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:	Cois na Gheata
Name of provider:	Inspire Wellbeing CLG
Address of centre:	Kildare
Type of inspection:	Unannounced
Date of inspection:	27 January 2026
Centre ID:	OSV-0007755
Fieldwork ID:	MON-0048175

About the designated centre

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

The centre is registered to provide residential care and support for up to 12 adults diagnosed as being on the autistic spectrum. The centre is located in a rural setting on a large campus in County Kildare. The centre comprises of three houses and two single studio apartments, supporting both male and female adult residents. Residents all have their own bedrooms and each house while configured differently, contains a kitchen, sitting room and adequate numbers of bathrooms. The campus has a large grounds, with sensory gardens, mini farm area, orchard, a poly tunnel where some residents engage in horticultural activities and a number of other designated areas for activities such as arts and crafts, cooking and massage. The centre is staffed by a mixture of social care staff, care workers and has nursing support available.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	10

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
Tuesday 27 January 2026	10:10hrs to 17:30hrs	Lisa Walsh	Lead
Tuesday 27 January 2026	10:10hrs to 17:30hrs	Karen Leen	Support

What residents told us and what inspectors observed

Overall, residents in Cois na Gheata were supported to have a good quality of life. The feedback from residents was that they were happy and liked living in the designated centre. The residents spoken with were complimentary of the staff and management team and of the care they received. Staff and management were knowledgeable about the residents' needs, and it was clear that they promoted and respected the rights and choices of residents living in the centre. While improvements had been observed on inspection in compliance levels in some areas, other areas still required significant improvement, for example, fire precautions, resources and management systems in place. Inaccurate information was also provided to the Chief Inspector of Social Services for the application to renew registration of the centre.

On arrival to the centre, inspectors were greeted by a person in charge from another designated centre that was located on the same campus. Inspectors were informed that the person in charge for this designated centre was on a planned day off and there were no team leaders working until 11am. Inspectors were introduced to staff in each house, who then accompanied them on a tour of the premises.

The centre was registered to accommodate 12 residents, however, two of the rooms registered as resident bedrooms had been converted to an office without consultation with the Chief Inspector, meaning the maximum number of residents that could be accommodated was 10. On the day of inspection, there were 10 residents residing in the centre and there were no plans for any new admissions.

As mentioned, the designated centre is located on a large campus in a rural part of Kildare, on a farm, which is located next to another designated centre which shares the same campus. The centre is set across three houses and two apartments. Each apartment is linked to one of the houses and staff work across both the house and apartment when supporting residents. Inspectors visited all houses and apartments as part of this inspection. Both apartments accommodated one resident in each and these residents also used the houses for recreation and meals during the day. They then slept in the apartments at night with the waking night staff in one house performing visual checks to ensure they were safe and to see if they required any assistance.

Overall, the centre was generally laid out to meet the needs of the residents. However, the inspectors observed that some areas required cleaning, maintenance and repair to ensure the premises was maintained to a good standard to meet the needs of the residents. The first house was registered to accommodate four residents. On the day of inspection, three residents were living there and the fourth bedroom had been converted into an office. There was a large sitting room, which opened out into a kitchen/dining area with a solid fuel stove placed centrally in the room. Residents' and staff walked past the stove every time they entered or left the

sitting room and kitchen/dining room or wanted to access the kitchen area. This stove was used to heat the house and was very hot to the touch with no safety guard around it; this was of concern as there was a resident who had mobility issues living there. The kitchen area was also very hot when the stove was heated. A toilet had also been removed some time ago and this room was currently used by a resident to store some personal items, however, the room required significant repair. The second floor of this house was detailed on the layout of the centre, however, inspectors were informed that this was being used as part of the running of the centre.

The first and second houses had a similar layout with an open plan kitchen and dining room on the ground floor and a sitting room on the first floor. In the second house, for a resident who had vision issues, they could only access the sitting room upstairs with the support of staff. On inspection, inspectors identified that some changes had been made to the layout of this home. For example, a resident's bedroom had been converted to an office and the office next to the sitting room was removed and additional space added to the sitting room area. In the first house some mould and damp was observed in different parts of the house, for example, in a resident's bedroom and in the shower. Some storage practices also required review with several boxes being stored in the sitting room.

Both apartments also had a similar layout with an open plan bedroom and sitting room area. These were observed to be very homely and personalised to each resident with a very pleasant atmosphere. One apartment had a kitchen area, however, inspectors were informed that this was not in use and was observed to be used for storage.

On arrival to the first house inspectors were greeted by one resident and two support staff. The resident was relaxing in the kitchen watching television while enjoying their breakfast. The resident greeted the inspectors, they told the inspectors that they like their home and showed the inspectors their bedroom. Inspectors found that the resident's bedroom was filled with personal items and that the resident had a small working station in the corner where they kept carpentry work, such as, birdhouses that they were working on for their garden. Later in the evening, inspectors returned to the resident's home and found them painting a number of birdhouses. The resident showed the inspectors the area of their garden where they would be placing the bird houses.

The inspectors met with one resident who lived in a small apartment to the rear of one of the properties. The resident invited the inspectors to view their apartment, they were receiving help from support staff to carry out household cleaning. The resident spoke to staff and inspectors using Lámh (a manual sign language), inspectors found that resident and staff spoke fluently and without barriers throughout their interactions. In addition, inspectors found that their was support and guidance folders present in common areas of the house to support staff with signs who may be unfamiliar in offering support. The resident told the inspectors that they like their home and that there is nothing that they would change. They

informed the inspectors that they would be finishing some cleaning in their house and then they had planned to go out for lunch with the staff supporting them.

The inspectors had the opportunity to speak to three residents who lived together in one house in the designated centre. One resident had recently started to work in a local hotel. They showed the inspector a number of pictures that they had taken that demonstrated the goals that they had achieved in 2025. These pictures included the resident attending their job interview and meeting with their new manager and colleagues. The resident also discussed the holidays and overnight stays that they had attended with friends. The resident discussed that they had set their goals out for the coming year and had a number of plans they were looking forward to.

The inspectors had the pleasure of having lunch with four residents who lived together in one house. Two residents had been out working on the farm all morning, one resident had been baking on the campus and one resident had spent time in their own apartment engaging in their own interests. Staff prepared fresh hot food for residents', which they said they enjoyed. Residents' food preferences were considered and alternative meals were made where requested. Residents sat with staff in the kitchen/dining room and ate lunch together. Staff and resident interactions were observed to be very friendly and respectful with a homely atmosphere. Residents said they were happy living in the centre. Staff gave residents options for activities to participate in after lunch and respected their choices. Some residents decided to go out for a walk and for a pint after. While a resident asked to stay home and rest after a busy morning.

During the course of the inspection, the inspectors had the opportunity to speak to seven staff, the person in charge, two team leaders and a relief team leader. The inspectors found the staff to be knowledgeable of the assessed needs of each resident in the designated centre. Staff were aware of changing needs for residents and had identified appropriate supports to promote each residents' accessibility in their home.

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.

Capacity and capability

Overall, the inspectors found that there had been improvements in some areas identified under quality and safety since the previous inspection in March 2025. It was evident that the registered provider was working towards compliance with the regulations. However, further actions were required to ensure the service provided

was safe, appropriate, consistent and effectively monitored, this is detailed under each regulation.

This was an unannounced risk-based inspection to assess compliance with the regulations, carried out by two inspectors over one day. This inspection also followed up on the registered provider's compliance plan actions from the previous inspection and was used to inform a decision on an application to renew the registration for the centre, which was under review.

While there were management structures in place in the centre, gaps were identified and these were not clearly defined. When inspectors arrived to the centre, the person in charge was on planned time off but there was no team leader working until 11:00. Inspectors were informed that another person in charge from a different centre supported the staff when needed, however, there were no clear systems in place for this and it was not clearly documented to ensure residents and staff were aware of the process to seek support if required. Inspectors were informed that this was an informal process. The person in charge, a team leader and a relief team leader later arrived to the centre.

The person in charge was responsible for the centre's day-to-day operations and reported to the director of services, who in turn reports to the chief executive officer and registered provider. They worked full-time and were supported by two team leaders in their role. From inspectors' observations, a review of documentation and staff spoken with there was insufficient team leader resources in the centre. The two team leaders had particular houses and apartments which they provided support for. From a review of records, this was to be a temporary arrangement due to funding, however, was still in place on the day of inspection. The person in charge also had oversight of the staff team.

The registered provider for Cois na Gheata was Inspire Wellbeing CLG, who had a number of other designated centres in Ireland. Following an earlier inspection in another centre within the group, the registered provider had begun to implement an improved communication system between the person in charge and the registered provider. A new meeting record template was being developed, which clearly documented discussions held, decisions, actions, person(s) responsible and action due date. There was one meeting held in January 2026 and the meeting record was available with evidence of the registered providers oversight in risk, quality and compliance, service updates, safeguarding, training, staffing arrangements and recruitment. While this new system was in place the minutes of any previous meetings held were not available for inspectors to review. Therefore, it was not fully clear what level of oversight the registered provider had previously regarding all key quality and safety areas.

Within the centre communication occurred at team leader and staff meetings. The records of these meetings were limited and inconsistently documented. There was no time-bound actions identified, nor were persons responsible for implementing these actions. Inspectors were informed that a new meeting template would be developed to use across all meetings.

Registration Regulation 5: Application for registration or renewal of registration

An application to renew registration of the designated centre in accordance with the requirements set out in the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulation 2013 had been made by the registered provider. This application was in the process of being reviewed at the time of inspection.

During the inspection, inspectors identified that the registered provider had made changes to the centre, which were not included in the application. For example, the registered provider had applied to register an occupancy of 12 residents, which could be accommodated in the centre. However, two bedrooms had been converted into offices, meaning that a maximum occupancy of 10 residents only could be accommodated.

In addition to the above changes to the premises, other parts of the centre description were also inaccurate. For example:

- A toilet had been removed in one house.
- Two buildings and a shed, which were used in the running of the designated centre were not reflected on the design and layout of the premises.
- An office had been removed in one house and was now part of the living area.
- A kitchen in one apartment was not functioning. There was no running water in the sink and the space was used as storage.
- The second floor of one house was used for storage within the centre, however, this was not included in the layout of the premises.

Judgment: Not compliant

Regulation 15: Staffing

Staff generally worked in a specific house/apartment, which formed the designated centre. On the day of the inspection, the centre was operating on a 0.5 full-time equivalent (FTE) staff vacancy. Where possible, the person in charge was attempting to use regular relief staff and some agency staff to fill in for any vacancies on the roster. Inspectors reviewed the rosters and found it was difficult to identify who was relief or agency staff. In addition, inspectors could not identify which rosters were the actual roster, as there were multiple versions of actual rosters for each month, each with differing information. This poor record keeping and inconsistent documentation will be reflected in the findings against Regulation 23:Governance and Management.

On a review of records, activities were cancelled twice in a three month period for some residents in one house, as they did not have a sufficient number of staff to meet the assessed needs of residents.

The inspectors observed staff engaging with residents in a respectful manner and it was clear that staff had knowledge of each residents assessed needs. Staff spoken to during the course of the inspection were aware of residents' changing needs and the supports that had been put in place in order to meet the needs of each resident in the centre. The inspector found that staff had the necessary competencies and training to support residents living in the centre.

Judgment: Substantially compliant

Regulation 23: Governance and management

From observations, communication and a review of documentation inspectors were not assured that there were sufficient resources available to ensure effective delivery of care and support. For example, there were two team leaders in place to cover the three houses and two apartments that made up the designated centre. One house in particular had residents' with very complex needs. Inspectors identified that this was supposed to be a temporary measure due to funding, however, it was still in place on the day of inspection. In addition, gaps were identified in the management structures in place within the centre. Inspectors were informed that a person in charge and team leaders from another designated centre on the campus supported the staff when needed. However, there were no clear systems in place for this arrangement and it was not clearly documented. Inspectors were informed that this was an informal process.

While the registered provider had begun to implement a new meeting record template for management meetings with the registered provider, this was only used on one occasion, there were no other meeting records previous to this for the inspectors to review. Therefore, it was not fully clear what level of oversight the registered provider had regarding all key quality and safety areas. In addition, the communication systems for team leader and staff meetings were limited and inconsistently documented. There were no time-bound actions identified, nor were persons responsible for implementing these actions. There were also gaps in the scheduled frequency of when these meetings were occurring.

Unannounced six monthly inspections were completed. While they were taking place they were ineffective at capturing and actioning key areas of improvement in the centre, which were identified on inspection. The system in place for reporting on these audits findings was inconsistent. Inspectors reviewed the two previous audits completed in the previous year and found that these varied extensively in how they were completed and the level of information contained in them.

The registered provider was not operating as required by Condition 1 and Condition 3 of the centre's certificate of registration. The inspectors identified that the registered provider had removed two bedrooms and converted them into offices in the designated centre without informing the Chief Inspector.

Judgment: Not compliant

Quality and safety

Overall, inspectors found that there was improved compliance with individual assessment and personal plans and positive behaviour support for residents. It was evident that residents' assessed needs in these areas were being met. Residents appeared to be happy and content in their homes and with the service provided to them. While some improvements were being made, inspectors found that significant action was required to come into compliance with fire precautions. Although some improvements were observed in relation to premises, some similar findings were observed from the previous inspection in relation to a resident's bedroom in particular.

The inspectors found that good practices were in place in relation to safeguarding. The provider had appropriate procedures in place, which included safeguarding training for all staff, the development of personal and intimate care plans, and support from a designated safeguarding officer within the organisation.

Residents' rights in relation to privacy and dignity had improved since the last inspection. Residents' bedrooms and bathrooms that had glass panels in the doors had been replaced. They could now have privacy in these rooms when the doors were closed. Inspectors found that some residents' were being offered a greater choice and quality of activities. However, inspectors were not assured that all residents had access to meaningful activities. The inspectors found that for some residents' choice around activities in the community were limited due to support measures in place.

For most residents, their bedrooms were found to be very homely, personalised and filled with items of significance to them. Some parts of the centre were also decorated to provide a homely atmosphere with some houses or apartments requiring more improvements than others. Inspectors were also informed that there was an improvement plan in place with some carpets and flooring planned to be replaced in the coming weeks. While some improvements were in place, some further action was required to come into compliance. Some similar findings were observed in one resident's bedroom in the previous inspection.

Inspectors found that staff were knowledgeable of the support needs required by each resident, both day and night in the event of a fire. All staff had up-to-date fire training and refresher dates were set to ensure that staff remained current in their

practice. The previous inspection in March 2025 identified that there were a number of concerns in relation to fire doors. This inspection found that fire door issues remained. For example, a number of fire doors were not closing fully when released and one door in a resident's bedroom was not a fire door. Additionally, fire checks completed had not identified the issues with the fire doors observed on inspection. Improvements were also required in relation to fire drills and resident personal emergency evacuation plans (PEEP's).

Regulation 17: Premises

As mentioned, inspectors observed some areas of improvement for the premises compared to the previous inspection. The centre was generally found to be tidy. However, in one resident's bedroom, inspectors observed stains and dried debris on their wardrobes, light switches and doors. This resident's bedroom was to be checked every two hours for any cleaning required, however, it was not being completed. Some similar findings were found on the previous inspection in March 2025.

Inspectors also observed that another resident's bedroom and some shower rooms required additional cleaning as there was mould found in damp areas. A toilet had also been removed some time ago and this room was currently used by a resident to store some personal items, however, the room required significant repair.

Other parts of the centre also required maintenance and repair with carpets, floors and walls observed to have visible damage on them. There was a solid fuel stove used to heat one of the houses which was very hot to the touch with no safety guard around it. Ventilation also required a review as the kitchen area where the stove was located was very hot when the stove was heated.

Some storage practices required review, with several boxes of residents records being stored in the sitting room in one house.

Judgment: Not compliant

Regulation 28: Fire precautions

Inspectors completed a walk through of all premises that make up the designated centre and carried out a manual check on all fire doors. Inspectors found that a number of doors were not fully closing when manually released. One resident's bedroom door was observed to not close fully when activated. Furthermore, inspectors found that the door was not aligned to the door frame when in a closed position, which in turn was leaving a large gap once fully closed. Inspectors found

that for one resident a side door leading to their bedroom was not a fire door. This door lead out toward the corridor to the kitchen area.

Inspectors reviewed the fire checks completed in the centre, which included daily fire checks of fire doors and emergency exits. Inspectors found that there was a number of days throughout all houses in the centre where daily fire checks had not been completed. For example, fire checks had not been completed on 02, 03, 04, 05, 12, 17, 27 and 30 of September 2025. In addition, the inspectors found that the checks completed by staff on the day of the inspection or the day prior to the inspection did not identify concerns in relation to fire door closures and safe door fittings in the event of a fire. The daily checks had identified that all fire doors where working as required on activation.

Inspectors reviewed fire drills completed in the centre in 2025 and found that while the person in charge was ensuring regular fire drills were occurring in the centre, these fire drills did not take into account the highest ratio of residents in the centre with the least amount of staff. The inspectors found that fire drills carried out to demonstrate night time fire drills had staff support greater than the support that would be in place in the centre at night time.

The inspectors reviewed personal emergency evacuation plans (PEEP's) for five residents in the designated centre. The inspectors found that the PEEP's had been subject to regular review by the person in charge and support staff, however, inspectors found that more information was required in relation to the level of support required by residents on exiting the building in the event of a fire. For example, one resident was noted to require one-to-one staff support for activities throughout the day. This was not highlighted in their PEEP or if staff were required to remain with the resident on evacuating the building. The inspectors reviewed the emergency fire plan for each of the houses in the designated centre and found that incorrect reporting structures had been placed in each of the emergency plans. This was brought to the attention of support staff and the person in charge and corrections were made on the day of the inspection. These corrections were communicated to the appropriate staff teams.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

The person in charge had ensured assessments of residents' needs were completed and informed the development of personal plans. Inspectors reviewed a sample of residents' assessments and plans. There was a comprehensive assessment of need in place for each resident, which identified their healthcare, personal and social care needs. These assessments were used to inform detailed plans of care, and there were arrangements in place to carry out reviews of effectiveness.

The inspectors reviewed five individual assessments of need, these informed

comprehensive care plans, which were written in a person-centres manner and detailed residents' preferences and needs with regard to their care and support. The inspectors reviewed a number of care plans which reflected identified supports in areas such as:

- sleep hygiene
- communication
- intimate care
- recreational support needs
- epilepsy management
- medication and self medication management
- finances

The inspectors identified that for a number of residents they were participating in a number of chosen activities within their local community. On arrival to one house in the designated centre, inspectors were greeted by a resident who wished to show the inspectors their personalised goal planner. This planner demonstrated pictures of activities completed throughout 2025 and those identified and in progress for 2026. These activities included day trips on trains, overnight holidays, visits to family and friends and shopping trips. The inspectors found that staff had completed training in social role valorisation in order to further support residents to identify meaningful choices and activities within their local community. However, inspectors found that for some residents activities were restricted due to support levels, the inspectors found that the person in charge and support team were actively attempting to increase social activities for residents. This will be discussed further in Regulation 9: residents rights.

Judgment: Compliant

Regulation 7: Positive behavioural support

The inspectors found that there were arrangements in place to provide positive behaviour supports to residents with an assessed need in this area. Inspectors reviewed a sample of three residents' positive behaviour support plans and found that they were detailed, comprehensive and developed by an appropriately qualified person. The inspectors found that the plans reviewed were detailed to guide staff in their everyday practice and support of residents. Positive behaviour support plans in place, were devised in a manner that set out individuals' identified triggers or environmental changes that may cause distress or anxiety for them. For example, one resident's positive behaviour support plan detailed how they liked to know how things worked in everyday life, therefore the plan detailed ways in which the individual could examine everyday objects in their life and prevent anxiety from building to a point of distress.

The person in charge had ensured that staff had received training in the management of behaviour that is challenging and received refresher training in line

with best practice. The inspectors had the opportunity to speak to seven support staff, two team leads and the person in charge throughout the course of the inspection and found that they were knowledgeable of support plans in place. In addition, staff had training on residents' individual communication styles and inspectors observed a number of interactions between residents and staff throughout the day that took place using their preferred communication style.

The person in charge and team leaders were completing weekly reviews of accidents and incidents occurring in the designated centre which were linked to residents participating in behaviours of concern or causing distress to residents. The inspectors found that through the review of each incident, the person in charge and team leaders were identifying possible environmental triggers or event stimulus that was leading to possible upset, resulting in behaviours of concern. The inspectors found that social stories were created in order to support residents post incident reviews in order to further support residents during future events.

The inspectors found that while there was a number of restrictive practices in place for residents throughout the designated centre, these were subject to regular review by the person in charge and team leads. The inspectors found that on a number of attempts had been made to reduce some restrictive practices in the centre, however, due to identified safety risks for one resident these restrictions were deemed a requirement. The team leader had developed social stories for residents in one house within the designated centre to explain the requirement of restrictive practices within their home.

Judgment: Compliant

Regulation 8: Protection

All staff had received up-to-date training in the safeguarding and protection of vulnerable adults. Staff spoken with were familiar with reporting systems in place, should a safeguarding concern arise.

The inspectors found that the provider and person in charge had implemented satisfactory systems to safeguard residents from abuse. Where there had been safeguarding incidents in the centre, the person in charge had followed up, reviewed, screened, and reported the incident in accordance with national policy and regulatory requirements.

Safeguarding plans were reviewed regularly in line with organisational policy. Formal and interim safeguarding plans were implemented and were supported by risk assessments. The control measures to protect residents from abuse were seen to be proportionate, person-centred and mindful of the residents' rights and wishes.

The inspectors completed a review of accidents and incidents occurring in the centre from November and December 2025 and January 2026 and found that the person in

charge and team leads were completing regular reviews of incidents occurring in the centre to ensure that the ongoing review of potential safeguarding concerns.

Judgment: Compliant

Regulation 9: Residents' rights

While it was evident that the person in charge and support staff were working towards offering residents greater choice and quality of activities, inspectors were not assured that all residents had access to meaningful activities. The inspectors found that for some residents choice around activities in the community were limited due to support measures in place. Inspectors reviewed the personal plans of four residents' and found that some residents had access to a number of activities and had regular review meetings with their key worker. However, on review of one resident's personal plan and their financial expenditures for October to December 2025, inspectors found that this resident had limited access to their activities and that their finances were being spent on a number of regular activities, such as, weekly take away food, bi-weekly train journeys to another county with a meal while out and visits to local shops to buy a favoured item. Inspectors found that across the three month period the resident had been to the cinema on one occasion. The inspectors acknowledge that residents positive behaviour support plans had undergone a recent review with the aim to encourage and promote residents choices in their community and how activities could be supported for residents. However, at the time of the inspection this was not identified as achieved for one resident. In addition, updated goals for the resident reflected the goals for 2025.

The provider had implemented additional mandatory training for staff in order to further enhance the lived experience of residents in the centre. At the time of the inspection, one staff was outstanding for training in social role valorisation. Staff spoken with discussed that this training had assisted them and residents' when identifying goals and wishes for the coming year.

The inspectors found that residents meetings were occurring monthly. Residents meetings held a standard agenda with areas for other topics to be discussed by residents as they required. However, inspectors found that requests made by one resident in June 2025 for greater WiFi speed to be upgraded into their home so that they could have greater access to entertainment channels on the Internet remained outstanding. When inspectors requested an update for the resident, support staff informed the inspector that initially families had not agreed. Inspectors discussed that the residents choice was to upgrade their WiFi within their home, support staff advised that they had held discussions with families and the resident and an upgrade was due to occur.

Residents living in the centre noted that they like living together and that they have done so for a number of years. However, inspectors found that in one premises within the designated centre where a number of restrictive practices were in place,

while deemed necessary to ensure the safety of one resident, was having a negative impact on peers in their home. For example, residents had made the decision to keep personal items in their bedrooms in order to ensure that they would not be dismantled by peer members.
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	
Registration Regulation 5: Application for registration or renewal of registration	Not compliant
Regulation 15: Staffing	Substantially compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Cois na Gheata OSV-0007755

Inspection ID: MON-0048175

Date of inspection: 27/01/2026

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
Registration Regulation 5: Application for registration or renewal of registration	Not Compliant

Outline how you are going to come into compliance with Registration Regulation 5: Application for registration or renewal of registration:

Reg 5(1)

- The Provider has updated the Application for renewal of the Centre's Registration to be submitted no later than the 27/03/26, to reflect the maximum number of residents who can be accommodated at the centre, and the maximum number who will be accommodated during the period of registration;
- The Provider will submit updated floor plans to accompany the updated application, to reflect:

o The removal of an unused toilet bowl, now converted to a storage area
o The two additional buildings and shed used by Residents but not previously captured on the floor plans;
o The office area in one room, now removed.
o The 'kitchen' space in Apartment 2 is now correctly reflected on floor plan as a storage area
o The second floor storage area of one house is now included in floor plans.

Reg 5(3)(g)

- The Provider has updated the Statement of Purpose on 13/03/2026 to reflect the maximum number of residents that can be accommodated at the centre;

Reg 5(3)(h)

- The Provider has updated the Statement of Purpose on 13/03/2026 to reflect the maximum number of residents who will be accommodated at the designated centre at any one time during the period of registration.

Regulation 15: Staffing	Substantially Compliant

Outline how you are going to come into compliance with Regulation 15: Staffing:
Reg 15(1)
- The PIC and Provider shall review and update, no later than 03/04/26, the centre's staffing contingency plan. This includes required measures to cover gaps, a dynamic risk assessment on the adequacy of arrangements, and required escalation to PIC.
- The Provider has a rolling recruitment plan in place to fill staffing vacancies
- The PIC will align the planned rota with the activity planner for each service user to make sure there is adequate staffing planned for residents' individual activities, by 13/03/2026. Where circumstances change on the rota, the PIC will ensure alternative suitable activities are organised.
Reg 15(4)
- The PIC has reviewed the local process for planned and actual rota creation on 09/03/2026. The PIC shall ensure a single version of each, and will continue to monitor to support full implementation by all staff.
- The person in charge has clearly identified agency and relief staff on the new rota system by having it clearly marked after their names.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
Reg 23(1(a) -The Provider has increased the Team leader resourcing in the Service on an interim basis from 02/02/2026 to facilitate effective delivery of care and support while a wider review of local management resourcing is undertaken;

Reg 23(1)(b)The Provider is reviewing the permanent local management structure of the centre to ensure adequate resourcing, clear guidance on lines of accountability, roles and responsibilities in line with the outcome of the review will be provided. Review to be completed by 30/03/2026

Reg 23(1)(c)
- The Provider has implemented revised meeting templates on 01/05/2026 for local meetings and departmental management meetings to ensure adequate records and reflection of timebound actions.
- The Provider is undertaking a review of quality monitoring processes to address gaps in

the identification of improvements found at inspection. Review will be completed by 01/05/26.
- The Provider will, as of 01/05/26, increase its frequency of quality monitoring to monthly support earlier identification of issues of quality and compliance.

Regulation 23(2)(a)
- The Provider has, on 12/03/26, reviewed its schedule of monitoring to ensure a suitable person is allocated to complete a quality monitoring visit at least every six months.
- The Provider will ensure a report with action plan is produced. Completion of the action plan will be further monitored through subsequent visits and the PIC's supervision.
- The Provider will review, no later than 01/05/26, the requirements for adequate completion of six-monthly reports and action plans with all those allocated the responsibility.

Regulation 23(3)(b)
- The Provider has reviewed its arrangements for staff to raise concerns about the quality and safety of the care and support provided.
o A recurring item has been added to template on 01/04/2026 agendas for team meetings, team leader meetings and supervisions to prompt the opportunity for any member of the team to raise concerns.
o The provider will, no later than 27/03/26, review its whistleblowing procedure and issue a communication to all workers on its use.
o An update to the standard team meeting, team leader meeting minutes template has been introduced to support more accurate recording of time bound, person allocated actions to address concerns.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
The Provider is undertaking a programme of refurbishment in partnership with the HSE funder:
- Reg 17(1)(a)
A complete refurbishment of what was a bathroom and is now a storage area for one resident will be completed by 30/06/26
- Reg 17(1)(b)
A programme of repairs to damaged walls and worn surfaces on floors has commenced with a planned completion of 30/06/2026.
- Reg 17(1)(c)
The PIC has reviewed and amended the cleaning schedule on 13/03/26 to enhance deep-cleaning tasks. The PIC has completed a check and cleaning programme of all areas of the centre to address issues identified at inspection. The PIC has removed the archive boxes containing resident records and archived these in a storage room in the

designated centre as of 31/02/2026.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions: Regulation 28(2)(a)
- The Provider commissioned a review of all fire doors from a competent person. All doors were as of the date of check, 19/02/26, in full working order. Daily fire checks are completed, including a check of adequate closure of fire doors. The PIC has commenced spot checks on adequate completion of fire checks. The PIC has on, 12/03/26, communicated with the team on the adequate completion of fire checks and the required corrective action for discovery of defects.
- Engaged an architect to update floor plans with correct fire escape routes. Updated plans will be in place no later that the 31/03/2026.

Reg 28(3)(a)
The PIC has:
- The door noted at inspection to not be a fire door will be fitted with a self close mechanism to make this door a full operating fire door to meet compliance.
This has been completed as of 13/03/2026
The PIC has, as of 13/03/26, checked all fire documents to ensure the correct telephone number for emergency services is stated.
Reg 28(4)(b)

- The PIC has reviewed with the team the correct method of completion of fire drills and clarified expectations on recording. This will be discussed further through team meetings to be completed during April 2026. This will include detail on the ratios of staff to residents and reflection of nighttime staffing.
- The PIC has reviewed all PEEPs, with updates to be completed by 31/03/2026.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights: Regulation 9(2)(b)

- The Provider will, no later than 30/04/26, review the allocation of staffing to ensure that adequate staffing and resources are in place to meet the choices and wishes of all residents.

- The PIC shall ensure that all residents activity plans are reviewed to reflect choices no later than 01/05/26.
- The PIC has reviewed the activity plan for the individual mentioned in the report to ensure that the individual is offered the opportunity to engage in activities of their choice, both inside and outside their home. The PIC shall ensure, no later than 01/04/26 that the person's goals are reviewed and updated to further promote a variety of activities and community access.
- Wifi for one resident has been installed on 10/03/2026.
- The PIC shall review, no later than 01/05/26, the restrictive practices identified at inspection that have an impact on others. The review will consider the impact on all individuals, their continued preference to live together and actions to minimise the impact. The PIC will review, no later 01/05/26, the positive behaviour support arrangements with the MDT for the individual whose behaviours impact others to ensure all possible support is in place to appropriately address behaviours.

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
Registration Regulation 5(1)	A person seeking to register a designated centre, including a person carrying on the business of a designated centre in accordance with section 69 of the Act, shall make an application for its registration to the chief inspector in the form determined by the chief inspector and shall include the information set out in Schedule 1.	Not Compliant	Orange	27/03/2026
Registration Regulation 5(3)(g)	In addition to the requirements set out in section 48(2) of the Act, an application for the registration or the renewal of registration of a designated centre shall be accompanied by a statement of the maximum number	Not Compliant	Orange	27/05/2026

	of residents the applicant considers can be accommodated at the designated centre.			
Registration Regulation 5(3)(h)	In addition to the requirements set out in section 48(2) of the Act, an application for the registration or the renewal of registration of a designated centre shall be accompanied by a statement of the maximum number of residents who will be accommodated at the designated centre at any one time during the period of registration, and for which the registered provider is requesting approval by the chief inspector in the application for the registration or the renewal of registration of the designated centre.	Not Compliant	Orange	27/03/2026
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	Substantially Compliant	Yellow	03/04/2026

	size and layout of the designated centre.			
Regulation 15(4)	The person in charge shall ensure that there is a planned and actual staff rota, showing staff on duty during the day and night and that it is properly maintained.	Substantially Compliant	Yellow	13/03/2026
Regulation 17(1)(a)	The registered provider shall ensure the premises of the designated centre are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.	Substantially Compliant	Yellow	30/06/2026
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Not Compliant	Orange	30/06/2026
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Substantially Compliant	Yellow	31/05/2026
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the	Not Compliant	Orange	02/02/2026

	effective delivery of care and support in accordance with the statement of purpose.			
Regulation 23(1)(b)	The registered provider shall ensure that there is a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.	Substantially Compliant	Yellow	30/03/2026
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	01/05/2026
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and	Substantially Compliant	Yellow	01/05/2026

	shall prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.			
Regulation 23(3)(b)	The registered provider shall ensure that effective arrangements are in place to facilitate staff to raise concerns about the quality and safety of the care and support provided to residents.	Substantially Compliant	Yellow	13/03/2026
Regulation 28(2)(a)	The registered provider shall take adequate precautions against the risk of fire in the designated centre, and, in that regard, provide suitable fire fighting equipment, building services, bedding and furnishings.	Not Compliant	Orange	31/03/2026
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	13/03/2026
Regulation 28(3)(c)	The registered provider shall make adequate	Substantially Compliant	Yellow	13/03/2026

	arrangements for calling the fire service.			
Regulation 28(4)(b)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Substantially Compliant	Yellow	30/04/2026
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	01/05/2026