Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	Cork City North 18
Name of provider:	Horizons
Address of centre:	Cork
Type of inspection:	Unannounced
Date of inspection:	19 January 2026
Centre ID:	OSV-0005628
Fieldwork ID:	MON-0048458

About the designated centre

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

A full-time residential service is provided for adults with an intellectual disability in this designated centre. The centre comprises two bungalows located on a campus in an inner city suburb of a large city. There are two other designated centres comprising five houses and a day service also located on the campus. A maximum of 16 people can live in the centre. Seven residents are accommodated in one bungalow, and nine in the other. Both bungalows are purpose built including accessible bathroom / shower facilities for residents who use mobility aids. The communal spaces in each house includes a large sitting room, a spacious sun room, a separate dining room and a kitchen. The staff team is nursing led and comprised of nursing staff and care assistants.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	16

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
Monday 19 January 2026	10:15hrs to 19:10hrs	Deirdre Duggan	Lead
Tuesday 20 January 2026	12:15hrs to 17:15hrs	Deirdre Duggan	Lead

What residents told us and what inspectors observed

From what the inspector observed, residents in this centre were offered an overall safe service that took into account their individual needs and preferences. Some issues were identified in relation to residents' rights, staff training and how unfamiliar staff would be informed about safeguarding plans and communication needs of residents.

This centre comprises two large bungalows with the same layout located on a campus operated by the provider in a large city. Overall, this premises offered appropriate space and facilities to residents. Nine residents lived in one house and seven in the other. Each resident has their own bedroom and there were ample toilet, bath and shower facilities to cater for residents. Communal areas were seen to be appropriately furnished at the time of this inspection. Radios, music players and televisions were available to residents in communal areas and in their bedrooms if desired. Comfortable seating including some new furniture was observed in some communal areas and residents were observed relaxing in bright and warm sitting room and conservatory areas. Where resident numbers were less in one bungalow a sensory room had been made available to residents.

Overall, the inspector saw that efforts had been made to make both premises a homely environment for the residents, and the environment and layout of the premises was suited to residents' assessed needs. Residents' bedrooms were personalised according to their own tastes and preferences. Residents were observed to use the communal areas and dining facilities and were seen to be comfortable to move freely about their home.

Information about safeguarding and complaints procedures were displayed in prominent areas in both houses. Activity timetables for the activation service on campus were displayed in communal areas and the activities on offer included chair yoga, music, art, mindfulness and outings to social events, cinema and walks etc. Pictorial menus and numerous photographs of residents were on display, along with religious memorabilia relevant to the preferences of residents and items to remember residents that had passed away.

The centre accommodates sixteen adult residents and was fully occupied at the time of this inspection. The inspector had an opportunity to meet with or observe fifteen of the residents present in the centre during the inspection and spent a good portion of the inspection in communal areas reviewing documentation and speaking with residents and staff. Some residents consented to speak with the inspector in more detail. Overall residents presented as very content in their homes and with the staff that supported them. Residents spoken with confirmed that they felt safe in the centre and liked the staff that worked with them. One resident indicated that at times other residents might "annoy" them but overall liked the other people they shared a home with. One resident who had recently moved into the centre returned

to the centre following a weekend visiting family members and told the inspector about their trip and travelling independently on the train and how they had been supported by staff with this. They told the inspector "I love this house" and that they were "going to stay here".

All residents were seen to be well presented during this unannounced inspection and staff were seen to be caring and very responsive to residents during the time spent in both houses of the centre. There were indications that this was an accurate representation of the centre. For example, a resident also told the inspector that staff would come if he called them at night.

Residents had the opportunity to attend a day service building on the campus if they wished but also could stay at home if they preferred. A resident told the inspector that they liked to stay at home "in peace and quiet". Staff were observed to regularly check in and interact with this resident. Staff were also seen to assist residents with hand hygiene prior to mealtimes, offer choices in relation to drinks, snacks and meals and spend time with residents. Some residents enjoyed foot spa's and hand massages while the inspector was visiting, others spent time chatting with staff and having coffee or preferred refreshments. Residents who required specific supports for eating and drinking were seen to be provided with this in a respectful and dignified manner and there was a practice of "protected mealtimes" in place.

Residents spoken with also told the inspector that they felt safe in their home and a sample of seven family and nine resident surveys were viewed that indicated residents felt safe in their home and were well supported there. These were not dated but the person in charge told the inspector that they had been returned to the provider in the previous month.

Aside from the person in charge, the inspector spoke in detail with five staff members and met with other staff members for brief periods during this two day inspection. The inspector also met with other members of management who made themselves available. Staff reported that they felt residents were safe and well cared for in the centre and that the provider was responsive to any issues or concerns raised.

Overall, the findings on this inspection indicated that residents were afforded a safe service and had a good quality of life in this centre and there was good compliance with the regulations. 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

The findings of this inspection showed that the management systems in place in this centre were ensuring that good quality services, safe and effective services were being provided to residents. This inspection found good compliance with the regulations. Some issues were identified in relation to how some staff were provided with information required to ensure residents were fully protected.

This was an unannounced adult safeguarding inspection. The previous inspection of this centre took place in March 2024. Documentation reviewed during the inspection included resident information, safeguarding documentation, the annual review, the report of the unannounced six-monthly provider visit, training records, rosters and incident reports. There was evidence that the provider was identifying issues and taking action in response to them and that ongoing consideration was being given to safeguarding residents in this centre.

The provider had policies and procedures in place that covered areas including complaints, fire safety, behaviour support, residents' finances, recruitment and Garda Vetting of staff, risk management and protecting residents' human rights when considering the use of a rights restriction/restrictive practice.

There was a clear governance structure in place that set out the lines of accountability within the service. The person in charge reported to a regional manager, who was a named person participating in the management of the centre (PPIM). The regional manager reported to a Chief Operations Officer. They in turn reported to a Chief Executive (CE) and a Board of Directors. Some individual roles were changing at the time of the inspection and a new regional manager/PPIM was incoming. The inspector had an opportunity to meet with both the outgoing and incoming PPIM during the inspection. There was evidence that the local management of this centre were maintaining good oversight and maintained a strong presence in the centre.

The person in charge had remit over two designated centres at the time of this inspection. They told the inspector about the arrangements the provider had in place to support them in their role. The person in charge was present on the day of the inspection and was seen to be very familiar with the assessed needs of residents and knowledgeable about care and support residents required in the centre. The staff team present for the duration of the inspection were core staff for this centre and were familiar with residents' needs and preferences. Staff reported that they were well supported by the management structures in the centre. The training needs of staff were being appropriately considered and all staff had completed training in the area of safeguarding.

In summary, this inspection found that there was evidence of good compliance with the regulations in this centre and the findings of this inspection indicated that residents were being afforded overall safe and person centred services. 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

The inspector reviewed a sample of eight weeks planned and actual rosters and saw that overall staffing levels were sufficient to provide for safe services to be provided to residents. Additional unfunded staffing had been put in place by the provider to ensure that residents' needs could be met and the inspector was told about a business case that had been submitted as part of ongoing efforts by the provider to improve staff allocations in the centre in line with the changing needs of residents. Usually four to six staff provided supports to residents in both houses by day. At night a waking staff in each house was available to residents. Additionally, due to this centre being located on a campus staff from other houses were available to call in the event of an emergency. Activation staff were also available to residents on weekdays and residents had access to and attended on site day services if they wished.

A review of rosters indicated that staff supports were maintained at least at minimum levels set out in the statement of purpose for this centre. The inspector noted that in one house up to nine residents could at times be supported by two staff during periods of minimum staffing and this had the potential to limit the opportunities to residents to take part in activity of their choosing at weekends in particular. However, activation staff were employed on weekdays and some residents went home at weekends. The inspector was told that additional staff supports from other designated centres on this campus were available if required.

The person in charge reported a generally low turnover among the staff team and on the date of this unannounced inspection the inspector met a number of staff who had worked in the centre for a number of years, as well as some staff who had joined the team in the previous year. There were some vacancies reported by the person in charge at the time of this inspection with 8 in total reported across this designated centre and one other designated centre under the remit of this person in charge. Both of these centres shared staffing resources to some extent. Some agency staff were used in the centre and the person in charge told the inspector how efforts were made to ensure that familiar staff worked with residents alongside agency staff and efforts were made to employ regular agency staff if possible. For example, one vacancy on a night shift was filled by a regular agency staff.

Judgment: Compliant

Regulation 16: Training and staff development

The person in charge had, for the most part, ensured that staff had access to appropriate training, as part of a continuous professional development programme. Staff were being provided with training appropriate to their roles and the person in charge was maintaining oversight of the training needs of staff. Some staff training

was overdue to be completed, including some refresher training. A local safeguarding procedure provided to the inspector also outlined that on-site safeguarding training was planned for later in the month that was designed to provide a more in-depth understanding in this area to staff.

The National Standards for Adult Safeguarding were not available to staff in the centre at the time of this inspection but when raised with the person in charge they committed to ensuring that staff were made aware of these and where to access them and some information in relation to these were viewed on the second day of the inspection.

A training matrix for 26 regular and relief staff named on the centre roster was reviewed by the inspector. The matrix viewed indicated that staff had access to training in keys areas to provide for safe care and support for residents and included training in safeguarding, manual handling, fire safety, positive behaviour support and hand hygiene. Staff were also seen to have access to refresher training. The matrix indicated that most mandatory training was up-to-date but some was not.

- Some staff were due training or refresher training in some areas. For example, one staff did not have up-to-date fire safety and seven staff did not have up-to date manual handling training. However, for some of these staff, this training was out-of-date for less than a month.
- A number of staff did not have up-to-date hand hygiene training completed.
- A number of residents in this centre required very specific supports with feeding, eating and drinking to minimize the risk of aspiration and choking. However, training records provided indicated that not all staff had received training in this area.

Judgment: Substantially compliant

Regulation 23: Governance and management

Management systems were in place to ensure that the service provided was appropriate to residents' needs and for the most part the service's approach to safeguarding was consistent and effectively monitored. Some issues in relation to how staff were informed of safeguarding issues in the centre are covered under Regulation 8.

This inspection found that the provider was ensuring that overall this designated centre was adequately resourced to provide for the effective delivery of care and support in accordance with the statement of purpose. For example, the premises was equipped to cater for residents in a manner that promoted privacy and dignity. Resident records reviewed indicated that residents living in the centre had access to good multidisciplinary supports. The premises was seen to be safe and suitable for the type of supports provided to residents and was overall well maintained. Although the minimum staffing levels provided for in the centre were low

considering the number and needs of residents, the provider had addressed this by providing additional unfunded staff to ensure that residents quality of life was not impacted. Staff members spoken to in the centre reported that the person in charge was very supportive to the staff team and that they would be comfortable to raise any concerns to any of the management team.

There was a clear governance structure in place that set out the lines of accountability within the service. The provider had appointed a designated officer to promote and manage safeguarding within the service. The inspector reviewed the safeguarding documentation in place in respect previous concerns in the centre and saw that any safeguarding concerns raised had been notified to the office of the Chief Inspector and were also reported to the Health Service Executive (HSE) Safeguarding and Protection team. The person in charge informed the inspector about the system for ensuring that this information was correctly notified and tracked. Regular governance meetings specific to safeguarding were attended by the centre management and records reviewed showed that pertinent issues were considered by the centre management, including safeguarding, resident compatibility and the changing needs of residents.

Safeguarding and risk management was seen to be considered as part of the auditing and review structures in the centre and an annual review and report on an unannounced six monthly visit completed in September 2025 were reviewed along with audit records. The annual review was limited in detail and did not include details of how residents and their family members had been consulted with but did include an action relating to this and this was seen to have been completed. Regular audits of safeguarding, complaints and accident and incident audits were being completed.

Judgment: Compliant

Quality and safety

Overall, safe and good quality supports were being provided to the sixteen residents that availed of residential services in this centre. The wellbeing and welfare of residents in this centre was maintained by a good standard of care and support, provided by a consistent and committed core staff team. Overall, there was evidence of good compliance with the regulations. However, some issues were identified in relation to how a resident consented and participated in their own care and supports. While some further issues were identified in positive behaviour support and protection these mainly related to documentation deficits that could impact staff awareness of specific issues and at the time of this inspection did not appear to be impacting residents significantly.

Residents were benefiting from a premises that provided a good standard of accommodation and continued to meet their assessed needs in relation to their

environment. Some residents told the inspector that they participated in some community based activity of their own choosing. Issues related to safeguarding and safety were discussed with residents and individualised personal plans and positive behaviour support plans were in place that generally provided clear guidance to staff about how to support residents in a manner that promoted their safety and wellbeing. However, some issues relating to some of the documentation in place and how staff were being informed about safeguarding plans and some residents' specific needs are discussed further in the report.

The inspector saw that residents were comfortable, content and happy in their home. There were no open complaints in the centre at the time of the inspection. Residents were offered choices in relation to food, drinks, snacks and activities. Risk management systems were in place that balanced the need to keep residents safe, while promoting residents independence and respecting the choices that residents made for themselves. For example, the inspector spoke with a resident who had been supported to travel independently on public transport to visit family.

Records provided indicated that all staff working in the centre had completed training in safeguarding and were Garda vetted. Resident forum meeting minutes were viewed that indicated that topics such as safeguarding, complaints, advocacy, health and safety, fire safety and infection prevention and control were discussed with residents. The staff spoken with during this inspection demonstrated a good working knowledge of safeguarding procedures and complaints procedures and presented as being very aware of these topics and how to manage any issues, should they arise. Staff and management spoken with during the inspection were familiar with safeguarding procedures and reported that residents were safe and well protected in the centre.

Regulation 17: Premises

The registered provider was ensuring that the premises was designed and laid out to meet the aims and objectives of the service and the number and current assessed needs of residents. The centre was designed to accommodate residents who had specific mobility needs if required. While overall, the centre was seen to be well maintained some improvements were required to ensure that any hazards associated with dampness in three separate bathrooms were fully addressed. This is addressed under Regulation 26: Risk Management procedures.

A walk around of both premises was completed by the inspector. The premises' were seen to be of a suitable size to meet the needs of the residents that lived there at the time of the inspection. Both houses were spacious and accessible throughout to the residents that lived in them and were laid out over one floor with no steps, reducing potential falls hazards. Overhead hoist facilities were available to residents that required this and these were serviced recently. One hoist was not in use and this was clearly identified to prevent unintended use of this equipment.

For example, dishwashers were raised to provide easier access and lowered hand-washing facilities were available to residents that used wheelchairs. The person in charge and staff spoken with reported good access to the providers' maintenance team if required. The inspector saw documentary evidence that equipment such as boilers and fire-fighting equipment were regularly serviced and maintained by competent professionals and a minor issue in relation to the labelling of some fire extinguishers was rectified during the inspection once this was brought to the attention of the management team.

Resident bedrooms and living areas were seen to be decorated in a manner that reflected the residents living in the centre and each resident had their own bedroom which enhanced privacy for residents. Bedrooms were personalised according to residents' tastes and preferences, and residents had photographs and personal objects on display in their bedrooms. Overall, the centre was observed to be clean on the day of the inspection Residents had access to outdoor areas including green areas and footpaths around the campus. Laundry, waste and cooking facilities were provided in each house.

Judgment: Compliant

Regulation 26: Risk management procedures

Overall, the provider had good systems in place to manage risk. The registered provider had a risk management policy and procedure in place to safeguard residents. This provided for the identification, assessment and review of risk in the centre, including reference to risks related to self-harm, accidental injury and safeguarding.

The inspector reviewed the incident reports for a six month period. A provider audit of incidents and accidents had been completed in recent months. The incident reports reviewed indicated that the staff and management team were responsive to residents and their needs. Individualised risk assessments were viewed in residents' files and a local risk register was in also in place and reviewed by the inspector. Risk assessments were seen to be subject to regular review and updating and included control measures in place to reduce or mitigate against identified risks. Individual risk assessments were seen to be in place that covered areas including behaviours of concern, skin integrity, choking, falls, road safety, swimming and epilepsy. There were no escalated risks in place at the time of this inspection. Some documentation issues in relation to the management of falls risks and minor premises issues that could present potential risks were highlighted to the management of the centre during the inspection but were not impacting significantly on safe service provision to residents at the time of this inspection.

A number of examples of good practice in relation to risk management were observed during this inspection. For example, staff were observed to practice hand hygiene and promote this for residents also, protected mealtimes were in place to

ensure that residents could be properly supported in line with their feeding, eating and drinking guidelines. Weekly sling and hoist checks were documented. A resident told the inspector about travelling independently on the train and some residents planning goals included trialling new activities, indicating that positive risk taking was a consideration in the centre.

The person in charge was seen to be responsive to risks identified. For example, a previously unidentified risk in relation to the identification of agency staff arriving on site was actioned during the inspection by the person in charge and the inspector was told about the measures that had been put in place to address this on this second day of this inspection.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The registered provider and the person in charge were ensuring that arrangements were in place in the centre to meet the assessed needs of the residents using the centre. Staffing levels were considered based on the assessed needs of each resident and were seen to be appropriate to provide a safe service that could meet the needs of residents. The centre was suited for the purpose of residents aging in place and this would provide for consistency of care and support for residents.

The inspector saw that individualised plans were in place for residents. A sample of four residents personal plans and files were reviewed during this inspection. Annual multi-disciplinary team meetings were completed for residents to identify assessed needs and any changes in support requirements. Plans were in place that reflected residents' assessed needs and annual reviews of plans were being completed at the time of this inspection. Support plans were in place that provided overall good guidance to staff about how best to meet residents' assessed needs, including healthcare and mental health support plans. This helped to ensure that the care and support offered to residents was evidence based and person centred.

Goals set as part of the personal planning process included day trips away, short breaks, concerts, attending international matches, afternoon tea and planning and celebrating big occasions. Person centred planning folders were viewed for four residents that included monthly key working records and evidence, including pictures and progress notes, that goals were being set and achieved. Information reviewed in residents' personal files indicated that goals were identified based on residents' assessed needs, preferences and capacities and that residents were afforded opportunities to participate in the personal planning process. Resident information viewed also indicated that residents' healthcare and mental health needs were considered and planned for.

Judgment: Compliant

Regulation 7: Positive behavioural support

The person in charge had ensured that overall the core staff team had knowledge and skills to respond to behaviours of concern and support residents to manage their behaviour. However, recommendations in one positive behaviour support plan were not fully in place and one plan required review to ensure the information provided was up-to-date and provided accurate guidance to staff.

While there were some restrictions in place in the centre, these were not observed to be significantly impacting on residents during this inspection and staff were all aware of the rationale for restrictions in place. A restrictive practice self-assessment questionnaire had been completed in October 2025 and risk assessments were in place in relation to any restrictions in place. Residents' representatives had also been informed about these and easy-to-read information was viewed to be in place for the use of residents in this area.

Generally a low level of peer-to-peer incidents was reported in this centre but some residents presented with behaviours that could impact their own well-being, including self-injurious behaviours. Residents had access to allied health professionals to support them with managing behaviours of concern including mental health supports such as psychiatry. Positive behaviour support plans were in place for two residents to support them to manage their behaviour and a referral had been submitted in respect of a third resident who had transferred from another centre. Another resident also had a management plan for mental health that provided clear, concise guidance in relation to supporting this resident during periods of mental health decline. Training records indicated that staff had access to and had completed training in the area of positive behaviour support also.

Regular staff working in the centre were aware of the positive behaviour support plans in place and strategies to support residents in this area. Incident records reviewed in the centre and observations during the inspection indicated that overall the guidance and strategies in these plans were being followed in practice. However:

- A positive behaviour support plan in place had not been reviewed since 2022.
- A positive behaviour support plan included a specific recommendation that all staff working with this resident should be provided with specific training in LAMH (an augmentative gesture based method of communication) to support communication. While some information was available to staff in relation to this type of communication, this communication need was not identified in the resident's communication profile or resident profile and all staff did not have training in this area. This meant that all staff were not provided with the information and skills to fully support this resident in line with their positive behaviour support plan.

Judgment: Substantially compliant

Regulation 8: Protection

The findings of this inspection indicated that for the most part, the registered provider had appropriate measures in place to protect residents from abuse but did not demonstrate that all staff, including agency staff, had timely access to some information required to fully protect residents.

Safeguarding documentation held in respect of the centre was reviewed. Generally there was good oversight of safeguarding in the centre and a low level of safeguarding incidents were reported. Safeguarding plans had been put in place in response to any safeguarding concern raised. These plans contained guidance on measures to take to ensure the safety of residents and there was evidence of review of these plans as per the providers' policy. Training and human resource records reviewed indicated staff were receiving appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse and that arrangements were in place to ensure that Garda vetting disclosures were received in respect of all staff employed in the centre.

Safeguarding measures in place in the centre included managing resident interactions to promote a positive and safe environment and ensuring that staffing levels were sufficient to meet the care and support needs of residents. Staff rotas reviewed, observations on the day of this inspection, and discussions with staff indicated that this was in place in the centre and that the person in charge maintained good oversight of this.

Guidance on supporting residents with intimate personal care was contained within residents' personal plans. Resident forum meetings were recorded that demonstrated that residents were provided with easy-to-read information to assist with education for self-care and protection. A sample of six residents' finance and audit information reviewed showed that there were processes in place to protect residents who were supported by the provider in this area. Some issues identified in relation to residents' who had alternative arrangements in place is discussed further under Regulation 9: Residents' rights.

Although core staff met during this inspection demonstrated a good awareness of issues in the centre, there was no evidence to demonstrate how all staff, and specifically redeployed or agency staff were fully and consistently communicated with about resident specific risks following incidents in the centre, including safeguarding incidents:

- While the person in charge told the inspector that learning was disseminated to staff through team meetings, a review of the minutes of team meetings documented showed that no full team meeting that discussed safeguarding or incidents had occurred between June 2025 and December 2025.

- There was also little evidence to demonstrate that relief or agency staff working in the centre were consistently provided with this information prior to commencing duties with residents in the centre. For example, no induction records were completed or maintained. Up-to-date safeguarding plans were in place but were not seen to be readily accessible to staff working in the centre. This was not in line with a local protocol for safeguarding dated August 2025 reviewed by the inspector. This meant that it was unclear if all staff, including relief and agency staff, had all of the necessary information to ensure that residents could be protected from abuse at all times.

Judgment: Substantially compliant

Regulation 9: Residents' rights

The registered provider was ensuring that each resident's privacy and dignity was being respected in relation to their living arrangements and efforts were being made to ensure that residents had the freedom to exercise choice and control in his or her daily life and to live a life of their own choosing. However, improvements were required to ensure that all residents were afforded equal opportunities in this area. The registered provider had not yet fully ensured that each resident, in accordance with his or her wishes, age and the nature of his or disability participates in and consents, with supports where necessary, to decisions about his or her care and support.

Supports were offered to residents in a calm and un-rushed manner and residents were afforded dignity in how care was provided to them. In relation to some aspects of their care residents were seen to be supported to exercise choice and control in their daily lives and to participate in decisions about their own care and support. For example, residents were seen to be offered some choices in relation to their activities, food and drinks. Capacity assessments had been completed that covered areas such as finances and medications and residents and rights based documentation was viewed to be in place in respect of various aspects of care provided.

Consent information and resident forum meetings were documented and the inspector reviewed these. These included details of choices provided in relation to food and activities and easy-to-read information about issues that might affect them. The inspector also reviewed activity records and daily records and spoke with five staff in the centre. While residents did have opportunities to leave the campus for planned activities and had access to an on-site activation service that they enjoyed, a culture of affording residents regular access to community based activity and ordinary lived experiences was not yet fully embedded and there was a noted reliance on one activation staff member to provide the majority of these opportunities for the sixteen residents. For example, records reviewed showed that

some residents would leave the campus grounds only once or twice a fortnight for short periods.

The provider was working on issues pertaining to residents' finances, however they needed to take further steps to promote autonomy and ensure proactive safeguarding measures were adopted pertaining to resident finances. One resident who was supported by their family to manage their money had some limited evidence on file that they had consented to this arrangement. There was no evidence to show that another resident had been provided with the opportunity to explore alternatives or had consented to the arrangements in place pertaining to their finances and other aspects of their day-to-day care. The previous inspection of this centre had highlighted some similar issues that had not yet been addressed in line with the compliance plan submitted at that time. The person in charge confirmed that advocacy supports had not yet been offered to the resident in relation to these matters. This meant that this resident continued to be limited in the choices that they could make and had not been afforded the same opportunities as their peers to develop their capacity to make choices about their day-to-day life.

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	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Compliant
Quality and safety	
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Cork City North 18 OSV-0005628

Inspection ID: MON-0048458

Date of inspection: 20/01/2026

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 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: The Person in Charge (PIC) has implemented an immediate review of all mandatory and role-specific training requirements to ensure staff are appropriately skilled to meet residents' assessed needs. - An up-to-date training matrix is now in place and reviewed monthly by the PIC to identify any gaps in mandatory or refresher training, including safeguarding, fire safety, manual handling, hand hygiene, and feeding, eating and drinking supports. - Priority training deficits identified during the inspection have been scheduled for completion, with interim controls in place to ensure residents' safety is not compromised. - Where delays in training completion may impact service delivery, these are escalated to the provider for immediate action. Progress against training compliance is reviewed at local management meetings and monitored through governance oversight to ensure full compliance is achieved within the revised timeframe.	
Regulation 7: Positive behavioural support	Substantially Compliant
Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:	

All Positive Behaviour Support (PBS) plans are reviewed at least annually through the MDT review process, and more frequently where changes in presentation or risk indicate the need for earlier review. The PIC monitors implementation of PBS strategies through incident review, supervision, and observation of practice.

The PBS plan identified during the inspection as requiring review has now been updated, and interim guidance was in place pending completion.
Where specialist input is required, the PIC submits referrals through the CASS referral pathway to ensure timely review and amendment of plans. A referral has been submitted to Speech and Language Therapy (SLT) to support the resident's communication needs, including guidance on the use of LAMH.
Residents' personal profiles and communication profiles have been updated to ensure staff have immediate access to current communication guidance. Peer-to-peer LAMH training has been delivered by a trained colleague, and staff competence is recorded and monitored through supervision and training records.

The PIC monitors implementation of PBS strategies through incident review, supervision, and observation of practice.

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection: Immediate actions have been taken to address the gaps identified in safeguarding communication and staff access to information.

- A standardised safeguarding induction process is now in place for all new, relief, and agency staff, with documented induction records completed prior to staff commencing duties.
- Up-to-date safeguarding plans are now readily accessible to all staff in a designated location within the centre, with oversight by the PIC.
- Safeguarding training compliance is monitored through the training matrix. All staff have completed mandatory safeguarding training, with additional 1:1 safeguarding input by the Designated Officer continuing for remaining staff.
- Safeguarding and incident learning is now a standing agenda item at scheduled team meetings. Minutes clearly record discussions and actions taken.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights: The PIC has reviewed arrangements to ensure residents are supported to exercise choice, control, and informed consent in line with their capacity. - Consent arrangements in relation to residents' finances have been reviewed, and documentation has been updated to reflect residents' wishes and agreed supports. - Advocacy supports have been offered to residents to ensure independent support where required. - Responsibility for activation and community participation is now shared across the staff team, reducing reliance on a single staff member and promoting everyday community engagement. - Residents continue to be supported in a calm, respectful, and unhurried manner, with opportunities to exercise choice in daily routines, activities, and personal decisions. - Compliance with Regulation 9 is monitored through regular review of personal plans, consent documentation, advocacy input, and resident feedback.	

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	30/06/2026
Regulation 07(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.	Substantially Compliant	Yellow	30/05/2026
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Substantially Compliant	Yellow	30/05/2026
Regulation 09(2)(a)	The registered provider shall	Substantially Compliant	Yellow	30/05/2026

	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 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.	Substantially Compliant	Yellow	30/05/2026
Regulation 09(2)(d)	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 access to advocacy services and information about his or her rights.	Substantially Compliant	Yellow	30/05/2026