



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

## Issued by the Chief Inspector

Name of designated centre:	Community Residential Service Limerick Group J
Name of provider:	Avista CLG
Address of centre:	Limerick
Type of inspection:	Unannounced
Date of inspection:	15 January 2026
Centre ID:	OSV-0005754
Fieldwork ID:	MON-0048638

## About the designated centre

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

Community Residential Service Limerick Group J comprises of two houses, one of which is a detached dormer bungalow located in a rural setting but within a short driving distance to a nearby city. The other house is a semi-detached two-storey house located within the same city. Each house has a capacity for four residents so combined the centre can provide full-time residential support for a maximum of eight residents, over the age of 18 with intellectual disabilities. Support to residents is provided by the persons in charge, social care workers and care assistants with some nursing support also. Each resident has their own bedroom and other facilities in the centre include bathrooms, living rooms, kitchen-dining rooms and staff rooms.

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

Number of residents on the date of inspection:	5
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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
Thursday 15 January 2026	09:35hrs to 17:35hrs	Conor Dennehy	Lead

## What residents told us and what inspectors observed

During this inspection four residents were met across the two houses that made up this centre. While one resident did not significantly engage with the inspector, he did have an opportunity to speak with the other three residents. General interactions between staff and residents were positively noted during the inspection. Overall, this inspection found progress from the previous regulatory engagement in 2025 with improved compliance found in areas such as governance and safeguarding. However, two judgements of non-compliance were identified relating to notifications while there were also some regulatory actions found relating to staffing and the use of personal protective equipment (PPE).

This inspection was conducted to assess progress with actions from a June 2025 inspection of the centre and a provider assurance report (PAR) that was issued to the provider in July 2025. The centre was made up of two houses, both which had a capacity for four residents each. These two houses were visited by the inspector during the course of this inspection. In total the inspector met four of the residents who were living between these two houses. The inspector also spoke with members of the centre's management and three staff members.

On arrival at the first house visited during the inspection, the inspector was initially met by a staff member who informed the inspector that just two residents were currently living that house. One of these residents had already left the house to attend day services and so was not met by the inspector. It was indicated at this time that the other resident was present in the house but was isolating in the house as it was suspected that the resident might have had an infectious disease. As a result, the inspector spent much of this time in this house speaking with staff and management while also reviewing documentation. It was indicated though to the inspector by a person in charge that he could meet the resident present provided that he wore PPE when doing so.

As such, when the inspector was preparing to leave the house he requested to meet this resident and was told to follow the direction of staff when doing so. However, of the two staff that were present in the house at the time, one staff member indicated that it was up to the inspector and the other staff member present if they wore PPE or not. This second staff member was seen in close proximity to the resident without any PPE on. PPE, such as gloves and facemasks, were present in the house and the inspector donned such PPE before meeting the resident. When the inspector met this resident they briefly looked at the inspector but otherwise did not interact with the inspector. Both of the staff present at time were overheard to engage very pleasantly and warmly with the resident.

Once he left this house, the inspector went to the second house that made up the centre. Upon entering there, the inspector was informed that the four residents living there were initially away from the house attending day services. Of these four

residents, one went directly to stay with their family from day services until the following week and so was not met by the inspector. The other three residents returned to the house shortly after the inspector arrived with the inspector meeting and speaking with all three of these. One of these residents specifically requested that their discussion with the inspector be kept private. This request was respected by the inspector.

Of the other two residents that were present in the house, both of these interacted with the inspector in a welcoming manner. For example, one of these residents offered the inspector a cup of tea or coffee. The same resident also spoke of the work that they did in day services and indicated that they were going a mindfulness session latter in the day. The other talked about an upcoming party to mark a landmark occasion. It was indicated that the resident had picked out music and a venue for this occasion. This resident went on to show the inspector their bedroom which they said that they liked. This bedroom was seen to be nicely furnished and personalised. This was evident by art works which the resident had done being hung on the walls with the resident pointing these out to the inspector.

While the inspector was present in the second house visited, a positive atmosphere was noted with residents appearing comfortable and at ease in the presence of staff. Such staff engaged with the resident in warm and respectfully while there seemed to be good relationship between residents and staff. For example, at one point while two residents were in the company of staff, one resident and a staff member interacted together in a humorous way after the resident had said that the inspector could stay in the house for the night. Management of the centre were also seen to interact with residents in a positive manner which indicated a familiarity between residents and management. This included one manager praising the appearance of a resident and a resident hugging another manager as they were leaving the house.

In summary, staff on duty in both houses of this centre were observed and overheard to interact with residents in a pleasant and warm manner. Positive interactions between staff and residents in both houses were observed or overheard by the inspector. Four residents were met during this inspection with the inspector speaking with three of them.

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

Progress was found with actions from the June 2025 inspection of this centre. This contributed to an improved compliance overall with areas of concern identified

during the previous inspection. However, some regulatory actions did remain relating to notifications.

This centre had been previously inspected on behalf of the Chief Inspector of Social Services in June 2025. That inspection focused on one house that made up the designated centre following the receipt of solicited and unsolicited information about the quality of care and support provided to residents living in the designated centre. During the June 2025 inspection information required to evidence actions taken in response to incidents and complaints in the centre were not provided to provide assurances that residents received a good quality of care and support in their home. This contributed to the issuing of urgent actions and high levels of non-compliance. Following that inspection a PAR was issued in July 2025 after a resident in the other house raised concerns around wanting to live elsewhere. The provider submitted satisfactory responses to the June 2025 inspection and the July 2025 PAR.

As such the current inspection was conducted to assess progress with these provider responses. Overall, this inspection found that the provider had implemented their stated actions from their responses. For example, guidelines for supporting residents during temporary transitions between designated centres had been introduced while a review of the staffing in one house to meet the assessed needs of the residents living there had been completed. This staff review led to one resident recently transitioning away from the centre while this was also being considered for a second resident. This will be returned to later in this report. The staffing review that had completed did recommend that a similar review for the second house be undertaken but this had yet to commence at the time of this inspection. It was also identified during this inspection that some required notifications to the Chief Inspector had not been submitted in a timely manner.

## Regulation 15: Staffing

As required by this regulation, the provider must ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents. The provider was found not to have to meet this requirement during the April 2024 and June 2025 inspections of this centre. Both of these inspections also identified that the staffing levels in place impacted on residents' ability to access community or social activities. The June 2025 inspection also highlighted how the needs of residents in one house had increased since the April 2024 inspection. In response to the June 2025 inspection, the provider indicated that a review of the staffing in one house of the designated centre to meet the assessed needs of the residents living there would be completed.

On the current inspection, the inspector was informed that this review had been completed in September 2025 with a copy of this provided to the inspector. When reading this review, it was noted that it recommended that a review of two residents' living arrangements be conducted due to their increased mobility and health needs. Such reviews had been conducted, as discussed further under

Regulation 5 Individual assessment and personal plan. As a result, one of these residents had since moved to another designated centre with a similar approach being considered for the other resident. A third resident, who had had also been considered in the September 2025 staffing review, was also confirmed as not returning to the house, having been previously temporarily transitioned elsewhere at the time of the June 2025 inspection.

As a result, at the time of the current inspection, just two residents were residing in this house which had a capacity for four residents. It was highlighted though that despite the resident changes in this house, the staffing levels there had remained unchanged. This was reflected in staff rotas reviewed from 1 November 2025 on and meant that, at certain times, two staff members were on duty to support the remaining two residents. Two staff spoken with working in this house during the inspection indicated that these were better staffing arrangements to support the two residents. Documentation reviewed though did indicate that both of these residents did need the support of two staff at certain times. For example, one resident's manual handling support plan, which had been reviewed in December 2025, outlined that the resident required the support of the two staff for toileting.

Despite this, one of the staff members working in this house spoken with during this inspection indicated that the resident only needed the support of one staff for toileting. This was highlighted to management of the centre. During the feedback for this inspection, centre management indicated that staff had been made aware that this resident required the support of two staff for toileting. It also noted that the annual review for the centre, as completed in October 2025, made reference to residents not being able to take part in activities of their choosing "due to staff availability". No such issues were raised by management and staff spoken with during this inspection nor any in other documentation reviewed.

The September 2025 staffing review for the first house, had recommended that a similar staffing review be conducted for the second house of the centre. During the feedback meeting for the inspection, it was indicated that this staff review had not yet commenced but was due to begin in February 2026. While the outcome of that staff review was awaited, the inspector was informed during this inspection that a need for an additional 0.9 whole-time equivalent (WTE) staff for one resident living in the same house had been identified. This was to allow the resident to have more 1:1 time with staff and to enable the resident to have a day service from their own home. The inspector was informed that the need for this additional staffing had been escalated to the Health Service Executive (HSE) but was not in place at the time of this inspection.

Aside from such matters, the staffing rotas reviewed in one house from 1 November 2025 on and discussions with management and staff in both houses indicated that there was a good continuity of staff working in the centre. Such continuity is important in promoting consistent care and professional with residents during this inspection seen to be comfortable in the presence of staff on duty. It was highlighted though that there was some agency staff (staff sourced from an agency external to the provider) working in the centre. The inspector was informed that such agency staff were regular agency staff. In addition, correspondence as

provided during this inspection indicated that the provider had agreed terms and conditions with staffing agencies to ensure that all agency staff had required documentation and training in place.

Judgment: Substantially compliant

### Regulation 23: Governance and management

Overall, this inspection found that the provider had implemented their stated actions following the June 2025. Examples of completed actions conducted by the provider included:

- Ensuring that quarterly staff meetings were held. This was evidenced by notes of three such meetings reviewed in one house from June 2025, September 2025 and December 2025 as well as comments by two staff working in this house. Notes of these meetings indicated that topics such as safeguarding, incidents and complaints were discussed during these meetings.
- Conducting a staffing review for one house of the centre. A copy of this review was provided during this inspection and is discussed further under Regulation 15 Staffing.
- Implementing recommendations from a local incident review following an injury to a former resident. Such recommendations included the introduction of guidelines for supporting residents during temporary transitions between designated centres. The inspector was informed by management of the centre that such guidelines had been introduced with a copy of these subsequently provided to the inspector.

The completion of these actions resulted in improved compliance overall with areas of concern identified during the June 2025 inspection. Although two areas of non-compliance were identified during this inspection related to notifications (as discussed elsewhere in this report), these did not detract from the overall progress since the last inspection. It was also positively noted during the current inspection that all documents and information requested by the inspector were readily provided. This was a noticeable improvement from the June 2025 inspection and also contributed to the improved compliance found on this inspection for Regulation 23 Governance and management. Aside from such matters, documentation provided during the current inspection also confirmed that the provider was meeting specific requirements under this regulation. This included conducting an annual review for the centre in October 2025 and two unannounced visits to the centre by a representative of the provider in June 2025 and December 2025. Such regulatory requirements were reflected in written reports which were provided to the inspector.

Judgment: Compliant

### Regulation 3: Statement of purpose

Under this regulation, the registered provider is required to ensure that there is a statement of purpose in place that contains specific information and which is reviewed at intervals of not less than one year. During this inspection the inspector read copies of statement of purposes that were present in the two houses of the centre. Both of copies of were dated June 2025 and were found to contain information required by this regulation such as the criteria for admission and details of the arrangements for accessing religious services. However, when reviewing both the inspector did notice some differences between the two documents relating to required information. For example, the statements of purposes included different names for one of the persons in charge while the stated WTE for the other person in charge was inconsistently stated. In addition, the staffing review that had been conducted for one house in September 2025 indicated that the actual staffing WTE for that house was not accurately stated in the statement of purpose. Despite this, the statement of purpose was not indicated as being reviewed since the staffing review was completed. Taking into account such findings, the statement of purpose for the centre required review to ensure consistency and accuracy of required information.

Judgment: Substantially compliant

### Regulation 31: Notification of incidents

To comply with this regulation the Chief Inspector must be notified of certain events at specific time frames. These events include allegations of a safeguarding matter which must be notified within three working days. When reviewing incident reports in the centre, the inspector read a report of an incident which occurred on 17 November 2025. This incident was of safeguarding nature and had been notified to the relevant HSE Safeguarding and Protection Team in keeping with national safeguarding policy. However, this incident had not been notified to the Chief Inspector at the time that this inspection took place. In the days following this inspection, it was suggested to the inspector that this incident had been notified to the Chief Inspector but that there had been a typing error with a notification submitted on 18 November 2025. When reviewing this notification, it was noted that this notification contained noticeable differences to the incident report from 17 November 2025. This included different times of the incident occurring and the incident being reported as well as different description of the incident in question and the impact on a resident affected. As such, a safeguarding incident from 17 November 2025 had not been appropriately notified to the Chief Inspector.

Judgment: Not compliant

## Regulation 32: Notification of periods when the person in charge is absent

In recent years, the role of person in charge for this centre was held by two individuals. Under this regulation, where a person in charge is absent from a centre due to an emergency or unanticipated event for 28 days or more, the registered provider must notify the Chief Inspector of the absence. Such a notification must be submitted as soon as it becomes apparent that the absence concerned will be for a period of 28 days or more. The provider had submitted a notification of such an absence on 8 October 2025 for one of the individuals holding the person in charge role at that time. However, based on the details in the notification this individual had been absent from the centre for 28 days by 28 September 2025 while remaining absent at the time the notification was submitted. As such, the inspector was not assured that the notification had been submitted as soon as it became apparent that the absence concerned was for 28 days or more.

Judgment: Not compliant

## Regulation 34: Complaints procedure

Information around how residents could make complaints and who the complaints officer for the centre was were seen to be on display in communal areas of both houses of the centre. A logs for recording complaints was also present in each of the houses. When reviewing these, the inspector noted that one complaint, as made by a resident, had been logged as having been made since the June 2025 inspection. The entries in the relevant complaint log outlined the nature of this complaint, the action taken on foot of the complaint and whether the complainant was satisfied with the outcome. From reviewing such entries, it was recorded that the resident was satisfied with the outcome of the complaint.

During the introduction meeting for the inspection, the inspector was informed though that the same resident had made another complaint just before the inspection. This complaint related to the resident wanting to live elsewhere with the resident having made similar complaints in 2023, 2024 and 2025 from documentation reviewing on the current inspection. Such complaints were also related to the July 2025 PAR. Records of the previous complaints made indicated that, after the resident's discussions with management of the centre, the resident has happy to continue living in their existing home. However, given the similarity in the complaints made, the inspector queried if the resident had availed of an independent advocate to assist them with such complaints. In response to this it was indicated that the resident was currently engaging with the provider's transforming lives officer and once the outcome of this was known, availing of an independent advocate would be considered further then.

Judgment: Compliant

## Quality and safety

Based on observations during this inspection, PPE was not used appropriately for one resident. Another resident had recently transitioned away from the centre following an assessment of needs of completed. This transition was intended to better support the needs of that resident.

Assessments of needs had been undertaken for two residents in line with regulatory requirements. Such assessments recommended that these residents required a different environment to meet their needs. One of these residents had recently transitioned to another centre operated by the provider but the other resident remained in Community Residential Service Limerick Group J at the time of this inspection. Another resident had briefly been living in the centre during November 2025 but owing to safeguarding concerns, this resident was longer living in the centre. Documentation provided during this inspection indicated that safeguarding matters were subject to appropriate preliminary screenings. Staff working in the centre had completed safeguarding training based on a training matrix provided. This also indicated that staff had completed training in infection prevention and control. Despite this, PPE was not seen to be used for one resident who was isolating on the day of inspection.

## Regulation 27: Protection against infection

Under this regulation, the provider must ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections. As mentioned in the opening section of this resident, one resident in one house was isolating as it was suspected that that they might have had an infectious disease. The inspector was informed that standard infection prevention and control precautions were to be followed with this resident. This included the use of PPE. Despite this, it was observed during this inspection that one staff member did use PPE when in close proximity to the resident while another staff member supporting the resident seemed unsure as to whether PPE was to be worn or not with the resident. This was despite, a training matrix provided indicating that staff working in this centre had completed training in infection prevention and control. Such observations were highlighted to management of the centre on the day of inspection. During the feedback meeting for the inspection, the inspector was informed that staff had been made aware of the need for the PPE to worn while this resident was to be isolated.

Judgment: Substantially compliant

### Regulation 5: Individual assessment and personal plan

This regulation requires that suitable arrangements must be in place to meet the assessed health, personal and social needs of each resident. It is also required that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident be carried out to reflect changes in need and circumstances. The staffing review that had completed for one house of the centre in September 2025 had recommended that a review of two residents' living arrangements be conducted due increased mobility and health needs. Following this, needs assessments for both residents had been conducted by the provider's multidisciplinary team.

Each of the residents' assessments had highlighted that the residents' needs health needs were increasing and that both residents required transfer to a nurse led centre to better support their needs. One of these residents had transitioned to such a centre just prior to this inspection being conducted. Documentation provided around this transition indicated that the resident had been supported with this transition with the inspector verbally informed that their transition had gone well. The other resident, remained living in Community Residential Service Limerick Group J at the time of this inspection.

As Community Residential Service Limerick Group J was not as nurse led centre, appropriate arrangements for the purposes of meeting the resident's assessed health needs were not in place at the time of this inspection. It was acknowledged though that the centre had some nursing support and that the potential transition of the resident to a nurse led centre was currently being considered based on management comments during this inspection. Such management and staff spoken with also indicated that a new vehicle for the house where the resident lived had been obtained since the June 2025 inspection. This gave residents of this house more ability to access activities away from the house which better provided for their social needs.

Judgment: Substantially compliant

### Regulation 8: Protection

Since the June 2025 inspection, the Chief Inspector had been notified of ten safeguarding matters from this centre. Documentation provided during this inspection confirmed that nine of these incidents had appropriately screened in keeping with national policy with no grounds for concern found following these screenings. Following queries by the inspector, the tenth safeguarding matter

notified was indicated as not being a safeguarding concern by a person in charge. Another incident had also been the subject of a preliminary screening but not notified to the Chief Inspector (as discussed during Regulation 31 Notification of incidents).

This incident related to a resident who had been briefly admitted to one house of this centre during November 2025. Following the incident in question, in line with a safeguarding plan that had been put in place, this resident had been transitioned elsewhere and was no longer a resident of Community Residential Service Limerick Group J. Following this transition, no safeguarding incidents of a similar nature had occurred. As such taking this into account, along with document reviewed such as incidents reports and staff discussions, no immediate safeguarding concerns were identified during this inspection.

Information around how to raise safeguarding concerns if they arose was seen on display in one house of the centre. This included details of the provider's designated officer (person who reviews safeguarding concerns). It was noted though that some of the information on display needed updating. For example, the identity of a services manager/deputy designated officer had changed. This observation was highlighted to management of the centre. Aside from this though, a staff training matrix provided confirmed that staff working in the centre had completed relevant safeguarding training.

Judgment: 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	Substantially compliant
Regulation 23: Governance and management	Compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 32: Notification of periods when the person in charge is absent	Not compliant
Regulation 34: Complaints procedure	Compliant
<b>Quality and safety</b>	
Regulation 27: Protection against infection	Substantially compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 8: Protection	Compliant

# Compliance Plan for Community Residential Service Limerick Group J OSV-0005754

Inspection ID: MON-0048638

Date of inspection: 15/01/2026

## Introduction and instruction

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

This document is divided into two sections:

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

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

A finding of:

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

## Section 1

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

### Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 15: Staffing	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 15: Staffing:            All staff working in the designated centre are aware of and have read and signed the manual handling plans for residents. The staff member was spoken with on the day once this was highlighted with management and they advised management that they were aware of the need for 2 staff support for the residents manual handling needs. This will be discussed again at team meeting on the 26th of February 2026. All staff have manual handling training completed and will be booked for refreshers as required.            A staffing review of the 2nd house in this designated centre is scheduled to begin week commencing the 16th of February 2026.            The business case for the 0.9 WTE has been escalated to the HSE again and the ACEO raises same at regular meetings with the HSE, most recently on the 13th of January 2026, this will also be considered as part of the staffing review being completed in the 2nd house in this group</p>	
Regulation 3: Statement of purpose	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 3: Statement of purpose:            The statement of purpose for this designated centre has been reviewed and updated on 5th of February 2026 in line with regulation 3. This was reviewed by the PIC and Service Manager on 05.02.2026 and a copy of same is in place in both houses. This will be discussed at staff meeting on 26.02.2026. The PIC and PPIM will ensure that this is reviewed annually or sooner if changes occur. This will also be discussed with all PICs on 16.02.2026 at governance meeting with service manager</p>	

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Regulation 31: Notification of incidents	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 31: Notification of incidents:</p> <p>The Person in Charge is attending training with other PICs and PPIMs in the notification of incidents on the HIQA Portal. 2 dates have been scheduled for this training by the Quality, Safety and Risk Advisor for PICs on 10th and 24th of February. The safeguarding notification which had not been notified appropriately has been completed retrospectively on 24.02.2026. This was also discussed with all PICs at Governance meeting with Service Manager on 16.02.2026. PPIM will have oversight of notifications and responsibility for reporting in the absence of the PIC.</p> <p>]</p>	
Regulation 32: Notification of periods when the person in charge is absent	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 32: Notification of periods when the person in charge is absent:</p> <p>All absences of the PIC's for longer than 28 days will be notified as per regulation 32. This has been discussed at Governance meeting on 05.02.2026 with PIC and PPIM to ensure any absence identified or foreseeable of the PIC from the designate centre over 28 days is notified. This was also discussed at Governance meeting with all PIC's on 16.02.2026. Service Manager reviewed the details on the portal on 05.02.2026 and all are correct.</p> <p>]</p>	
Regulation 27: Protection against infection	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 27: Protection against infection:</p> <p>This was discussed with the staff member involved on the day of the inspection when it was highlighted to management. All staff were reminded to wear PPE as clinically indicated and to ensure this was handed over to staff who were coming on shift before any interaction with residents. Contingency plan in place to guide staff when supporting</p>	

residents' presenting with infectious illnesses. All staff have training completed and in date in relation to IPC. The PIC has a current training matrix which was reviewed by PIC and service manager at governance meeting on 05.02.2026. For discussion again at next team meeting scheduled for 26.02.2026

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Regulation 5: Individual assessment and personal plan

Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:

The transition plan for the resident has commenced with a new location identified in line with their assessed needs. IPNA/MDT review meeting held on 12.02.2026. Transforming Lives officer is supporting with a transition plan and Individualised Personalised Needs Assessment. Transition to commence on 19.02.2026, with initial visit. Social story in place for resident with photos of proposed new accommodation and bedroom.

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## Section 2:

### Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Substantially Compliant	Yellow	01/05/2026
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated	Substantially Compliant	Yellow	26/02/2026

	infections published by the Authority.			
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	05/02/2026
Regulation 31(1)(f)	The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: any allegation, suspected or confirmed, of abuse of any resident.	Not Compliant	Orange	24/02/2026
Regulation 32(3)	Where the person in charge is absent from the designated centre as a result of an emergency or unanticipated event, the registered provider shall, as soon as it becomes apparent that the absence concerned will be for a period of 28 days or more, give notice in writing to the chief inspector of the absence, including the information referred to in paragraph (2).	Not Compliant	Orange	05/02/2026
Regulation 05(2)	The registered provider shall	Substantially Compliant	Yellow	01/05/2026

	ensure, insofar as is reasonably practicable, that arrangements are in place to meet the needs of each resident, as assessed in accordance with paragraph (1).			
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