of these multidisciplinary reviews indicated that they were attended by various health and social care professionals including management of the centre, a psychologist, a social worker and a speech and language therapist.
- Residents and their families were supported to be involved in the review of their personal plans by participating in person-centred planning meetings that had taken place in recent months. These meetings were used to identify goals for residents (as discussed further under Regulation 13 General welfare and development) with areas such as safeguarding also recorded as being discussed.
- Residents' personal plans were available in an accessible format for residents.

Such findings were in keeping with this regulation's requirements which also requires that appropriate arrangements be in place to meet the assessed needs of residents. Based on the overall findings of this inspection, the provider was meeting this requirement.

Judgment: Compliant

Regulation 7: Positive behavioural support

Based on documentation provided and observations on the day of inspection limited environmental restrictive practices were in use in this centre. What restrictions that were in use included some locked gates. Such restrictions were indicted as being discussed with residents in individual one-to-one meetings with their key-worker (a staff specifically assigned to support a resident) based on records present within residents' personal plans. Restrictions had also been reviewed by the provider's multidisciplinary team in October 2025. It was noted that following this review, efforts had been made to reduce the restrictions in place for one resident by supporting them to be able to unlock the locked gates themselves.

These efforts had been successful and meant that from January 2026 the locked gates were no longer a restriction for this resident which was a positive development and provided assurance that the provider was seeking to reduce restrictive practices. When reviewing a PEEP for the other resident, the inspector noted reference to the resident's bedroom having window restrictions. Window restrictions were not listed in other restrictive practice documentation reviewed so the inspector queried this with the person in charge. In response, it was indicated

that the reference to the window restrictors in the PEEP was an error with this promptly removed from the PEEP. It was also demonstrated to the inspector that there was no window restrictors in this resident's bedroom.

Aside from this, from reviewing incident reports in this centre and the two most recent provider unannounced visits conducted for the centre, one resident could display certain behaviours. Discussions with management of the centre, indicated that such behaviours had increased during 2025 but had started to decrease following recent input from a psychiatrist. Documentation reviewed for this resident in their personal plan confirmed that such input had happened in January 2026 and December 2025 along with further multidisciplinary reviews.

The resident in question also had a positive behaviour support plan in place that had been reviewed in November 2025. This contained guidance on how to support the resident to engage in positive behaviour. Staff spoken with were aware of this resident's behaviour and how to support them with it. A training matrix provided also confirmed that staff working in this centre had undergone relevant training in de-escalation and intervention.

Judgment: Compliant

Regulation 8: Protection

During the introduction meeting for this inspection, management of the centre indicated that there were three active safeguarding plans for the centre. These safeguarding plans corresponded with a previous matter and safeguarding notifications that had been received from this centre since the October 2024 inspection. Copies of the active safeguarding plana were provided during this inspection and were seen to outline specific safeguarding measures to prevent certain incidents reoccurring. Such safeguarding plans were also subject to review by the person in charge and the provider's designated officer (person who reviews safeguarding concerns) based on further documentation provided.

Information about the designated officer was seen to be on display in the centre. Safeguarding, including highlighting the identity of the designated officer, was indicated as being discussed in residents' meetings that took place regularly in the centre based on meeting notes review from 1 December 2025 on. A copy of a safeguarding audit for the centre completed in May 2025, also referenced that residents had attended safeguarding awareness training in March 2025. All staff working in the centre had also completed safeguarding training based on a training matrix provided during this inspection. Both staff spoken with during this inspection were aware of the active safeguarding plans in place. Such staff raised no further safeguarding concerns and none were observed during the course of the inspection.

Judgment: Compliant

Regulation 9: Residents' rights

It had been identified by the provider that particular arrangements were in place related to residents' finances which amounted to restrictions. These restrictions meant that residents did not have direct access to and control over their personal financial accounts. Such arrangements impacted the residents' legal rights and were also not consistent with the provider's policy on residents' finances. This stated that the provider would "respect a resident's right to control their finances" and was "committed to supporting residents who use our services to use and manage their money". While this impacted residents' rights, staff spoken with during this inspection indicated that residents were never short of money.

Such staff also spoke of residents in a respectful manner. Records review indicated that residents were being given information related to the running of the centre. This was done through meetings between individual resident and their assigned key-worker. For example, one resident had four such meetings since 26 September 2025 with topics discussed during these meetings including goals, safeguarding, complaints and restrictive practices. Communal residents' meeting were also taking place regularly in the centre based on further records provided. In line with the centre's residents' guide, such meetings were used for resident consultation.

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	Substantially compliant
Regulation 19: Directory of residents	Compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Compliant
Regulation 3: Statement of purpose	Compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Compliant
Regulation 20: Information for residents	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Buttevant House OSV-0003839

Inspection ID: MON-0040878

Date of inspection: 21/01/2026

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: To come into compliance with Regulation 15: Staffing; the Registered Provider is committed to recruiting staff for the two vacant social care positions in the centre. The HR department are aware of these vacancies and recruitment is ongoing. The PIC continues to endeavour to cover these shifts with the organisations relief panel and with agency should relief be unavailable. In the event a relief/agency social care staff cannot be secured, the Person in Charge/Area Manager will delegate a HCA to cover the social care shift in line with SJFs guidelines re Stepping up HCAs to cover Social Care Staff in emergencies. The centres Statement of Purpose has been updated to reflect this on 17/02/2026.	
Regulation 29: Medicines and pharmaceutical services	Substantially Compliant
Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services: To come into compliance with Regulation 29: Medicines and pharmaceutical services; there has been no further incidents of monthly medicines not being administered as prescribed. To reduce the risk of reoccurrence the PIC has spoken with staff to ensure vigilance and has spoken with the Pharmacist who has agreed to add the monthly medicine to the resident's blister pack as of 01/03/2026. The PIC has spoken with staff to ensure the effect of all PRN medications administered is recorded and the PIC will continue to monitor same. This was discussed with the team again on 18/02/2026 at the center's team meeting. The PIC wishes to confirm the residents in the centre have not expressed an interest in self-administering medications however an appointment has been scheduled for both residents on 02/03/2026 with their consultant Psychiatrist to explore same.	
Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
The Provider wishes to confirm St. Joseph's Foundation is actively reviewing its practices in terms of supporting residents to manage and access their finances. This involves reviewing and updating the policies impacting our residents, particularly our Finance and Restrictive Practice Policies, mindful of our responsibilities of implementing the Assisted Decision-Making Act 2015 and the Health Act 2007. As previously indicated, the Provider has been liaising with its bank in regard to access to finances for its' service users. Following the most recent discussion with the bank the original implementation date of the 31st December 2025 unfortunately can no longer be met. The Provider wishes to assure the Chief Inspector that it is fully committed to resolving this and thus coming into compliance with Regulation 9. To that end, it is now envisaged that a solution will be implemented by 31st May 2026. The banks compliance unit and its local compliance manager are involved at both local and national level in determining a solution. The Provider wishes to assure the Chief Inspector that until this issue is resolved that monies are available to all residents at all times through the Finance department and in line with the Provider's Policy; To Support People who use our services to manage their money.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Substantially Compliant	Yellow	17/02/2026
Regulation 29(4)(b)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine which is prescribed is administered as	Substantially Compliant	Yellow	02/03/2026

	prescribed to the resident for whom it is prescribed and to no other resident.			
Regulation 09(2)(c)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability can exercise his or her civil, political and legal rights.	Substantially Compliant	Yellow	31/05/2026