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:	Goldfinch 1
Name of provider:	Corlann
Address of centre:	Limerick
Type of inspection:	Unannounced
Date of inspection:	25 February 2026
Centre ID:	OSV-0004828
Fieldwork ID:	MON-0049751

About the designated centre

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

Goldfinch No 1 is a residential service providing full-time care for adults with intellectual disabilities. The centre comprises of three residences located in Limerick City environs. The houses are all located in residential areas with good access to public transport, local shops and amenities. All residents have their own bedrooms; there are adequate dining and kitchen facilities in each area. Each residence has a sitting room /reception area to receive visitors. Residents have access to transport and the service is provided through a social care model of support. All residents regularly attend either day services, employment or a vocational training centre outside of the designated centre. Residents are not usually present in the centre between 08:30 – 16:00hrs. However, the centre can also provide limited support in the centre, if required due to changing needs of a resident. Residents are supported by social care staff during the day, with sleep over staff at night time in each of the houses. Individuals are supported to access other services such as general practitioner (GP) and consultant services as required.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	8

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 25 February 2026	16:00hrs to 21:00hrs	Lisa Redmond	Lead
Thursday 26 February 2026	08:55hrs to 16:15hrs	Lisa Redmond	Lead

What residents told us and what inspectors observed

This was an unannounced inspection completed in the designated centre Goldfinch 1. This centre comprised of three houses, and it was registered to provide full-time residential services to a total of 10 adult residents. At the time of this inspection, eight residents lived in the centre. This inspection was completed over two days.

Overall, residents communicated their satisfaction with the services they were provided in their home. It was evident that residents were supported to access their local community, and that they were appropriately safeguarded in their home. However, areas such as risk management, premises and residents' rights did require improvements to meet the requirements of the regulations.

On the second day of this inspection, the inspector identified a high level risk relating to fire evacuation. This resulted in the registered provider being issued with an urgent action under Regulation 28, fire precautions. An urgent action is issued by the Chief Inspector of Social Services when a risk is identified which requires the registered provider to take urgent action to mitigate the risk it poses to residents living in the centre. It was evident from the response submitted by the registered provider after the inspection had taken place that actions had been taken to address the risk.

The inspector met with the eight residents who lived in Goldfinch 1. Each of the eight residents attended day services, employment or volunteer work each day. Therefore, the inspector met with residents on their return in the evening, or before they left in the morning during the two days the inspection took place.

Residents told the inspector they were supported to engage in their local community, and to develop and maintain friendships and relationships. A monthly social had been organised for the day after the inspection, with residents telling the inspector that they were looking forward to meeting their friends there for a drink and a dance. One resident pointed to the event on the calendar in the kitchen as they told the inspector about their excitement for this event. A second resident spoke about concerts they had attended, and plans for concerts they had sourced tickets for and were due to attend. The resident spoke with the inspector about their love of music, and also showed them their guitar which was in the sitting room of their home.

It was evident that residents were supported to raise issues about the care and support they received in their home. One resident excitedly told the inspector that they were going to receive a new vehicle in two weeks. Staff noted that the resident had been supported to make a complaint regarding the current vehicle with the registered provider agreeing to provide new transport to better meet the assessed

needs of the residents. It was also noted that an electric fire had been put in place in one home in response to a request for this made by the residents that lived there.

Throughout the inspection days, residents were observed to be relaxed and comfortable as they accessed the communal areas of their home, and their bedrooms. Residents in one of the houses sat together in the sitting room where they watched a football match, while another resident watched a rugby match on the television in their room. One resident told the inspector 'I am safe' and 'I am happy' when they spoke about what it was like to live in their home. One resident told the inspector that the staff were 'lovely'. Residents living in each of the houses knew each other, and spoke about their friendships. One resident told the inspector that the residents they lived with were 'my family', and that they were happy in their home.

Four residents living in one of the houses were supported by two staff members to go on a five day holiday to Spain in 2025. Photographs of the holiday were on display in the kitchen of their home. Residents and staff told the inspector that residents really enjoyed going on holidays, and spoke about residents enjoying the music and entertainment, swimming pool and cocktails.However it was acknowledged by staff on duty that the location was a comprise so that all residents could have a holiday. This practice required review to ensure that residents had choice and control in their daily life with respect to holidays.

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

Capacity and capability

This inspection of Goldfinch 1 found that overall, there was effective oversight of the designated centre, and the supports provided to the residents that lived there. It was evident that effective resources were provided to ensure residents were supported to engage in their local community, and to meet with friends and family.

The inspector met with the person in charge, the social care leader and six staff members providing direct supports to residents in the centre. It was evident that staff knew residents well and advocated on their behalf. For example, when residents were having dinner in one of the houses the staff members noted that a resident may be at risk if distracted by the inspector while eating. Therefore, the inspector left the area during dinner in line with the assessed needs of the resident. Residents were observed to be comfortable in the presence of staff at all times, with supports provided by staff members observed to be kind, respectful and inclusive. When one resident told staff their shoes were uncomfortable, they were supported to wear another pair with staff ensuring they were comfortable for the resident.

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

Regulation 23: Governance and management

Monitoring and oversight systems in Goldfinch 1 had not identified that the layout of one of the centre's houses impeded the ability of staff and emergency services to access a resident for the purposes of supporting them to evacuate in the event of an emergency. Management systems required improvements to ensure the service provided to residents was safe, and that they were consistently and effectively monitored.

The registered provider had ensured that an annual review of the quality of care and supports provided to residents had been carried out in 2025. Six monthly unannounced visits were carried out in addition to these. The six monthly unannounced visit completed in October 2025 noted that staff members had not received supervision in some time. The inspector reviewed the supervision records for four staff members and it was evident that they had been completed in December 2025 and January 2026 as a result of the findings of the audit.

A clear governance structure was in place, as outlined in the centre's statement of purpose. All staff reported to the centre's team leader and person in charge. There were plans that the centre's team leader would become the person in charge after the inspection had taken place. This proposed change would increase the managerial presence in the centre, with the current person in charge then returning to their senior management role.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

A statement of purpose had been developed by the registered provider. It was noted that this document contained the information set out in Schedule 1 of the regulations. For example, it outlined the specific care and support needs the designated centre intended to meet. It had also been uploaded to reflect the new name of the registered provider, Corlann.

Judgment: Compliant

Quality and safety

The wellbeing of residents living in Goldfinch 1 was maintained by a good standard of direct care and support by staff members. However, improvements were required to ensure the safety of residents with regards to risk management, residents' rights, premises and fire precautions.

It was evident that residents were effectively safeguarded from potential abuse. Overall, there was a low level of incidents occurring in Goldfinch 1. However, discussions regularly took place at residents' weekly house meetings about safeguarding and residents' privacy following alleged incidents of a safeguarding nature.

Clear plans of care were observed to be in place to ensure staff provided supports in line with their assessed needs. Residents were supported to develop and achieve goals in line with their likes, interests and wishes.

Regulation 13: General welfare and development

The person in charge had ensured that residents were supported to access opportunities for education, training and employment. One resident was had employment in a local gym, while another resident was volunteering in a local shop as they linked with a job coach in the hopes of seeking paid employment. One of the residents told the inspector that they were due to graduate from their college course soon.

Residents were supported to attend concerts, sporting events and hotel breaks for holidays. One resident had plans to celebrate a birthday in a local hotel and smiled as they told the inspector about their upcoming party. Residents were supported to travel independently to their social events and employment in line with their assessed needs.

Judgment: Compliant

Regulation 17: Premises

The registered provider had ensured that the premises of the designated centre was clean and suitably decorated. Each of the three homes in Goldfinch 1 were decorated in line with residents' personal likes and preferences. One of these houses was a new home that residents moved into since the previous inspection. Residents told the inspector that they liked their new house. Each resident also had their own private bedroom. Four residents showed the inspector their bedrooms. It was noted

that they were decorated in a manner chosen by each resident to include posters and music memorabilia in line with their interests.

The registered provider had not ensured that the designated centre adhered to best practice in promoting accessibility for each resident. One resident was identified as being at high risk of falls, following an assessment of risk. While a review of the internal areas of their home had been completed, a review of the external building had not been carried out. The back garden of the resident's home was not accessible to the resident for the following reasons;

- Steps were observed at the back door and to access the lawn and shed. It was noted in the resident's falls risk assessment that they did not access the upstairs of their home due to their risk of falls on the stairs.
- Trip hazards including uneven paving and damaged ground work was observed. It was also noted that a blocked drain had caused the area to become slippery, increasing the likelihood of a fall.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

Improvements were required to ensure that the registered provider had effective systems in place for the management and ongoing review of risk in the centre. During the walkaround of one of the centre's houses, the inspector observed chemicals used for cleaning were stored in the two bathrooms in this house. When asked by staff, it was noted that this should not be accessible to residents living in this house in line with the assessed needs of one resident who lived there, following a near miss incident that occurred in December 2025. These were removed immediately by staff on duty.

An unplanned evacuation of the designated had occurred due to a loss of heating in the centre. This impacted on one resident with the resident being supported in a local hotel for two nights while the boiler in their home was repaired. Staff noted that the resident enjoyed this unplanned night away to ensure the resident's safety at the time. This was in line with the emergency plan in place in the centre for emergency events.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The registered provider had not made adequate arrangements for evacuating, where necessary in the event of a fire, all persons in the designated centre and

bringing them to safe locations. It had not been identified by the registered provider that the layout of one of the centre's houses impeded the ability of staff and emergency services to access a resident for the purposes of supporting them to evacuate from their bedroom. This was evidenced as follows;

- The layout of the designated centre meant that the only route to access the resident in the event of a fire at night was through the kitchen. However, staff on duty told the inspector that should a fire occur in the kitchen, the resident could be accessed via an external pathway at the back of their home. It was identified that the entrance to this pathway was blocked by an approximately 6 foot high gate which was locked. Staff in the centre were not aware this gate impeded their ability to access the resident until it was identified by the inspector on the inspection day. Management and staff did not have access to open this gate on the inspection day.
- The assessed needs of the resident, including their risk assessments relating to fire evacuation and falls stated that they required staff support to evacuate their home. It was also noted that there was a risk assessment in place outlining that the resident may not evacuate on hearing the fire alarm without staff support.
- There was no evidence of a fire drill being completed in the previous 12 months where the resident had exited via the emergency exit by their bedroom without staff support to reflect.

As a result of these findings, the registered provider was issued an urgent action on the second day of the inspection. The urgent compliance plan response submitted by the registered provider did assure the Chief Inspector of Social Services that appropriate actions were taken to reduce the risk to the resident. This included plans to add a protected escape route so that staff members could safely evacuate the resident in the event of a fire at night. After the inspection had taken place, the provider sourced a number of fobs which meant that staff could access the resident if required by opening the electric gate.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

The inspector reviewed the personal files of three of the residents living in the designated centre. Each resident had been supported to have a comprehensive assessment of their health, personal and social care needs. Staff noted that the changing needs of one resident were under review by the multi-disciplinary team at the time of the inspection.

There were two resident vacancies in the designated centre. Management noted that a recent multi-disciplinary team meeting had agreed that these two vacancies

would not be filled due to the assessed needs of the current residents. As such, there were no plans for new residents to be admitted to this centre.

Judgment: Compliant

Regulation 7: Positive behavioural support

The person in charge had ensured that staff had up-to-date knowledge and skills to respond to behaviour that is challenging and to support residents to manage their behaviour. The inspector reviewed three of the positive behaviour support plans in place for residents living in Goldfinch 1. It was noted that these included guidance for staff to support residents and to respond to behaviour that is challenging. East-to-read information was also available to support residents to decrease the risks associated in line with their behaviour support plans and assessed needs.

Judgment: Compliant

Regulation 8: Protection

The registered provider had put measures in place to ensure residents were protected from all forms of abuse. There was evidence of investigations taking place following allegations of suspected abuse in line with the registered provider's policy on the safeguarding of residents. The inspector reviewed the documentation related to four allegations of suspected abuse of residents living in Goldfinch 1. It was evident that such allegations had been reviewed and notified in line with organisational policy.

There were no open safeguarding plans in the designated centre at the time of the inspection. Risk assessments to ensure residents were effectively safeguarded had been developed. There was also evidence of discussions taking place at residents' weekly house meetings about safeguarding, and residents' privacy following alleged incidents of a safeguarding nature.

Judgment: Compliant

Regulation 9: Residents' rights

Improvements were required to ensure that residents had the freedom to exercise choice and control in their daily lives, and that they were supported to consent with supports relating to their care and support.

- Two of the residents living in the designated centre did not have a bank account in their own name. It was noted that the multi-disciplinary team were reviewing this at the time of the inspection.
- A restrictive practice was put in place where one resident had restricted access to their cigarettes following medical advice some years previously. An easy-to-read document had been developed which noted the reasons why this practice was in place, and outlined that the resident would be supported to have cigarettes daily. It was documented that the resident could have more cigarettes should they request it, and staff on duty were aware of this. It was noted that this practice was reviewed on a regular basis by the multi-disciplinary team. However it was not evident that the resident consented to this restriction, or that they were consulted as part of the regular multi-disciplinary reviews of this restrictive practice.
- It was noted during a review of safeguarding documentation that an unplanned restrictive practice had been put in place where a resident could not access their local community independently over a weekend. Although the registered provider's policy on the use of restrictive practices did not provide guidance on the use of unplanned restrictive practices, it did state that restrictions that occur due to safeguarding planning should be written up as a restrictive practice as it 'changes the level of freedom previously enjoyed' by the resident. This had not been carried out at the time of the restrictive practice being put in place, however the restrictive practice had been discontinued following a screening of the alleged incident identifying that there were no reasonable grounds for concern. This required review.
- It was noted in one resident's behaviour support plan that they love holidays and that they will repeat phrases indicating that they want to go on their holiday. Staff spoken with noted that the resident had recently begun to repeat these phrases with staff providing reassurance that a holiday would be booked soon. However, it was noted that holidays and hotel breaks were reliant on the goodwill of staff, or the ability of management to save allocated funding hours for use during planned holidays. It was noted that management in the centre had completed this to ensure this resident, and the residents they lived with could go to Spain in 2025. However it was acknowledged by staff on duty that the location was a compromise so that all residents could have a holiday. This practice required review to ensure that residents had choice and control in their daily life with respect to holidays.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Quality and safety	
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Goldfinch 1 OSV-0004828

Inspection ID: MON-0049751

Date of inspection: 26/02/2026

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 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • Egress plans reviewed and update as required. • Fire upgrade works are being progressed in line with plan submitted to Inspector following the inspection. • Fire Safety Engineer was consulted based on feedback from HIQA inspector and recommendations from the fire safety engineer have been followed as an interim measure. • External works will be completed as set out in urgent plan submitted to HIQA. All works will be completed by 31st August 2026. • In the coming weeks the Team leader of the designated center will be appointed as the Person in Charge. • All staff supervisions are up to date and staff will continue to have quarterly support & supervision in line with policy. • The Services will continue to advocate for person in care accounts for people we support.	
Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: • Fire Safety Engineer carried out a Fire Evacuation and Egress report for the Designated Centre. Timebound action plan to address deficits agreed and agreed actions are currently being undertaken. These actions include: Installation of Fire Assembly point to rear of house (completed), replace window with door for emergency egress, update Peep & Egress Plan(completed), secured fob for back gate access (Completed). All work will be completed by 29th May 2026. • Facilities Manager visited Designed Center. Timebound action plan agreed to address the general landscaping and accessibility works and agreed actions are currently being	

undertaken. These actions include: Install level Access from back door, install accessible ramp, install hand rail (completed) & steps, install foot path to rear gate, lock on shed door (completed). All work will be completed by 28th August 2026.

• PAT Test completed, all items in order with no electrical concerns. Certificate on file'
• All drains are jetted.
• Grass cutting and weeding in back garden completed. Power washing completed.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:

• A risk assessment is in place regarding chemical safety. All cleaning products are locked away after use.
• A locked press is secured under the kitchen sink for all chemical cleaning products
• All staff have completed training on chemical safety in workforce
• An Easy read on chemical safety products is developed in all areas
• Safe and Eco friendly products will be purchased as much as possible for the use of cleaning supplies in each area.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:

• The Kitchen has a standard type electric cooker, fridge and other electrical household appliances. As per recommendation from Fire Safety Engineer, as an interim arrangement, PAT (Portable Appliance Test) Test has been completed on all kitchen appliances and all items are in order with no electrical concerns. Certificate on file
• The Kitchen is provided with a Heat Detector and the Living Room area is provided with a Smoke Detector (L1 standard). These systems are tested quarterly.
• Fire Drill completed following inspection as agreed. Fire drills will continue on a monthly basis until such time as agreed upgrades take place. This will include periodic drill at night when resident is in bed.
• Hand Rail is installed in the rear garden.
• Secured the fob that allows the opening of the rear gate.
• Risk assessment regarding Fire Evacuation in one residential house completed.
• Window will be changed to a door.
• External works to be completed to ensure safe egress from the house.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:

• The Corlann Limerick policy on the Handling of the Personal Assets of Adults Supported by the Services includes a permission form which supports people to
• No resident is restricted from managing their own personal assets if they choose to opt out of support from Corlann Limerick.

• Residents may choose to manage their personal assets independently, with a decision supporter or another person outside of the services should they choose to.
• In order to support people to make an informed decision information is provided to them regarding the nature of the support that Corlann Limerick can offer to them in terms of the management of their personal assets.
• At present Corlann Limerick have identified one suitable deposit account and one suitable current account through which support can be offered in a safe manner both for the person supported and for staff.
• The Corlann Policy on the Handling of the Personal Assets of Adults Supported by the Services clearly sets out the limitations on direct access to personal assets inherent in the use of this type of account in order to ensure full transparency when a person is choosing to opt in or opt out of support.
• Every effort is made to mitigate the impact of the restrictions on direct access to personal assets inherent in the use of this type of account and these are set out in the policy.
• Limitations on direct access to personal assets inherent in the use of this type of account as well as those in place to minimize the vulnerability to misappropriation of funds are not notified to the regulator as restrictions as each person support has the right to opt in or opt out of support.
• Corlann Limerick is committed to exploring all alternative accounts that may facilitate less restrictive direct access to personal assets for people supported who opt in to support from Corlann Limerick. In this regard the engagement with the assisted decision-making department with the HSE seeking guidance in assisting residents in relation to banking arrangements was commenced on 11/11/2024. Engagement with banking institutions has also been perused to identify possible suitable banking products that would be a less restrictive alternative for residents within the service.
• As the actions of Bank institutions in response to this demand for type of bank account are outside of the control of Corlann Limerick the date for compliance has been reflected as the 31st December 2026 to reflect this reality.
• Appendix 11 from the Corlann Policy on the Handling of the Personal Assets of the Adults Supported by the Services relates to supporting holidays for people supported.
• 2 residents in the designated centre that don't have a personal care account are happy with the current arrangements that are in place and support is offered by family members and staff arrangements.
• MDT took place for 2 residents on 25/2/2026 with support from Social worker who has spoken with family members to put other alternative arrangements in place for the future to ensure the resident will always have access to their finances. This is in the process currently.
• Every effort is made to facilitate a holiday for residents. However, this is limited to the roster of staff attached to each service location as there is no specific budget outside of the normal roster to provide holidays to residents.
• Where a resident has identified in their person-centred plan that they wish to go on a specific holiday this is identified as a goal for the individual. From time to time this goal can be achieved through planning and consultation. The holiday may be facilitated within the existing roster or through an element of volunteerism by staff or a family member.
• The ability to plan for a holiday is also limited to the extent of the individual assets of the person support.
• This matter has been raised by the National Advocacy Council with the National Leadership Team of Corlann Limerick. As a result, national guidelines are being

developed in relation to social outings and holidays.
• Two residents plan to go to Spain in September 2026 as part of their PCP and arrangement are in place.
• One other resident went to Killarney on 15/3/2026 and is going to Ennis on 11/4/2026 on overnight stay.
• All residents have plans to go away for an overnight stay in Ireland in which can be facilitated during the summer holidays or during weekend rosters.
• All Restrictive practices will be continued to be reviewed and monitored quarterly in line with our restrictive practice policy
• Any unplanned or temporary restrictive practice going forward will be completed and reviewed with MDT going forward in the designated centre in line with policy
• A consent form will be put in place in consultation with SLT to support residents understand and support will and preference around their cigarette restriction.

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 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 premises of the designated centre to ensure it is accessible to all.	Substantially Compliant	Yellow	31/08/2026
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate	Substantially Compliant	Yellow	31/08/2026

	to residents' needs, consistent and effectively monitored.			
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Substantially Compliant	Yellow	31/03/2026
Regulation 28(1)	The registered provider shall ensure that effective fire safety management systems are in place.	Not Compliant	Orange	31/03/2026
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.	Not Compliant	Red	31/03/2026
Regulation 09(2)(a)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability participates in and consents, with supports where necessary, to	Substantially Compliant	Yellow	31/12/2026

	decisions about his or her care and support.			
Regulation 09(2)(b)	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.	Not Compliant	Orange	31/12/2026