



# Report of an inspection of a Designated Centre for Disabilities (Adults).

## Issued by the Chief Inspector

Name of designated centre:	Desmond Community Residential Houses
Name of provider:	Corlann
Address of centre:	Limerick
Type of inspection:	Unannounced
Date of inspection:	18 February 2026
Centre ID:	OSV-0005179
Fieldwork ID:	MON-0044510

## About the designated centre

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

Desmond Community Residential Houses consists of detached two detached bungalows, one located within a town and the other located a short driving distance outside the same town. This designated centre can provide a residential service for a maximum of eight residents with intellectual disabilities, over the age of 18 and of both genders. Each resident in the centre has their own bedroom and other rooms throughout the two houses of the centre include bathrooms, kitchens, sitting rooms and staff rooms. Residents are supported by the person in charge, a social care leader, social care workers and health care assistants.

**The following information outlines some additional data on this centre.**

Number of residents on the date of inspection:	4
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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 18 February 2026	08:45hrs to 17:35hrs	Kerrie OHalloran	Lead

## What residents told us and what inspectors observed

This inspection was an unannounced inspection to monitor and review the arrangements the provider had in place to ensure compliance with the Care and Support of Residents in Designated Centres for Persons with Disabilities Regulations (2013). The centre had been last inspected in February 2024. This inspection had some positive findings, however improvements were required which will be discussed in the next two sections of the report.

From what the inspector observed, residents enjoyed a good quality of life and were well supported and cared for in this designated centre. There were four residents living in this centre at the time of this inspection. The inspector had the opportunity to meet with all four of the residents during the inspection.

The designated centre consisted of two detached bungalows, one located within a town and the other located a short driving distance outside the same town. This designated centre can provide a residential service for a maximum of eight residents.

The inspector spent the morning and afternoon in one of the centres houses. On arrival to this house, the inspector was greeted by a member of staff on duty and a resident. The inspector was welcomed into the house and signed into the centres visitor's book. There were two residents living in this centre at the time of the inspection. The inspector had the opportunity to spend some time with both residents and the staff member on duty before they went to their day service which was located in the town nearby. Both residents were ready for their day ahead. The resident led the inspector to the sitting room where the inspector discussed pictures of the resident with family and friends which were displayed. The resident appeared happy and content in their home.

The other resident living in the centre was in their bedroom, the staff informed the inspector the resident enjoyed to spend time here and the inspector was invited to meet the resident. The inspector greeted the resident and the resident indicated that they were happy to speak to the inspector. They then spoke to the inspector about a restaurant they like to visit and also confirmed that they were happy in their home.

Later in the evening the inspector returned to this house to review some documentation that had gone with the residents to their day service to ensure that they were consistently supported. The inspector briefly meet two staff member who were on duty and they appeared to know the residents well and were supporting the residents in a caring and respectful manner. The staff members on duty was very knowledgeable about the residents assessed needs and supports required. For

example, staff informed the inspector about the residents communication needs and the inspector also observed meals were prepared to the needs of the residents.

While the inspector was in this house they observed residents personal information was displayed on the notice board in the kitchen area. This included resident's full names and date of births. Each resident had completed a questionnaire from the provider in 2024, this document contained the resident's responses. Resident's timetables were also displayed with their names. This will be discussed under Regulation 9: residents' rights.

In the afternoon, the inspector visited the second house that is located in the town. On arrival, the two residents residing in this house were attending day service. Later in the evening they arrived back to their home and the inspector had the opportunity to meet both residents. One resident spoke to the inspector about their day and the day service they attend. The other resident greeted the inspector and relaxed in their chair. The inspector met two staff on duty in this house. They discussed with the inspector the assessed needs of the residents and activities the residents enjoy. One staff spoke with the inspector about the residents and their communications needs, along with activities they enjoy and their support needs. The staff was found to be very knowledgeable of the residents and their assessed needs.

When the inspector arrived to this house in the afternoon they observed an audio monitor was in place and turned on in the office/staff room. This is in place to support a residents assessed needs and the use of such is reported to the Office of the Chief Inspector as a restrictive practice as require by the regulations. However, this restrictive practice is only to be used at night time to support the resident as per their assessed needs. When the resident returned from their day service the inspector could hear the resident and the staff supporting the resident in their room. This required review to ensure the residents privacy was being upheld. This will be reviewed under Regulation 9: Residents Rights'.

Overall this inspection found that some improvement was required to come into compliance with the regulations reviewed under both Capacity and capability and Quality and Safety. Residents were seen to be happy and content in there homes, with provider audits also indicating that residents felt safe in their homes. However, some issues were identified to ensure reviews were taking place of the residents and designated centres documentation to ensure the quality and safety was the centre was being maintained along with supporting residents. The next two sections of the report present the findings of this inspection in relation to the overall management of the centre and how the arrangements in place impacted on the quality and safety of the service being delivered

## Capacity and capability

There was a clearly defined management structure in place, and lines of accountability were clear. The provider had oversight strategies in place to monitor the centre such as six monthly audits and annual reviews. However, during this inspection it was found that improvement was required to ensure the centres monitoring identified areas which required review to meet the regulations.

There was a competent staff team who were seen on the day of the inspection to have kind and caring interaction with the residents. Staff demonstrated good knowledge of the support needs of residents.

The provider had arrangements in place for the management of complaints. For example, there was an organisational complaints policy in place. However, review was required to ensure that complaint records were being fully documented. This will be discussed under Regulation 34: Complaints.

The inspector completed a review of the designated centres training matrix. For the most part the majority of staff had received training to support the needs of the residents. However some review was required to ensure all staff had completed training.

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 15: Staffing

A planned and actual staffing roster was maintained as required by the regulations. The inspector reviewed a sample of roster from January 2025 to the end of February 2026. There was a consistent staff team in place at the time of the inspection. Staff spoken to on the day were knowledgeable in the residents care and support needs.

The inspector spoke to five staff members. Some of these conversations were brief as the staff were supporting residents. The inspector found that they were knowledgeable about the support needs of residents and about their responsibilities in the care and support of residents. For example, they could describe the support required for residents during mealtimes and knew about the specific likes and dislikes of residents.

Judgment: Compliant

## Regulation 16: Training and staff development

Staff received training in a number areas to ensure the safety and to meet the assessed needs of the residents in the centre. The inspector reviewed the training matrix which identified all staff had received training in areas such as safeguarding and children first training. For the majority, where refresher training was required staff were booked to complete in the coming weeks and this was identified on the training matrix.

Some review was required to ensure all refresher training was up to date to support staff to support residents with their assessed needs and to support the safety of the residents. This included:

- One staff required refresher training in Manual handling.
- One staff required refresher training in Fire.
- One staff required refresher training in safe administration of medications.

Judgment: Substantially compliant

## Regulation 23: Governance and management

The provider had governance and management systems in place to oversee and monitor the quality and safety of the care of residents in the centre. There was a management structure in place, with staff members reporting to the person in charge. The person in charge was also supported in their role by the Area manager. However a review was required to ensure that the provider's auditing and oversight systems were identifying and responding to the areas that required improvement with compliance as identified in this inspection.

The inspector found that a number of the designated centres documentation required review and had surpassed an annual review or the identified review dates on the documents in place. This included documentation such as, residents risk assessments, the designated centres risk register, hard copy of the centres policies, some residents personal planning process, behaviour support plans and some complaints that had been logged in the centre. These were not highlighted in the designated centres audits and action plans which provide oversight of the service and guidance where actions need to be addressed.

The inspector reviewed the staff team meeting minutes that were available in the designated centre. It was seen that staff team meetings were not taking place on a consistent basis. For example, in 2023 five team meetings occurred, 2024 had one staff team had taken place and in 2025 three meetings had taken place in April, May and August. No meeting minutes were present that a meeting had occurred in 2026. The inspector observed that a schedule of monthly team meetings was planned for 2026 and this was displayed in the office of one of the houses. The inspector identified this to the area manager after the inspection and it was confirmed that

staff team meetings should be completed on a regular monthly/ bi-monthly basis to ensure support and continuity for the staff team in the designated centre.

An annual review of the quality of care and support provided to residents had been completed for 2025. The annual review had sought input from residents and resident's family. This feedback was positive with families and residents expressing high levels of satisfaction with the service. The designated centre had an action tracker in place. This monitored all actions identified by the provider from the centres unannounced six monthly audits and annual review. This had been last updated with actions in August 2025 after the six monthly review. The tracker outlined status of actions and progress with actions. However, as mentioned, on this inspection a number of regulation areas required review to ensure the designated centre and residents documents were being reviewed on a regular basis that ensured up-to-date information was in place. The internal audits being completed had not identified compliance issues found in this inspection.

The audits mentioned above also did not identify that the providers own procedures were being followed at all times. For example, as discussed under Regulation 34: Complaints, the providers documentation was not fully completed from complaints made in 2024, this was referenced in the providers internal audit that took place in August 2025 to ensure resolution is recorded. However on the day of the inspection this had not been completed and no action was recorded on the centres action tracker for Regulation 24: Complaints. These systematic failures identified demonstrated that the governance and management systems require significant improvement to ensure consistent oversight.

Judgment: Not compliant

### Regulation 3: Statement of purpose

The provider had prepared a statement of purpose and function for the designated centre. This is an important governance document that details the care and support in place and the services to be provided to the residents in the centre. For the most part this included all the required information and adequately described the service.

Some review to this document was required to ensure the current person in charge was reflected in the management and staffing of the designated centre and under the management and governance information for the centre. The current person in charge has been in place since June 2025.

Judgment: Substantially compliant

### Regulation 31: Notification of incidents

Documentation in relation to notifications which the provider must submit to the Chief Inspector under the Regulation was reviewed during the inspection. Such notifications are important in order to provide information around the running of a designated centre and matters which could impact the residents. All notifications had been submitted as required. For example, the provider had notified the Chief Inspector of any use of a restrictive practice within the centre on a quarterly basis.

Judgment: Compliant

### Regulation 34: Complaints procedure

The provider had arrangements in place for the management of complaints. There was a designated complaints officer nominated and information on the complaints procedure was displayed. Residents also had access to an easy-to-read complaints procedure.

The inspector reviewed the complaint logs for the designated centre. Each house had a complaints log present. The designated centre had a total of five complaints logged for 2024 and 2025. For one house there was evidence that complaints received were recorded in a timely manner, with follow up also record to ensure the complainant was satisfied with the outcome of the complaint. However some improvement was required. The complaint log for the other house had three complaints recorded for 2024. These complaints reviewed were not fully documented. For example, the three complaints were recorded in June and October 2024 did not recorded if the complaint had been resolved or if the complaint was satisfied with the outcome of the complaint they had made. This was discussed with the area manager during feedback and it was confirm that these complaints were closed.

Judgment: Substantially compliant

### Regulation 4: Written policies and procedures

The inspector reviewed the hard copy of Schedule 5 policies in place in one of the houses that comprises of the designated centre. However, fourteen of these policies had exceeded the three year review period by the provider. These included:

- Incident where a resident goes missing, due for review May 2023
- Admissions, discharge and absence of residents, due for review April 2024
- Provision of intimate care, due for review December 2023

- Provision of behaviour support, due for review May 2022
- The use of restrictive procedures and physical, chemical and environmental restraint, due for review May 2024
- Residents' personal property, personal finances and possessions, due for review April 2025
- Communication with residents, due for review January 2025
- Visitors policy, due for review May 2025
- Recruitment, selection and garda vetting of staff, due for review November 2021 and December 2024
- Staff training and development, due for review November 2023
- Health and safety, including food safety, of residents, staff and visitors, due for review May 2023
- Risk management and emergency planning, due for review July 2025
- Access to education, training and development, due for review September 2024
- Closed circuit television (CCTV) in designated centres, due for review July 2025

During feedback the following day, the Area manager identified that policies were available on an online system for staff to access, however on the day of the inspection when the inspector requested the policies a staff member showed the inspector the hard copy of the policies in the centres policy folder and an online system was not mentioned at this time. This required review to ensure all staff are aware of policies maintained on an online system.

The provider's National policy on Safeguarding was displayed on the notice board in the kitchen area of one of the houses and this was dated May 2020 with the next review identified to take place in three years. The visitors policy was also displayed here which had been due for review in May 2025. The complaint policy was displayed here also and was in date.

Judgment: Not compliant

## Quality and safety

This inspection found that some improvement was required to ensure residents rights' were promoted and that all aspects of the care delivered to residents was

reviewed and maintained on a regular basis. However the inspector did note some positive aspect to support residents rights were also in place. Such as, residents were also supported with weekly residents meetings. The inspector reviewed a sample of these meetings from January to February 2026. These meeting discussed residents goals, health and safety, fire drills and a policy was reviewed, for example, safeguarding was reviewed in a February meetings. Residents also had easy to read consents in place in their personal plans for taking photographs.

The provider had an advocacy process in the organisation and staff were also aware of the external advocacy process that was available to residents. Information for this was displayed in the centre. The inspector seen that each house had easy read documentation for residents in place.

Residents were supported to exercise choice and control in their daily lives. Residents choose the daily activities they would like to complete, if a resident requested not to complete an activity this was respected. The staff on duty discussed that each resident had different likes, interests and preferences with social activities and the staff in the centre supported residents with this. Residents informed or indicated to the inspector they were happy living in the centre.

The centre had measures in place to identify risks and controls measures also in place to mitigate from these risks. However, on review of the designated centres risk register and residents' individual risks these were not regularly reviewed.

Where some residents' required behavioural support, the provider had ensured these residents received this support with input from a behavioural support therapist and behaviour support plans were in place. However, from the inspectors review of the behaviour support plans in place it was clear that these were not always reviewed as required.

The residents had various communication needs. The communication plans reviewed by the inspector were seen to be clear and person centred to each resident and their assessed needs. Staff were familiar and knowledgeable of residents communications needs.

## Regulation 10: Communication

From observations made in the morning and later in the afternoon on the day of the inspection, staff members were familiar with the ways in which residents communicate. The inspector had the opportunity to speak to the staff members on duty and they discussed how they support the residents with their communication needs. For example, one staff member informed the inspector that a gesture one resident made was a positive signal and a staff in another house spoke to the inspector about a picture board and timetable they have in place to support a resident.

Residents each had communication support plans in place. These plans also went daily with the residents to their day services to ensure continuity of support for residents. These plans were seen to be detailed with information about residents likes, dislikes and supports required. There was also a communication dictionary in place for residents which included information around specific meanings around resident's communication and how staff should respond to support the resident's. This provided a very clear guide for staff which was very person centred for each resident.

It was clear that communication with residents was facilitated by consistent and familiar staff team and that supporting documentation was in place to support staff and residents. The documentation in place also provided a support for any new staff to the centre.

Judgment: Compliant

### Regulation 13: General welfare and development

Residents had access to a range of opportunities, to attend day services and complete recreation and leisure activities that they enjoyed.

The provider had ensured that residents had the opportunity to engage in meaningful activities. Staffing and transport arrangements were in place to support this. One resident told the inspector about a restaurant they liked to visit. The staff spoke about how having two staff on in the evenings and weekends supported the residents living in the houses to complete different activities of their choice. This was very important in both houses that comprised of the designated centre. Residents enjoyed accessing their local community by going to shops, visiting churches, cafes and restaurants. Some residents also enjoyed going to walks and swimming.

Judgment: Compliant

### Regulation 17: Premises

The premises was clean and homely and meet the assessed needs of the residents living there. The property consisted of a two detached bungalows with outdoor/garden areas also available to residents. Residents has access to laundry facilities. Each resident in both houses had their own bedroom which was decorated with the residents personal items and preferences. Residents had access to communal areas in both houses which includes a kitchen, dining and living/sitting room area.

During the walk around of one of the houses, one bedroom which was currently vacant required painting. While during a walk around of the other house the inspector observed two of the vacant bedrooms being used for storage. One was locked with a sign on the door identifying it for storage and the second bedroom was being used fully for storage. This required review to ensure sufficient storage was in place in the centre.

Judgment: Substantially compliant

### Regulation 26: Risk management procedures

The provider had systems in place and processes in place for risk management. The centre had a risk register for the designated centre in place, the inspector reviewed the risk folder in place in both of the houses. From this it was seen that the majority of these risks had not been reviewed recently. Resident's had individual risk assessments in place, where risks to their well being and safety were identified, assessed and had control measures in place to migrate from the risk. However, also on review, these risks these had not been reviewed regularly as identified on the risk assessments.

Examples include:

- A medication risk assessment identified it was due for review in May 2024, a risk for the tumble dryer was due for review in March 2024, risk of aggression was due for review in September 2024.
- Two resident's individual risks assessments were reviewed and these risks had not been regularly reviewed. A total of sixteen risk assessments had identified dates in 2024 and 2025 that they were due for next review. For example, a risk assessment for epilepsy in place was due for review in May 2024 and a service user experience risk was due for review in February 2025. These risks had also exceeded a year since there last review.

Judgment: Not compliant

### Regulation 28: Fire precautions

The provider had fire safety precautions in place. This included fire detection and containment arrangements and emergency lighting was in place. These were all regularly serviced by a competent person. For example, The emergency lighting had been serviced in February 2026. Staff were also ensuring to carry out regular fire safety check, this included that exits were clear. This inspector reviewed a sample of these checks from November 2025 to February 2026 in both houses and these were

being completed as required. The designated centre was also completing fire drills, with records of these drills being maintained to ensure that staff could support residents to evacuate the residents in a timely manner.

Residents had personal emergency evacuation plans in place. The inspector reviewed the records for all four residents living in the designated centre. Some of these plans required review to ensure they were being reviewed on an annual basis or sooner if required. For example, in one house, one resident's personal emergency evacuation plan had not been reviewed since June 2022, while the other resident living in the centres plan had been reviewed in October 2025. In the other house that comprises of the designated centre one of the residents plans had last been reviewed in March 2023.

Judgment: Substantially compliant

### Regulation 5: Individual assessment and personal plan

There were assessments in place for residents in the centre. These assessments were then used to develop personal plans for each resident which considered each resident's health, personal and social care needs. There was information available on residents' likes and dislikes. Records of medical and multidisciplinary supports were well maintained. For example, residents were supported with regular dental, general practitioner appointments and where required were registered for national screening programmes.

The inspector reviewed documentation for resident goals they had in place. This required review as some residents had completed person centred planning meetings, while other residents were overdue their meetings. For example, One resident in one house had completed their person centred planning meeting in May 2025 and had goals in place for 2025 to 2026. From this personal plan reviewed it was seen that the residents goals were personalised and being progressed during the year. This included one goal of putting a bird feeder/house in place and this was seen by the inspector on the day. However, another residents last person centre planning meeting had taken place in November 2024, therefore they did not have an annual review and no updated documentation was in place to support the resident with goals they would like to be supported with.

Judgment: Substantially compliant

### Regulation 7: Positive behavioural support

The provider had ensured residents had access to behavioural support and residents who required assistance in this area of care had behavioural support plans in place.

The inspector reviewed two of the behaviour support plans in place for residents. These were found to identify clear triggers for residents, pro-active and reactive strategies for residents, along with post intervention support. The staff were found to be knowledgeable on the residents support plans and while speaking to the inspector identified triggers for residents and how they recognise an escalation in behaviour for a resident. Staff also identified to the inspector that these plans go with the resident to their day service in order to ensure and support continuity of care and support for the residents assessed behavioural needs. However, some review was required to ensure behavioural support plans were reviewed as identified by the provider or as part of the residents personal planning process. For example, one residents behaviour support plan was dated September 2023 and had identified on the plan to be reviewed every 18 months or sooner if required. There was no evidence that this had been reviewed on the day of the inspection. Another plan reviewed by the inspector was dated March 2024, this plan highlighted it was reviewed annually at the residents multi-disciplinary meeting. The resident had a multi-disciplinary meeting in February 2026.

The centre had restrictive practices in place. The inspector reviewed the restrictive practices in place for the residents in one of the houses of the designated centre. The documentation in place in the resident's personal plans reflected the restrictions in place that are notified to the Office of the Chief inspector on a quarterly basis. However, the documentation reviewed by the inspector had not been reviewed on a regular basis. For example, a residents key fob in place, use of audio monitor at night and locked kitchen cupboard review had taken place in January 2025, with the providers restrictive practice document identifying the next review to take place in April 2025 (three monthly reviews). No documented evidence was in place on the day of the inspection to provide assurances that these reviews had taken place.

Judgment: Substantially compliant

## Regulation 9: Residents' rights

The provider had systems in place to support residents' human rights, however some review was required to ensure residents privacy was upheld. On arrival to the first house of the designated centre the inspector seen a notice board with information for residents displayed. On review of this notice board the inspector observed that this contained personal information for each resident. For example, residents full names and dates of birth displayed, activity planners with the residents full names or initials, both residents providers questionnaires that they had completed for 2024 were also present, along with some out of date policies which included the National policy for safeguarding dated 2020. This required review to ensure the resident autonomy.

When the inspector arrived at the other house in the afternoon, an audio monitor located in the staff room/office was turned on. This monitor was recorded as a restrictive practice and also notified as required to the Office of the Chief Inspector

on a quarterly basis as a night time only use audio monitor to support a resident as per their assessed needs. This required review to ensure its use was reflective of the restrictive practice in place and did not impact of the resident's privacy and dignity.

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
<b>Capacity and capability</b>	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Substantially compliant
Regulation 4: Written policies and procedures	Not compliant
<b>Quality and safety</b>	
Regulation 10: Communication	Compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 9: Residents' rights	Not compliant

# Compliance Plan for Desmond Community Residential Houses OSV-0005179

Inspection ID: MON-0044510

Date of inspection: 18/02/2026

## 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 16: Training and staff development	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 16: Training and staff development:</p> <p>Training matrix has been reviewed and all staff reminded by work email to attend training that they are booked on.</p> <ul style="list-style-type: none"> <li>• Continue to monitor the training matrix on a monthly basis and discuss the importance of attending training at staff meetings.</li> <li>• If attendance is poor at staff meeting, ensure all staff read the staff meeting minutes.</li> </ul>	
Regulation 23: Governance and management	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 23: Governance and management:</p> <ul style="list-style-type: none"> <li>• Head of Community Services scheduled meeting with Area Manager &amp; PIC for 30/03/2026 to review report received and review the learning from this report to ensure no recurrence of the deficits identified.</li> <li>• Head of Community will meet with Team on a monthly basis for next 3 months to ensure actions are completed/</li> <li>• Head of Community will visit both houses in the Designated centre to evidence compliance.</li> <li>• Meeting of Governance team to take place in June to review status of all actions in 6 months unannounced report and HIQA action plan.</li> <li>• Staff meeting held on 26/02/2026, and the minutes are printed and filed in the centre.</li> <li>• Monthly meetings have been planned until the end of the year.</li> <li>• Hardcopies of policies have been removed from the centre with access available to up to date policies online.</li> </ul>	

- As appropriate easy read policies are available for house meetings.
- Red Level risk assessments for 2 individuals are reviewed at the escalated risk clinic every 6-8 weeks and are stored on the shared drive. These risks relate primarily to staffing & meeting the assessed needs of the two individuals concerned.
- All risk registers are up to date and in place and copies can also be found on the share drive.
- Importance of documenting follow up on local complaints as they are resolved was discussed at recent staff meeting and will continue to be on the agenda.
- The last internal audit was completed on 26/02/2026. Feedback from the HIQA inspection will be shared with QET department.

Regulation 3: Statement of purpose	Substantially Compliant
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Outline how you are going to come into compliance with Regulation 3: Statement of purpose:

- The statement of purpose has been updated to reflect the change of person in charge and the service name change.

Regulation 34: Complaints procedure	Substantially Compliant
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Outline how you are going to come into compliance with Regulation 34: Complaints procedure:

- One complaint recorded had been resolved by putting a shift planner in place and ensuring that residents received the time to complete activities that they preferred this has been recorded and updated in the complaints book.
- Importance of documenting follow up on local complaints as they are resolved was discussed at recent staff meeting and will continue to be on the agenda.

Regulation 4: Written policies and procedures	Not Compliant
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Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:

- Hardcopy of policies have been removed and all staff reminded to access the online system for policies. A laminated poster is on display in the office directing staff on how to find the policies and procedures on line.
- A laminated poster is on display in the office directing staff on how to find the policies and procedures on line.

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

- Room identified in one house will be painted
- Appropriate storage areas will be identified in one house

Regulation 26: Risk management procedures	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 26: Risk management procedures:</p> <ul style="list-style-type: none"> <li>• Medication risk last review 02/02/2026 and due again on 02/05/2026. While this was noted on the Shared Drive, the hard copy risk register was not updated to reflect the updates on the Shared Drive.</li> <li>• Tumble dryer risk last review 22/12/2025 and again on 22/03/2026. While this was noted on the Shared Drive, the hard copy risk register was not updated to reflect the updates on the Shared Drive.</li> <li>• All risk assessments are on a shared drive. An up to date hard copy of general risks are now in place in both houses in a red general risks folder.</li> </ul>	
Regulation 28: Fire precautions	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 28: Fire precautions:</p> <ul style="list-style-type: none"> <li>• Residents personal emergency evacuation plans (PEEPs) were all reviewed following inspection.</li> <li>• Staff advised to continue to report any issues or concerns with evacuations so that PEEPS can be updated.</li> <li>• PEEPs will be annually reviewed going forward.</li> </ul>	
Regulation 5: Individual assessment and personal plan	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:</p> <ul style="list-style-type: none"> <li>• All person centred plans are now up to date and in each person's file.</li> </ul>	
Regulation 7: Positive behavioural support	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:</p> <ul style="list-style-type: none"> <li>• Two residents had positive behaviour support plans updated in December 2025, these are now on file.</li> <li>• One positive behaviour support plan was updated in June 2025 and is on file.</li> <li>• One positive behaviour support plan is currently being updated with first draft sent on</li> </ul>	

17/03/2026. All staff are now invited to respond with any possible changes or updates and a final draft to be completed 30/03/2026.

Regulation 9: Residents' rights

Not Compliant

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

- All personal information has been removed from notice boards. This was discussed with staff to ensure they understood why this is inappropriate.
- All hardcopy of policies have been removed. A laminated poster is on display in the office directing staff on how to find the policies and procedures on line.
- The staff have been informed that the audio monitor is only to be activated when the resident is going to bed. This will then be reviewed in conjunction with MDT and if required, risk assessment and restrictive practice will be updated.

## 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 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	13/03/2026
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Substantially Compliant	Yellow	20/05/2026
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	13/03/2026

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.	Not Compliant	Orange	13/03/2026
Regulation 28(4)(a)	The registered provider shall make arrangements for staff to receive suitable training in fire prevention, emergency procedures, building layout and escape routes, location of fire alarm call points and first aid fire fighting equipment, fire control techniques and arrangements for the evacuation of residents.	Substantially Compliant	Yellow	13/03/2026
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose containing the information set out in Schedule 1.	Substantially Compliant	Yellow	13/03/2026
Regulation 34(2)(f)	The registered provider shall ensure that the nominated person maintains a record of all complaints including details of any investigation	Substantially Compliant	Yellow	13/03/2026

	into a complaint, outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.			
Regulation 04(3)	The registered provider shall review the policies and procedures referred to in paragraph (1) as often as the chief inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.	Not Compliant	Orange	13/03/2026
Regulation 05(6)(c)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall assess the effectiveness of the plan.	Substantially Compliant	Yellow	13/03/2026
Regulation 07(3)	The registered provider shall ensure that where required, therapeutic interventions are implemented with the informed consent of each resident, or his or	Substantially Compliant	Yellow	30/03/2026

	her representative, and are reviewed as part of the personal planning process.			
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.	Substantially Compliant	Yellow	13/03/2026
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 living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.	Not Compliant	Orange	31/05/2026